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Strategic and Subversive: The Case of the Disappearing Diaphragm and Women's Information Practices

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Graduate Program in Library & Information Science
A thesis submitted in partial fulfillment of the requirements for the degree in Doctor of Philosophy
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Abstract

Birth control options for women have advanced significantly over the past century. Barrier methods such as diaphragms became readily available in the first half of the 20th century, while hormonal contraceptives such as the birth control pill have defined advances in the latter half. While the diaphragm is still contextualized in modern sexual health discourse as an accessible birth control option, women in North America, and across the globe, are finding it increasingly difficult to obtain. This is partly because the skill of fitting a diaphragm is disappearing in medical practice, and also due to pharmaceutical influence on medicine that promotes hormonal methods and IUDs (intrauterine devices) as being more efficacious and profitable. However, many women eschew hormonal and IUD options in favour of less invasive ones such as barrier methods like diaphragms or cervical caps. These women must navigate learning about the devices and where to obtain them, finding practitioners who will fit them, and learning about their own anatomy to properly use cervical barriers. Thus, numerous information practices are at work, in the contexts of information sharing, information-seeking, and embodied knowledge.

While feminist scholars suggest that women have historically, and presently continue to carve their own spaces in medicine to account for embodied knowledges and women's experiential approaches to health, these knowledges have nevertheless been marginalized and subjugated in favour of a masculinized medical expertise that prioritizes the scientific method. Thus, it is important to evaluate these women-centred epistemologies as conduits for information sharing and seeking behaviour, and to analyze the information strategies women undertake when the necessity of circumventing barriers put forth by mainstream medical practice emerges. Using a feminist qualitative methodology, data was collected from semi-structured interviews, as well as from four editions of the feminist health text *Our Bodies, Ourselves* spanning nearly four decades. To analyze the data, constant comparison and thematic analyses were utilized. By examining how subversive information seeking and sharing occur in contexts of marginalized health knowledges and investigating how women subvert boundaries to keep information flowing, this project helps illuminate how women who

choose diaphragms and cervical caps exchange information.

Keywords

Diaphragm; cervical barrier; contraceptives; birth control; information; authoritative knowledge; embodied knowledge; subversive information strategies; women's information practices

Summary for Lay Audience

Birth control options for women have advanced significantly over the past century. Barrier methods such as diaphragms became readily available in the first half of the 20th century, while hormonal contraceptives such as the birth control pill have defined advances in the latter half. While the diaphragm is still contextualized in modern sexual health sources as an accessible birth control option, women in North America, and elsewhere, are finding it increasingly difficult to obtain. This is partly because the skill of fitting a diaphragm is disappearing in medical practice, and also due to pharmaceutical influence on medicine that tends to promote hormonal methods and IUDs (intrauterine devices). However, many women prefer less invasive forms of birth control such as barrier methods like diaphragms or cervical caps. These women must navigate learning about the devices and where to obtain them, finding practitioners who will fit them, and learning about their own anatomy to properly use cervical barriers. Thus, numerous information practices are at work, in the contexts of information sharing, information-seeking, and embodied knowledge.

While feminist scholars suggest that women have historically, and presently continue to carve their own spaces in medicine to account for embodied knowledges and women's experiential approaches to health, these knowledges have nevertheless been marginalized and repressed in favour of a masculinized medical expertise that prioritizes the scientific method. Thus, it is important to evaluate these women-centred knowledges as means of information sharing and seeking behaviour, and to analyze the information strategies women undertake when the necessity of circumventing barriers put forth by mainstream medical practice emerges. Using a feminist qualitative methodology, data was collected from semi-structured interviews, as well as from four editions of the feminist health text *Our Bodies, Ourselves* spanning nearly four decades. To analyze the data, constant comparison and thematic analyses were utilized. By examining how subversive information seeking and sharing occur in contexts of marginalized health knowledges and investigating how women subvert boundaries to keep information flowing, this project helps illuminate how women who choose diaphragms and cervical caps exchange information.

Acknowledgments

I would like to extend thanks to the participants in this project who so generously contributed to the work presented in this dissertation by sharing their stories and experiences with me. Without their ethos of sharing, this project would not be possible.

Profound gratitude goes to my wonderful supervisor, Pam McKenzie. I thank Pam immensely, not only for her amazing academic support, but also for giving me so many opportunities and for continuing to believe in me when I struggled to believe in myself.

Special mention goes to my partner Filip Stasiak, whose encouragement and support helped me to stay motivated to complete this journey. Similarly, I could not have done this without the support of my wonderful friends – Patti Luedecke, Morgan Brittan van Wyk, Michael Aloisio, and Rachel Melis – their positive words meant so much to me at times when optimism seemed out of reach.

Finally, but by no means least, thanks go to my parents Donna and Art Williams for relentless words of support and morale-boosting, as well as financial assistance. I dedicate this thesis to them.

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1 Introduction

Information access is often lauded in LIS as integral to a democratic society. Informational barriers are viewed as obstructive and problematic within information behavior research, whereas readily available, easily accessible information is the gold standard that librarians and other information providers are encouraged to strive for.¹ Marginalized groups often have difficulties in accessing information, and systematic and institutional barriers exist despite the best efforts of information purveyors and researchers to facilitate an equal informational playing field.

This dissertation focuses on ways in which certain types of birth control information are marginalized and how this marginalization can effectually create barriers for the women who seek it. Further, this research embraces a feminist perspective that asserts that women, as a marginalized social group, often encounter institutional deprecation of their own unique knowledges in favor of dominant masculinized (authoritative) ones. This project rejects an approach that solely emphasizes the harmful effects of the marginalization of both women's knowledges and the information necessary for women's reproductive autonomy. Rather, it evaluates ways in which women actively circumvent these informational challenges, subverting dominant authoritative knowledges and carving out niches wherein embodied knowledges are communicated in women-centered communities and networks of sharing.

¹ Michael Harris and Stan Hannah, *Into the Future: The Foundations of Library and Information Science in the Post Industrial Era* (Norwood: Ablex, 1993), 34.

1.1 Overview

LIS research has tended to treat informational barriers as an issue for information seekers that can be remedied by information providers.² This project seeks to contribute to LIS research on how information users and seekers mitigate the failure of institutions' information provision by circumventing and subverting mainstream information sources. Using cervical barrier contraceptive methods as a case study, I evaluate the shortcomings of birth control information providers (medical practitioners and non-profit organizations among other sources) and how women seeking information about these forms of contraception actively circumvent misinformation, and frequently, a total lack of information. This circumvention is frequently achieved by turning to informal women-centered communities that collaboratively share the knowledge about cervical barrier methods that is increasingly being marginalized by mainstream medical practice. Practical information about efficacy and availability is frequently shared in these communities, but more pertinent to this project is the embodied knowledge that cervical barrier users must possess in order to properly employ this method (knowledge of one's own anatomy and what "feels right" in terms of proper insertion and use). This seemingly rudimentary self-knowledge of the body conflicts with mainstream information provision that heavily stresses expert or authoritative knowledge in the context of health, and more specifically, birth control.

For many forms of birth control, women are encouraged to visit their doctor or other medical practitioners to obtain information and often require prescriptions for their

² Roma M. Harris and Patricia Dewdney, *Barriers to Information: How Formal Help Systems Fail Battered Women* (Westport, CT: Greenwood Press, 1994).

contraceptives. Thus, reliance on experts for one's own reproductive autonomy is the norm. Despite the fact that contraceptive methods dependent on women's knowledge of their own bodies and menstrual cycles exist and cost next-to-nothing (sympto-thermal methods and various other approaches based on timing within the menstrual cycle), women in western nations are increasingly encouraged to use hormonal methods that require a prescription and frequent visits to a medical practitioner rather than their own embodied knowledge. This sends a strong message that women, despite living within and commanding their own bodies, are unable to effectively maintain their own reproductive capacities and therefore must rely on "authorities" to tell them about their own bodily systems and functions. This has been the norm for centuries³ and is an accepted protocol for obtaining contraceptive information. But what happens when birth control information is inaccurate, heavily biased or totally unavailable? What recourse do women have then?

1.2 Context

On December 7, 1995, an episode of *Seinfeld* entitled "The Sponge"⁴ first aired. The plot centered around the character Elaine's discovery that her preferred contraceptive, the Today Sponge, was being withdrawn from the market. Elaine, in addition to a few other minor characters, was distraught to hear this news and began a quest to seek out pharmacies that still had the product on shelves and buy out the remaining stocks. Threatened by the fact that her choice birth control option was being rendered obsolete, she felt obligated to scrutinize her sexual partners more thoroughly, only becoming intimate with men deemed

³ Barbara Ehrenreich and Deirdre English, *For Her Own Good: Two Centuries of the Experts' Advice to Women* (New York: Anchor Books, 2005).

⁴ Peter Melhman, "The Sponge," *Seinfeld*, directed by Andy Ackerman (December 7, 1995 Ep. No. 709 Shapiro/West Productions, Castle Rock Entertainment).

“sponge-worthy.” Elaine was thrust into a difficult informational landscape in which she had difficulty locating what she needed. While the characters and their struggles were fictitious, and depicted in a slapstick and over-the-top narrative, the scenario was real. The Today Sponge has disappeared from the market twice now in recent history, once in 1994 until 2003, and again in 2007 until 2009. Fortunately for women who choose contraceptive sponges for birth control, the sponge is presently available at most drugstores in the US and Canada.

For women who choose the diaphragm, however, obtaining their preferred method of birth control is becoming increasingly complex. These women must navigate a rough informational terrain that gives them mixed messages about their already marginalized choice of contraception, circumvent boundaries put in place by the modern pharmaceutical marketplace, and seek out practitioners that possess the dying skill set of fitting diaphragms. Due to the varying sizes of female pelvises and cervixes, diaphragms are available in a number of different size increments and must be fitted accurately for efficacy. While once a common practice among medical professionals, the skill set necessary to fit diaphragms is becoming increasingly obsolete. And while the Today Sponge was fortunate enough to have the pop-culture powerhouse *Seinfeld* on its side, sharing its story, the diaphragm’s disappearance is sliding under the radar. This has serious implications for women who reject or simply cannot tolerate hormonal contraceptives such as the pill, ring, hormonal IUD, implant, or patch, and who prefer a woman-controlled contraceptive method rather than condoms, which are dependent on men for use and effectiveness. This has serious implications for women such as myself.

This dissertation originated from personal experience when I decided to cease hormonal contraceptives in favor of less invasive ones, only to find an abundance of misinformation, marginalization, and authoritative knowledge at play. My own difficulty in obtaining a diaphragm was the impetus for writing this dissertation. However, my experiences are not entirely unique. Via this research, I hope to tell a story that is largely being ignored by the medical establishment. This a story of women sharing information with each other. This is a story of resistance, subversion, embodied knowledge, and community.

1.3 Background

Birth control options for women have advanced significantly over the past century. Barrier methods that work by blocking the cervix have been used for thousands of years,⁵ but it wasn't until Charles Goodyear patented the rubber vulcanization process in 1844 that their current design came into development and use. In the 1880s, a German gynecologist named C. Haase published the first description of a rubber contraceptive device with a spring molded into the rim. Haase wrote under the pseudonym Wilhelm P.J. Mensinga, and the Mensinga diaphragm was the sole available brand for many decades. In the United States, Dr. Edward Bliss Foote developed and sold an occlusive pessary and called it a "womb veil" starting in the 1860s. Comstock laws, which prohibited sending information about contraception or actual contraceptive devices through the mail, made it difficult to dispense diaphragms to women. However, the activist work of Margaret Sanger helped

⁵ Planned Parenthood Federation of America, "A History of Birth Control Methods," (NY, New York: Katharine Dexter McCormick Library 2006), http://www.plannedparenthood.org/files/PPFA/history_bc_methods.pdf.

overturn these laws to allow women more reproductive freedom, and the diaphragm became readily available in North America.

The diaphragm is a dome-shaped device, traditionally made of rubber or latex, and more recently, silicone, that is inserted into the vagina and held in place over the cervix by a woman's vaginal muscles and pubic notch. Various types made by various companies have existed throughout the twentieth century; however, Deborah Narrigan notes that, "Since 1925, when Margaret Sanger's spouse started a company in the United States to manufacture diaphragms, little has changed in their design."⁶ At present, three models are available: the arcing spring, coil spring, and wide-seal diaphragm. Depending on brand and region, these are made varying of rubber or silicone. Arcing spring diaphragms have a sturdy and firm rim that exerts pressure evenly and folds into an arc shape regardless of where it is compressed, facilitating insertion. It is appropriate for most women. The coil spring rim is less rigid and is intended for women with average vaginal muscle tone. The wide seal diaphragm is available with either the arcing or coil spring rim, and has a flexible skirt extending inward from the rim, which is supposed to decrease dislodgement or displacement.⁷

Similar to the diaphragm is the cervical cap, which generally covers less surface area inside the vagina, but is deeper and comes in significantly fewer size options. Currently, the Milex Wide-Seal diaphragms in both arching and omniflex springs are available in the US,⁸ with the Ortho All-Flex arcing diaphragm discontinued in 2014, and

⁶ Deborah Narrigan, "Women's Barrier Contraceptive Methods: Poised for Change," *Journal of Midwifery & Women's Health* 51, no. 6 (2006): 478.

⁷ *Ibid.*, 478.

⁸ "Diaphragms," Cervical Barrier Advancement Society, accessed June 27, 2019, <http://www.cervicalbarriers.org/products/diaphragms.cfm>

the Milex arcing is available in Canada, on special order. The FemCap is the only cervical cap still in production in North America and is available online or at specialty health stores/practitioners in both Canada and the US.⁹ The Caya diaphragm, a one-size fits most diaphragm was introduced in Europe in 2013 and is available via online orders or some smaller clinics in Canada and the US.

Cervical barrier methods are generally safe, relatively affordable, have few side-effects, and are women-controlled. When used correctly and consistently, they are about 80% effective in preventing pregnancy.¹⁰ However, over the past 40 years, the use of cervical barrier methods has steadily decreased. According to Nager,

Among all women in the United States using a contraceptive method, the percentage using the diaphragm fell from 8.1% in 1982 to 0.3% in 2002. The percentage of women who report currently using the cervical cap, sponge, or female condom has always been very small, but it also dropped from a total of 1.3% to 0.9% over the same two decades.¹¹

Current statistics on the use of cervical barriers are not available, but the numbers are likely lower than they were in 2002. This is due to medical practitioners emphasizing hormonal contraceptives to new users of birth control as the most efficacious in pregnancy prevention, as well as a general lack of availability of these methods.

Despite its marginal use and availability, the diaphragm is still contextualized in modern sexual health discourse as a viable and accessible birth control option. A general internet search for the diaphragm garners a number of results that suggest the diaphragm is still readily available for purchase, or that practitioners are able to fit diaphragms. In

⁹“About FemCap,” FemCap. Accessed June 27, 2019, <https://FemCap.com/about-the-FemCap/>.

¹⁰ Narrigan, 478.

¹¹ Ibid.

Canada, sexual health websites are generally more cautious, warning women that diaphragms are difficult to find and that the spermicidal jelly that should be used with them is not available in Canada. The internet resource from Planned Parenthood Toronto “TeenHealthSource.com,” warns that, “Spermicidal jelly is not currently sold in Canada. You will need to order it from an online pharmacy or travel to the US to buy it,” and that, “It can be difficult to find a clinician who is trained to fit diaphragms. It can also be difficult to find a pharmacy that carries or can order diaphragms.”¹² However, HassleFreeClinic.org, also based in Toronto, suggests that women can “buy a diaphragm and spermicidal jelly or cream at any drug store or birth control clinic.”¹³ This is just one example of the mixed messages that women in Canada are getting regarding the availability and ease of access to diaphragms. The Halifax Sexual Health Centre’s website articulates specifically that the only diaphragm available in Halifax is the Milex Wide-Seal Omniflex Style of the diaphragm, and that while it must be used with spermicide, that spermicide is no longer available in Canada.”¹⁴

The information available to women in Canada and elsewhere about diaphragms is often inaccurate or out-of-date. Women in North America, and across the globe, are finding the diaphragm more and more difficult to obtain. This is partly because the skill of fitting a diaphragm is disappearing in medical practice,¹⁵ and also due to pharmaceutical influence

¹² “Diaphragm,” Teen Health Source, accessed May 23, 2019, <http://teenhealthsource.com/birthcontrol/diaphragm-details/>.

¹³ “Women’s Birth Control Methods,” Hassle Free Clinic, accessed May 23, 2019, <http://hasslefreeclinic.org/home/women-trans-clinic/womens-birth-control-methods/#1401907255-1-95>.

¹⁴ “Diaphragm,” Halifax Sexual Health Centre, accessed May 23, 2019, <http://hshc.ca/diaphragm/>.

¹⁵ Andrzej Kulczycki et al, “Barriers to Diaphragm Use: The Views of Advanced Practice Nurses,” *Journal of Family Planning and Reproductive Health Care* 36 (2010):79-82; Robert S. Wigton and Patrick Alguire, “The Declining Number and Variety of Procedures Done by General Internists: A Resurvey of Members of the American College of Physicians,” *Annals of Internal Medicine* 146 no. 5(2007):355–360.

on medicine that pushes for hormonal methods as the gold star for efficacy (and profitability). However, many women eschew hormonal options in favor of less invasive ones such as barrier methods like the diaphragm or cervical cap. These women must subsequently navigate the territory of learning about the devices and where to obtain them, finding practitioners who will fit them, and also learning about their own anatomy to properly use this form of birth control. Thus, numerous information practices are at work, in the context of information sharing, authoritative knowledge, and embodied knowledge.

1.4 Outline

This project draws on historical data comprised of nearly four decades worth of *Our Bodies, Ourselves* women's health reference books as well as interview data with participants who have used, currently use or are considering using cervical barrier methods. This chapter has offered readers a basic introduction to the current landscape of cervical barrier methods and scratches the surface on some implications for those interested in using them as a form of contraception. Chapter 2 is a framework and literature chapter, which presents the guiding research questions for this study as well the scholarly research undergirding it. Chapter 3 describes the methods and methodology employed in the study, describing how data was collected and analyzed for this project. Chapter 4 offers a historical account of cervical barrier methods, including their origins, commercialization and how they came to be, at one time, the most popular form of contraception in North America.

The next three chapters (5,6, and 7)) comprise the crux of this study, wherein the case study data and interviews with participants are evaluated for thematic relevance. Chapter 5 draws on four editions of *Our Bodies, Ourselves* to evaluate how a feminist health reference text represents cervical barrier methods over time (1973 to 2011) and attempts to locate particular shifts in thinking about cervical barriers that might have led to its present-day marginalization. Chapter 6 presents the general trajectory typically encountered by those seeking cervical barriers and also introduces each participant in this study, explaining why they came to be interested in these birth control methods. Chapter 7 offers more detailed accounts of participants' experiences and identifies how these experiences may relate to themes of information seeking, authoritative knowledge, embodied knowledge, and acts of resistance and subversion. Finally, Chapter 8 provides concluding remarks, indicating the implications of this project and suggesting how LIS research and practice may benefit from the findings of this work.

2 Framework and Literature Review

2.1 Introduction

This study examines how women interested in using diaphragms as a method of birth control subvert the boundaries set forth by traditional medicine by seeking information about diaphragms, collaboratively sharing information with one another online in women-centered communities and networks, and ultimately, embodying the knowledge that allows them to successfully use diaphragms for pregnancy prevention.

Admittedly, the premise of this project derives from my own experiences in exploring and ultimately obtaining a diaphragm for contraception. After taking oral contraceptives for over a decade, I decided to seek out information about alternative birth control methods and found a climate of misinformation or totally non-existent information. Further, the skill of fitting a diaphragm (choosing the appropriate size based on a woman's specific pelvic anatomy) is becoming increasingly obsolete within Canadian medical practice, which meant that for me, "expert" authoritative knowledge on the topic was difficult to obtain. I ultimately took to online searches and discovered various women-centered communities that serve as conduits for the sharing of experiences and knowledge about cervical barrier methods, and it was this discovery of what I consider to be somewhat subversive informational practices¹⁶ that inspired me to investigate these issues further.

This study, thus, derives from both personal experience and my attraction to women's subversive information strategies. My own difficulties in obtaining a diaphragm greatly inform the approach that I utilize in analyzing this problem, but it is the efforts of

¹⁶ I utilize a third-wave feminist definition of subversion, which views a subversive act as any attempt to transform the established social order and its structures of power, authority, and patriarchy.

a sisterhood of women that refuse to allow the medical industry to dictate what birth control methods they can and cannot use, and the communicative strategies via sharing and active resistance, that forms the bulk of this project. Concerned with issues of women's knowledges and embodied knowing, the concerted subjugation of women-centered approaches to medicine and healing in favor of patriarchal, science-based medical expertise, and the ways in which women-centered communicative strategies of information sharing not only continue to persist, but also to thrive, this study addresses the following set of questions:

- (1) How have women's knowledges (embodied and otherwise) been subjugated and repressed by a climate of patriarchal, science-dominated medicine? Are women actively circumventing the idea of authoritative knowledge in favor of women-centered communities of information sharing, and if so, how?
- (2) How do women interested in the diaphragm as a contraceptive method gain knowledge about their methods, and how do communities of women work collaboratively to facilitate the sharing of knowledge about this form of contraception?
- (3) Does the marginalization of women's knowledge facilitate strategies that women undertake to challenge the boundaries to accessing this information, and if so, do these strategies constitute acts of subversion?

These questions are addressed utilizing the diaphragm as a case study of women's embodied knowledge being marginalized to support the widespread adoption of more "efficacious" contraceptive methods like hormonal birth control. An interdisciplinary approach using literature from a variety of sources informs this study, drawing from work in LIS on information behavior, authoritative knowledge, and from feminist evaluations of medical practice, embodied knowledge, and women's ways of knowing. Further, literature

on gender essentialism will be touched upon, as one of this study's participants identifies as gender non-binary and it is important to address the implications of this rejection of gender binaries.

This study addresses gaps in LIS work related to information sharing in the wake of knowledge marginalization and contributes new approaches to evaluating how information exchanges can lead to empowerment. Further, investigating how communities of women challenge the shortcomings of authoritative birth control information sources by sharing more traditional and embodied women's knowledges via discreet collaborative communities has broader implications for LIS research in the realm of rectifying information barriers in addition to subversive information strategies of marginalized seekers and users.

2.2 Information Behavior

Information behavior research in LIS has undergone a shift in focus, moving from an emphasis on systems to an emphasis on users.¹⁷ In his review of the history of information needs, Wilson notes that in earlier work on user studies, more focus had been given to how people used information sources and services rather than to other areas of study such as information exchange, or use and transfer. However, Wilson suggests that this is beginning to change in LIS.¹⁸

¹⁷ Brenda Dervin and M. Nilan, "Information Needs and Uses," *Annual Review of Information Science and Technology* 21 (1986): 3–33.

¹⁸ Tom D. Wilson, "Information Needs and Uses: Fifty Years of Progress," in *Fifty Years of Information Progress: a Journal of Documentation Review* ed. B.C. Vickery (London: Aslib, 1994): 15-51, [Available at <http://informationr.net/tdw/publ/papers/1994FiftyYears.html>].

In her article on sense-making theory, Dervin criticized LIS research on information behavior, suggesting it has been too focused on the observers of systems and not focused enough on the systems' users. Dervin suggests a sense-making model to integrate the user's experiences within a system and to make sense of the information behavior enacted therein. She conceives of users experiencing gaps within certain information situations, and is concerned with the ways in which the user interprets and bridges the gap: "what strategy he or she used to define the situation which was the gap; how he or she conceptualized the discontinuity as gap and the bridge across it; how he or she moved tactically to bridge the gap; how he or she proceeded with the journey after crossing the bridge."¹⁹ Dervin's model is oft-cited and marks a pivotal moment in which LIS research starts to focus more on how users interact with information and less on how information systems are used.

Ross criticizes the literature in information behavior for its narrow focus on workplace settings and formal queries. She states that in order to be considered as an information-seeker in the majority of information-seeking research, "individuals must experience a 'problem situation' and then formally initiate a search process by querying one of our systems."²⁰ Research on information seeking has typically "constructed the searcher as a person in a state of uncertainty who queries an information system hoping to get answers that help with a specific goal/task/or problem."²¹

¹⁹ Brenda Dervin, "From the Mind's Eye of the User: The Sense-Making Qualitative-Quantitative Methodology," *Qualitative Research in Information Management* 6 (1992): 68-69.

²⁰ Catherine Sheldrick Ross, "Finding Without Seeking: The Information Encounter in the Context of Reading for Pleasure," *Information Processing and Management* 35, no. 6 (1999): 784.

²¹ *Ibid.*, 783.

Ross advocates a move into issues of pleasure and unstructured contexts, such as incidental encounters. She acknowledges that some studies have begun to escape this tunnel-vision in information behavior research, and highlights community or citizen information or information related to everyday life, where the research participants are often marginalized or disadvantaged.²² Ross cites the work of Elfreda Chatman as being representative of this different approach, but articulates that this type of research often “tries to explain or understand why nonusers of services are indeed nonusers, i.e. why they *don't* ask questions even though it is assumed they have problem situations.”²³ Such research often emphasizes barriers to information, and according to Ross, means active information seeking is difficult due to the marginalization that those being studied are experiencing.

Ross explains that information seeking research often has the goal of improving systems designs, but that there are fruitful and often unstudied areas of research outside of structured queries. Her own work demonstrates how readers (for pleasure) can encounter information without actually seeking it. Further criticizing the problematic nature of existing information seeking research, Ross states that any model of information seeking that “emphasizes *matching* of terms rather than the reader’s *making* of meaning is inadequate.”²⁴

Extending Chatman’s research approach of observing people in their everyday settings, Savolainen²⁵ has developed and popularized a model of everyday life information

²² Ibid.

²³ Ibid.

²⁴ Ibid., 796.

²⁵ Reijo Savolainen, “Everyday Life Information Seeking: Approaching Information Seeking in the Context of ‘Way of Life’.” *Library & Information Science Research* 17, no. 3 (1995): 259-294.

seeking (ELIS), which is now a flourishing field of inquiry in LIS work. Savolainen defines ELIS as “the acquisition of various informational (both cognitive and expressive) elements which people employ to orient themselves in daily life or to solve problems not directly associated with the performance of occupational tasks.”²⁶ Savolainen suggests that ELIS habits and attitudes allow people to use their personal values and beliefs to make meaningful life choices. He describes the development of the model as being “primarily motivated by the need to elaborate the role of social and cultural factors that affect people’s way of preferring and using information sources in everyday settings.”²⁷ He introduces the concepts of way of life and mastery of life for understanding the role of information seeking in individuals’ daily problem-solving activities. Although Savolainen emphasized information seeking in non-work contexts, he did not exclude work-related information seeking from the study of ELIS, suggesting that that everyday life and work are sometimes inseparable or overlapping: “The introduction of the concept of ELIS should not be interpreted as an attempt to create a false dichotomy between processes of job-related and ‘other’ information seeking because job-related information seeking and ELIS complement each other.”²⁸ Savolainen is often credited with taking LIS research into a more social constructionist direction as opposed to the more systems-based research or cognitive approaches to user studies that defined it previously. Ocepek argues that information behavior researchers should integrate a wholistic approach to everyday life information practices into research praxis as it “will address the totality of the everyday

²⁶ Ibid., 266-267.

²⁷ Reijo Savolainen, “Everyday Life Information Seeking,” in *Theories of Information Behavior* eds. Karen E. Fisher, Sanda Erdelez, and Lynne McKechnie (Medford: Information Today, 2005), 143.

²⁸ Savolainen 1995, 266.

world, leading to a more complete understanding of how individuals actually use information in all aspects of their lives.”²⁹

In their article on social constructionist metatheory in LIS, Tuominen, Talja, and Savolainen contrast a cognitive research approach (“the information transfer model”) with a constructionist approach. They note that while the information transfer model tends to conceptualize information as a “granular, uniform, and self-sufficient kind of entity, a nugget of informing content that can be mined from texts and classified with great precision for retrieval,”³⁰ constructionism “stresses the dialogic and contextual nature of knowledge production and the dialogic and contextual nature of users, information needs, and relevance criteria.”³¹ They argue further,

Constructionism speaks about discourses, articulations, and vocabularies, and replaces the concept of cognition with *conversations*. Constructionism differs from sociocognitive and constructivist theories in that it is a dialogic theory about the conversational constitution of knowledge, as opposed to monologic theories that place the formation of knowledge inside individual minds.³²

Thus, it would seem that these authors are attempting to distance themselves from research paradigms that emphasize the study of information behavior as context-free and dependent on the success or failure of a system, or cognitive prowess or ineptitude within a system. More explicitly, they assert that there “are no outside criteria or a God’s eye view that we

²⁹ Melissa G. Ocepek, "Bringing Out the Everyday in Everyday Information Behavior," *Journal of Documentation* 74, no. 2 (2018): 409.

³⁰ Bernd Frohmann, as cited in K. Tuominen, Talja S., and R. Salvolainen, “Discourse, Cognition, and Reality: Toward a Social Constructivist Metatheory for Library and Information Science,” in *Emerging frameworks and methods: CoLIS 4. Proceedings of the Fourth International Conference on Conceptions of Library and Information Science, Seattle, WA, USA, July 21-25, 2002*, eds. H. Bruce, R. Fidel, P. Ingerwersen, and P. Vakkari, 271-283. (Greenwood Village, CO: Libraries Unlimited, 2002), 274.

³¹ K. Tuominen, Talja S., and R. Salvolainen, 277.

³² *Ibid.*, 273.

could utilize to assess the truth value of different knowledge claims, because the criteria and standards we use are also constructed in conversation...The basic assumption of constructionism is that knowledge is always positioned: we do not know about reality, we know in reality."³³ In this sense, they are arguing for situated knowledges in LIS research, and their suggestion of a constructionist metatheory as opposed to a cognitive or constructivist approach makes sense in the context of information behavior research.

Savolainen notes that the ELIS model "provides a holistic framework for social and psychological factors affecting people's source preferences in everyday life contexts."³⁴ His work has been highly influential in the field, and his concept of ELIS paired with a constructionist research paradigm offers many fruitful pathways for research on information behavior outside of structured settings and through socially constituted language and discourse.

The recent turn in LIS research to social practice approaches shifts the analytic focus from the behavior of autonomous individuals to the ways that information is constituted and shared within knowledge communities.³⁵ A social practice perspective challenges many traditional approaches that still prevail in much information seeking research. First, although there are exceptions,³⁶ LIS studies still primarily emphasize

³³ Ibid., 278.

³⁴ Savolainen 2005, 147.

³⁵ Sanna Talja and Preben Hansen, "Information Sharing," in *New Directions in Human Information Behavior*, eds Amanda Spink, and Charles Cole, 113-34 (Dordrecht: Springer, 2006); Sanna Talja and Pamela J. McKenzie, "Editors' Introduction: Special Issue on Discursive Approaches to Information Seeking in Context," *Library Quarterly* 77, no. 2 (2007): 97-108; Reijo Savolainen, "Information Behavior and Information Practice: Reviewing the 'Umbrella Concepts' of Information Seeking Studies," *Library Quarterly* 77, no. 2, 109-132; Reijo Savolainen, *Everyday Information Practices: a Social Phenomenological Perspective* (Lanham, MD: Scarecrow Press, 2008).

³⁶ See for example Sanda Erdelez, "Information Encountering: a Conceptual Framework for Accidental Information Discovery," *Information Seeking in Context: Proceedings of an International Conference on Research in Information Needs, Seeking, and Use in Different Contexts, 14-16 August, 1996, Tampere,*

active forms of information seeking, searching, and retrieval. These studies see the seeker as an autonomous actor, simultaneously enlightened and ignorant, at a deficit because of “information needs.”³⁷ Second, studies tend to be theorized and evaluated in positivist terms, focusing on instrumental tasks and cognitive behavior. Third, and not surprisingly given the instrumental focus, most studies consider workplace settings, and the literature broadly dichotomizes workplace and everyday life contexts.³⁸ Finally, although there is much attention to librarianship as a gendered profession,³⁹ gender is primarily treated as a stable construct that is analyzed as a differentiating variable.⁴⁰ Gendered contexts and practices have received little attention.⁴¹ A social practices approach offers many ways to challenge traditional thinking about information seeking and opens many new directions

Finland; Pertti Vakkari, Reijo Savolainen, and Brenda Dervin, 412-20 (London: Taylor Graham, 1997); Tom D. Wilson, "Information Behaviour: An Inter-Disciplinary Perspective," *Information Seeking in Context: Proceedings of an International Conference on Research in Information Needs, Seeking and Use in Different Contexts*, eds. Pertti Vakkari, Reijo Savolainen, and Brenda Dervin, 39-50 (London: Taylor Graham, 1997); Kirsty Williamson, "The Information Needs and Information-Seeking Behaviour of Older Adults: an Australian Study," *Information Seeking in Context: Proceedings of an International Conference on Research in Information Needs, Seeking and Use in Different Contexts, 14-16 August, 1996, Tampere, Finland*, eds. Pertti Vakkari, Reijo Savolainen, and Brenda Dervin, 337-50 (London: Taylor Graham, 1997); Pamela J. McKenzie, "Model of information practices in accounts of everyday-life information seeking," *Journal of Documentation* 59, no. 1 (2003), 19-40.

³⁷ Bernd Frohmann, "The Power of Images: a Discourse Analysis of the Cognitive Viewpoint," *Journal of Documentation* 48, no. 4 (1992): 365-86; Kimmo Tuominen, "User-Centered Discourse: An Analysis of the Subject Positions of the User and the Librarian," *Library Quarterly* 67, no. 4 (October) (1997): 350-71; Katriina Byström, "Information Seekers in Context: an Analysis of the 'Doer' in INSU Studies," *Exploring the Contexts of Information Behaviour: Proceedings of the Second International Conference on Research in Information Needs, Seeking and Use in Different Contexts* Tom D. Wilson, and David K. Allen, 82-95 (London: Taylor Graham, 1999).

³⁸ Savolainen, 1995.

³⁹ See for example Roma M. Harris, *Librarianship: The Erosion of a Woman's Profession* (Norwood, NJ: Ablex, 1992).

⁴⁰ See for example Maureen Hupfer and Brian Detlor, "Gender and Web Information Seeking: A Self-Concept Orientation Model," *Journal of the American Society for Information Science and Technology*, 57 no. 8 (June 2006), 1105-15.

⁴¹ For exceptions see Paulette M. Rothbauer, "Finding and Creating Possibility: Reading in the Lives of Lesbian, Bisexual and Queer Young Women," The University of Western Ontario, 2004; Christine Urquhart and Alison Yeoman, "Information Behaviour of Women: Theoretical Perspectives on Gender," *Journal of Documentation* 66, no. 1 (2010): 113-39.

for inquiry in evaluating subversive information sharing within women's communication networks.

This study utilizes a social practices perspective, embracing information sharing within specific communities, rather than individualized needs and uses. I therefore look at information seeking and sharing as collaborative practices. Collaborative information behavior (CIB) has been defined as document- or human-based activities "where two or more actors communicate to identify information for accomplishing a task or solving a problem."⁴² Foster's review of the literature⁴³ demonstrates that, like the early information-seeking literature, much of the research on collaborative information seeking exhibits a focus on the workplace, on deliberate searching to meet instrumental goals, and on experimental research methods.

Talja and Hansen, however, propose that processes of CIB are embedded in dimensions of social practices, "instances and dimensions of our participation in the social world in diverse roles, and in diverse 'communities of sharing.' Retrieving, interpreting, and indexing information -- giving names to pieces of information for the purposes of retrieval and re-use -- are part of the routine accomplishment of work tasks and everyday life."⁴⁴ They propose a social practices approach that takes up calls⁴⁵ to understand information users "in the context of their work or social life."⁴⁶

⁴² Talja and Hansen 2006, 114.

⁴³ Jonathan Foster, "Collaborative Information Seeking and Retrieval." *Annual Review of Information Science and Technology*. ed. Blaise Cronin, vol. 40. (Medford, NJ: Information Today, 2006), 329-56.

⁴⁴ Talja and Hansen 2006, 125

⁴⁵ See for example Elisabeth Davenport and Blaise Cronin, "Texts at Work: Some Thoughts on 'Just for You' Service in the Context of Domain Expertise," *Journal of Education for Library and Information Science* 39, no. 4 (1998): 264-74.

⁴⁶ Tom D. Wilson, "On User Studies and Information Needs." *Journal of Documentation* 37, no. 1 (1981): 12.

Talja and Hansen distinguish collaborative information seeking and retrieval, which involves a cooperative search for information, from information sharing, which involves both active and explicit as well as less goal-oriented and implicit exchanges of already acquired information.⁴⁷ Talja characterizes information sharing as “an umbrella concept that covers a wide range of collaboration behaviours, from sharing accidentally encountered information to collaborative query formulation and retrieval.”⁴⁸ Savolainen observes that, although few scholars have taken up the study of information sharing, this endeavor is important “since it sheds light upon the communicative aspects of everyday information practices”; information sharing explicitly attends to the social nature and context of information seeking.⁴⁹

Talja takes a social practices approach to the study of information sharing among scholars from diverse academic disciplines. She identifies contextual characteristics of the scholars’ social groups rather than characteristics of individual members to show how these contexts shaped and were in turn shaped by information sharing. Talja’s work is significant both for its approach and for its identification of several interconnected forms of information sharing. Strategic sharing consciously strives to meet instrumental goals such as maximizing efficiency in a research group, paradigmatic sharing enables cross-disciplinary communication, directive sharing functions bi-directionally between junior and senior scholars, and social sharing contributes directly to relationship- and community-

⁴⁷ Talja and Hansen 2006, 115

⁴⁸ Sanna Talja, “Information Sharing in Academic Communities: Types and Levels of Collaboration in Information Seeking and Use,” *New Review of Information Behaviour Research* 3 (2002): 145.

⁴⁹ Reijo Savolainen, *Everyday Information Practices: A Social Phenomenological Perspective* (Lanham, Md.: Scarecrow Press, 2008), 183.

building activity.⁵⁰ Although Talja's study offers a fresh approach, it is typical of the small number of information sharing studies in its focus on settings such as academic contexts or computer-mediated settings⁵¹ where participants share instrumental and organizational goals. There has been little study of information sharing in everyday life where it may fulfil more personal goals such as the nurturing and development of social circles and networks, catharsis, healing, and creative self-expression. A small number of LIS scholars explicitly or implicitly address information sharing in everyday life.

Savolainen explores the information sharing of unemployed people and environmental activists through the framework of social capital, and seeks to answer questions about motivational factors for information sharing.⁵² His empirical findings "support the view that, like social capital in general, information giving draws on networks, norms, trust, and mutual understanding that bind together the members of human networks."⁵³ Additionally, he identifies three major motives for information sharing: serendipitous altruism, pursuit of the ends of seeking information by proxy, and duty-driven needs characteristic of people elected to positions of trust.⁵⁴ Savolainen's findings seem to mesh well with the broader literature of information behavior, namely with respect to motivations (needs, uses, and gratifications). Information is treated as an informing entity with the capacity to build up useful knowledge stores. For the participants in his study, altruism is the primary motivating factor in fostering information sharing behavior.

⁵⁰ Talja, 2002.

⁵¹ Caroline Haythornthwaite, "Networks of Information Sharing Among Computer-Supported Distance Learners," *Proceedings of the 1999 Conference on Computer Supported Collaborative Learning*, p. 26. International Society of the Learning Sciences, 1999.

⁵² Savolainen 2008, 188.

⁵³ Ibid., 196.

⁵⁴ Ibid.

However, Savolainen's research does not consider any benefits to the information sharer. Information does not necessarily have to "help" the person on the receiving end to be of value. The processes of producing and sharing information may be of benefit in themselves. This approach to information sharing – one that emphasizes process and the benefits of creativity and voice – has rarely been addressed by LIS scholars.

Karen Pettigrew/Fisher's concept of information grounds is another fruitful site of evaluating information sharing. Fisher defines information grounds as synergistic "environment[s] temporarily created when people come together for a singular purpose but from whose behavior emerges a social atmosphere that fosters the spontaneous and serendipitous sharing of information."⁵⁵ Information grounds are generally not conceived of as storehouses of information (in the way that a library may be considered as such), and those who interact in the information ground may or may not be actively seeking information. Fisher notes that, "as people gather at an information ground, they engage in social interaction, conversing about life, generalities, and specific situations that lead to serendipitous and sometimes purposive, formal and informal sharing of information on varied topics."⁵⁶ Information grounds are context-rich, and actors play different roles in information exchange. Fisher suggests that information grounds can occur in a multitude of settings, and offers examples including hair salons and barber shops, city buses, and quilting bees.⁵⁷ While the information ground is a promising concept, data analysis to date

⁵⁵ Karen E. Fisher et al, "Social Spaces, Casual Interactions, Meaningful Exchanges: 'Information Ground' Characteristics Based on the College Student Experience," *Information Research* 12, no. 2 (2007), n.p., paper 291 [Available at <http://informationr.net/ir/12-2/paper291.html>].

⁵⁶ Karen E. Fisher, "Information Grounds" in *Theories of Information Behavior* eds. Karen E. Fisher, Sanda Erdelez, and Lynne McKechnie (Medford: Information Today, 2005), 185-186.

⁵⁷ *Ibid.*, 188.

has consisted largely of content analyses of respondents' perspectives on such issues as the kinds of information grounds visited, the kinds of information exchanged in information grounds, the directions in which 'information flow' occurs, and the value of the information and the information sources (e.g., relevance, quality, accessibility).⁵⁸ Fisher has not yet analyzed the actual processes at work in information sharing, or the benefits experienced by those on the giving end of information exchange.

Although McKenzie's work on midwife/client communication does not explicitly address the concept of information sharing, it considers several related aspects little studied by other LIS researchers. First are the social functions of information seeking and giving such as the building of relationships through information sharing.⁵⁹ Second are the ways that information seeker and giver roles are jointly and flexibly enacted during the course of the ongoing interaction.⁶⁰ Third is the situated evaluation of information sources in context of community values rather than individual.⁶¹ Tiffany Veinot similarly explores the ways that social networks mediate information evaluation,⁶² and in a later work with

⁵⁸ Karen E. Fisher and Charles M. Naumer, "Information Grounds: Theoretical Basis and Empirical Findings on Information Flow in Social Settings," *New Directions in Human Information Behavior* eds. Amanda Spink, and Charles Cole (Dordrecht: Springer, 2006): 93-112.

⁵⁹ Pamela J. McKenzie, "Informing Relationships: Small Talk, Informing, and Relationship Building in Midwife-Woman Interaction," *Information Research* 15, no. 1 (2010): 423 [Available at <http://InformationR.net/ir/15-1/paper423.html>].

⁶⁰ Pamela J. McKenzie, "Informing Choice: the Organization of Institutional Interaction in Clinical Midwifery Care," *Library & Information Science Research* 31, no. 3 (2009): 163-73.

⁶¹ Pamela J. McKenzie and Tami Oliphant, "Informing Evidence: Claimsmaking in Midwives' and Clients' Talk About Interventions," *Qualitative Health Research* 20, no. 1 (2010), 29-41.

⁶² Tiffany C. Veinot, "Interactive Acquisition and Sharing: Understanding the Dynamics of HIV/AIDS Information Networks," *Journal of the American Society for Information Science and Technology* 60, no. 11 (2009): 2313-32.

Jones, Wright, and Wallace, evaluates how information sharing occurs among African-American women with hypertension.⁶³

While Savolainen, Chatman, Fisher, McKenzie, and Veinot evaluate information exchanges in contexts of everyday life and address issues such as social capital, there is as yet little attention in LIS to the ways that information sharing within networks and in collaborative contexts can be both empowering and subversive. For women in situations where information or knowledge is not readily available or is increasingly difficult to obtain, as is the case with women seeking the diaphragm as a contraceptive method, collaborative information practices within groups or networks become a lifeline to information seeking.

2.3 Information Barriers, Circumvention, Agency & Subversion

As mentioned previously, LIS research tends to view information seekers as at a deficit because of “information needs,” or worse, “information poverty.”⁶⁴ Contributing to this deficit are information barriers, often contextualized as originating within information provision and therefore failing the user. For example, Harris and Dewdney evaluated the ways in which organizations that provide information for battered women fail to give women the information required for bettering their situations. They make suggestions from a systems-to-user approach, but do not address ways in which women might circumvent

⁶³ Lenette Jones, Kathy Wright, McKenzie Wallace, and Tiffany Veinot, “‘Take an opportunity whenever you get it’: Information sharing among African-American women with hypertension”, *Journal of the Association for Information Science and Technology* 69, no. 1 (2018): 168-171.

⁶⁴ See for example Johannes Britz, “To Know or Not to Know: A Moral Reflection on Information Poverty,” *Journal of Information Science* 30, no. 3 (2004): 192- 204.

these barriers to get the information they need, for example through unofficial sources.⁶⁵ This dissertation rejects the argument that women seeking information on cervical barrier contraceptives who encounter difficulties or barriers are information-poor and are doomed to failure. Rather, it is concerned with the ways in which these barriers lead to creative circumvention or subversion strategies undergirded by collaborative information sharing practices that ultimately enable and empower these women to access the information they desire.

Much has been written in LIS about information provision within library settings and ways in which librarians may fail users by inadequately addressing their needs (often specifically focusing on reference librarianship).⁶⁶ Focusing on library users' experiences with information barriers, Ross and Dewdney analyzed patrons' descriptions of reference transactions and identified two major themes: librarian communication strategies that served as or fostered barriers to the reference process, and user "counterstrategies" that facilitated users receiving the information they wanted.⁶⁷ McKenzie employed a constructionist discourse analytic perspective to analyze the descriptions of the barriers that women pregnant with twins encountered when communicating with medical practitioners and the information practices they used to overcome these barriers.⁶⁸

⁶⁵ Harris & Dewdney, 1994.

⁶⁶ Lynda M. Baker and Judith J. Field, "Reference Success: What Has Changed Over the Past Ten Years?" *Public Libraries* 39, no. 1 (2000): 23-27; Patricia Dewdney and Catherine Sheldrick Ross, "Flying a Light Aircraft: Reference Service Evaluation from a User's Viewpoint," *RQ* 34, no. 2 (1994): 217-30; Ross & Dewdney, 1994; Catherine Sheldrick Ross and Patricia Dewdney, "Best Practices: An Analysis of the Best (and Worst) in Fifty-Two Public Library Reference Transactions," *Public Libraries* 33, no. 5 (1994): 261-66.

⁶⁷ Catherine Sheldrick Ross and Patricia Dewdney, "Negative Closure: Strategies and Counter-Strategies in the Reference Transaction," *Reference & User Services Quarterly* 38 no. 2 (1999): 151-163.

⁶⁸ Pamela J. McKenzie, "Communication Barriers and Information-Seeking Counter Strategies in Accounts of Practitioner-Patient Encounters," *Library & Information Science Research* 24, no. 1 (2002): 31-47.

McKenzie notes that informational barriers can arise both from the provider's side as well as the seeker's.⁶⁹ She extends Ross and Dewdney's concept of counterstrategies of library users and suggests that counterstrategies are frequently employed by patients in healthcare settings to keep communication flowing even after the source failed or refused to disclose the desired information. She states,

Rather than presenting an image of uncomplicated asymmetry in the practitioner-patient relationship, the participants represented themselves as active, even vigilant, information seekers who asked premeditated questions, made lists to organize their behavior, and looked for opportunities to intervene and get feedback when a process was not going as expected.⁷⁰

While McKenzie does not contextualize these counterstrategies as circumvention or subversion of information barriers, she presents clear indication that women seeking health information are not simply passive receivers, and rather, are active in the process of information exchange and will, when necessary, employ certain strategies as a means of gaining information that is not otherwise readily or easily available.

Subversive information strategies are generally not theorized in LIS research. Elfreda Chatman's work on the information behavior of people in the margins consistently invoked notions of sharing and withholding information. Chatman's theories of a small world⁷¹ and life in the round⁷² evaluate information exchanges within small, localized, and disenfranchised populations such as unemployed low-skilled workers, janitors, and prison inmates, and illuminate which types of information are shared and which types are

⁶⁹ Ibid., 37

⁷⁰ Ibid.

⁷¹ Elfreda Chatman, "Life in a Small World: Applicability of Gratification Theory to Information-Seeking Behavior," *Journal of the American Society for Information Science* 42, no. 6 (1991): 438-449.

⁷² Elfreda Chatman, "A Theory of Life in the Round," *Journal of the American Society for Information Science* 50, no.3 (1999): 207-217.

withheld in these contexts. In *The Information World of Retired Women*, Chatman used ethnographic methods to explore the information worlds of retired women living in an independent living facility. She observed that women in this community are part of a social network⁷³ and often gain certain types of information from their interactions with one another. However, this information is often superficial; women's continued independent living is contingent on their ability to take care of themselves both health-wise and in terms of finances and thus "risky" information is often withheld.⁷⁴ While Chatman did not specifically articulate a theory of subversion or circumvention, and this withholding of information could be viewed as problematic because in many cases illnesses (and treatments) were kept in secrecy and became burdensome for the women embodying these nondisclosures, I argue that their withholding information that might have impacted their lives negatively if disclosed could also constitute informational tactics of empowerment rather than subjugation, and serve as informational counterstrategies.

Hope Olson's work is an exception in LIS, clearly articulating and theorizing subversion. Using feminist deconstructionist approaches to theorize how mainstream cataloguing systems employ patriarchal binaries (subject – object, male – female, universality – diversity, etc.) to organize information,⁷⁵ Olson suggests that information professionals must instigate "techniques" that decenter and destabilize the binaries embroiled in assumptions of universality, and that in doing this, subversive action is

⁷³ Elfreda Chatman, *The Information World of Retired Women* (Westport, CT.: Greenwood, 1992), 73.

⁷⁴ *Ibid.*, 117.

⁷⁵ Hope A. Olson, "The Feminist and the Emperor's New Clothes: Feminist Deconstruction as a Critical Methodology for Library and Information Studies," *Library and Information Science Research* 19, no. 2 (1997): 181-198; Hope A. Olson, "How We Construct Subjects: A Feminist Analysis," *Library Trends* 56, no. 2 (2008): 509-541.

mobilized. Olson gives textual examples of binaries and tactics of resistance. In one such explication from Helene Cixous' "The Laugh of the Medusa," Olson describes how women's assertion of literacy and sexuality (via "sexts" – a combination of sex and texts) serve as acts of resistance and subversion, via embodying sexuality that challenges male authority. Olson notes, "In a discourse of resistance, women subvert the sacred text, women are innovative, provocative and assertive. Their 'sexts' embody resistance."⁷⁶ Drawing on Olson's implication that innovation, provocation, and assertiveness are crucial for resistance and subversion, my own project evaluates the ways in which women challenge the binaries put forth by the medical establishment in the context of birth control ("authority" vs. "layperson" among others) and ultimately subvert them by circumventing the challenges they face.

Rothbauer applies de Certeau's notion of "tactics" and "strategies" to LIS contexts; for de Certeau, resistance to dominant forces often exists within the normative boundaries of those forces and Rothbauer applies this theoretical approach to evaluate the ways in which LGBTQ readers form spaces for their communities in public libraries. Rothbauer explores "de Certeau's insistence on the power of readers to grab hold of what the system provides to find or produce a space in the grid of discipline that imposes social control,"⁷⁷ and suggests that,

De Certeau's conceptualization of tactics and strategies of everyday life allows us to see that it is not just a matter of escaping dominant systems that treat all consumers and users as dupes, nor on the other

⁷⁶ Hope A. Olson, "Patriarchal Structures of Subject Access and Subversive *Techniques* for Change," *Canadian Journal of Information and Library Science* 26, no 2-3 (2001) 1-29.

⁷⁷ Paulette Rothbauer, "Beyond a Signpost for Resistance: The Promise of Michel de Certeau's Practices of Everyday Life for LIS Scholarship" in *Critical Theory for Library and Information Science: Exploring the Social from Across the Disciplines*, eds. Gloria Leckie, Lisa Given and John Buschman (California: Libraries Unlimited, 2010), 59.

hand, is it simply a matter of positing an active agent who nevertheless, exerts no real power to change the system. Everyday tactics are iterative, wily, and difficult to reify into stable and lasting representations, but this does not render them meaningless or trivial--in many ways it is this plurality and heterogeneity that grants power to everyday ways of operating.⁷⁸

While Rothbauer does not speak explicitly about subversive acts, her view that establishing alternative spaces within dominant societal forces constitute resistant strategies of everyday life is suggestive of subversive action: “As [LGBQ readers] make their way through various imposed systems--information, library, and publishing--they find personally relevant reading materials that resonate with their sense of themselves as readers and as people belonging to a large community of sexual minority citizens.”⁷⁹

Feminist health scholars have traced power dynamics in health settings, historically and at present, articulating the differences between an “old regime” (characterized by patriarchal hierarchy wielding power over female patients)⁸⁰ and “new regimes” (characterized by webs instead of central decision making, a variety of practitioners and settings instead of one singular doctor, and numerous information sources including internet websites and discussion forums).⁸¹ According to Susan E. Bell, “Feminist scholars and activists have uncovered ways in which women patients have been active agents and not just passive recipients of medical sovereignty and in which medicine has been beneficial to women, as well as tensions, contradictions, ambiguities and uncertainties in

⁷⁸ Ibid.

⁷⁹ Ibid.

⁸⁰ See for example Barbara Seaman, *The Doctor's Case Against the Pill* (New York: P. H. Wyden, 1969), and Barbara Ehrenreich and Deirdre English, *Witches, Midwives, and Nurses: A History of Women Healers* (New York, New York: Feminist Press, 1973).

⁸¹ Susan E. Bell, *DES Daughters: Embodied Knowledge and the Transformation of Women's Health Politics* (Philadelphia: Temple University Press, 2009), 3.

medicine itself.”⁸² The suggestion that women patients are active agents in their own medical treatment echoes McKenzie’s assertion that employing counterstrategies in times that information barriers emerge allows women patients to be active rather than passive in medical settings. Bell argues that the concept of “old” versus “new” regimes is too simplistic and essentialist, and that there is often an interplay of power dynamics in medical settings – old regimes have not completely disappeared, whilst new ones helped launch a new kind of women’s help movement that decentralizes power and emphasizes experiences and embodiment.⁸³

Feminist scholars have grappled with ideas of women’s agency, seeking to articulate both gendered discrepancies of power and subordination and inequalities embedded within social norms, and sites of women’s and other marginalized people’s active resistance or subversion via agency. As Nancy Fraser eloquently surmises,

...we have often opted for theories that emphasize the constraining power of gender structures and norms, while downplaying the resisting capacities of individuals and groups. On the other hand, feminists have also sought to inspire women’s activism by recovering lost or socially invisible traditions of resistance in the past and present...The net result of these conflicting tendencies is the following dilemma: *either* we limit the structural constraints of gender so well that we deny women any agency *or* we portray women’s agency so glowingly that the power of subordination evaporates. Either way, what we often seem to lack is a coherent, integrated, balanced conception of agency, a conception that can accommodate both the power of social constraints and the capacity to act situatedly against them.⁸⁴

⁸² Ibid., 4.

⁸³ Ibid.

⁸⁴ Nancy Fraser, “Introduction,” in *Revaluing French Feminism: Critical Essays on Difference, Agency, and Culture*, eds. Nancy Fraser and Sandra Lee Bartky (Bloomington: Indiana University Press 1992), 17.

Autonomy and agency are often used interchangeably in research on women's health, but as Susan Sherwin notes, the two concepts must be differentiated. According to Sherwin, exercising agency requires only that one exercises reasonable choice, whereas autonomy, as conventionally understood, requires that one is competent, has enough information to make the most appropriate choice, and is free of coercion.⁸⁵ Sherwin argues that an active agent cannot sufficiently be described as an autonomous individual:

When we limit our analysis to the quality of an individual's choice under existing conditions (or when we fail to inquire why some people do not even seek health services), we ignore the significance of oppressive conditions. Minimally, autonomous persons should be able to resist oppression—not just act in compliance with it—and be able to refuse the choices oppression seems to make nearly irresistible. Ideally, they should be able to escape from the structures of oppression altogether and create new options that are not defined by these structures either positively or negatively.⁸⁶

Using the diaphragm as a case study, this study locates women's agency via subversion and resistance within a context of knowledge marginalization. Drawing on feminist accounts of agency, subversion, and resistance, whilst bearing in mind the differentiation between agency and autonomy, and articulating an LIS framework for resistance against and subversion of informational barriers, this project tells a story of, as Fraser suggests, "the power of social constraints and the capacity to act situatedly against them." Further, since the key players in this story refuse to adopt the birth control methods mainstream medicine seems to present as the only legitimate options, and seek out alternatives through

⁸⁵ Susan Sherwin, "A Relational Approach to Autonomy in Health Care," in *The Politics of Women's Health: Exploring Agency and Autonomy*, The Feminist Health Care Ethics Research Network, coordinator Susan Sherwin (Philadelphia: Temple University Press), 32-33.

⁸⁶ *Ibid*, 33.

subversive communication and informational strategies, I argue that in addition to agency, diaphragm and cap users are also exercising autonomy.

2.4 Authoritative Knowledge – Women’s Knowledges vs. Experts

In her anthropological analysis of childbirth across cultures, Jordan evaluated the ways in which the birth practices of Americanized medicine were starting to permeate those of developing regions and conflicting with the more indigenous knowledges and approaches to birthing.⁸⁷ Davis-Floyd and Sargent note that, “Jordan made it clear that the wholesale exportation of the American system of birth to the Third World was having extremely detrimental effects on indigenous systems, reminding us that these systemic effects were also individual and personal - felt by women in their bodies.”⁸⁸

Jordan discusses the concept of authoritative knowledge in childbirth, and suggests that it is the knowledge that matters and is the locus of decision-making:

For any particular domain several knowledge systems exist, some of which, by consensus, come to carry more weight than others, either because they explain the state of the world better for the purposes at hand (efficacy) or because they are associated with a stronger power base (structural superiority), and usually both. In many situations, equally legitimate parallel knowledge systems exist and people move easily between them, utilizing them sequentially or in parallel fashion for particular purposes. But frequently, one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing.⁸⁹

⁸⁷ Brigitte Jordan, *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden, and the United States* (St. Albans, Vt.: Eden Press Women's Publications, 1978).

⁸⁸ Robbie E. Davis-Floyd and Carolyn F. Sargent, *Childbirth and Authoritative Knowledge: Cross-cultural Perspectives* (Berkeley: University of California Press, 1997), 112.

⁸⁹ Jordan, 152.

LIS tends to operationalize Patrick Wilson's concept of cognitive authority⁹⁰ rather than authoritative knowledge. According to Wilson, people construct knowledge in two different ways. The first is based on their first-hand experience, and the second is what they have learned second-hand from others. Wilson argues that all people know of the world outside their own experience is based on what others tell them. Essentially, knowledge about the world is hearsay, and people often decide whose representation of the world is most correct, or authoritative. We differentiate between credible and non-credible information, and those offering what is deemed as credible information are the cognitive authorities. For Wilson, cognitive authority is related to trustworthiness and competence—not necessarily to expertise. One can be an expert in a field of knowledge but not have authority, or contrariwise have authority but no expertise.

McKenzie differentiates between cognitive authority and authoritative knowledge, suggesting that cognitive authority decisions may not tell the full story of decision-making and knowledge acquisition, as they tend to operate within the prevailing forms of authoritative knowledge that are held as legitimate and official by participants in a particular context.”⁹¹ McKenzie notes that,

Jordan's concept provides a particularly useful counterpoint to Wilson's because it explicitly acknowledges the broader community's role in determining what forms of knowledge (and, correspondingly, what information sources) should carry weight. Jordan allows that authoritative knowledge is not something stable, but that, as Suzanne Kettler shows, participants can redefine what constitutes authoritative knowledge within particular settings.⁹²

⁹⁰ Patrick Wilson, *Second-Hand Knowledge: An Inquiry into Cognitive Authority* (Westport, Conn.: Greenwood, 1983).

⁹¹ Pamela J. McKenzie, “Justifying Cognitive Authority Decisions: Discursive Strategies of Information Seekers,” *Library Quarterly* (2003), 261-288.

⁹² *Ibid*, 265.

Oliphant examined how people with depression use information in discourse to justify healthcare decisions and to create credible and authoritative accounts. She used the concept of authoritative knowledge to show people used a variety of discursive strategies and regular speech patterns to create credible and authoritative accounts, to portray themselves as competent information-seekers and users, to support their claims for either using or foregoing a certain treatment, and to counter the authoritative knowledge of biomedicine.⁹³

The idea of certain knowledge being accepted as more legitimate than others can be seen in medical practice, and is specifically observed in feminist analyses of medicine that note a delegitimization of women's knowledges in favor of a masculinized, patriarchal system of medicine.⁹⁴ Authoritative knowledge thus functions to undermine certain, often marginalized, knowledges and approaches to knowledge sharing in favor of centralized and hierarchical systems. For instance, Barbara Ehrenreich and Deirdre English note that,

While the female lay healer operated within a network of information-sharing and mutual support, the male professional hoarded up his knowledge as a kind of property, to be dispensed to wealthy patrons or sold on the market as a commodity. His goal was not to spread the skills of healing, but to concentrate them within the elite interest group which the profession came to represent. Thus the triumph of the male medical profession is of crucial significance for our story: it involved the destruction of women's networks of mutual help—leaving women in a position of isolation and dependency—and it established a model of expertism as the prerogative of a social elite.⁹⁵

Ehrenreich and English articulate a shift in medicine that represents the undermining of women's collaborative approaches to healing and medicine and the consequent rise of a

⁹³ Tami Oliphant, "The Information Practices of People Living with Depression: Constructing Credibility and Authority," (PhD diss., University of Western Ontario, 2010).

⁹⁴ Ehrenreich and English, *For Her Own Good*, 38.

⁹⁵ *Ibid.*

more rational, instrumental, and scientific medical model that places experts (often male) at the forefront. As male knowledge became the norm as the accepted form of authoritative knowledge within medicine, the collaborative and often embodied approaches of women became further marginalized. However, they never disappeared and play a central role in this project.

Sherwin acknowledges that a common tendency within mainstream medical practice is for health practitioners to assume, due to their technical experience and expertise, that they are better able to discern what is best for the patient than is the patient.⁹⁶ She contends that, “By privileging their own types of knowledge over that of their patients (including both experiential knowledge and understanding of their own value scheme), health providers typically ignore patients’ expressed or implicit values and engage in paternalism (or the overriding of patient preferences for the presumed benefit of the patient) when prescribing treatment.”⁹⁷ This type of paternalistic authoritative knowledge permeates all facets of mainstream medical practice, but is particularly evident in birth control counselling; hormonal methods are advocated, and sometimes, insisted upon, whereas more embodied and less “scientific” methods such as diaphragms and caps are pushed further into the margins.

2.5 The Medicalization of Women’s Bodies

The above discussion of authoritative knowledge and masculinized medicine discrediting or marginalizing women’s lay healing and midwifery practices warrants a

⁹⁶ Sherwin, 20.

⁹⁷ Ibid, 21.

brief explication of how science and medicine have served to medicalize the bodies of women. The ways in which medicalization occurs have been studied extensively by feminist scholars; the bodies of women specifically have become highly medicalized over time. Feminist researchers are concerned with how medicalization, a social process, categorizes bodies (generally bodies differing from the white male status quo) as different in some way and thus contextualizes them as needing some type of medical intervention. This medicalization of the othered body upholds gender inequality and has serious implications for women's health outcomes.⁹⁸ Stotland offers some key examples of how the process of medicalization may unfold:

Many of the procedures performed on women's reproductive organs, and medications administered to control them, have been unsupported by empirical evidence. They have been driven by women's desire to have babies, on the one hand, and unconscious motivations of historically male medical professionals on the other. Reproductive technologies penetrate the female genitalia, whether medically or surgically. They allow physicians to fantasize that it is they, rather than mothers, who conceive and gestate children. They expose every secret of the hidden female anatomy to view, study, and treatment. Finally, women's doctors decreed that menopausal women are deficient, that women must maintain childbearing levels of hormones rather than progress through the normal stages of life. Each of these interventions has been justified by 'science'... [but]

⁹⁸ See Ehrenreich and English, *For Her Own Good*; Diana Scully and Pauline Bart, "A Funny Thing Happened on the Way to the Orifice: Women in Gynecological Textbooks," in *The Sociology of Health and Illness: Critical Perspectives*, eds. Peter Conrad and Rochelle Kern (New York: St Martin's Press, 1981), 350-5; Elizabeth Fee, "Women and Health Care: A Comparison of Theories," in *Women and Health: The Politics of Sex in Medicine*, ed. Elizabeth Fee (Farmingdale, NY: Paywood Pub. Co., 1983); Diana Dull and Candace West, "Accounting for Cosmetic Surgery: The Accomplishment of Gender," *Social Problems* 38 (1991): 54-70; Judith D. Auerbach and Anne E. Figert, "Women's Health Research: Public Policy and Sociology," *Journal of Health and Social Behavior* (Extra Issue, 1991): 115-31; Annette L. Stanton and Sharon Danoff-Burg, "Selected Issues in Women's Reproductive Health: Psychological Perspectives," in *The Psychology of Women's Health: Progress and Challenges in Research and Application*, eds. Annette L. Stanton and Sheryle J. Gallant (Washington, DC: American Psychological Association, 1995), 261-305; Nancy Krieger and Elizabeth Fee, "Man-made Medicine and Women's Health: The Biopolitics of Sex/ Gender and Race/Ethnicity," in *Man-made Medicine: Women's Health, Public Policy, and Reform* ed. Kary L. Moss (Durham, NC: Duke University Press, 1994), 15-36.

seldom have we examined the reasons we ask the ‘scientific’ questions.⁹⁹

Stotland highlights how normal physiological functions of women’s bodies such as menstruation, pregnancy and menopause have been pathologized into diseases that need to be treated rather than merely accepted as common physiological occurrences. Researchers are increasingly challenging this tendency, asking why, for instance, symptoms of premenstrual syndrome have been categorized as a psychiatric disease called PMDD,¹⁰⁰ or why menopause has become a disease requiring treatment,¹⁰¹ or why the size of women’s bodies has increasingly permeated medical discourse resulting in stigmatization of certain bodies and consequently, inferior health care.¹⁰² Feminist scholars also note that the monolithic category of “women” is overly simplistic and does not take into account differences in race, class, and sexuality on women’s lived experiences and interactions with medical practitioners; accordingly medicalization impacts women differently, some even benefitting from medicalization, while others suffering serious consequences. In collecting participants’ accounts of medical interactions with regard to their fertile bodies and a desire to reduce said fertility, I accept that medicalization is a social process with varying impacts on the participants involved; some describe embracing the medicalization of their own bodies, while others articulate

⁹⁹ Nada L. Stotland, “Women’s Bodies, Doctors’ Dynamics,” *The Journal of the American Academy of Psychoanalysis and Dynamic Psychiatry* 32 no. 1 (Spring 2004): 190.

¹⁰⁰ Alia Offman, and Peggy J. Kleinplatz, “Does PMDD belong in the DSM? Challenging the Medicalization of Women’s Bodies,” *Canadian Journal of Human Sexuality* 13 no. 1(2004): 17-27.

¹⁰¹ Janet Stoppard, “A Suitable Case for Treatment? Premenstrual Syndrome and the Medicalization of Women’s Bodies,” in *The Anatomy of Gender: Women’s Struggle for the Body*, eds. Dawn H. Currie and Valerie Raoul (Ottawa, Canada: Carleton University Press, 1992), 119-29.

¹⁰² Sharon Wray and Ruth Deery, “The Medicalization of Body Size and Women’s Healthcare,” *Health Care for Women International* 29 no 3 (2008):227-243.

how the othering of their bodies by mainstream medicine has caused difficulty in healthcare interactions.

2.6 Embodied Knowledge

This dissertation aligns with the feminist perspective that knowledge, specifically that of women and other marginalized peoples, exists and is learned not only cognitively, but also via the body. Further, the concept of embodied knowledge is valuable to this project because it is often in conflict with masculinized authoritative knowledge. Donna Haraway asserts that research, scientific or otherwise, must be grounded, from below, situated, embodied, and partial. This directly challenges the methodological approach of distanced “objectivity” that is so frequently employed in positivist research paradigms. She argues that science can still be valid without employing disengaged, distanced, view-from-nowhere “god tricks.” Articulating a feminist standpoint informed by experiences and that views its research subjects as active agents, she states that,

...feminist embodiment resists fixation and is insatiably curious about the webs of differential positions. There is no single feminist standpoint because our maps require too many dimensions for that metaphor to ground our visions. But the feminist standpoint theorists’ goal of an epistemology of politics of engaged, accountable positioning remains eminently potent. The goal is better accounts of the world, that is, ‘science.’¹⁰³

In her insistence on partial knowledge and embodiment, Haraway seeks a research paradigm that is self-aware, and contends that there is no single fixed truth, but rather many truths:

¹⁰³ Donna Haraway, “Situated Knowledges: The Science Question in Feminist and the Privilege of Partial Perspective,” in *The Feminist Standpoint Reader: Intellectual and Political Controversies* ed. Sandra Harding (New York: Routledge, 2004), 93.

We seek not the knowledges ruled by phallogocentrism (nostalgia for the presence of the one true Word) and disembodied vision. We seek those ruled by partial sight and limited voice – not partiality for its own sake but, rather, for the sake of the connections and unexpected openings situated knowledges make possible. Situated knowledges are about communities, not isolated individuals.¹⁰⁴

Haraway's insistence that we embrace situated and embodied research paradigms is an important consideration when thinking about the ways in which LIS tends to operationalize information as a unit of analysis, studied in a behavioral sense, disembodied and often surrounded by the notion of scientific objectivity. This project aligns with Haraway's thinking in critiquing dominant, masculinized authoritative knowledges and suggesting that there is indeed value in the embodied knowledges of women that are often subjugated in favor of a more rigorous scientific protocol.

A useful theoretical approach in supporting women's voices and challenging traditional notions of what constitutes knowledge, or who (often he) constitutes as knower can be found in Belenky et al.'s *Women's Ways of Knowing: The Development of Self, Voice, and Mind*. The authors state,

...we believe that conceptions of knowledge and truth that are accepted and articulated today have been shaped throughout history by the male-dominated majority culture. Drawing on their own perspectives and visions, men have constructed the prevailing theories, written history, and set values that have become the guiding principles for men and women alike...Feminists are beginning to articulate the values of the female world and to reshape the disciplines to include the woman's voice, while continuing to press for the right of women to participate as equals in the male world.¹⁰⁵

¹⁰⁴ Ibid.

¹⁰⁵ Mary Belenky et al., *Women's Ways of Knowing: The Development of Self, Voice and Mind* (New York: Basic Books, 1986), 5-6.

The authors draw data from interviews with 135 women (mostly privileged college students) regarding their search for truth and knowledge and seek to identify the characteristics of “women’s way of knowing.” Despite the progress of the women’s movement, many women in the study still felt silenced in their families and schools. The authors evaluate reasons for women’s silence and the ways they go about developing and utilizing their voices. Belenky et al. originated a framework of connected knowing, which emphasizes experiential knowledge and empathetic encounters with others.¹⁰⁶

Haraway’s perspective on situated knowledge and the experiential knowledge and connected knowing identified by Belenky et al. tie in with more fundamental ideas of embodied knowledge. The notion of embodied knowledge is derived from the phenomenology of the French philosopher, Maurice Merleau-Ponty (1908-1961). In *Phenomenology of Perception*, Merleau-Ponty emphasizes our experiences as embodied subjects in the world. He uses the example of touch typing to explain how embodied knowledge works:

To know how to touch type is not, then, to know the place of each letter among the keys, nor even to have acquired a conditioned reflex for each one, which is set in motion by the letter as it comes before our eye. If habit is neither a form of knowledge nor an involuntary action, what then is it? It is knowledge in the hands, which is forthcoming only when bodily effort is made, and cannot be formulated in detachment from that effort.¹⁰⁷

Feminist scholars have critiqued Merleau-Ponty’s concept of embodied knowledge,

¹⁰⁶ Ibid., 113.

¹⁰⁷ Maurice Merleau-Ponty, *Phenomenology of Perception* (London: Routledge, 1962), 144.

suggesting that it fails to acknowledge gendered differences of bodily existence.¹⁰⁸ Regardless of these criticisms, the rudimentary idea behind embodied knowledge, that we are able to integrate the physical or biological body and the phenomenal or experiential body is an important one.

Embodied knowledge is not often drawn upon in LIS research, but a few studies that utilize the concept do exist. Tiffany Veinot uses a qualitative case study approach to examine the workplace information practices of a blue collar worker—a vault inspector at a hydroelectric utility company. Veinot draws on social practice theory to offer a definition of embodied knowledge, stating that, “the concept of ‘embodied knowledge’ relies on bodily or practical experience that is context specific, or that which is ‘learned by doing’.”¹⁰⁹ She argues that vault inspection is a practice involving situated judgment, embodiment, educated perception, finding and navigating, and classification.

Annemaree Lloyd examined the nature and manifestation of workplace information literacy amongst a group of fire fighters, finding that information literacy is a holistic process that involves “social, physical and textual relationships with information, that requires a range of information practices and acknowledges the complexity and diversity of information sources within a landscape.”¹¹⁰ She argues that, “Information-literate people are more usefully described as being engaged, enabled, enriched and embodied.”¹¹¹

¹⁰⁸ See for examples Judith Butler, "Sexual Ideology and Phenomenological Description: A Feminist Critique of Merleau-Ponty's Phenomenology of Perception," in *The Thinking Muse: Feminism and Modern French Philosophy* eds. Jeffner Allen and Iris Marion Young (Bloomington: Indiana University Press, 1989): 85-100; Elizabeth A. Grosz, *Volatile Bodies: Toward a Corporeal Feminism* (Bloomington: Indiana University Press, 1994).

¹⁰⁹ Tiffany Veinot, "The Eyes of the Power Company," *The Library Quarterly*, 77 no. 2 (2007): 160.

¹¹⁰ Annemaree Lloyd, "Information Literacy Landscapes," *Journal of Documentation*, 62 no. 5 (2005): 571.

¹¹¹ *Ibid*, 570.

Bearing in mind Haraway's call for situated and embodied knowledges in research paradigms and praxis, and the ways in which experiential knowledge comes into being via the body's interaction with the world, the ways that this study makes use of the concept of embodied knowledge is twofold: firstly, as a researcher I approach my work from a situated, grounded perspective. Secondly, this study evaluates the ways in which users of cervical barrier methods must embody the knowledge of how to use diaphragms and caps (whether it feels "right"), but also in interacting with medical professionals, they must rely on their own embodied knowledge to articulate which contraceptive choice is best for them.

2.7 Gender Essentialism

This project is concerned primarily with women's health, women's information sharing, and women's strategies of subversion, and draws on feminist perspectives to help make sense of participant experiences. However, it is important to note that despite the fact that the utilization of cervical barrier methods for pregnancy prevention must occur in conjunction with a female reproductive system, the notion of womanhood and experiencing pregnancy prevention in the context of living and identifying as a woman is not a given. One participant in this study, while physically embodying a female¹¹² reproductive system and actively seeking to prevent pregnancy with a biologically male partner, rejects identifying as a woman and refuses to take on a gender identity. Initially I pondered if this would complicate my intended modes of analysis and then later worried

¹¹² I am aware that articulating the notion of a "female" or "male" body can be problematic, but this particular participant referred to their own anatomy as "female".

that I may be guilty of essentialism myself. However, in the context of marginalized and embodied knowledges, this participant's experiences and refusal to be imbued with a binary gendered identity merely adds a new and illuminating facet to this project. Many feminist scholars contend that gender is a social construction, and despite physiological differences between the male and female sexes, any notion of ingrained characteristics in terms of personal traits, preferences, and 'masculinity' or 'femininity' is imposed on us culturally. Simone de Beauvoir, in her seminal work *The Second Sex*, stated "one is not born a woman, but becomes one."¹¹³

Gender, according to West and Zimmerman, is not a personal trait; it is "an emergent feature of social situations: both as an outcome of and a rationale for various social arrangements, and as a means of legitimating one of the most fundamental divisions of society."¹¹⁴ The concept of gender was historically used to help people conceptualize and articulate perceived differences between men and women, which both justified and perpetuated discrepancies in labor, social and legal status, aesthetic superficialities such as clothing and hairstyles, and social roles such as caregiving.

Judith Butler, in *Gender Trouble* describes the performative aspects of the categories of sex, gender and sexuality. Repetitive acts work to normalize these categories and make them seem natural despite their social construction. These performances, via their repetition, work to construct what is perceived as an essential gender identity. Butler views these performed acts as involuntary and describes them as falling under the sphere of regulative discourses. Further, Butler suggests that employing feminist theory and using

¹¹³ Simone de Beauvoir, *The Second Sex* (New York: Vintage Books, 1973), 301.

¹¹⁴ Candace West and Don H. Zimmerman, "Doing Gender," *Gender and Society* 1, no. 2 (1987): 126.

“women” as a catch-all phrase, “has effectively refused the multiplicity of cultural, social, and political intersections in which the concrete array of ‘women’ are constructed.”¹¹⁵ Butler questions if feminist work, employing a singular concept of a unified “woman” sets up an “exclusionary norm of solidarity at the level of identity that rules out the possibility of a set of actions which disrupt the very borders of identity concepts, or which seek to accomplish precisely that disruption as an explicit political aim.”¹¹⁶ Butler contends that so long as we reject notions of fixity or normativity in the context of gender, but rather, view it as an effect that is produced or generated, we can work to open up “possibilities of ‘agency’ that are insidiously foreclosed by positions that take identity categories as foundational or fixed.”¹¹⁷

For Butler, feminist work should seek to reject essentialism but also be open to the ways in which gender identities can illuminate the experiences of those enacting them; if we understand the ways that essentialism works to reify the status quo, we can also perhaps create ways to challenge and subvert the status quo. And because gender identity is so normalized and pervasive, regardless of its construction it still has implications on the lives of people adhering to or enacting the binary structure. In this sense, this research draws on theories of women’s knowledge to explore the ways in which participants have described their own experiences. However, I contend that there is no universal “woman,” and I am careful to not impose a binary gender structure on those who assertively reject it.

¹¹⁵ Judith Butler, *Gender Trouble* (New York: Routledge, 1990):20.

¹¹⁶ *Ibid.*, 21.

¹¹⁷ *Ibid.*, 187.

2.8 LIS and Birth Control Information

This study is concerned with everyday life information practices focusing on agency and strategies of subversion. Situated within discourse communities, subversive, collaborative and embodied information practices are often also situated within forms of authoritative knowledge that prescribe and circumscribe. Given the particular context of cervical barrier methods as difficult to obtain at this particular moment, the search for information on cervical barrier methods is an apt case study demonstrative of the intersection of all of these aspects. Thus, this dissertation focuses on contraceptive information to unite the various theoretical strands and adds to the small but compelling body of LIS research into contraceptive information seeking.

Norma Lundberg conducted an institutional ethnography of Canadian libraries and how they organize and contextualize birth control information. Lundberg articulates how feminist research distinguishes between mainstream knowledge about women, and women's knowledges that are aimed at equality and from a women's standpoint.¹¹⁸ She states,

Women's knowledge in the area of health and particularly reproductive health has been the focus of considerable feminist scholarship. The historical conflict between women as capable and knowing and an expanding and increasingly authoritative medical profession has coincided with women's loss of control over the reproductive process...Indeed, women's control over reproductive processes forms the foundation of women's social equality...¹¹⁹

¹¹⁸ Norma J. Lundberg, "The Social Organization of Birth Control Information in Public Libraries" (PhD diss., University of Western Ontario, 1991), 25.

¹¹⁹ Ibid., 26.

Lundberg found that libraries, for a number of reasons (time constraints, decontextualization of information, and non-involvement of the surrounding community) tend to emphasize mainstream materials and neglect women-centered materials, therefore marginalizing women's knowledges.

Johanna Rivano Eckerdal examined birth control counselling between midwives and young women patients as loci of knowledge production. Drawing on Haraway for a theoretical perspective on science (using the concept of the "god-trick," which is what Haraway calls and critiques the patriarchal distanced objectivity in science as opposed to the situated and embodied knowledge that she calls for in research practice and praxis), Rivano Eckerdal discusses the embodied knowledge of midwives (for example knowing the weight of a patient by seeing it)¹²⁰ and also in taking blood. Rivano Eckerdal notes that,

The god-trick performed is thus to a certain extent a positive outcome of the interaction, in contrast to Haraway's use of the concept. As the young women learn to use the god-trick on their own bodies, they are given an opportunity to situate the knowledge that is produced through their bodies. They have a possibility to be active in the production; they are actors with power to, at least to some extent, control what is produced. It is an important learning achievement for future meetings in similar settings.¹²¹

Rivano Eckerdal found that both midwives and young women are information sources to each other, and the information conveyed is negotiated in both words and actions, that is, through discourse and through physicality.¹²²

¹²⁰ Johanna Rivano Eckerdal, "Information Sources at Play: The Apparatus of Knowledge Production in Contraceptive Counselling," *Journal of Documentation* 68, no. 3 (2012): 278-298

¹²¹ *Ibid.*, 294.

¹²² *Ibid.*

2.9 Conclusion

This Chapter described the various academic work that underpins this project's key questions. This project is interdisciplinary, drawing on literature from women's studies, anthropology and LIS. The following chapter provides the methodological considerations in undertaking this research and describes the specific methods utilized to collect and analyze the data for this study.

3 Methodology and Methods

This dissertation is fundamentally concerned with how women navigate birth control information and medical consultations, circumvent informational barriers, and how information sharing manifests in this informational landscape; accordingly, I use a feminist methodological approach to employ multiple methods for data collection and analysis. Undergirded by feminist ethnographic principles, I collected and analyzed the perspectives and experiences of participants who actively seek or share information about cervical barrier methods. Bearing in mind the differences between epistemology (a theory of knowledge), methodology (a theory and analysis of how research does or should proceed), and method (a technique or tool for gathering evidence),¹²³ this study utilizes a feminist epistemological approach more broadly in research praxis and analysis of data, whilst reflecting on feminist methodological approaches and ultimately, on implementation of methods.

Feminist ethnographic research seeks to identify emergent cultural phenomena and then interrogate them from the perspectives of those directly tied to such phenomena.¹²⁴ Inherently concerned with issues of representation, patriarchy, and hierarchy, a feminist research methodology respects participants' views, cultures, and individuality, and seeks to avoid participant objectification. Specifically, feminist ethnographic research is wholly dependent on participants for data collection, namely through interviews and participant observation. To be considered "feminist," ethnographic research must reject a hierarchical

¹²³ Nancy Naples, *Feminism and Method: Ethnography, Discourse Analysis, and Activist Research* (New York: Routledge, 2003), 3.

¹²⁴ Wanda S. Pillow and Cris Mayo, "Toward Understandings of Feminist Ethnography," in *Handbook of Feminist Research: Theory and Praxis* ed. Sharlene Nagy Hesse Biber (California: SAGE Publications, 2007), 155.

researcher-subject relationship and emphasize reciprocity, respect, and a non-judgmental research environment. In studying women-centered issues and social phenomena, feminist ethnography as a research method facilitates the sharing of information in a more egalitarian way than traditional social science methods and allows participants to tell their stories using their own voices. Since ethnographic research takes place within specific settings or on specific groups, the research site is a significant element of this type of scholarly work. Selecting a research site is often a personal process on the part of the feminist ethnographer, but generally speaking, feminist ethnographic research sites are ones that facilitate critical inquiry on issues of representation of women, empowerment (or disempowerment) of women, issues of gender inequality, and so forth.

Because my own research is inherently concerned with sites of resistance and empowerment for women, this dissertation embraces key principles of feminist ethnographies and applies them to 1) an online community of users or seekers of barrier methods information and 2) a feminist news organization's social media account which serves as a hub for dialogue pertaining to women's issues. The first community serves as a network of information exchange to assist others who choose cervical barrier methods make informed decisions about the method, access resources that aren't available to them by their medical practitioners, or even, at times, to assist them in locating practitioners that still actively fit diaphragms; the second community allows for information sharing and discussion regarding mediated women's issues, which often include contraception.

In her article on feminist interviewing practices, Ann Oakley provides various accounts of her own experiences with interviewing women and suggests that adhering to the traditional male social science interviewing guidelines is morally unacceptable in

studies where women interview other women or conduct feminist research. According to Oakley, women researchers interviewing other women should not reinforce patriarchal research norms, should not be hierarchical or objectifying, and should foster a mutual relationship where both interviewee and interviewer engage with one another and interact in ways that go beyond “objective” research. For Oakley, feminist interviewing should be reciprocal and mutually beneficial. Interviews should not tell women’s stories for them, but rather, provide a means for women to tell their own stories. She states, “Interviewing women, was, then, a strategy for documenting women’s own accounts of their lives.”¹²⁵ Oakley emphasizes the interpersonal relationships that must accompany feminist research, and concludes that,

A feminist methodology of social science requires that this rationale of research be described and discussed not only in feminist research but in social science research in general. It requires, further, that the mythology of ‘hygienic’ research with its accompanying mystification of the researcher and the researched as objective instruments of data production be replaced by the recognition that personal involvement is more than dangerous bias – it is the condition under which people come to know each other and to admit others into their lives.¹²⁶

Pillow and Mayo define feminist ethnography as beginning “from a different place than traditional ethnography; a place that questions the power, authority, and subjectivity of the researcher as it questions the purposes of the research.”¹²⁷ They identify four stages of feminist ethnography that demonstrate the purposes and practices of doing this type of research: *choosing*, *doing*, *analysis/writing*, and *endings*. *Choosing* involves deciding on

¹²⁵ Ann Oakley, “Interviewing Women,” in *Doing Feminist Research* ed. Helen Roberts (London: Routledge & Kegan Paul, 1981), 48.

¹²⁶ *Ibid.*, 58.

¹²⁷ Pillow and Mayo, 158.

what topic to research, whether it constitutes feminist research, and how researchers will go about collecting data for their studies. *Doing* involves the actual act of research, namely creating relationships with participants and engaging with subjects via interviewing. Pillow and Mayo note that “the attention to and concern about relationships with subjects—including concerns about issues of reciprocity, representation and voice—is uniquely feminist.”¹²⁸ Concerns about ethics, advocacy, and interpersonal interaction are also characteristic of this stage. Following *doing*, *analyzing and writing* is the next task for the feminist ethnographer. They note that “Analyzing data cannot be separate from data collection and writing. Feminists have claimed that writing and choosing how to tell the stories of our research are political acts as well as places of responsibility—as we code, theme, and imagine our data chapter, we are in essence writing and constructing our text.”¹²⁹

Pillow and Mayo explain that feminist ethnographers approach issues of representation, authority, and power using greater reflexivity, and that “reflexivity remains integral to feminist practices of writing ethnography.”¹³⁰ Finally, the last task of the feminist ethnographer is to *end* the research, which more often than not consists of ongoing relationships with participants even after the study as technically finished. A key concern of feminist ethnography is the ethical completion of research (easing out over time, facilitating advocacy when required, etcetera). The authors conclude by stating that, “feminist ethnography remains a ripe vehicle for doing and unpacking this thinking in all

¹²⁸ Ibid., 163.

¹²⁹ Ibid., 165.

¹³⁰ Ibid., 166.

its intricacies, intersectionalities, nuances, and ruins.”¹³¹ The various stages of feminist ethnography all take into consideration ethical approaches to interaction with participants. Avoiding objectification of respondents in a study is paramount to feminist research principles.

In her analysis of feminist ethnographies, Nancy Naples also suggests that reflexivity is pivotal in evaluating power relations between researchers and subjects and to counter the reproduction of inequalities in the ethnographic investigation. A frequent approach used by feminist ethnographers in this sense involves greater interpersonal relationships with research subjects in an attempt to level the playing field and lessen the hierarchical relationship of researcher and subject. However, this approach is also met with criticisms: some researchers suggest that greater intimacy can mask an objectivist stance of conducting research, and that friendships are not legitimate because the subject is the object of the research and is aware of this objectification.¹³²

From the outset, my goal was to interview participants in ways that were most comfortable for them, and to also include myself in the conversation throughout. As a woman who had also sought and used a cervical barrier, I had faced similar issues as my participants; I could empathize with them about the systematic and physiological difficulties in acquiring and using cervical barriers because I myself also experienced them. Accordingly, I felt as though a relational hierarchy was not present in my interviewing and that I was thus able to uphold what would be considered “feminist research.” In including myself in the conversation, I invited participants to ask me questions as well, and most

¹³¹ Ibid., 168.

¹³² Naples, 40.

embraced the opportunity. Several participants stated that because cervical barrier users are so rare, there were few if any opportunities to speak with other women about their experiences other than in an online forum setting; accordingly, I felt that this type of reciprocity was beneficial not only to me as a researcher, but to my participants in that they were able to speak one-on-one to a fellow cervical barrier user in an open and non-patriarchal environment.

3.1 Online Communities and Digital Ethnographies

Due to the varying geographical locations of participants and the abundance of online resources such as forums, groups and social media, this dissertation utilizes a digital ethnographic approach. Online forums and feminist-related social media are examined in this study in the context of computer-mediated communities. Early research on digital communities questioned the legitimacy of digital places serving the role as communities. Siddhartha Menon notes that literature examining online communities and computer-mediated communication (CMC) can be split into two broadly defined levels of debate. According to Menon,

The first involves the debate over whether CMC-related communities function as real or legitimate communities according to a rather strict sense of the term or are merely fly-by-night forums with no communal rules, social norms, or attachments that resemble the strong social bonds that tend to define the traditional community experience of face-to-face communication.¹³³

¹³³ Siddhartha Menon, "A Participation Observation Analysis of the Once & Again Internet MesSage Bulletin Boards" *Television & New Media* 8 no. 4 (2007): 345.

Scholars aligned with this type of thinking include Doheny-Farina,¹³⁴ Stoll,¹³⁵ and Bird.¹³⁶ On the other side of this early debate are those who believe that online communities are indeed possible and serve to foster civic engagement, activism, and empowerment. Turkle,¹³⁷ Bakardjieva,¹³⁸ Baym,¹³⁹ and Rheingold¹⁴⁰ are some scholars aligned with this side of the debate. In *The Virtual Community*, Rheingold confronts criticisms of the potential of online communities. He states,

What should those of us who believe in the democratizing potential of virtual communities do about the technological critics? I believe we should invite them to the table and help them see the flaws in our dreams, the bugs in our designs. I believe we should study what the historians and social scientists have to say about the illusions and power shifts that accompanied the diffusion of previous technologies. CMC and technology in general has real limits; it's best to continue to listen to those who understand the limits, even as we continue to explore the technologies' positive capabilities. Failing to fall under the spell of the "rhetoric of the technological sublime," actively questioning and examining social assumptions about the effects of new technologies, reminding ourselves that electronic communication has powerful illusory capabilities, are all good steps to take to prevent disasters.¹⁴¹

¹³⁴ Stephen Doheny-Farina, *The Wired Neighborhood* (New Haven, CT: Yale University Press, 1996).

¹³⁵ Clifford Stoll, *Silicon Snake Oil: Second Thoughts on the Information Highway* (New York: Doubleday, 1995).

¹³⁶ S. Elizabeth Bird, "Chatting on Cynthia's Porch: Creating Community in an E-mail Fan Group" *Southern Communication Journal* 65 (1999): 49-65.

¹³⁷ Sherry Turkle, *Life on the Screen: Identity in the Age of the Internet* (New York: Simon & Schuster, 1995).

¹³⁸ Maria Bakardjieva, "Virtual Togetherness: An Everyday-Life Perspective" *Media, Culture & Society* 25 (2003): 291-313.

¹³⁹ Nancy Baym, "Interpreting Soap Operas and Creating Community: Inside a Computer-Mediated Fan Culture," *Journal of Folklore Research* 30 (1993): 143-77.

¹⁴⁰ Howard Rheingold, "A Slice of Life in My Virtual Community," in *High Noon on the Electronic Frontier: Conceptual Issues in Cyberspace* eds. Peter Ludlow and Mike Godwin (Cambridge, MA: MIT Press, 1996), 413-36.

¹⁴¹ Howard Rheingold, *The Virtual Community: Homesteading on the Electronic Frontier* (Cambridge: MIT Press, 2000), 320.

More recent research accepts that online communities function as such and examines more deeply what goes on within these digital realms. In her study on online infertility support communities, Haas raises the question, “Does the internet, as a network connecting geographically dispersed users, empower women and members of other traditionally subordinate groups to find community and organize politically in pursuit of their own interests...or are feminist and other nonmainstream forums especially vulnerable...?” Haas contends that medicine, particularly that which pertains to reproduction, is still dominated by patriarchy and subjugation, but that communicating in online forums dedicated to topics of reproduction and women’s bodies allows women to share their embodied knowledge in more inclusive and liberating ways.¹⁴² She notes that certain women-centered online spaces, where free sharing of feminist information occurs without patriarchal intervention (she cites blogs specifically), “not only...allow women to control the language and content included in their safe space, but they also serve as a way of promoting the community among other cybercysters webbing their own infertility practices, embodied knowledge, scientific knowledge, opinions, and more.”¹⁴³

In her study on teenage girls and blogging communities, Jessalynn Marie Keller argues that the practice of blogging affords teenage girls a new format for participating in feminist politics, and that these online spaces contribute to helping teenage girls develop new understandings of community, activism, and feminist politics.¹⁴⁴ Morrow, Hawkins

¹⁴² Angela M. Haas, “Wired Wombs: A Rhetorical Analysis of Online Infertility Communities,” in *Webbing Cyberfeminist Practice: Communities, Pedagogies and Social Action*, eds. Kristine Blair, Radhika Gajjala and Christine Tulley (Cresskill, New Jersey: Hampton Press Inc., 2009), 79.

¹⁴³ *Ibid.*, 77.

¹⁴⁴ Jessalynn Marie Keller, “Virtual Feminisms” *Information, Communication & Society*, 15 no. 3 (2012): 429-447.

and Kern interrogate online spaces as sites for feminist research and note that while they are indeed fruitful sources of data, they are bound by complex issues such as privilege, politics and over-arching capitalist structures. They note that,

From our current vantage point we are able to see online spaces as simultaneously public and private sites that are being continuously (re)constructed across virtual and material places, through a variety of social relations, including capitalism. In place of the endless frontier of comments, tweets, and posts, we have pointed to an alternative vision of online spaces as relational places (Massey 2004) deserving of serious ethical consideration. In constructing this alternative geography of online space, we have relied extensively on feminist theories and methodologies that advocate for reciprocal, participatory, and embodied approaches to qualitative research.¹⁴⁵

A number of researchers have evaluated the role of online spaces in fostering health-related support communities and found that users turn to these communities for support, empathy, information-exchanges and social connection.¹⁴⁶

¹⁴⁵ Oona Morrow, Roberta Hawkins, and Leslie Kern, "Feminist research in online spaces," *Gender, Place & Culture*, 22 no. 4 (2015): 537.

¹⁴⁶ For example, see J.L.Bender et. al., "Online Communities for Breast Cancer Survivors: A Review and Analysis of Their Characteristics and Levels of Use," *Supportive Care in Cancer* 21, no. 5 (May 2013): 1253-1263; Priya Nambisan, "Information Seeking and Social Support in Online Health Communities: Impact on Patients' Perceived Empathy," *Journal of the American Medical Informatics Association* 18, no. 3 (May 2011): 298-304; Phoenix K. H. Mo and Neil S. Coulson, "Exploring the Communication of Social Support within Virtual Communities: A Content Analysis of Messages Posted to an Online HIV/AIDS Support Group," *CyberPsychology & Behavior* 11, no. 3 (June 2008): 371-74; Sumaira H.Malik and Neil S. Coulson, "Computer-Mediated Infertility Support Groups: An Exploratory Study of Online Experiences," *Patient Education and Counseling* 73, no. 1 (October 2008): 105-113; C.F. van Uden-Kraan, C.H.C.Drossaerta et al, "Participation in Online Patient Support Groups Endorses Patients' Empowerment," *Patient Education and Counseling* 74, no. 1 (January 2009): 61-69; Mark W. Newman, Debra Lauterbach, et. al, "It's Not That I Don't Have Problems, I'm Just Not Putting Them on Facebook': Challenges and Opportunities in Using Online Social Networks for Health," Proceedings of the ACM 2011 conference on Computer supported cooperative work (2011): 341-350; S. Ziebland, and S Wyke, "Health and Illness in a Connected World: How Might Sharing Experiences on the Internet Affect People's Health?" *The Milbank Quarterly* 90, no. 2 (2012): 219-49.

For the purpose of this dissertation, I contend that while the internet is not an entirely empowering and liberating force and is often undergirded with political and capitalistic motivations as well as privilege of access, there are many women-centered online spaces that function in empowering and liberating ways; specifically in the context of online spaces that foster discussions about reproductive health and contraceptive options, these forums that allow for the exchange of experiential information have the potential to empower their users. The forum and social media that I draw data from fall into that typification.

3.2 Methods

This dissertation utilizes a multiple methods approach, emphasizing triangulation. Proponents of multiple methods approaches in feminist research suggest that this approach allows feminist researchers to link past and present, data collection and action, and individual behavior with social frameworks.¹⁴⁷ Triangulation is a strategy often utilized in qualitative research to strengthen methods employed in a study. Validation of a qualitative analysis is approached using multiple modes of data collection and varying sources in addition to multiple theoretical approaches. Triangulation helps ensure that a study's conclusions are well-supported, rather than simply resulting from a single method or a single source that is potentially limited in scope or perspective.¹⁴⁸ This project consists of two key components: The first component is a case study of the history of the *Our Bodies, Ourselves* series to examine how feminist contraceptive information for women has

¹⁴⁷ Shulamit Reinharz, *Feminist Methods in Social Research* (New York: Oxford University Press, 1992), 197.

¹⁴⁸ M. Q. Patton, "Enhancing the Quality and Credibility of Qualitative Analysis," *Health Service Research*, 34 no 5 (1999):1189–1208.

changed over time, focusing specifically on cervical barrier methods but also tracking changes in the contraceptive landscape generally. The second component is interviews with individuals who use, have used, or are considering using cervical barrier methods. Discourse analysis is used for the case studies, while constant comparison is used for the interview data; explications of these approaches are provided below.

3.3 Justification for Methods Used

Combining a case study approach with interviewing provided an ideal method of conducting research for this study. This case study allowed for a qualitative analysis of current trends and relationships in contraceptive information provision and representation, while interviews with women interested in or actively using this method of contraception offered in-depth, personal accounts of these relationships.¹⁴⁹ The semi-structured interviews with people seeking or using cervical barrier methods, in addition to one with a health practitioner that provides information and access to these methods helped facilitate a greater understanding of circumventing and subversive information strategies undertaken to challenge marginalized information. Interviewing individuals that were members of women-centered online communities that discuss contraceptives was the best method to gain insight into the social practices and contexts of information marginalization and oppositional strategies because they offered in-depth, detailed accounts of their experiences. These interviews proved an effective method in gathering information that would otherwise not be available for analysis.

¹⁴⁹ Bent Flyvbjerg, "Five Misunderstandings About Case-Study Research," *Qualitative Inquiry* 12, no. 2 (April 2006): 219-245.

3.4 Research Questions

This dissertation began with a series of research questions:

- (1) How have women's knowledges (embodied and otherwise) been subjugated and repressed by a climate of patriarchal, science-dominated medicine? Are women actively circumventing the idea of authoritative knowledge in favor of women-centered communities of information sharing, and if so, how?
- (2) How do women interested in the diaphragm as a contraceptive method gain knowledge about their methods, and how do communities of women work collaboratively to facilitate the sharing of knowledge about this form of contraception?
- (3) Does the marginalization of women's knowledge facilitate strategies that women undertake to challenge the boundaries to accessing this information, and if so, do these strategies constitute acts of subversion?

In describing the research question stage of grounded theory research, Strauss and Corbin note that, "While the initial question starts out broadly, it becomes progressively narrowed and more focused during the research process, as concepts and their relationships are discovered to be relevant or irrelevant."¹⁵⁰ This was certainly the case with my own research questions, which were initially generated and then further refined as I interviewed more participants. While my initial research questions were primarily focused on information access, it later became apparent that information sharing practices were equally, if not more important to this project.

¹⁵⁰ Anselm L. Strauss, and Juliet Corbin, *Basics of Qualitative Research: Grounded Theory Procedures and Techniques* (Newbury Park, CA: Sage Publications, 1990), 38.

3.5 The Sites of Recruitment

All participants in this study were recruited from one of two online social networks, the first being an obscure¹⁵¹ members-only group dedicated to gaining and sharing information about cervical barrier methods, and secondarily, the comments section of an article about the Caya diaphragm on the feminist news site *Jezebel*'s Facebook page. The cervical barriers group is a unique informational hub that allows those interested in using cervical barriers to access up-to-date knowledge about practitioners who still fit diaphragms and caps, manufacturers still producing them, and pharmacies (brick and mortar or online) that sell them. Group members can ask questions about difficulties or confusing aspects of barrier usage and can expect experiential accounts from others. Some interested health practitioners also use the group occasionally to help advise members about where to obtain fittings and devices, or how to know if a fit is accurate. Many users worry about proper fit and can get detailed information about how a well-fitted barrier should feel; it is preferential for practitioners to offer proper fittings, but in some instances this is untenable and thus women can learn how to fit their own barriers as a last resort. Further, for regions where spermicide is no longer available, a list of recipes for homemade spermicides is offered in a resources section.

The comments section of articles posted to Facebook is less of a place for sharing experiences and insights for circumvention of mainstream medical hindrances, and is more conversational for topics du jour. In this instance, the feminist news site *Jezebel* had posted a link to an article about the Caya diaphragm on its Facebook page, and women convened

¹⁵¹ To protect the privacy of group members, I am withholding the specific name of the group.

in the comments section to discuss this new device and cervical barriers in general. There is less anonymity in that Facebook profiles are used to comment, whereas in the cervical barriers group, usernames can be established for the sole purpose of accessing the group. Further, the group administrators must approve members as opposed to *Jezebel's* Facebook page, which is public. In that regard, those who interact with the group can expect a reasonable amount of privacy when discussing cervical barriers, while those posting to Facebook might anticipate that their friends and family can see their posts. In interacting with both formats, I noticed that the general tone on Facebook was conversational and significantly less personal when compared with the cervical barriers group, wherein participants inquired about and divulged deeply personal information about themselves.

Rather than conduct a digital ethnography of the collective users of these sites in group contexts, I chose to interview individual users one-on-one; while my research questions are concerned with the sharing and informational dynamics that occur within the group or Facebook page comments section, the process and journey of selecting and obtaining a contraceptive method is highly individualistic. And although group members and Facebook posters do divulge highly personal information about themselves to strangers within the context of their online communities, the nuances of a personal narrative yielded what I believe to be richer data than what would have been collected via group interviews.

Having used the cervical barriers group myself to access information about diaphragms, I can attest that its chief function is to assist members with accessing information that is not readily accessible. The group's moderator explained to me that she never anticipated taking on an important leadership role, but that since so many cervical

barriers were being phased out, as was the practice of fitting them, she came to see her position as one of significance given that in many cases, the group was the only place where women could both speak freely about their cervical barrier experiences and gain what was effectively marginalized information about them. In my own experience, the group armed me with information about where to actually purchase a diaphragm after I had struggled for some time to find a practitioner who would fit me for one; despite getting fitted, no local pharmacy carried diaphragms. The group offered me the names of online pharmacies out of the UK that would ship diaphragms to Canada. It was with this information that I was able to actually get a diaphragm; the group served this function for many other cervical barrier seekers and users, in addition to myriad other informational aspects. Much of my data comes from users of this group and their experiences therein. After broadening recruitment criteria, I recruited the remainder of participants from Facebook. These participants use other social networks but are unfamiliar with the cervical barriers group. Their experiences with sharing and community are no less significant, however.

Participants shared their experiences in different geographic regions including the United States, Canada, the United Kingdom and Europe, and accordingly, certain aspects of their encounters were specific to their respective locales.

3.6 Recruitment

Prior to recruitment, my ethics protocol was approved by the Western University Non-Medical Research Ethics Board (see appendices A, B, and C). As briefly touched upon above, recruitment of participants occurred in two discrete phases, the first phase occurring via the online cervical barrier methods forum and the second through the *Jezebel*

feminist news page on Facebook. In phase one, I gained permission from the forum's moderator (see Appendix I) to post a document to their community resource section which included information about the study and directions on how to contact me if anyone was interested in participating (see Appendix G). From there, I sent interested parties detailed study information including ethical considerations (Appendix D) and a consent form (Appendix E). I offered prospective participants a choice of interview method, including options such as guided email or IM questionnaire (Appendix H), Facebook chat, Skype, telephone, or any other method of their preference. I chose to include a questionnaire as one of the interview options because it offered participants with specific time constraints or scheduling difficulties an opportunity to read and respond to interview questions when it was most convenient for them. Questionnaires were sent via email or instant message and allowed for follow-up questions and back-and-forth asynchronous communication. King and Horrocks note that this asynchronous email format allows participants time to reflect, is a medium many people are comfortable with and offers timing convenience for participants.¹⁵² In total, seventeen participants from the diaphragm group completed the interview process.

In the second phase of data collection, I posted a short blurb about my study in the comments section of a *Jezebel* article about the Caya diaphragm; in a similar vein as before, I offered a brief description of the study and invited interested parties wanted to learn more to contact me through Facebook Messenger (see Appendix J). This resulted in nine participants from Facebook completing their interviews. I generally found this approach

¹⁵² Nigel King and Christine Horrocks, "Remote interviewing." in *Interviews in qualitative research* (Los Angeles: SAGE, 2010), 79-102.

to be fairly smooth, straightforward, and transparent, however, the process was not entirely without difficulties; due to specificity of desired interviewees and the niche contraceptive they used or desired, locating an adequate sample of participants willing to divulge such personal information about themselves took some time. Diaphragm users are relatively rare in the birth control landscape and even though recruiting was via somewhat niche sources with a concentration of the target demographic, whether or not users were interested in participating was a different matter altogether. Nevertheless, over the span of 2.5 years, I interviewed 26 participants in total, 25 of whom were cervical barrier seekers or users. Initially I had intended to interview several health practitioners about their interactions with and thoughts on cervical barriers, but recruiting practitioners proved challenging and ultimately, one doctor who regularly fits and prescribes diaphragms was interviewed using a more targeted questionnaire (Appendix I), resulting in a total of 26 participants.

3.7 Interviewing

For this project I embraced specifically feminist approaches to interviewing as described above while keeping in mind more general quantitative approaches; Kvale writes, “The qualitative research interview attempts to understand the world from the subjects’ points of view, to unfold the meaning of people’s experiences, to uncover their lived world prior to scientific explanations”¹⁵³ Interview materials included emailed questionnaires, Gmail chat, Facebook chat, Skype text chat, telephone, Skype video chat,

¹⁵³ Steinar Kyale, *Interviews: An Introduction to Qualitative Research Interviewing* (Thousand Oaks, CA: SAGE), 1.

and despite the variances in interview media, I strived to implement feminist principles such as reflexive and participatory interviewing style and reciprocity; even in questionnaire formats, I invited participants to contact me if they had any additional questions and I also gained consent for follow-up questions and additional interviewing if I thought it necessary (for instance, if a participant was still waiting for the pharmacy to contact them regarding their order for a diaphragm, I sought follow-up to see how that process manifested). I found that participants were often curious about my own experiences and use of the diaphragm. Some interviewees said that they didn't have friends with whom they could discuss these issues. I didn't attempt to maintain distanced objectivity; in every case, I attempted to make things more conversational, or give regional context for comparison. I had no issues disclosing personal information about myself, because in this relationship, there was a form of mutuality. At times, I would offer advice about obtaining cervical barrier methods if it appeared to me that participants were undergoing distress due to difficulty in locating them, or if it seemed to me that participants were following a course of action that would lead to difficulty and potential distress in locating these methods (i.e., some participants didn't know that Ortho discontinued its models of diaphragms and that most mainstream pharmacies don't deal with the smaller company Cooper Surgical, manufacturer of Milex diaphragms). This interventionist approach is vastly different from distanced objectivity, but maintains its integrity under the umbrella of feminist ethnographies because reciprocity is paramount as is minimizing harm or distress.

3.8 Data Collection

In total, 26 participants were interviewed, including 25 seekers or users of cervical barrier methods (24 women and one gender non-binary person), and one male practitioner.

Interviews commenced in May 2013 and concluded in February 2016, with ethics renewed continually throughout the interviewing process. The data that resulted from interviews included the following:

- 8 interview questionnaires (participants #1, 2, 5, 6, 7, 8, 9, 13)
- 6 Skype text chats (participants #3, 4, 10, 11, 14, 16)
- 5 phone interviews (participants #12, 18, 21, 22, 24)
- 2 Skype video chats with only audio retained (participants #15, 25)
- 4 Facebook text chats (participants #7, 20, 23, 36)
- 1 Gmail chat (participant #15)

The totality of data includes approximately 324 minutes of audio and over 500 pages of text. I personally transcribed all audio data. In data sets where participants wrote their responses (the questionnaire and real-time online textual chats), I generally left their statements unaltered except for minor typos. I assigned pseudonyms to each participant, selecting a name similar in character to their actual first names. The participant who identifies as gender non-binary specifically requested a gender-neutral pseudonym, so I selected “Charlie” on their behalf.

3.9 Limitations of Interviewing

Any difficulty in conducting interviews was contingent on the level of disclosure that the participant felt comfortable in revealing to me; given the intimate nature of the subject matter, participants occasionally expressed the notion that what they wanted to say may be “TMI” (too much information) about their sexual practices or anatomy. I attempted to quash these concerns by explaining my own diaphragm use and that I was not squeamish and was very open-minded. However, I contend that participants may have withheld some

accounts from me due to their own cultural or personal views on discussing sexuality. The advantages of using semi-structured interviews included gaining an in-depth perspective of the respondent's experiences and opinions. Using semi-structured interviews was beneficial because it allowed me the freedom to ask additional or follow-up questions after the initial response to questions, while simultaneously providing me with some guidelines and a very basic organizational structure with which to proceed.

3.10 Qualitative vs Quantitative "Rigor"

While quantitative research seeks to identify causality, locate statistical relationships, generate predictions, and produce generalized findings, qualitative research often leads to a broader illumination of the issues at hand and a more thorough understanding of the situation under investigation.¹⁵⁴ Through an abundance of data, quantitative researchers seek to eliminate biases via maintaining objectivity in research and endeavor to produce results that reflect a certain level of rigor. As mentioned in a previous chapter, this dissertation aligns itself with Donna Haraway's view that research need not be objective in order to be valid; all research is situated somewhere, and to deny that can be dangerous.

Embracing a high level of reflexivity and utilizing a data collection method that often sees the researcher-interviewee relationship inverted, this dissertation rejects a notion of objective rigor in favor of theoretical saturation via thorough data collection. In order to generate internal validity in the research process, it was important for data collection to

¹⁵⁴ Marie C. Hoepfl, "Choosing Qualitative Research: A Primer for Technology Education Researchers," *Journal of Technology Education* 9, no. 1 (Fall 1997): 47-63.

reach a level of theoretical saturation. In order for a level of theoretical saturation to be achieved, “no additional data are being found whereby the researcher can develop the properties of the category.”¹⁵⁵ During the process of data collection, certain themes reappeared, such as being dismissed or ridiculed by a medical practitioner and feeling that hormonal birth control methods were wrong for the participant’s body. While certain concepts were present in a number of interviews, other themes occurred less frequently, but often enough to be deemed important.

In accordance with grounded theory approaches, data collection and preliminary analysis were conducted simultaneously. Based on the literature it was probable that between 20 and 30 interviews would be needed to reach the point of theoretical saturation;¹⁵⁶ The sample of 26 interview participants surpasses the minimum numbers of 15 to 20 cases recommended by Miles and Huberman,¹⁵⁷ among others. After a somewhat difficult and long recruitment process, data collection was capped at 26 participants.

3.11 Case Study/Discourse Analysis

In using a multiple method, triangulated approach to data collection and analysis, I comparatively analyzed older and newer versions of *Our Bodies, Ourselves* to evaluate in what ways discourse about diaphragms has changed over four decades. This series offered feminist-centered health information for women at a time when it was not readily available and was the most comprehensive source of sexual health information for women

¹⁵⁵ B. Glaser and A. Strauss, *The Discovery of Grounded Theory: Strategies for Qualitative Research* (Mill Valley, CA: Sociology Press, 1967), 61.

¹⁵⁶ John Creswell, *Qualitative Inquiry and Research Design: Choosing Among Five Traditions* (Thousand Oaks, CA: SAGE, 1998), 128.

¹⁵⁷ M.B. Miles and A.M. Huberman, *Qualitative Data Analysis* (Thousand Oaks: SAGE, 1994).

before the internet emerged as a dominant source for information. Because *Our Bodies* published new editions over the span of nearly forty years and continually updated the information within to reflect scientific and cultural shifts, but has always maintained a feminist approach, it serves as an ideal source of data to observe how certain contraceptive methods, namely cervical barriers, have been reflected and represented over time. Looking at editions published in 1973, 1984, 1992 and 2011 offered a range of temporal periods over which to evaluate the diaphragm's general reputation as a contraceptive option for women.

To analyze this particular case study data, I employed a materialist feminist discourse analysis. According to Naples, a materialist feminist approach views social movements and acts as

constituted in discourses that organize and are structured by ruling relations and are embedded in everyday activities. Ruling relations and resistance are evident in both the processes that generate a particular social movement frame as well as in the way the frame is circulated, interpreted, and reinscribed with alternative meanings, and taken up by potential allies as well as opponents. Collective action frames can also resist domination or at least demonstrate the cracks and fissures in the dominant discursive field.¹⁵⁸

More generally, discourse analysis conceptualizes language as social interaction, and is concerned with the social contexts in which discourse is embedded. Wetherell notes, "At its most basic, the study of discourse and persons investigates how people tell stories about themselves and how they present themselves in talk. We can look at how people put together an account, the discursive practices and routines they use and the consequences

¹⁵⁸ Naples, 91.

of choosing one way of talking about oneself over another.”¹⁵⁹ Gumperz contends “that to understand the role of language...in social processes in general, we need to begin with a closer understanding of how linguistic signs interact with social knowledge in discourse”¹⁶⁰ I employed a materialist discourse analysis to examine feminist birth control texts’ coverage of cervical barrier methods over time, to seek out and identify the social contexts in which information about diaphragms is contained, and how the language used in these data sources is embedded and discursively constructed within these social contexts. Chapter 5 elucidates the rationale and approach more thoroughly.

3.12 Interview Data Analysis: Constant Comparative Method

I employed the constant comparative method to analyze interview data collected via feminist ethnographic approaches. The constant comparative method was originally developed for the use in a grounded theory methodology and is now applied more widely as a method of analysis in qualitative research. In utilizing this mode of analysis, the researcher compares one piece of data to all other pieces of data. In analyzing interview data, I used the qualitative comparative method of data analysis¹⁶¹ to construct categories and themes, and to isolate recurring patterns that emerged from the data. While broadly generating categories and themes as interviews were being conducted, I had a sense of major reoccurring concepts before embarking on a formalized coding process. Once data

¹⁵⁹ Margaret Wetherell, “Part Three: Mind, Selves and Sense-Making, Editor’s Introduction,” in *Discourse Theory and Practice: A Reader*, eds. Margaret Wetherell, Stephanie Taylor and Simeon J. Yates (London: Sage, 2001), 186.

¹⁶⁰ J. J. Gumperz, *Language and Social Identity* (Cambridge: Cambridge University Press, 1982).

¹⁶¹ C. Ragin, *The Comparative Method: Moving Beyond Qualitative and Quantitative Strategies* (Berkeley: University of California Press, 1987).

collection was complete, I went through the transcripts again and used the procedure of open coding. Open coding allowed the highlighting of particular words or chunks of responses that indicated concepts and categories that fit the data. Utilizing Strauss and Corbin's¹⁶² approach to open coding, I began generating tentative codes observed in the data. Each interview transcript was reviewed on an individual basis and interesting concepts were outlined. After going through each of the interview transcripts, it was evident that some similarities in responses were emerging to the degree that definitive themes could be identified. Color codes were assigned based on thematic concepts and thematically similar data were compiled into separate documents where I then flagged overarching and sub-themes.

Utilizing a recursive approach, wherein “a constant moving back and forward between the entire data set, the coded extracts of data... and the analysis of the data”¹⁶³ was employed, I was able to isolate themes and also analyze factors (social, political, personal, etc.) that that undergirded them. In communicating the findings of the data, it was important for me to draw on participants' own words and experiential narratives as much as possible as to avoid the imposition of over-synthesis; their stories and experiences are their own, and my analysis of the themes that bore out from them hopefully will serve to illuminate rather than objectify.

This chapter has described the methodological considerations of this dissertation, emphasizing the importance of feminist ethnographic principles; rejecting hierarchy and

¹⁶² Strauss and Corbin, 1990.

¹⁶³ V. Braun and V. Clarke, “Using Thematic Analysis in Psychology,” *Qualitative Research in Psychology* 3, no. 2 (1990): 86.

objectivity in favour of mutuality and reciprocity ultimately garnered in-depth interviews about women's experiences and facilitated a level of sharing that may not have manifested otherwise.

The following chapter offers a historical overview of the rise and fall of cervical barrier methods, which provides the temporal background that ultimately undergirds current market conditions and biomedical/pharmaceutical trends positioning cervical barriers as an unpopular method today.

4 Historical Context

4.1 Introduction

Birth control is neither a novel idea nor a recent invention; woman and men have been using methods to prevent pregnancy since ancient times.¹⁶⁴ While it is beyond the scope of this dissertation to explicate a comprehensive history of contraceptives, this chapter will endeavor to synthesize some key events in a birth control narrative that tells the tale of the rise and subsequent fall of the diaphragm. The main protagonist of this chapter is Margaret Sanger, a prominent American birth control activist in the early-to-mid twentieth century. Sanger's journey is an important one to the narrative structure of this dissertation; having championed for women's reproductive freedom in the United States, and then travelling across Europe to learn more about contraceptive methods being used in England, France and the Netherlands, she provides the historical backdrop for the status of the diaphragm today. And since participants in this study come from the United States, Canada, and the United Kingdom, Sanger's trajectory is able to illuminate some regional contexts of the women who share their stories in the chapters to come.

Her journey is one that spans globally, and her activities elucidate the story of commercial birth control in America (and indirectly Canada) via Europe. Her narrative is one that has culminated in certain birth control methods displacing others. As this chapter will go on to demonstrate, Sanger's work was integral to the democratization of birth control, but also effectively relegated it the realm of medical authority. Her desire to keep contraception under the control of doctors and medical practitioners has had longstanding

¹⁶⁴ Andrea Tone, *Devices and Desires: A History of Contraceptives in America* (New York: Hill and Wang, 2002), 13.

effects on birth control and the women who use it, and the facilitation of paternalistic practices in contraceptive medicine that continue to dominate western medicine today.

4.2 Barrier Methods History

Barrier methods of contraception have been the most widely used contraceptive techniques throughout recorded history.¹⁶⁵ Many ancient texts discuss the insertion of different materials into the vagina for the purpose of contraception. The Ebers Papyrus, dated to approximately 1500 B.C.E., offers a recipe to stop pregnancy that includes creating a pessary of plant fiber saturated with honey, colocynth, dates and acacia and inserting it into the vagina.¹⁶⁶ The Kahun Papyrus, a medical resource dating back to around 1900 B.C.E., makes mention of contraceptive pessaries, several of which include acacia gum.¹⁶⁷ In *A Clinical Guide for Contraception*, Speroff and Darney note that, “Intravaginal contraception was widespread in isolated cultures throughout the world. The Japanese used balls of bamboo paper, Islamic women used willow leaves, and the women in the Pacific Islands used seaweed. References can be found throughout ancient writings to sticky plugs, made of gumlike substances, to be placed in the vagina prior to intercourse.”¹⁶⁸

While the success of many of these early intravaginal methods was likely related to luck, and perhaps made sexual relations awkward or uncomfortable, Andrea Tone

¹⁶⁵ Leon Speroff and Philip D. Darney, “Barrier Methods of Contraception,” in *A Clinical Guide for Contraception 5th Edition* (Philadelphia, PA: Lippincott Williams & Wilkins, a Wolters Kluwer Business, 2011), 281.

¹⁶⁶ John M. Riddle, *Eve’s Herbs: A History of Contraception and Abortion in the West* (Cambridge, Mass.: Harvard University Press, 1997), 35-36.

¹⁶⁷ Riddle, *Eve’s Herbs*, 36.

¹⁶⁸ Speroff and Darney, “Barrier Methods,” 281.

suggests that, “not all were devoid of contraceptive properties. Honey-based suppositories likely impeded sperm motility,”¹⁶⁹ and other substances used in the vagina, such as elephant dung and olive oil, also likely exhibited legitimate contraceptive properties.¹⁷⁰

In more recent history, the Victorian era paved the way for many developments in contraceptive technology. Preindustrial Americans tended to rely on prolonged lactation, male withdrawal, abstinence, suppositories, and douching for their contraception, but also imported condoms made of linen or animal intestines from Europe.¹⁷¹ Herbs with abortifacient properties, namely savin and pennyroyal, grew in the wild and could also be procured from urban centers.¹⁷² As the demand for more birth control options begin to grow, new technological developments began to pave the way for a burgeoning industry.

Charles Goodyear, a self-taught chemist and manufacturing engineer, developed the process to vulcanize rubber in 1839 and perfected and patented the rubber vulcanization process in 1844.¹⁷³ This process allowed for a mass manufacturing industry to develop, and facilitated an abundance of new contraceptive devices such as condoms, intrauterine devices, douching syringes, womb veils (the 19th century precursor to the modern diaphragm), pessaries, and many other apparatuses novel to that era.¹⁷⁴ Vulcanized rubber not only led to a boom in birth control innovation, but also a greater reliance on the market to provide these goods.¹⁷⁵ According to Tone, “In the early 1870s, condoms, douching

¹⁶⁹ Tone, *Devices and Desires*, 13-14.

¹⁷⁰ *Ibid.*, 14.

¹⁷¹ *Ibid.*

¹⁷² *Ibid.*

¹⁷³ Charles Goodyear, 1844. Improvement in India Rubber Fabrics. US Patent 3633.

<https://patents.google.com/patent/US3633A/en>

¹⁷⁴ Tone, *Devices and Desires*, 14.

¹⁷⁵ *Ibid.*

syringes and solutions, vaginal sponges, diaphragms, and cervical caps could be purchased from mail-order houses, wholesale drug-supply houses, pharmacies, and dry-goods and rubber vendors.”¹⁷⁶ The mass availability of rubber cervical caps and diaphragms both domestically and abroad saw new innovations in tweaking their design.

In 1842, a German gynecologist named C. Haase, using the pseudonym Wilhelm P.J. Mensinga, invented the first modern diaphragm, which was fashioned from a hard rubber ring covered by a thinner sheet of rubber. After vulcanized rubber became available via widespread distribution, he altered the design to use the new form of rubber instead of natural rubber to increase the device’s hygienics.¹⁷⁷ In the 1880s, Mensinga updated the design and published the first description of a rubber contraceptive device with a spring molded into the rim.¹⁷⁸ By 1900, the Mensinga diaphragm became a popular contraceptive offering in birth control clinics in Europe.¹⁷⁹ Inspired by European technologies, inventors in the United States began to add their own modifications to the basic diaphragm design.

In 1846, John B. Beers of Rochester patented “the wife’s protector,” a device consisting of a wire hoop covered with a thin membranous substance to be inserted in the vagina to cover the cervix for the purpose of preventing conception.¹⁸⁰ In the 1860s, Dr. Edward Bliss Foote developed and sold an occlusive pessary for the purpose of contraception.¹⁸¹ Foote introduced his device, what he called “the womb veil,” in a self-published book entitled *Medical Common Sense*:

¹⁷⁶ Ibid.

¹⁷⁷ Ibid., 56.

¹⁷⁸ Wikipedia Contributors, “Diaphragm (birth control),” *Wikipedia, The Free Encyclopedia*, accessed June 28, 2019, [https://en.wikipedia.org/w/index.php?title=Diaphragm_\(birth_control\)&oldid=887000919](https://en.wikipedia.org/w/index.php?title=Diaphragm_(birth_control)&oldid=887000919)

¹⁷⁹ Tone, *Devices and Desires*, 56.

¹⁸⁰ Ibid.

¹⁸¹ Wikipedia, “Diaphragm.”

This consists of an India-rubber contrivance which the female easily adjusts in the vagina *before* copulation, and which spreads a thin tissue of rubber before the mouth of the womb so as to prevent the seminal aura from entering. ... Conception cannot possibly take place when it is used. The full enjoyment of the conjugal embrace can be indulged in during coition. The husband would hardly be likely to know that it was being used, unless told by the wife...It places conception entirely under the control of the wife, to whom it naturally belongs; for it is for her to say at what time and under what circumstances, she will become the mother, and the moral, religious, and physical instructress of offspring.¹⁸²

This one-size-fit-all diaphragm is both affordable, simple, and touted by its inventor as a way for women to control their own fertility and reproduction. This notion of women being squarely in charge of their own procreative destinies was fairly progressive for the time, and indeed, numerous other inventors in the 19th century, both in North America and Europe, continued to augment and update designs for cervical barrier methods, giving women a greater amount of choice for contraception than was previously available. However, in America, that was set to change shortly.

4.3 Comstock Act

In 1873, Ulysses S. Grant's second inauguration was scheduled for March 4. As citizens prepared for a flurry of activity, Congress rushed to complete unfinished business. Having been associated with multiple scandals at the time, the Forty-second Congress sought to end the session by passing a glut of legislation in order to appear more credible.¹⁸³ In the final hours of the term on March 3, some 260 acts were passed, including the anti-

¹⁸² Edward Bliss Foote. *Medical Common Sense; Applied to the Causes, Prevention, and Cure of Chronic Diseases and Unhappiness in Marriage* (New York, 1863), 380.

¹⁸³ Elizabeth S. Watkins, *On the Pill: A Social History of Oral Contraceptives, 1950- 1970* (Baltimore: Johns Hopkins University Press, 2001), 14.

obscenity bill, the act for the “Suppression of Trade in, and Circulation of, Obscene Literature and Articles of Immoral Use,” also referred to as the Comstock Act. Named after its primary proponent Anthony Comstock, leader of the New York Society for the Suppression of Vice,¹⁸⁴ the Comstock Act banned the sale and trade of goods deemed to be immoral from traveling across state lines.¹⁸⁵

Comstock believed that pornography and “lascivious” or “immoral” materials could be controlled by the federal government because it was the U.S. postal system that was the primary mode of distributing such goods.¹⁸⁶ Contraceptive devices, which had seen a recent rise in both development and sales, were not exempt from the act, which reads as follows:

Be it enacted.... That whoever, within the District of Columbia or any of the Territories of the United States... shall sell... or shall offer to sell, or to lend, or to give away, or in any manner to exhibit, or shall otherwise publish or offer to publish in any manner, or shall have in his possession, for any such purpose or purposes, an obscene book, pamphlet, paper, writing, advertisement, circular, print, picture, drawing or other representation, figure, or image on or of paper or other material, or any cast instrument, or other article of an immoral nature, or any drug or medicine, or any article whatever, **for the prevention of conception**¹⁸⁷, or for causing unlawful abortion, or shall advertise the same for sale, or shall write or print, or cause to be written or printed, any card, circular, book, pamphlet, advertisement, or notice of any kind, stating when, where, how, or of whom, or by what means, any of the articles in this section... can be purchased or obtained, or shall manufacture, draw, or print, or in any wise make any of such articles, shall be deemed guilty of a misdemeanor, and on conviction thereof in any court of the United States... he shall be imprisoned at hard labor in the penitentiary for not less than six months nor more than five years for each offense,

¹⁸⁴ Riddle, *Eve's Herbs*, 245.

¹⁸⁵ The Comstock Act, chap 258, 17 Stat. 598 (1873). <https://www.loc.gov/law/help/statutes-at-large/42nd-congress/session-3/c42s3ch258.pdf>

¹⁸⁶ Riddle, *Eve's Herbs*, 245.

¹⁸⁷ Emphasis added.

or fined not less than one hundred dollars nor more than two thousand dollars, with costs of court.¹⁸⁸

While the Comstock Act itself specifically banned these goods from traveling through the postal service, additional clauses banned the importation of contraceptives and abortifacients, while another banned the manufacture, advertisement, and sale of “obscene” materials in D.C. and U.S. territories.¹⁸⁹ This act effectually banned pornography, erotica, sex toys, contraceptives, abortifacients, and any information regarding the aforementioned. While Congress had passed obscenity laws before, this marked the first time that contraceptives made the list of obscene items.¹⁹⁰

Although this period marked a pivotal moment in birth control ingenuity and a burgeoning contraceptive market, this boom was effectively halted with the passing of the Comstock Act. As Tone notes, “Comstock’s demonization of contraceptives was a direct response to their newfound commercial visibility, not to their invention or use.”¹⁹¹ And while birth control was also distributed in established medical settings as well as pharmacies, it was the marketing of these goods via mail order alongside other materials of a sexual nature that resulted in their inclusion in the act. According to Tone,

...what Comstock and his cronies found so threatening was the prominence of contraceptives in the vice trade—a robust and increasingly visible commerce in illicit products and pleasures that seemed to encourage sexual license by freeing sex from marriage and childbearing. Entrepreneurs advertised contraceptives in newspapers, broadsides, home medical manuals, and private cards placed strategically on street corners, in railway and steamship depots, and in hotel lobbies.¹⁹²

¹⁸⁸ The Comstock Act 17 Stat. 598.

¹⁸⁹ Tone, *Devices and Desires*, 23.

¹⁹⁰ *Ibid.*, 5.

¹⁹¹ *Ibid.*, 13.

¹⁹² *Ibid.*, 15.

Regardless of the arguable legitimacy of contraceptives being used by married couples or otherwise, the Comstock Act had detrimental effects on both the bottom line of birth control purveyors and the accessibility to these devices by their users and seekers. However, the act did not go without resistance. Some who opposed the act went the legal route, as is the case with Edward Foote, who attempted to repeal the Comstock Act due to both his political views and economic interests, but was ultimately unsuccessful.¹⁹³ Foote continued to market and sell diaphragms and was arrested twice, once in 1874 and once again in 1876. In each case he was fined, but not jailed, and he remained determined to circumvent the law in order to assist women in controlling their own fertility (and pull a profit simultaneously).¹⁹⁴

Enforcement of the Comstock Act was difficult, and an underground trade persisted. The Act disproportionately affected smaller scale companies, inventors and entrepreneurs as large pharmaceutical companies and drug-supply houses were generally allowed to operate without intervention, since they had established a reputation for being legitimate and ethical businesses.¹⁹⁵ Regardless, choice was reduced and without the aid of the postal service, many women had difficulties obtaining the birth control that they desired.

4.4 Margaret Sanger

According to Tone, “Scholars have often characterized the period between criminalization in the 1870s and Margaret Sanger’s movement in the second decade of the

¹⁹³ Tone, *Devices and Desires*, 57.

¹⁹⁴ *Ibid.*

¹⁹⁵ *Ibid.*, 30.

twentieth century as birth control's bleakest chapter, a time when only a privileged few could afford the services of sympathetic doctors or of a dwindling number of merchants who would ignore the law for the right price."¹⁹⁶ She notes that Sanger herself articulated this very perspective, when, after a nearly year-long search for birth control information, found "no information more reliable than that exchanged by any back-fence gossips in any small town."¹⁹⁷

Sanger, born the sixth child out of eleven in 1879 to poor parents in Corning, New York, had, over time due to her own experiences, come to associate large families with all of the negative aspects of poverty.¹⁹⁸ In her late teens, Sanger took a probationary nursing position at a small hospital in Westchester County, and her employment in the medical sector helped fuel her desire to champion birth control: "The training, severe as only it can be in a small hospital where the equipment is less modern than in the larger city hospitals, nevertheless equipped me to organize myself for the battle of life, and later became the background which gave support to the ordeals of motherhood. It influenced tremendously the direction the birth control movement was to take and is taking."¹⁹⁹

She later married and had three children of her own. She described her own motherhood as "joyous, loving, happy"²⁰⁰ due to her fairly stable economic status and ability to space her pregnancies, but she also observed that a lack of access to birth control had detrimental effects on mothers, husbands and children who were not as fortunate as

¹⁹⁶ Tone, *Devices and Desires*, 26.

¹⁹⁷ Margaret Sanger, as cited in Tone, *Devices and Desires*, 26.

¹⁹⁸ Margaret Sanger, *My Fight for Birth Control* (New York: Farrar & Rinehart, Inc., 1931), 5.

¹⁹⁹ *Ibid.*, 33.

²⁰⁰ *Ibid.*, 44.

she was.²⁰¹ Sanger stated, “Since the birth of my first child I had realized the importance of spacing babies, but only a few months before had I fully grasped the significant fact that a powerful law denied and prevented mothers from obtaining knowledge to properly space their families. This was so outrageous, so cruel, so useless a law that I could not respect it.”²⁰²

While working as a nurse in the early 1910s, Sanger often attended home births (which were more common than hospitalized births at the time), and was horrified by the conditions that impoverished mothers lived in. In working with lower class mothers, Sanger often heard stories of dangerous “cheap” abortions conducted by questionable professionals, or worse, dangerous self-administered abortions involving herbal tinctures or knitting needles, and how, consequently, pregnancy was both feared and unpreventable: “The menace of another pregnancy hung like a sword over the head of every poor woman I came in contact with that year.”²⁰³ According to Sanger, “many of the women had consulted midwives, social workers, and doctors at the dispensary and asked a way to limit their families, but they were denied this help, sometimes indignantly or gruffly, sometimes jokingly; but always this knowledge was denied to them.”²⁰⁴

Sanger continued to see her patients suffer, and occasionally, die, from the burdens of unfettered motherhoods. They would ask her advice on preventing pregnancy, but the only two options readily available at the time, coitus interruptus, or condoms, were generally eschewed by the male counterparts of lower-class couples. Sanger quit nursing

²⁰¹ Ibid.

²⁰² Ibid., 45.

²⁰³ Ibid., 49.

²⁰⁴ Ibid., 50.

because she could no longer endure to see her patients in anguish. Sanger sought a better approach to birth control, and committed to making a difference:

I resolved that women should have knowledge of contraception. They have every right to know about their own bodies. I would strike out--I would scream from the housetops. I would tell the world what was going on in the lives of these poor women. I *would* be heard. No matter what it should cost. I *would* be heard.²⁰⁵

She endeavored to explore the availability of birth control information in America and discovered that it was either very difficult to locate, or of no practical value.²⁰⁶ Refusing to accept defeat, she, upon suggestion from her friend Bill Haywood (noted labor radical and executive member of the Socialist Party of America), embarked on a journey to France in order to “find new ways to solve old problems in Europe.”²⁰⁷ Accordingly, in the fall of 1913, Sanger and her family set sail from Boston bound for Glasgow, and then for Paris, with the intention of gathering practical information on contraception.²⁰⁸ So impassioned by the prospect of making birth control and information about it readily available in the United States, she sold her house and withdrew money from her children’s education savings to pay for the trip.²⁰⁹ Sanger hoped that her trip to Europe might result in a successful model of population control via contraception that could be brought back to the United States and subsequently emulated.

Staying in Glasgow before arriving in Paris, Sanger was disappointed to observe poor and crowded living conditions for lower class women. Her first observations of Paris were equally dismal: “The atmosphere of petty penury, of pinched poverty, destroyed my

²⁰⁵ Ibid., 56.

²⁰⁶ Ibid., 60.

²⁰⁷ Ibid., 61.

²⁰⁸ Ibid., 62.

²⁰⁹ Ibid., 63.

illusions and made us homesick at once.”²¹⁰ However, once putting aside her initially pessimistic observations, she delved fully into the population issue and began to observe that the French were much more open and considerate of population and reproductive issues and solutions.²¹¹ A number of devices and methods, while unsatisfactory in efficacy, were identified by Sanger in her discussions with women, druggists and doctors in Paris.²¹² She discovered that in France, “The right to knowledge of contraceptive technique was almost a national right. Even the Catholic Church could not deter its practice.”²¹³ “And while information about contraception was easy to obtain in France through druggists or in social conversation, Sanger noted that “the weakness of the movement was that it had no direction. It was an entirely individual affair. Methods learned from any sources were practiced...consequently there were too many failures, and abortions resulted.”²¹⁴ Unsatisfied by these observations, but simultaneously inspired by European open-mindedness regarding issues of contraception, she returned home and came to the realization that Anthony Comstock’s laws against obscenity must be defeated in order to fully combat the issue of unwanted pregnancies. For Sanger, Comstock was the enemy: “His stunted, neurotic nature and savage methods of attack had ruined thousands of women’s lives. He had indirectly caused the death of untold thousands...directly responsible for the deplorable conditions of a whole generation of women left physically

²¹⁰ Ibid., 66.

²¹¹ Ibid., 68.

²¹² Ibid., 72.

²¹³ Ibid., 72.

²¹⁴ Ibid., 73.

damaged and spiritually crippled from the results of abortion.”²¹⁵ Sanger found that she was alone in her fight against Comstock.

She began publishing a monthly magazine, *The Woman Rebel* in order to both suss out authorities on the Comstock laws (via instigation) and to gain supporters on the issue via readership.²¹⁶ While support for the magazine was sizeable, the publication was banned, deemed “unmailable” in March 1914.²¹⁷ Having been stifled, Sanger was determined to generate additional public interest in the contraceptive movement. She decided that a punchy name was necessary to convey the social and personal significance of the movement, and after careful thought, came up with the phrase “Birth Control” to describe the cause.²¹⁸ As Sanger notes, that was the first time the words were used together, although now we tend to take the phrase for granted as a given description for a common endeavor.²¹⁹

With the name of her movement solidified, she was urged by her readers and supporters to continue publishing in the name of free speech, and that was exactly what she did. Simultaneously, Sanger was working on publishing an informational pamphlet called “Family Limitation” that contained practical advice and knowledge about contraception, in addition to information regarding the devices in France that she had learned about.²²⁰ Pleased with the factual and easy-to-read nature of her pamphlet (geared toward the wives of working-class men), Sanger was flummoxed by the refusal of dozens

²¹⁵ Ibid., 79.

²¹⁶ Ibid., 80.

²¹⁷ Ibid., 81.

²¹⁸ Ibid., 83.

²¹⁹ Ibid.

²²⁰ Ibid., 84.

of different printers to publish the document. Eventually she found a printer to take on the work, and 100,000 copies were printed and stored with the intention of distributing them throughout the United States.

Meanwhile, *The Woman Rebel* was continually suppressed by the postmaster.²²¹ Violating the Comstock Act meant that Sanger risked being arrested and imprisoned. However, Sanger continually demanded to know what specific content in *The Woman Rebel* was deemed obscene. Sanger, fully prepared to go to prison for her cause, enacted a plan with her supporters to release her pamphlets from storage if she was indeed to end up behind bars. However, before she could articulate clear instructions for distribution, she learned in August 1914 that she had been indicted by the grand jury for articles in *The Woman Rebel*.²²²

Sanger decided that the imminent threat of her imprisonment put the advancement of the birth control movement at risk and enacted a plan to flee. Before she exiled to England, Sanger sent a letter to her *Woman Rebel* subscribers explaining her decision to flee in order to avoid being jailed, and her desire to eventually repeal the very laws that put her at risk.²²³ Sanger spent some time in Canada before sailing to England. Without a passport, and at risk for being extradited for her felonious offenses, Sanger had to keep a low profile while still trying to advance her cause. She discussed contraception with different neo-Malthusian thinkers in Britain including Havelock Ellis, although Sanger viewed Malthusianist theory as too highbrow for the working class and sought more practical approaches to contraception.

²²¹ Ibid., 86.

²²² Ibid., 88.

²²³ Ibid., 95.

While staying with noted women's rights advocate Alice Vickery, Sanger was invited to tell her story at Fabian Hall to an audience of women activists. There she met Dr. Marie Stopes, who expressed an ignorance about contraceptive methods generally, and an interest in learning more. Sanger shared her knowledge, and Stopes incorporated some rudimentary information in her book *Married Love*, which was released shortly thereafter. Unbeknownst to her at the time, this would push Stopes into the forefront of the birth control movement in England, ultimately leading to the creation of dedicated birth control clinics in England and the dispensing of cervical caps under medical supervision.²²⁴

In January of 1915, Sanger visited Holland, which was "doubtless the most instructive of all [her] travels, and from it [she] derived the greatest benefit."²²⁵ Having studied the vital statistics of Holland while still in England, Sanger was flummoxed to see both falling birth rates and increased population. She realized that Holland's approach to birth control and maternal health meant significantly fewer maternal deaths, stillbirths and infant deaths, which accounted for why the population was able to increase despite fewer births overall.²²⁶ Sanger received the contact information of noteworthy people in Holland, namely Dr. Aletta Jacobs in Amsterdam and Dr. Johannes Rutgers of The Hague. Travelling during the war was risky, and Sanger was urged by her friends and colleagues to stay in England. However, Sanger's desire for knowledge and facts propelled her to risk travelling under an assumed name.

²²⁴ Wikipedia Contributors, "Marie Stopes," *Wikipedia, The Free Encyclopedia*, accessed June 28, 2019, https://en.wikipedia.org/w/index.php?title=Marie_Stopes&oldid=903849937.

²²⁵ Sanger, *My Fight*, 107.

²²⁶ *Ibid.*, 108.

She arrived, and quickly met with Dr. Rutgers, who encouraged her to learn the techniques of fitting and adjusting the Mensinga diaphragm, and other pessaries.²²⁷ Sanger notes that, “Under his tutelage, I began to realize the importance of individualized instruction for each woman if the method was advised to benefit her.”²²⁸ Sanger was surprised to observe “over fifteen different kinds of devices in use as contraceptives, and fourteen sizes of the diaphragm or Mensinga pessary devised by Dr. Mensinga in 1885 adopted and generally recommended in Holland.”²²⁹

Sanger was eager to observe that each woman seeking a diaphragm was individually consulted with and fitted by Dr. Rutgers. At this point in time, there were already over fifty centers dedicated to fitting pessaries, and Dr. Rutgers called these centers “clinics.” She was intrigued by this notion, as well as the fact that those who had the skill to fit the pessaries were trained as “experts.”²³⁰ Sanger notes that, “These nurses or experts not only advise women as to the best methods to employ to prevent conception, but they examine each applicant, supply her with a well fitted pessary suited to her special need, and instruct her in its use. The nurse teaches how to insert the diaphragm or cervical pessary and how to preserve its use.”²³¹

In Holland at the time, contraceptive devices could also be readily purchased in shops, and customers could be fit for their pessaries by the saleswomen. Dr. Rutgers strongly disapproved of this commercial venture and thought that it was problematic because shop staff had no formal anatomical training; in short, they lacked the expertise

²²⁷ Ibid., 109.

²²⁸ Ibid., 110.

²²⁹ Ibid.

²³⁰ Ibid.

²³¹ Ibid.

that he believed was necessary for effective contraception instruction. Indeed, the culture of contraception knowledge in Holland was one of privileging expertise. Even Sanger herself was categorized as a layman by Aletta Jacobs when it came to issues of birth control: “She refused to see me and stated bluntly that she did not wish to have anything to do with me or my studies; that it was not for ‘laymen’ to interfere in this work; it was the doctor’s subject, and only professional men and women should take it up.”²³² Sanger was hurt by this rejection, and Jacobs later apologized. However, being on the novice end of the expert-novice dichotomy did little to hinder Sanger’s increasing inspiration driven by Holland’s medicalization of birth control; Sanger internalized the idea of experts and proper medical instruction: “I saw that personal instruction must depend upon physiological and anatomical knowledge. Only persons equipped with such knowledge could instruct properly and safely.”²³³ Embodying the fundamental principles of authoritative knowledge, Sanger decided to take Holland’s approach to contraception back to America, changing the course of the birth control movement and ultimately creating a system of medical experts determining the best course of action for women and their reproductive destinies.

Sanger returned to America in October of 1915, and despite a small amount of ideological progress that had been made in the US regarding birth control during the time she was away, found that her indictment was still pending.²³⁴ Anthony Comstock had died a month prior to her return, and thus one of the most outspoken opponents against Sanger’s mission was no longer part of the debate. Sanger found herself rallying support from

²³² Ibid., 113.

²³³ Ibid., 116.

²³⁴ Ibid., 124.

various leftist organizations. On February 18, 1916, her case was ultimately dismissed. Following the verdict, Sanger sent out a letter of thanks to her friends and supporters, and stated therein, “My object is to establish Free Clinics in the various industrial districts throughout the United States, where a poor woman can go to be instructed in the methods to prevent conception and thereby preserve her health and enable her to care for the children to whom she has already given birth.”²³⁵

Sanger’s vision for these clinics was to disseminate properly fitted pessaries:

The safest method and the one advised over a long period of years in Holland, England, France and Germany was, and is today, the occlusive diaphragm or cervical pessary. That article must be made to fit the special requirements of the cervix and the vaginal canal as carefully as eyeglasses fit the eyes. Consequently, without a physical examination by a qualified person, who has some knowledge of anatomy, the advice of a pessary is useless. No woman is safe nor reliably protected from conception who obtains her information from a general source.²³⁶

While the Comstock Laws were still in effect and continued to ban the dissemination of contraceptive information, Sanger found that New York state enacted a legal exception (Section 1145 of the Penal Law), that allowed physicians to offer advice regarding conception and venereal disease. This exception existed namely to allow doctors to treat patients’ venereal disease, but Sanger thought it to be a possible loophole worth exploring.

Sanger and her partners Fania Mindell and Ethel Byrne opened the doors to the first birth control clinic in America on October 16, 1916. Situated at 46 Amboy Street in Brooklyn, NY, the Brownsville Clinic geared its services to the local working class, highly impoverished women who were mostly either of Italian or Jewish descent.²³⁷ Women from

²³⁵ Ibid., 140.

²³⁶ Ibid., 144.

²³⁷ Ibid., 154.

both nearby and distant locales utilized the clinic's services during its short tenure, and these services primarily included fitting diaphragms and offering information about pregnancy prevention. Word spread quickly about the clinic and several days later, a police raid of the clinic occurred. The clinic had been under police surveillance from the time it opened, and an undercover female officer was sent to the clinic to attempt to purchase contraceptives. On October 26, 1916 a vice squad conducted a raid of the clinic and confiscated information related to birth control as well as the actual contraceptive devices. Sanger, Byrne and Mindell were arrested and were released the next morning on \$500.00 bail.²³⁸ Sanger opened the clinic again on November 14 but was once again forced by police to close it. She tried once more to open it on November 16, but she was evicted shortly after and the clinic closed its doors permanently.²³⁹

The Brownsville Clinic had been opened as a test for the perceived loophole in New York State law, and consequently, it appeared as though there was no legal grounds for spreading birth control information. In court, Sanger refused to cease her activities and she was jailed for thirty days. She appealed the case, and on January 8, 1918, Judge Crane ruled that Section 1145 "does not permit advertisements regarding such matters, nor promiscuous advice to patients irrespective of their condition, but it is broad enough to protect the physician who in good faith gives such help or advice to a married person to cure or prevent disease."²⁴⁰ This protection could also extend to vendors acting upon physicians' orders, and thus that charge was dropped against Sanger.

²³⁸ Esther Katz, "Anniversary of the Brownsville Clinic Raid," *Margaret Sanger Papers Project*, accessed June 28, 2019, <https://sangerpapers.wordpress.com/2012/10/26/anniversary-of-the-brownsville-clinic-raid/>.

²³⁹ Ibid.

²⁴⁰ Sanger, *My Fight*, 188.

Judge Crane's ruling allowed Sanger to open another clinic, so long as it was under medical supervision.²⁴¹ In 1922, Dr. Dorothy Bocker agreed to supervise Sanger's second birth control clinic, and on January 2, 1923, the Birth Control Clinical Research Bureau (BCCRB) was opened in New York City.²⁴² This new venture, backed financially by Sanger's then-husband James Noah Henry Slee, was more conservative than Sanger's previous radical initiatives, and it was Sanger and Bocker's hope that increased medicalization of birth control and contextualizing contraception in the realm of science would help legitimize the movement going forward: "With a subsidy from Slee, Bocker published a study of patients' experiences in February 1924. It was the first clinical evaluation of contraceptives published in the United States and was distributed solely to doctors. Here was the BCCRB's chance to discredit quackery while shoring up the clinic's scientific reputation."²⁴³

Whereas Sanger's earlier clinic initiative included providing condoms to interested women, and her pamphlets discussed over-the-counter pessaries, Bocker's report asserted that the only legitimate contraceptive method was the fitted diaphragm, and it eschewed all other methods including the commercially available Mizpah pessary. As Tone notes, "Bocker's report made much of a distinction between legitimate and fraudulent contraceptives--a distinction determined by the devices' retail status, not their efficiency."²⁴⁴ Bocker refused to even test devices that were readily available, as it was her ultimate goal to "divide commercial contraception into two distinct realms: the ethical

²⁴¹ Tone, *Devices and Desires*, 122.

²⁴² Ibid.

²⁴³ Ibid., 125.

²⁴⁴ Ibid, 126.

medical market and the fraudulent patent medicine market.”²⁴⁵ Bocker’s report praised the efficacy of the Mensinga diaphragm, which Slee was smuggling into the United States from Europe via Montreal.²⁴⁶ While contraception in Canada was also illegal at the time by way of the 1892 Criminal Code, attitudes were also liberalizing and a Canadian birth control movement was burgeoning in tandem with that of the United States.²⁴⁷

Sanger’s international importation of contraband was risky, and she sought a domestic manufacturer for diaphragms. While Julius Schmid was manufacturing condoms and by 1923 was beginning to branch out into diaphragms, Sanger rejected the commercial availability of his contraceptives and sought something for professional medical use only. She turned to Slee and in 1925, he funded the development of the Holland-Rantos Company, a contraceptive manufacture who would deal solely with medical professionals.²⁴⁸ Holland-Rantos primarily used the postal service to distribute goods (primarily the Mensinga-type diaphragms they produced and corresponding lactic acid spermicidal jelly) to medical practitioners, but despite the fact that the Comstock Act was still in effect, the medicalization of diaphragm production and distribution meant that nobody in Sanger’s network was arrested.²⁴⁹ Further, in July 1930, a New York circuit court of appeals exempted manufacturers of contraceptives who dealt exclusively with legitimate vendors from federal prosecution.²⁵⁰

²⁴⁵ Ibid.

²⁴⁶ Ibid.

²⁴⁷ Mary F Bishop, “Birth Control,” in *The Canadian Encyclopedia*, accessed June 28, 2019, <https://www.thecanadianencyclopedia.ca/en/article/birth-control>.

²⁴⁸ Tone, *Devices and Desires*, 127.

²⁴⁹ Ibid.

²⁵⁰ Ibid.

Sanger also partnered strategically with James Cooper, a Boston-based gynecologist who agreed to promote the Mensinga diaphragm in his practice and among his colleagues for a fee of \$10,000 annually.²⁵¹ Sanger's advocacy for diaphragms fitted in established clinical settings and made available exclusively via prescription put an end to a systematic structure that saw birth control relegated to the realms of midwives and patent medicine brokers. As Spar and Huntsberger note,

This arrangement essentially reversed the power dynamic that had held sway since the Middle Ages, when the emerging medical elite disdained contraception as criminal and left its practice to the midwives. It also offered the doctors a brand new market, one that, by definition, belonged only to them.²⁵²

For Sanger, birth control information and instruction were the fundamental aspects of the movement she was leading. Operating birth control clinics, in her view, was not only essential for women's health, but they also would ideally serve as hubs of education and information sharing:

I saw the clinic not as an isolated social agency, but functioning as an integral factor of public and racial health, forming an integral part of all pre-natal and post-natal agencies for maternal and child welfare. I envisaged it as well-organized as the public school system. Indeed, from my point of view, these systems of clinics were to be schools--centers of instruction, primarily in contraceptive technique, but schools as well for all problems of parenthood for men as well as for women, in the psychic as well as the physical aspects of marriage and love, centers where all sorts of difficulties might be straightened out and adjustments made; centers where parents might be taught how to teach their own children the basic factors in human relationships.²⁵³

²⁵¹ Debora L. Spar and Briana Huntsberger, "The Business of Birth Control," *Harvard Health Policy Review* 6, no.1 (Spring 2005): 13.

²⁵² *Ibid.*, 11.

²⁵³ Sanger, *My Fight*, 311.

In association with other medical professionals, dedicated birth control clinics emerged, and a science-based approach to contraceptives saw the efficacy testing of various birth control methods. Physician-fitted diaphragms paired with contraceptive jellies became more accessible, and “by the 1930s, thanks largely to Sanger, the diaphragm and jelly had become the most frequently prescribed form of birth control in America.”²⁵⁴

While Sanger refused to endorse specific brands or devices due to the fear that it might discredit the movement as a whole, Holland-Rantos rose to the top and was the best-known manufacturer of diaphragms at the time.²⁵⁵ Tone notes that, “consciously distancing the birth control business from manufacturers who made contraceptives for the laity, Sanger helped inaugurate a regime of doctors, diaphragms, and corporate science.”²⁵⁶ Birth control clinics were flourishing in the 1930s, and gained even more popularity and legitimacy in 1937, when the case of *US v. One Package* virtually dislodged the issue of birth control from the Comstock laws.²⁵⁷ Concurrently, the American Medical Association (AMA) formally asserted that contraception was a legitimate and necessary aspect of medical practice.²⁵⁸

When the Comstock Act first took effect, it was targeting an unregulated group of entrepreneurs and vendors at a time when birth control was widely accepted as immoral. By 1937, the entire landscape had changed and crusaders against contraception were dealing with corporate and medical behemoths such as an established and profitable condom trade dominated by a handful of firms, legitimate diaphragm and jelly companies

²⁵⁴ Tone, *Devices and Desires*, 118.

²⁵⁵ *Ibid.*

²⁵⁶ *Ibid.*

²⁵⁷ Spar and Huntsberger, 13

²⁵⁸ *Ibid.*

like Holland-Rantos, Sanger's organized legions of followers, and most significantly, the authoritative American Medical Association."²⁵⁹

The birth control movement was rapidly gaining legitimacy and social acceptance in the United States, and Canada was following suit. Canada's first birth control clinic opened in Hamilton, Ontario in 1932, and while the postwar baby boom of the 1950s further undergirded public support, birth control wasn't decriminalized until 1969 with an amendment to the Criminal Code,²⁶⁰ with the United States leading the way by only a short margin with full decriminalization occurring in 1964. However, despite a legal lag, public perception of birth control in both Canada and the USA was generally favorable from the 1930s onward, largely due to the work of Sanger and other birth control activists. Spar and Huntsberger note that, "By the 1940s, the size of the US contraceptive market had made the surviving remnants of Comstockery impossible to uphold. Americans were obviously using birth control; they were buying it openly; and some among them had grow rich from the trade."²⁶¹

The postwar baby boom had similar outcomes in both the US and Canada; the public desired regulation of contraceptives rather than prohibition, and for clear and accessible information that enabled couples to choose their best contraceptive fit.²⁶² Meanwhile, as the diaphragm and condoms were dominating the contraceptive scene, research was underway to develop more efficacious, or at least, scientifically rigorous

²⁵⁹ Ibid., 14.

²⁶⁰ Wikipedia Contributors, "Criminal Law Amendment Act, 1968–69," *Wikipedia, The Free Encyclopedia*, accessed June 28, 2019, https://en.wikipedia.org/w/index.php?title=Criminal_Law_Amendment_Act,_1968%E2%80%9369&oldid=903807672.

²⁶¹ Spar and Huntsberger, 14.

²⁶² Ibid., 15.

methods. The climate of 1950s America was one of technological determinism -- any perceived problem could be met with a scientific or technological solution. As Watkins notes, “In the early part of the decade, for example, most Americans still approved of the use of the atomic bomb to end World War II; they did not yet understand the full implications of nuclear weapons and technology. In the field of medicine, scientists working in the laboratory produced antibiotics, the cure for bacterial infections, and Americans eagerly anticipated the next wonder drug.”²⁶³

4.5 The Pill

According to Spar and Huntsberger, “In scientific terms, the Pill’s development really began in the 1920s, when researchers first identified estrogen and demonstrated its effects on pregnancy. Urged, once again, by Sanger, the scientific community realized that estrogen (together with progesterone) could potentially play a role in contraception.”²⁶⁴ While the science was there, the legal and moral landscape surrounding contraception at the time meant that researchers had little desire to develop the findings into a pharmaceutical product.²⁶⁵ Sanger’s colleague, Katherine McCormick, a wealthy widow and proponent of female-controlled contraception, decided to use her inheritance to fund the development of an oral contraceptive.²⁶⁶

In 1952, with support from Sanger, McCormick began financially backing controversial geneticist Gregory Goodwin Pincus, whose work on “test tube” rabbits in

²⁶³ Watkins, *On the Pill*, 19.

²⁶⁴ Spar and Huntsberger, 15.

²⁶⁵ Ibid.

²⁶⁶ Watkins, *On the Pill*, 20.

the 1930s was both lauded and condemned.²⁶⁷ Sanger and McCormick sought the development of a highly efficacious, scientifically-rigorous and technologically advanced method that was controlled by women, and Pincus was an expert in mammalian sexual physiology.²⁶⁸ Pincus was eager for the opportunity to research human hormonal contraception. Spar and Huntsberger note that, “Between 1952, and her death in 1967, McCormick gave Pincus and his foundation nearly \$2 million in research funding, a princely sum for a single, risky project.”²⁶⁹

The time was right, as social values were starting to become more progressive, and Americans were keen on technological innovation. As Watkins states,

...a combination of scientific, economic, social, and cultural forces acted in concert to drive contraceptive research in the direction of a hormonal pill for women. The state of the scientific knowledge in biology and chemistry, the passion and conviction of Katherine McCormick and Margaret Sanger, the cultural reluctance in America to deal openly with sexuality, and the public’s faith in the ability of science and technology to solve social problems dictated the path of contraceptive research in the 1950s.²⁷⁰

Funding for Pincus’ work also came from the pharmaceutical firm G.D. Searle, a small company that had supported some of Pincus’ previous projects. As Pincus developed what would become a viable contraceptive in pill form, Searle surreptitiously leaked stories to the media about Pincus’ breakthroughs in order to garner public support when the pill was finalized.²⁷¹ Searle also sought to gain support of medical practitioners, and because direct public advertising to potential consumers was illegal, began a publicity campaign to market

²⁶⁷ Spar and Huntsberger, 15.

²⁶⁸ Watkins, *On the Pill*, 21.

²⁶⁹ Ibid.

²⁷⁰ Ibid.

²⁷¹ Spar and Huntsberger, 15.

the pill to doctors, placing emphasis “--with echoes of Sanger -- on the ways in which the Pill promised to give doctors more regular contact with their female patients and more direction in supervising their care.”²⁷²

With research underway and clinical trials occurring in Puerto Rico to skirt the federal laws that still existed against birth control, a final formula was developed that “proved to be almost 100 percent effective in preventing contraception,”²⁷³ despite a number of side effects observed in the clinical trial subjects. By late 1959, Pincus and Searle felt that testing was complete and that their formulation was ready for FDA evaluation. Named ‘Enovid’, the drug was approved by the FDA as a prescription drug to be used for contraceptive purposes in May 1960.²⁷⁴ Since efficacy was proven, but long-term safety was not, the drug was approved for limited use of no more than two years at a time. As long as Enovid met the FDA’s limited safety criteria, Searle was free to begin marketing the drug. This marked a pivotal moment in contraceptive history, and for the fate of the diaphragm. As Watkins states,

Within five years of the FDA’s decision to approve marketing of Enovid, the pill became the most popular form of birth control in the United States, prescribed by 95 percent of obstetricians and gynecologists. By 1965, six and a half million married women and hundreds of thousands of unmarried women had obtained prescriptions for oral contraceptives (the number of unmarried users cannot be determined accurately because they were not included in the official reports). Among married women under the age of forty-five, 26 percent had used oral contraceptives since they had become available, another 19 percent thought they might use them in the future, and only 3 percent had never heard of the birth control pill.²⁷⁵

²⁷² Ibid.

²⁷³ Watkins, *On the Pill*, 32.

²⁷⁴ Ibid.

²⁷⁵ Ibid., 34.

Acceptance for the pill was swift and widespread. By 1966, seven out of every ten women visiting Planned Parenthood for contraceptive services walked out with a prescription for oral contraceptives.²⁷⁶ Doctors enjoyed the ease of prescription and greater “authority and control in the realm of family planning,”²⁷⁷ as well as the high financial incentive for frequent patient visits for checkups and prescription renewals.²⁷⁸ Women enjoyed the ease of use of this new method, and while cost may have been a factor in ease of access, Planned Parenthood began subsidizing the pill early on making it easily within reach for many American women.²⁷⁹ The media also played a role in the rapid popularization and adoption of the pill, frequently and favorably covering it as a technological marvel.²⁸⁰ This rapid adoption of the pill quickly pushed the diaphragm into the margins, as it was less economically viable and more complicated to use than the pill.

4.6 Conclusion

Sanger’s efforts to make effective birth control both accessible to women and a legitimate faction of modern medicine had implications both domestically and abroad. Although contraception in Europe was more accepted and readily available than in the United States and Canada, Sanger’s impacts were felt, evident with her influence on Marie Stopes in England. Inspired by Sanger’s desires for clinical contraceptive contexts, Stopes went on to open several of her own birth control clinics. Stopes’ clinics became a respected source of birth control information and methods and have even been used by some

²⁷⁶ Ibid.

²⁷⁷ Ibid.

²⁷⁸ Ibid.

²⁷⁹ Ibid.

²⁸⁰ Ibid.

participants in this study. Further, Sanger's organization The Birth Control League gradually evolved into what is now Planned Parenthood in both the US and Canada. The implications for information studies are also significant. Sanger's impetus for starting the birth control movement was a climate of inaccessible and inaccurate information. While she was fueled by the desire to make contraception itself accessible to women, she sought a pairing of efficacious and easily obtainable birth control with accurate and accessible information. To properly use birth control, Sanger reasoned, one must be properly instructed and informed.

Sanger considered her greatest achievement in her career as having kept "the movement strictly and sanely under medical auspices."²⁸¹ The medicalization of birth control served to legitimize the movement; it had difficulty gaining ground when contraceptives were primarily available through mail order via questionable entrepreneurs, and was more easily discredited as lewd or obscene. Locating contraceptives in the realm of medicine and science allowed for its broader acceptance in society. Further, safety concerns could be addressed in laboratory settings, which was not the case when entrepreneurs were selling at times questionable or ineffective devices through mail-order advertisements. These factors, and Sanger's hard work meant that birth control would finally be taken seriously, and therefore, would be more accessible to women.

However, the medicalization of contraception has had longstanding impacts on women; physician control of birth control means that a medical perspective will always supersede that of a woman who desires contraception. If doctors deem a contraceptive

²⁸¹ Tone, *Devices and Desires*, 117.

method inferior, it will be more difficult to get, whether or not there is demand for it. This is the case with the diaphragm. The very movement that brought the diaphragm into mainstream use as the most scientifically advanced contraceptive of choice, was, and still is, pushing it into the margins of obscurity.

Sanger's efforts in developing and promoting efficacious, affordable, and accessible contraception in medicalized settings culminated in the creation of the revolutionary birth control pill. With the pill, high rates of pregnancy prevention could be achieved via suppression of ovulation. The pill required (and still does) a prescription and consultation with medical professionals, but unlike the diaphragm, came with a host of unwanted side effects.

The late 1960s and early 1970s marked a pivotal and revolutionary time for birth control. The pill's rapid succession of development, release, heavy marketing, and mass adoption redefined the contraceptive landscape, which had previously been dominated by barriers -- male condoms and diaphragms. However, the reality wasn't as rosy as the pharmaceutical industry suggested; short safety trials meant that the data generated was insufficient to determine long-term safety of oral contraceptive formulations. There were consequences. Some women became ill, some women died, and pockets of women throughout the world began questioning the implications of a profit-centered contraceptive model: would pharmaceutical and medical industries risk the health of women for the sake of a bottom line? As women collectivized to answer this question, a movement was coming into fruition. This movement would lead to the creation of one of the most respected and renowned women-centered sources of health and birth control information, the *Our Bodies, Ourselves* series. The following chapter will examine different iterations of this text in

detail, and how the trajectory of the diaphragm and other contraceptive methods manifested over the next 40 years.

5 Our Bodies, Ourselves

5.1 Introduction

Keeping women ignorant about our bodies is another way to control women, to decrease our ability to make choices, and to create dependence on the medical establishment. This can be countered by learning to examine and understand our own bodies; by learning that there is a range of variation, rather than one standard norm; by validating our experiences through sharing them; by exploring what we all have in common as women.²⁸²

Because this dissertation is concerned with the ways in which information on cervical barrier methods is obtained, used, and generated by women, how birth control information has changed over time, and whether these changes are genuinely reflective of the birth control landscape in real-world contexts, analyzing a prominent, longstanding and respected informational text regarding sexuality and birth control is a logical step in gaining a holistic picture of cervical barrier and other contraceptive information over time. Information about sexual health and contraception has continually evolved in tandem with social, cultural and scientific forces; tracking these changes in one continually revised text assists in showcasing the fluid and transitional nature of birth control information.

Feminist scholars have problematized and critiqued notions of truth, and have emphasized the need to reconcile multiple forms of knowledge as well as multiple views

²⁸² Fertility Consciousness Group, "Women Controlled Birth Control" in *Birth Control and Controlling Birth: Women-Centred Perspectives*, eds. Helen B. Holmes, Betty B. Hoskins, and Michael Gross (Clifton, N.J.: Humana Press, 1980), 75.

of reality.²⁸³ Consequently, feminist approaches to medicine and health information²⁸⁴ are inclined to take into account women's experiences, feelings, perceptions and desires in a way that mainstream medical practice often neglects. A key information source on women's health and contraception is the *Our Bodies, Ourselves* series, which has been informing women about their bodies for almost fifty years while explicitly rejecting a traditional authoritative biomedical approach. As Kline notes,

The book's message was revolutionary not only for its attack on the medical establishment, but also for its creation of an alternative knowledge base structured around personal stories. *Our Bodies, Ourselves* legitimized the notion of experiential knowledge as a central component of health. In other words, every woman's body contained the seeds of knowledge crucial to defining her own well-being.²⁸⁵

The *Our Bodies, Ourselves* series advocates for the validity of different types of information, merging traditional biomedical knowledge of women's health with women's actual lived experiences. In one of the early editions of the series, the authors call for women to "demand answers and explanations from the people you come in contact with for medical care; know your right to refuse treatment with or without these answers and explanations; and insist on enough information to negotiate the system instead of allowing

²⁸³ See for example Michele Barrett and Anne Phillips, eds., *Destabilizing Theory: Contemporary Feminist Debate* (Stanford, CA: Stanford University Press, 1992); Nancy Fraser and Linda J. Nicholson, "Social Criticism Without Philosophy: An Encounter Between Feminism and Postmodernism," in *Feminism/Postmodernism*, ed. Linda J. Nicholson (New York: Routledge, 1990), 19-38; Donna Haraway, *Simians, Cyborgs and Women* (New York: Routledge, 1991).

²⁸⁴ For other examples see Federation of Feminist Women's Health Centres, *A New View of a Woman's Body* (Feminist Press, 1982); Nancy Fugate Woods, "New Models of Women's Health Care," *Health Care for Women International* 6, no. 4 (1985):193-208; Margarete Sandelowski, *Women, Health, and Choice* (Englewood Cliffs, NJ.: Prentice-Hall) 1981.

²⁸⁵ Wendy Kline, *Bodies of Knowledge: Sexuality, Reproduction and Women's Health in the Second Wave* (Chicago: University of Chicago Press, 2010), 11.

the system to negotiate you.”²⁸⁶ In this call, which has remained an integral impetus for the *Our Bodies* project over time, the authors position women as active agents in their own information exchanges, advocating for themselves in practitioner-patient scenarios whilst simultaneously using their own bodies as sources of valid information in addition to traditional evidence-based biomedical knowledge on women’s health. A key component of the *Our Bodies* series is birth control information, emphasizing not only efficacy, but suitability and impact on women’s pleasure.

Cervical barrier methods, since the emergence and subsequent widespread adoption of oral contraceptives, have become increasingly marginalized by mainstream medical practice, and consequently, have followed a similar fate in birth control information sources. However, cervical barrier methods tend to be better represented both qualitatively and quantitatively in feminist texts. Accordingly, this project employs a materialist feminist discourse analysis of *Our Bodies, Ourselves* in order to observe how a collaborative, feminist, women-centered text on birth control and sexuality represents information about cervical barrier and other contraceptive methods over time.

5.2 The Origins of Our Bodies, Ourselves

First published in 1970, with updated versions published periodically until its most recent English-language print edition in 2011, *Our Bodies* has been a facilitator of women-centered dialogue and discourse. *Our Bodies* originated from a 1969 feminist workshop called “Women and Their Bodies,” held at one of the first feminist conferences in the

²⁸⁶ Boston Women’s Health Book Collective, *Our Bodies, Ourselves* (New York: Simon and Schuster, 1973), 268-69.

United States, in Boston. Here, the attendees, “talked about their sexuality (which was still, despite the sexual revolution, very much taboo), abortion (which was illegal -- Roe v. Wade wasn’t decided until 1973), their experiences with pregnancy and childbirth (several were young mothers) and their frustrations with physicians and health care.”²⁸⁷ The group began meeting regularly, and collected and shared information about women’s health issues -- information, which, at the time, was fairly obscure and not readily available. This information was often compiled into papers and readings, and these discussion papers were formatted into a collection in 1970 and sold as an underground manual for women about their bodies and health.

This early version, entitled *Women and Their Bodies: A Course* was printed on newsprint and cost seventy-five cents. In what was essentially a 192 page zine, this collection “was full of personal experiences and contained useful information on issues ranging from masturbation (how to do it) to birth control (which methods were available and how to use them) to vaginal infections, pregnancy and nursing.”²⁸⁸ This early edition offered scathing critiques of patriarchal medicine and the medicalization of women’s bodies as well as interrogated the political economics of the pharmaceutical industry (it contains a highly critical exposé of the inadequate drug trials for the birth control pill and the consequent health issues and deaths in hundreds of women).²⁸⁹ But most importantly, “*OBOS* validated women’s embodied experiences as a resource for challenging medical

²⁸⁷ Kathy Davis, *The Making of Our Bodies, Ourselves: How Feminism Travels Across Borders* (Durham, NC: Duke University Press, 2007), 3.

²⁸⁸ *Ibid.*, 4.

²⁸⁹ *Ibid.*

dogmas about women's bodies and, consequently, as a strategy for personal and collective empowerment.”²⁹⁰

The *Our Bodies* series was a way for women to shift the narrative away from patriarchal medicalization of women's bodies to one that was women-controlled and women-centered. Even in this early incarnation of the text, it was the authors' intention for it to evolve, change, be updated and be shared. It was not intended to be final, but rather, to be continually augmented, adapted, and rebuilt via collaboration with other women:

So after a year and much enthusiasm and hard individual and collective thinking and working, we're publishing these papers. They are not final. They are not static. They are meant to be used by our sisters to increase consciousness about ourselves as women, to build our movement, to begin to struggle collectively for adequate health care, and in many other ways they can be useful to you. One suggestion to those of you who will use the papers to teach others: the papers in and of themselves are not very important. They should be viewed as a tool which stimulates discussion and action, which allows for new ideas and for change. Often, our best presentations of the course were done by a group of women (we could see a collective at work--in harmony, sharing, arguing, disagreeing) with questions throughout, and then splitting the larger group into smaller groups to continue talking about whatever part of the topic that was especially relevant to the women in that group. It was important that we talked about our experiences, (often we came from very different situations), raised our questions, expressed our feelings, were challenged to act, than that we learned any specific body of material.²⁹¹

Thus, there was an explicit rejection of biomedical authoritative knowledge from the very beginnings of the text. The authors intended the text to function as a catalyst for discussion and collectivization. Reciprocity and sharing of embodied knowledges were paramount to the initial goals of the creators of *Our Bodies*. As they state above, the content wasn't as

²⁹⁰ Ibid.

²⁹¹ Boston Women's Health Collective, *Women and Their Bodies: A Course* (1970) 4, retrievable at <http://www.ourbodiesourselves.org/cms/assets/uploads/2014/04/Women-and-Their-Bodies-1970.pdf>

important as the outcomes of its use: exchanging experiences and maintaining a constant dialogue with one another about our bodies, our health, and our lived realities, and critiquing, and ultimately challenging and changing the patriarchal medical system that sought to subjugate us.

In a 1999 reflection upon the history of the text, Judy Norsigian et al. explain that,

At a workshop on “Women and Their Bodies,” we discovered that every one of us had a “doctor story,” that we had all experienced feelings of frustration and anger toward the medical maze in general, and toward those doctors who were condescending, paternalistic, judgmental, and uninformative in particular. As we talked and shared our experiences, we realized just how much we had to learn about our bodies, that simply finding a “good doctor” was not the solution to whatever problems we might have.²⁹²

Thus, the *Our Bodies* endeavor was a way for women to come together to find answers to the questions they had about their own health and sexuality without relying on the typically male-dominated medical system. Citing Dorothy Smith,²⁹³ Davis notes that while the authors of *Our Bodies* rely on mainstream medical knowledge, they also remind readers to be mindful of the “relations of ruling” inherent in the ways it is produced (namely via white male privilege).²⁹⁴ According to Davis,

The text not only forces the reader to become aware of the limitations of medical knowledge, however. It also continually juxtaposes medical knowledge with women’s local experiential knowledge, whereby neither is given absolute precedence over the other. Medical knowledge (and, for that matter, any form of knowledge) will always need to be interrogated against the specifics of the reader’s own body and health needs because problems and

²⁹² Judy Norsigian et. al., “Boston Women’s Health Book Collective and Our Bodies, Ourselves: A Brief History and Reflection,” *Journal of the American Medical Women's Association* 54, no.1(Winter, 1999): 35.

²⁹³ Dorothy Smith, *Texts, Facts and Femininity: Exploring the Relations of Ruling*. (London: Routledge, 1990).

²⁹⁴ Kathy Davis, *Making of Our Bodies*, 162.

remedies have different meanings for different women depending on their circumstances and the circumstances of their lives.²⁹⁵

In the sense that *Our Bodies* first emerged as a response to an alienating and insufficient medical system and positioned itself as an information resource for women by women, in addition to the fact that it originated in a time when diaphragms were still a common and popular form of birth control that was rapidly being displaced by the heavily marketed birth control pill, it serves as an ideal point of enquiry to evaluate feminist representations of contraceptive information over time.

5.3 The Validity of Information in *Our Bodies*

At a time of increased pharmaceutical innovation, subsequent patient experimentation and questionable ethical treatment,²⁹⁶ in a medical landscape comprising almost entirely men,²⁹⁷ and amidst a “paternalistic, condescending, and judgmental” climate that had “medicalized reproductive issues and turned women into human guinea pigs,”²⁹⁸ women increasingly sought accurate, readily available and easy-to-comprehend information on issues affecting their health.²⁹⁹ The Boston Women’s Health Collective was faced with a seemingly paradoxical task of providing women with accurate, up-to-date health information while rejecting many aspects of the mainstream medical system. Ruzek notes that *Our Bodies* became a highly trusted information source because “editions were painstakingly updated to translate scientific information into health information for

²⁹⁵ Ibid., 163.

²⁹⁶ Wendy Kline, “‘Please Include This in Your Book’: Readers Respond to *Our Bodies, Ourselves*,” *Bulletin of the History of Medicine* 79, no. 1 (2005): 84.

²⁹⁷ Ibid., 85.

²⁹⁸ Ibid., 86.

²⁹⁹ Ibid.

women,” and that “the success of the book really lies in the powerful combination of presenting solid evidence framed in terms of self-determination, patients’ rights and social justice through women’s own voices.”³⁰⁰

In her article “Please Include This in Your Book,” Kline offers an anecdote about how in one woman’s case, both the Collective and mainstream medical practice failed to provide accurate health information. She explains that one reader’s experience, shared in the form of a letter to the Collective, highlights the importance of not only accurate and up-to-date health information, but also compassion: In April 1981, a woman contacted the Collective by telephone to ask for help regarding a recurrent bout of vaginitis. Jane Pincus advised her to try a non-sulfa antibiotic ointment called “Furacin,” which was also the suggested treatment printed in the 1979 edition of *Our Bodies*.³⁰¹ The woman asked her doctor to prescribe the ointment, and only learned that Furacin was discontinued when the pharmacist informed her of its unavailability. The pharmacist suggested two other treatments, and when the woman asked her doctor about which was preferable for her condition, he expressed indifference. In this instance, the woman was frustrated with both her doctor and the Collective.³⁰² According to Kline,

Of the three medical advisors she sought out—Pincus, her doctor, and her pharmacist—only her pharmacist had accurate information, she believed. But in a hastily typed postscript, she updated her story: even the pharmacist had “lied” to her—Vagisec had no antibacterial properties and was therefore useless. Though Frances’s experience might have led to disenchantment with the women’s health movement, instead it made her more intent on contributing to the cause. She did not bother complaining to her doctor; according to

³⁰⁰ Sheryl Ruzek, “Transforming Doctor-Patient Relationships,” *Journal of Health Services Research and Policy* 12 no. 3 (July, 2007): 182.

³⁰¹ Kline, “Please Include This,” 90.

³⁰² *Ibid.*, 91.

her, he did not care. In her opinion, the pharmacist was a liar. But she noted the compassion and earnestness of Pincus, and the importance of the movement: “Believe me the only hope for women lies in feminist organizations like yours.” For this reason, medical knowledge and accuracy were all the more important. “So PLEASE, be careful in the information you dispense because no one else is, not in the medical industry, anyway.” Her motive for writing the Collective was not simply to chastise, but to correct a potentially damaging error, and it worked: the next edition of the book, *The New Our Bodies, Ourselves* (1984), omitted the reference.³⁰³

From its very origins, a feedback system was integral to upholding the core values of *Our Bodies*, and this anecdote is an example of how that was expected to function in practice. Despite the fact that misinformation was indeed disseminated, the non-hierarchical, interactive and reciprocal approach to information meant that misinformation could be identified (via the shared experiences of members) and corrected. Further, as Kline notes, the out-of-date information given by health collective staff was altered right away because the goal was to ensure accuracy and privilege women’s concerns, whereas the mainstream medical and pharmaceutical system seemed less concerned about correcting inaccurate information. Describing how *Our Bodies* became a trusted source of birth control information, Ruzek states,

Looking back over 35 years, [*Our Bodies*] has retained its core strategy of providing the best available evidence accompanied by women’s own voices. It has also earned the distinction of being a trusted source of information. That trust is deeply embedded in the organization’s steadfast refusal to accept funding from the pharmaceutical industry or other sources that would create conflicts of interest. This sets it apart from many of the newer, highly professionalized women’s health advocacy groups that have flourished from such infusions of resources. As one of a small number of women’s health organizations that has survived beyond the active phase of the second wave of feminism, *Our Bodies*,

³⁰³ Ibid., 92.

Ourselves continues to be a source of trustworthy health information for women.³⁰⁴

The constant feedback loop embedded in the operations of *Our Bodies* and the Collective meant that even though there was a rejection of traditional medical practice and its relevant corporate interests, the sharing of experiences ensured that information was up-to-date. And while the validity of information is of the utmost importance when it comes to health, the above anecdote also demonstrates the importance of patient-centeredness, compassion, and reciprocity.

5.4 Critique of Experiential Knowledge

While this project tends to contextualize embodied knowledge and being informed about one's own body and the relevant medical and health interventions as empowering, it is important to point out that feminist critiques of the women's health movement also exist. The authors of *Our Bodies* advocate greater self-awareness and knowledge of one's own body through exploration. Out of necessity, cervical barrier users must come to learn their own anatomy in order to properly use the devices; but as medical practitioners trained in fitting become fewer and fewer over time, knowledge of the body becomes even more significant in that potential users may have to learn how to fit themselves. While many feminist scholars and activists suggest that empowerment can be achieved by becoming comfortable with one's own body, Donna Haraway cautions us that examining our genitalia through a feminist lens is simply reinforcing patriarchal medical approaches that seek to objectify women and reduce them scientific subjects.³⁰⁵ According to Haraway,

³⁰⁴ Ruzek, "Transforming Relationships," 181.

³⁰⁵ Donna Haraway, "The Virtual Speculum in the New World Order," in *Revisioning Women, Health and Healing* eds. Adele E. Clarke and Virginia L. Olesen (New York: Routledge, 1999), 46-96.

whether we hold our speculums ourselves, or a doctor does it for us, we are simply reinforcing mainstream scientific (and patriarchal) knowledge.³⁰⁶

In the context of *Our Bodies* and feminist approaches to health, greater knowledge of the self and bodily autonomy achieved through literacy of traditional medical terminology and discourse and the ability to self-advocate is considered an asset. The authors of *Our Bodies* state,

Out of our concerns we are acquiring specific medical knowledge. In response to our questions, many doctors have become aware of women's growing interest in medical issues. Some are genuinely cooperative. Yet many others appear outwardly pleased while continuing to "manage" their patients with new tactics. Equally important as learning technical facts, we are sharing our experiences with one another. From this sharing we develop an awareness of difference as well as similarity in our anatomy and physiology. We start having confidence in our knowledge, and that confidence helps us change our feelings about our bodies.³⁰⁷

Countering Haraway's concern that becoming fluent in mainstream medical discourse also serves to reify it, *Our Bodies* asserts that self-sufficiency is indeed empowering: "We still have many bad feelings about ourselves that are hard to admit. We have not, of course, been able to erase decades of social influence in a few years. But we have learned to trust ourselves. We *can* take ourselves."³⁰⁸ From this angle, the *Our Bodies* series provides a fruitful site of inquiry to gain a better understanding of feminist sources of birth control information that seek to advocate for active participation, agency, and peer-based social networks with regard to researching and selecting contraceptive methods.

³⁰⁶ Ibid.

³⁰⁷ Boston Women's Health Collective, *Our Bodies, Ourselves* (New York: Simon and Schuster, 1976), 25.

³⁰⁸ Ibid., 26.

5.5 Four Editions of Our Bodies, Ourselves Spanning Four Decades

Between the development of the initial booklet in 1970, to the most recent English-language edition printed in 2011 and subsequent online presence thereafter, there have been dozens of iterations of several editions printed in 30 different languages.³⁰⁹ A sampling of editions over time serve as a cross-section of the North American landscape of birth control information over the past four decades; this chapter is chiefly concerned with how the waxing and waning popularity and availability of methods, emergence of new contraceptives and related biomedical innovations, and pharmaceutical scandals are represented and communicated in information sources over time, as well as how birth control information itself has shifted over time (namely via the transition of print to digital sources and the preference for interactive sources). Materialist discourse analysis comes into play as I evaluate the scientific, medical, and societal forces that impact the shifts in birth control discourse and language through time; a feminist lens is used to observe how shifting power dynamics (i.e. the rise of “big pharma”) impacts the language of an explicitly feminist women’s health resource.

The changes made to the various editions of *Our Bodies* were contingent on submissions by readers as well as reflecting changes occurring more generally in the landscape of women’s health. Readers ensured that the text was more inclusive and would over time shed its somewhat privileged white perspective, whereas the realities of women’s health and medicine dictated changes pertaining to emergent issues such as birth control

³⁰⁹ Our Bodies, Ourselves, “History,” accessed June 28, 2019, <http://www.ourbodiesourselves.org/history/>.

innovations, new diseases (HIV/AIDS) and the shifting structures and systems undergirding both health politics and feminism itself.

The core data for this chapter comprise the first commercial edition of *Our Bodies, Ourselves* published in 1973, in comparison with versions from 1984 (the first major revision of the original text), 1992 (a major revised edition to address changes occurring in the late 1980s and early 1990s), and the most recent 2011 edition (selected because it is the most recent published English-language version and also fully represents the shift from print to digital culture, but is also the official fortieth anniversary edition of *Our Bodies*). These editions and their core revisions encompass the major scientific, cultural, and epidemiological changes affecting the birth control landscape for the past forty-plus years and therefore offer a rich set of data for analysis. While the print editions specified encompass the bulk of the data for this chapter, the present-day online successor to the 2011 print edition will also be briefly discussed, as it serves as an example of an online birth control information resource.

Participants in the interview portion of this study frequently mention both birth control pills and other hormonal methods (i.e. NuvaRing, the Ortho Evra patch, and the Implanon implant) as well as intra-uterine devices (IUD or IUS, both hormonal and the hormone-free copper version) as popular birth control methods recommended to them by their doctors. Additionally, fertility awareness methods (FAM), female condoms, male condoms, the Today Sponge, and withdrawal represent the non-hormonal methods often chosen by them as a complement to or instead of cervical barrier methods. The ways in which information about cervical barriers and some other contraceptive methods identified

by participants³¹⁰ transform over time are analyzed as follows, with discussions of the specific contextual factors affecting the major changes in each edition.

Table 5:1 All methods by edition

Method	1973	1984	1992	2011
Male condom	✓	✓	✓	✓
Female Condom	-	-	✓	✓
Diaphragm	✓	✓	✓	✓
Cervical Cap	✓	✓	✓	✓
Sponge	-	-	✓	✓
Spermicides	✓	✓	✓	✓
Pill	✓	✓	✓	✓
Minipill	✓	✓	✓	✓
Sequential Pills	✓	-	-	-
Vaginal Ring	-	-	-	✓
Hormonal Patch	-	-	-	✓
Depo Provera Shot	-	✓	✓	✓

³¹⁰ Cervical barrier methods including diaphragms, caps, the sponge and female condoms are the focal point of the analysis, but the pill, IUDs (both hormonal and copper), and fertility awareness methods (FAM) are also evaluated as they represent some of the most frequently mentioned contraceptive methods by participants.

Contraceptive Implant	-	-	✓	✓
IUD	✓	✓	✓	✓
Tubal Ligation	✓	✓	✓	✓
Essure	-	-	-	✓
Adiana	-	-	-	✓
Male Sterilization	-	✓	✓	✓
Withdrawal	✓	✓	✓	✓
FAM/Rhythm Method	✓	✓	✓	✓
Breastfeeding	-	(listed as a non-method)	(listed as a non-method)	✓
Abstinence	-	✓	✓	✓
Emergency Contraception	✓	✓	✓	✓

5.6 1973 Edition

Overview

Following the publication of the course *Women and Their Bodies*, the first edition of the text to bear the title *Our Bodies, Ourselves* was printed in 1971 and then reprinted

in 1973. In the 1973 edition, the authors³¹¹ declare in the chapter entitled, “Women and Health Care” that, “Knowledge is power.” They argue for women’s agency in navigating the health care system, and further state that this agency “begins with getting control of your own health everywhere in your life.”³¹² This call for women to take control of their own health and to reject exploitation by the medical establishment marks a key moment in the women’s health movement, and consequently, this text represents a fascinating feminist point of inquiry through which birth control methods such as the diaphragm can be evaluated. Further, *Our Bodies* emerged with the goals of reflexivity and reciprocity and has from its very origins continually evolved in tandem with the needs of its readers. Continually soliciting feedback from women about what they want and need in a birth control and sexuality resource, *Our Bodies* evolved to become more inclusive, to reflect advances in contraceptives, and to meet the needs of its readers over time.³¹³

In the early 1970s, oral contraceptives were fast becoming the contraceptive of choice for women. While pill formulations at the time came with significantly greater side-effects than modern versions, hormonal birth control was nevertheless heralded as nothing short of revolutionary.³¹⁴ Despite what was oft-contextualized as a contraceptive marvel, women deciding on their birth control method had to grapple with using a method that although highly effective and convenient, came with a host of side effects including potentially fatal ones, or using barrier methods such as condoms and diaphragms with no

³¹¹ The editors of the 1973 edition are Wendy Sanford based on work by Abby Schwartz and Pamela Berger, with the help of Thayer Williams, Betsey Sable, and Joanna Caplan.

³¹² *Our Bodies*, 1973, 268.

³¹³ Wendy Kline, “Please Include This.”

³¹⁴ Watkins, *On the Pill*, 2.

side effects but a higher chance of pregnancy.³¹⁵ Women sought more information about birth control and its implications, and, as Watkins notes, “their physicians’ inability or reluctance to provide adequate information strained relations between women patients and doctors and by 1970 increased the distance between consumers and providers of health care.”³¹⁶ Thus, *Our Bodies* emerged at a pivotal moment in women’s health care and was a key component in furthering the advancement of the women’s health movement.³¹⁷

The authors of *Our Bodies* intended for the text to function inclusively and hoped that other women would share their experiences; however, they were primarily white, middle-class and college educated women, and unwittingly the experiences of minorities and other marginalized women were not heavily represented in the initial publications.³¹⁸ The 1971 version of *Our Bodies* had a greater distribution and readership than the 1970 *Women and Their Bodies* and it soon became clear to the authors that what was printed in 1971 was insufficient. Women began writing in to the authors about their experiences, and it was evident that the text needed updating to reflect a greater diversity of readers.³¹⁹ Simultaneously, the text attracted the attention of commercial publishers and the authors had to grapple with idea of “selling out” to reach a greater audience, or remain authentic without sacrificing their anti-capitalist values.³²⁰

They ultimately chose Simon and Schuster as their publishing firm, with the goal of reaching a greater audience, but were able to draft a contract that gave them total creative

³¹⁵ Ibid., 3.

³¹⁶ Ibid.

³¹⁷ Wendy Kline, “Please Include This,” 82.

³¹⁸ Davis, *Making Of*, 23.

³¹⁹ Ibid.

³²⁰ Ibid., 24.

control over the text, discounts for women-centered clinics, and the assurance that the book would be published in different languages.³²¹ The greater distribution and marketing of the 1973 edition that resulted from partnering with a huge publishing house meant that *Our Bodies* soon became a household name. As Davis notes,

It was an immediate success, selling nearly 2.5 million copies by 1976. The increased public exposure of the book brought laudatory reviews nationwide and positive responses from readers, educators, and physicians, some of whom even suggested that it be included in the medical curriculum. It appeared on the *New York Times* best seller list in 1976 and 1977. The *Chronicle of Higher Education* listed it as fifth in 1973 and fourth in 1974 on its list of best-selling books on U.S college campuses. In 1976, it was named one of the ten all-time best books for young people by the American Library Association.³²²

The book was being read by women and practitioners alike and began to pull tremendous clout as a source of birth control information. The text offered women a vast amount of health information that wasn't otherwise available, and a range of birth control options in a time where doctors and health practitioners began viewing the pill as the status quo. In this compendium of birth control options, *Our Bodies* described efficacy rates, ease-of-use, ease-of-accessibility, cost, benefits and disadvantages, side effects, and responsibility (is it in the male partner's control, or is the woman in charge of the method?), among other categories. In the following section, I will analyze the specific content found within the chapter about birth control found in this edition.

³²¹ Ibid.

³²² Ibid.

Table 5:2 Selected content of 1973 Edition

Method	Cost	Brands	Side Effects	Effectiveness Rate	Page length of entry
Diaphragm	\$4.50 plus jellies and medical exam	N/A	Irritation from jelly, possible rubber allergy	90-98%	4.5
Cervical Cap	N/A	N/A	N/A	Less than diaphragm	1 paragraph
Pill	N/A	13 listed	Blood clots, headaches, nausea, fatigue, menstrual changes, breakthrough bleeding, breast changes, weight gain, rise in blood pressure, vaginitis, increased susceptibility to venereal disease, depression, acne, gum inflammation	99.5%	9
IUD	\$35-\$50 in Boston, \$50-\$100 in	Lippes Loop, Saf-T Coil, Majzlin Spring, Copper-T,	Bleeding, cramping, backache, expulsion, heavier and irregular	98% in parous women, 96-97% in	3.5

	New York, as little as \$10 some places	Dalkon Shield	periods, menstrual cramps, breakthrough bleeding	nulliparous women	
FAM/ Rhythm Method	N/A	N/A	N/A	80% at best	2

In the introduction to the chapter on birth control methods in the 1973 edition of *Our Bodies*, an emphasis is placed on impartiality: “This chapter and some of the books recommended in the bibliography (especially the McGill booklet) try to give an impartial and honest view of the available methods of birth control.”³²³ Despite this articulated attempt at impartiality, references to the pharmaceutical industry and its drive to promote methods like the pill and the IUD in a for-profit model are rather scathing, and readers are directed to an entire chapter dedicated to the ways in which the American health care system fails women.³²⁴

The introductory section of the birth control chapter also contains an overt critique of the pharmaceutical industry and medical institutions: “Drug companies, doctors, and clinics have a lot of control over our choice and acquisition of birth-control methods,”³²⁵ and articulate a gap in independent research on contraception: “There is a great need for independent research on birth-control methods: It has been shown that many of the

³²³ Ibid, 105.

³²⁴ Ibid., 107.

³²⁵ *Our Bodies*, 1973, 107.

‘independent’ studies so favorable to the pill have been done by scientists and doctors are actually financed by drug company grants.”³²⁶ Consequently, the authors assert that women must inform themselves rather than rely on medical practitioners to provide a complete picture of the birth control landscape:

We must learn for ourselves and teach each other about every available method of birth control. We have to know enough to recognize when a doctor is not examining enough or explaining enough or demonstrating enough. When we are at doctors’ offices or at clinics we have to be responsible enough to ourselves to ask questions and make sure that they are answered. We can’t take the place of doctors, but we have to demand to know what is pertinent to our health and safety.³²⁷

Acknowledging that birth control information in general is insufficient for fully-informed decision-making to occur, and that other social and cultural obstacles occur (repressive laws in some states; anti-sex attitudes in churches, schools and families; poor publicity about sources of birth-control care; misleading or inadequate information from profit-oriented drug companies--and even from doctors; difficulty in getting back-up abortions when a birth-control method fails; or, simply but critically, the high cost of medical examinations and contraceptive materials such as pills and jellies),³²⁸ the authors position their chapter as a comprehensive resource for birth control information, when paired with exchanging information and stories with other women and also consulting with medical professionals.³²⁹ As an early iteration of the text, the mandate to challenge a hostile and often dangerous medical landscape and to advocate for women’s informed decision-making and health autonomy is apparent.

³²⁶ Ibid.

³²⁷ Ibid.

³²⁸ *Our Bodies*, 1973, 106.

³²⁹ Ibid, 107.

The entry for the diaphragm in the 1973 edition of *Our Bodies* is introduced with an anecdote about how women express a look of distaste when diaphragms are mentioned because it's messy and conceptualized as an older method of birth control. It is posited that this is ironic since the diaphragm was a revolutionary way to prevent pregnancy in the late 1800s.³³⁰ The section notes that the birth control pill has quickly replaced the diaphragm in terms of popularity, but that at one point, "one-third of American couples practicing birth control used the diaphragm."³³¹ Since *Our Bodies* emphasizes a greater level of self-knowledge and positive body image, it makes sense that this edition's diaphragm entry suggests that a shift to more positive perspectives women's sexuality allow for a more pleasant use of the diaphragm than with previous generations because women are more comfortable with their sexual partners. It states, "If you are just starting to have intercourse you may not want to add a diaphragm to your sex life immediately, but in a few months, when you are more easy about sex, you may be glad to get off the pill or the IUD for a method that is effective if you use it well and that has no side effects at all."³³² The tone is favorable toward the diaphragm, despite the insinuation that the diaphragm has fallen out of favor with women. The authors assert that "the diaphragm is perfectly safe. The only risk you run is that of getting pregnant—and if you use it well, that risk is low."³³³ Being fitted for a diaphragm is contextualized as something that is easily achievable in standard medical practice, but also a skill that readers could learn themselves: "In this country, it is usually a doctor who measures you ('fits' you) for a diaphragm. But this is not a hard thing

³³⁰ *Our Bodies*, 1973, 123.

³³¹ *Ibid.*

³³² *Ibid.*

³³³ *Ibid.*

to learn and could be one of the tasks that doctors start to share with nurses, midwives, or paramedical assistants.”³³⁴ This indicates a view that knowledge of fittings should be shared via generativity (the concern for guiding and sharing knowledge with those from other generations)³³⁵ and also should be proliferated and broadened. The authors strongly imply that doctors will readily give prescriptions for diaphragms and jellies and that they can easily be obtained at the local drugstore.³³⁶ The entry also contains a discussion about inserting the diaphragm as sexual foreplay rather than doing it in secrecy.³³⁷ The authors emphasize the importance of getting a sense of feeling for the diaphragm, and practicing to know what feels right with regard to insertion. Overall, this edition represents the diaphragm as a safe, effective, woman-friendly contraceptive method that is old-fashioned but still holds much potential for future use. The authors express a hopefulness for the method to spread again in popularity and for women to share information about use and fittings so that we may no longer need to rely on medical doctors to acquire and learn how to use the devices.

The entry for the cervical cap in the 1973 edition comes with a bracketed caveat that it is “no longer much used,”³³⁸ and a short, singular paragraph description. It notes that the method hasn’t been used much since the 1950s, and that the diaphragm is a typical substitute. At the time of publication, no mainstream brands of cervical caps were readily

³³⁴ Ibid.

³³⁵ Charles L. Slater, “Generativity Versus Stagnation: An Elaboration of Erikson's Adult Stage of Human Development,” *Journal of Adult Development* 10, no 1 (2003): 53-65.

³³⁶ *Our Bodies*, 1973, 123

³³⁷ Ibid.

³³⁸ Ibid., 127.

available, which may account for the seeming reluctance of *Our Bodies* to represent it as a method worth pursuing.

Listed under the sub-heading “Birth Control Methods that Don’t Work Very Well,” the 1973 edition’s entry for “Rhythm Method” depicts a fairly overt bias against Fertility Awareness methods (FAM). The authors introduce the method by justifying their detailed account of it: “We mention it in such detail because some Catholic couples are trying to use rhythm without the assistance of a doctor or clinic, and because too many teen-agers and college students, unable to get good contraceptive advice and care, try to avoid pregnancy by timing their intercourse according to some vague idea that there is a ‘dangerous’ time around mid-cycle.”³³⁹ The authors assert that there is no safe time in a cycle to prevent pregnancy. The entry offers a fairly detailed account of how to practice the rhythm method, including a formula to calculate fertile and “safe” days. It also offers a brief explanation of how to incorporate basal temperature into the calculation of fertile days.³⁴⁰

In 1973, a few different IUD models were on the market, but the devices were still novel and as such, side-effects and fatalities were not being reported in abundance. The entry begins with a one paragraph description of IUDs and how they are inserted into the uterus. The subheading concludes with the following passage: “Some people find it a little unsettling that no one knows exactly how the IUD works. Others, uneasy with the pill’s more generalized effects and the pregnancy rates of other methods, choose an IUD. At least the effects of the IUD are local—if something goes wrong, your uterus hurts and you

³³⁹ *Our Bodies*, 1973, 132.

³⁴⁰ *ibid.*

seek medical help.”³⁴¹ The authors go on to describe the newest innovation of the time, the Copper-T, a small plastic T-shaped device wrapped in copper, but they articulate concerns the FDA had about introducing copper into the bloodstream. However, they provide an anecdote about a doctor using this IUD experimentally in patients and having a high success rate with the model.³⁴² They also state that “many doctors feel responsible for an IUD failure to the point that they will give you an abortion if your IUD fails,” and that “If you do become pregnant with an IUD in place, a miscarriage can be caused about 50 percent of the time simply by having the doctor remove the IUD.”³⁴³

The introduction to the chapter on birth control in this edition describes the myriad ways that the pharmaceutical industry and capitalist drive for profit dominates the landscape of birth control options, often resulting in detrimental outcomes to women’s health.³⁴⁴ The birth control pill is mentioned several times as an example of a method that is not fully researched and has the potential to harm women.³⁴⁵ Accordingly, the entry for the birth control pill is written in such a way as to caution women about choosing this method. Of its eight-and-a-half-page long content, over three pages are dedicated to dangers, risks, side-effects, and a number of other safety concerns. The authors include a brief description of how the pill functions to prevent pregnancy, and also direct readers to a different chapter on reproduction.³⁴⁶ A detailed chart describing women’s hormonal shifts during menstrual cycles on and off the pill is also presented. This information

³⁴¹ *ibid.*, 121.

³⁴² *Ibid.* It is worth noting that the Copper-T described here is essentially the same device (with only minor design tweaks) as Paragard, which is still on the market today.

³⁴³ *Ibid.*

³⁴⁴ *Ibid.*, 107.

³⁴⁵ *Ibid.*

³⁴⁶ *Ibid.*, 111.

overarches specific entries for combination pills (estrogen and progesterone), progesterone only pills and sequential pills (an outdated strategy that involved combining combination and progesterone only pills in different intervals throughout the cycle). Under the subheading “Safety,” the authors preface a long list of side effects, risks and health hazards with the following ominous statement:

Many of us are uneasy about taking a hormone-affecting medication every day for months and years since its effects have not been conclusively tested and since it has been in wide use for only fifteen years. Yet many of us choose to take whatever risks are involved because we absolutely don't want to get pregnant. What price do we pay for such perfect protection against pregnancy?³⁴⁷

Again, the issue of risks versus benefits and informed consent are mentioned, and despite many exposés released at that time showcasing the dangers of the pill working in opposition to accounts of pill advocates (the examples given by the authors are *The Doctors' Case Against the Pill*³⁴⁸ and *Birth Control Handbook*³⁴⁹ respectively), the authors of this entry ultimately conclude that, “We feel that every woman deserves to be able to make, and must make, an ‘informed decision’ (Barbara Seaman’s phrase) about using birth control pills. She must know the risks, and she must know about other birth control methods that she could use.”³⁵⁰ Despite the tendency to encourage women to take responsibility for their own sexuality and contraception, the authors remind women that if considering the pill, they must undergo proper medical evaluation and to make sure the pill is prescribed to them by a doctor (as opposed to getting pills from friends or relatives). The authors assert that readers must inform themselves about potential interactions and

³⁴⁷ Ibid, 113.

³⁴⁸ Barbara Seaman, *The Doctors' Case Against the Pill* (New York: P.H. Wyden).

³⁴⁹ Handbook Collective, *Birth Control Handbook* (1968).

³⁵⁰ *Our Bodies*, 1973, 115.

risks of use because “too many doctors prescribe birth-control pills hurriedly.”³⁵¹ Women are instructed to simultaneously arm themselves with knowledge and defer to medical authority as gatekeepers of hormonal birth control. While this edition expresses a general level of wariness toward the pill, the authors caution women against hypochondria: “sometimes, particularly when we aren’t sure we want to be taking the pill at all, we start to blame every mental and physical problem on the pill instead of looking for other causes as well...we must keep in mind that a majority of women notice no side effects at all...”³⁵²

Despite its emphasis on impartiality, this edition of *Our Bodies* represents some methods as safer and more desirable than others; the perspective that the diaphragm offers a woman-controlled, fairly reliable method with limited side-effects and greater bodily knowledge stands out when compared with the cautionary tone of the pill. Since the IUD was still in its early stages of development and use, the information provided by the authors does sincerely come across as being neutral. FAM, despite its demand for women to have a greater sense of their own cycles and physiology, is essentially ridiculed as a highly flawed and failure-prone method, whereas the cervical cap is barely represented at all.

5.7 1984 Edition

Overview

The creators of *Our Bodies* intended for the text to be collaborative and sought feedback from their readers. The authors³⁵³ solicited responses in venues such as *Ms. Magazine*, and their readers delivered. According to Kline, in the 1970s and 1980s more

³⁵¹ Ibid., 116.

³⁵² Ibid.

³⁵³ Susan Bell, eds. Jane Pincus and Wendy Sanford

than 200 women wrote to the Collective to “share stories, seek advice, chastise, or praise. They commented on what was helpful, what was vague, what made sense, and what was missing, on subjects ranging from dental care to diaphragms.”³⁵⁴ What women wanted, in addition to greater accuracy and thoroughness of sexual health information, was greater inclusivity. Commenters suggested that the singular chapter dedicated to lesbianism in the 1973 edition of *Our Bodies* effectually ghettoized gay readers.³⁵⁵ The first edition prior to the 1973 reprint had only one page of lesbian-specific content, which was wholly insufficient to the needs of its readers given that the 18 page chapter in the reprint still did not meet readers’ needs.³⁵⁶ Further, the fact that the gay content was written by a separate group of lesbian authors involved in gay liberation causes without much consultation or interaction with the Collective meant that the chapter lacked cohesiveness with the rest of the text, rendering it even more alienating.³⁵⁷ After much discussion and deliberation and utilizing its readers’ valuable feedback, the 1984 edition features a much longer chapter dedicated to lesbian sexuality and also integrates gay perspectives throughout (although the contraceptive chapter is entirely heteronormative).³⁵⁸

In addition to a more inclusive approach to women’s sexual identities, *Our Bodies* also responded to readers’ concerns about ableism and a general disregard for disabled bodies in the earlier edition.³⁵⁹ Kline notes that, “The disability rights movement led to greater awareness and discussion of disabilities in the 1970s. This, in turn, prompted some

³⁵⁴ Kline, “Please Include This,” 89.

³⁵⁵ *Ibid.*, 107.

³⁵⁶ *Ibid.*

³⁵⁷ *Ibid.*

³⁵⁸ *Ibid.*

³⁵⁹ *Ibid.*, 106.

readers to critique the limited discussion of women with disabilities in *Our Bodies, Ourselves*.³⁶⁰ In the preface of the 1984 edition, Wendy Sanford addresses these criticisms, stating that that concerns about the previous edition lacking the experiences of disabled women have been addressed.³⁶¹ As a result, *The New Our Bodies, Ourselves* incorporated the stories of women with disabilities in various chapters on health and sexuality.³⁶² Davis notes that,

While the authors of *OBOS* initially addressed their readers in an unreflective way as ‘we women,’ as conflicts around racism, class privilege, and homophobia arose within the feminist movement, they became more sensitive to the additional work that needed to be done in order to make *OBOS* inclusive of a greater diversity of women. Their initial strategy was to hand over chapters to women who could write from firsthand experience. In subsequent editions, a more intersectional strategy was followed whereby specific readers were enlisted to read chapters through the lens of difference (able-bodiedness, age, race or ethnicity, and class) in order to maximize the critical potential of different perspectives. It was, ultimately, however, their strategy of mobilizing hundreds of readers from different groups to help read, criticize, and (re)write *OBOS* that made it, literally, a more collaborative, and therefore more inclusive, feminist enterprise.³⁶³

³⁶⁰ Ibid.

³⁶¹ Boston Women’s Health Collective, *The New Our Bodies, Ourselves* (New York: Simon & Schuster, 1984): xi.

³⁶² Kline, “Please Include This,” 107.

³⁶³ Davis, *Making of*, 48.

Contents

Table 5:3 Selected Content from 1984 Edition

Method	Cost	Brands	Side Effects	Effectiveness Rate	Page length of entry
Diaphragm	\$12 plus medical exam and jellies	Koro-Flex mentioned as a recalled brand	Cramps, cystitis or urethritis, discomfort, yeast infections	90%-98%	4
Cervical Cap	\$7-\$10	Prentif, Dumas, Vimule	Odor, infections, cervical erosion	Theoretical: 98%, actual, 87%	2
Pill	N/A	21 listed	Heart attack and stroke, high blood pressure, cancer, birth defects, headaches, diabetes, depression, change in libido, nausea, fatigue, vaginitis, urinary tract infection, menstrual changes, breakthrough	98%-99.5%	9

			bleeding, breast changes, skin problems, gum inflammation, liver and gallbladder disease, epilepsy and asthma, viral infections, cervical dysplasia, pleurisy, arthritic symptoms, visual disturbances, mouth ulcers, bruising, antagonism with Rifampin, lupus, abdominal cramping, thyroid issues, photodermatitis, alopecia, hirsutism, benign growths, autophonia, nutritional deficiencies		
IUD	\$35- \$100, as little as \$10 at some clinics	Lippes Loop, Saf-T Coil, Copper 7, Copper T, Progestasert	Expulsion, infections, excessive bleeding and cramping, embedding, perforation, ectopic	96%-98.5%	6

		Removed from market: Majzlin Spring, Birnberg Bow, Dalkon Shield	pregnancy, allergic reaction, long-term infertility and pelvic inflammatory disease		
FAM/ Rhythm Method	N/A	N/A	N/A	Ovulation: theoretical rate of 94.3%-99.9%, actual rate of 60.3%-97.7%; Sympto-thermal: theoretical rate of 86.9%-99.5%, actual rate of 65.6%-95.5%, both rates improve if using barrier too	2.5
Sponge	N/A	N/A	Potential link to toxic shock	83.2%	1

			syndrome, allergic reactions, odor		
--	--	--	------------------------------------	--	--

In the introduction to the chapter on birth control methods, the Collective clearly explicates that they maintain biases toward certain methods of birth control and advocate some methods over others:

The Collective favors certain methods of contraception over others and has chosen to place them first. Most of us who use birth control choose a diaphragm, cervical cap, or foam and condom, because they are both effective and safe. We have become increasingly discouraged about the Pill and the IUD after receiving hundreds of letters from women who have been harmed by these methods. Research also documents Pill and IUD risks. We believe that the Pill and IUD are dangerous enough to warrant their use as methods of “second choice” rather than “first choice,” and so we describe them toward the end of the chapter.³⁶⁴

This is noteworthy as it marks a significant shift from the statement about impartiality found in the birth control introduction of the 1973 edition. Organizing methods by perceived safety and drawing on women’s stories about side effects to effectively shun methods like the pill and the IUD demonstrate a key point in the *Our Bodies* narrative; the authors view advocating for women’s health as more fundamental than recommending methods based on efficacy. While aspects of disability are not added to the “who cannot use a diaphragm” segment of the diaphragm entry in this edition, the general tone of the edition is more inclusive overall.

Additionally, the medical context undergirding the 1984 edition of *Our Bodies* is one of increasingly expanding pharmaceutical industry. Oral contraceptives had become the

³⁶⁴ *New Our Bodies*, 1984, 225.

norm with IUDs following closely behind, and this is clearly articulated in the diaphragm entry, which states,

It was popular until the 1960s—at one time, a third of all U.S. couples practicing birth control used it. By 1971, however, Planned Parenthood reported that only 4 percent of its clients were choosing diaphragms. What had happened? In the late 1950s and 1960s, the drug industry, the medical profession, private foundations and the U.S. government began to pour money into researching, developing and distributing the Pill and the IUD, virtually excluding any research on the diaphragm and other barrier methods. Usually, these interests were more concerned with developing new technologies and/or making profits than with the health and well-being of women. Many of us believed the drug industry's and physicians' proclamations about Pill and IUD safety and had hoped that the Pill and IUD would allow us more sexual spontaneity and protection against pregnancy than diaphragms.³⁶⁵

After the initial basic description of the diaphragm and articulating its decline, this edition optimistically notes that in recent times women have begun using diaphragms again.³⁶⁶ The authors attribute this to increasing levels of body confidence and more positive views of sexuality, and also, more open dialogue with sexual partners than in previous years.³⁶⁷ This edition also posits that women are more concerned with contraceptive safety and may opt for the diaphragm due to its superior safety over its counterparts, the Pill or IUDS, and also suggests that diaphragms are more reliable than IUDS.³⁶⁸ Interestingly, the authors also articulate potential issues with obtaining diaphragms:

Yet there are still obstacles to diaphragm use: Only a practitioner can legally prescribe it. Some practitioners, especially physicians, do not

³⁶⁵ Ibid., 225

³⁶⁶ Ibid.

³⁶⁷ Ibid.

³⁶⁸ Ibid.

include time in their schedules and often charge high fees for their services. A practitioner's attitudes about sexuality *can* affect his/her attitudes about certain methods of birth control and affect ours in turn. **Many practitioners don't trust our ability to use a barrier method well; they frequently assume that IUDs or pills are "better"**³⁶⁹ and that we wouldn't want to "mess" with the diaphragm.³⁷⁰

They assert the need to obtain proper size fittings from doctors, nurse-practitioners or other health providers. Readers are instructed to make sure they are able insert it themselves before leaving the practitioner's office. According to the authors, practice makes perfect; insertion may feel awkward at first but will become comfortable with practice. In terms of proper fit, the authors state that the diaphragm is a good method for body education and that, "When it's in right and fits properly, you should not be able to feel the diaphragm at all."³⁷¹ This serves to both support and normalize an embodied knowledge approach (as opposed to urging readers to rely on a doctor's examination that discerns visually whether the diaphragm is properly placed). The authors assert that the more a woman knows about her own body, the more she will enjoy sex.³⁷² The authors also depict the diaphragm as having potential to prevent against sexually transmitted infections: "Repeated studies indicate that the diaphragm with cream or jelly reduces your chances of getting gonorrhea or trichomoniasis infections in the vaginal canal. In terms of "Responsibility," the diaphragm is chiefly in the sphere of women (they must get fitted and insert it before sex). Partners can help sometimes, but most women choose to do it themselves."³⁷³

³⁶⁹ Emphasis added.

³⁷⁰ *New Our Bodies*, 1984, 225.

³⁷¹ *Ibid.*, 227.

³⁷² *Ibid.*, 229.

³⁷³ *Ibid.*

The entry for the cervical cap in this edition is considerably longer than the one in the 1973 edition, as the Prentif cap was under review for FDA approval and was easily obtainable in metropolitan areas.³⁷⁴ This entry offers a brief introduction to the cervical cap, including a short physical description, how it works, and how it can be used with spermicide to improve performance. The authors note that, “Used in some European countries, the cap was also used during the early twentieth century in the U.S. With the rise in the use of the Pill and the IUD, the cervical cap, like the diaphragm, declined in popularity. By the mid-1960s, U.S. companies had completely stopped producing it for contraceptive purposes.”³⁷⁵

In terms of actually obtaining a cap, this edition’s entry suggests writing or calling a feminist health center in New Hampshire for a list of practitioners and clinics that fit cervical caps.³⁷⁶ Further, it states that caps must be fitted and that different models may not be available. Also, the authors of the entry instruct women going for cap fittings to “be sure that the practitioner gives you time to try inserting and removing it. A cervical cap is somewhat more difficult to use than a diaphragm, since you have to be able to reach your cervix with your fingers to put the cap in place.”³⁷⁷

In a section entitled “Who Shouldn’t Use the Cervical Cap,” this edition states that many women, even those who cannot use diaphragms, can use caps. However, it stipulates that women with cervical erosions or lacerations should not.³⁷⁸ Vimule caps (a brand that was widely available but never FDA approved) are suggested as an alternative for women

³⁷⁴ Ibid., 231.

³⁷⁵ Ibid.

³⁷⁶ Ibid.

³⁷⁷ Ibid.

³⁷⁸ Ibid.

with irregularly shaped cervixes, and the authors of this entry also warn that some women have anatomy that makes cap removal difficult, if not impossible. Advantages of the cap are listed as being very effective, being affordable, the ability to insert it in advance of sexual activity, the fact that it is less messy than the diaphragm even if used in conjunction with spermicide, and that the cap “helps us get to know our bodies better³⁷⁹.”

The contraceptive sponge (“Today Sponge”) was invented in the mid 1970s by Bruce Ward Vorhauer³⁸⁰ and received FDA approval in July of 1983,³⁸¹ and is thus not represented in the 1973 edition. The sponge is a polyurethane single-sized dome of about 2.25 inches in diameter and 3/4 of an inch with a dimple in the center and loop of tape attached for removal. It is impregnated with spermicide and is used and functions in a similar fashion as a diaphragm. It is first mentioned in the 1984 edition and is discussed largely in relation to its novelty, innovativeness, and as an alternative to hormones and IUDs.³⁸² The authors of this edition note that the sponge also emerged in part due to “a growing recognition by the medical establishment that women are seeking alternatives, [and] a slight rise in publicly and privately funded research for improving barrier methods and producing new ones.”³⁸³

The description of the sponge, how it works and how to use it is fairly straightforward aside from a caution about toxic shock syndrome during menstruation.

³⁷⁹ Ibid.

³⁸⁰ Steve Emmons, “Sequel: Bruce Vorhauer: The Final Fall,” *LA Times* (February 15, 1993), accessed June 28, 2019, http://articles.latimes.com/1993-02-15/news/vw-241_1_contraceptive-sponge.

³⁸¹ United States Food and Drug Administration, FDA's Approval of the Today Contraceptive Sponge: Hearing Before a Subcommittee of the Committee on Government Operations, House of Representatives, Ninety-eighth Congress, first session, July 13, 1983.

³⁸² *New Our Bodies*, 1984, 230.

³⁸³ Ibid.

The advantages listed in the 1984 edition liken the sponge to the diaphragm in many regards (safety and effectiveness, reversibility, learning about one’s body and possible reduction in STD transmission),³⁸⁴ but also note that unlike the diaphragm, the sponge doesn’t need to be fitted and can be purchased over the counter, and that it is less messy.³⁸⁵

Fertility awareness methods receive an updated entry in the 1984 edition. Headed under “Fertility Observation (sometimes called Natural Birth Control)”, and then further broken down by subheadings “The Ovulation Method (Awareness of Mucus) and “The Sympto-Thermal Method (STM), the updated edition no longer reduces FAM to the rhythm method as did the previous edition.³⁸⁶ In fact, in the second paragraph of the entry, the authors clearly explicate the differences between the rhythm method and the approaches they’re describing:

“Most of us have heard of the rhythm method, notorious for its high failure rate. It tries to predict a woman’s cycles based on information from past cycles. However, since no one has absolutely regular cycles all the time, it fails frequently. Bad experiences with rhythm have led many women to discount so-called “natural methods” of birth control; yet natural methods that work have been developed, and their scientific basis is well documented.”³⁸⁷

They also note that fertility observation has far-reaching implications including learning basic information about one’s own body, to prevent or achieve pregnancy and to predict menstruation.³⁸⁸ The entry goes on to explain the role cervical mucus plays in fertility and determining if one is in a fertile phase, and how using this information to time intercourse

³⁸⁴ Ibid.

³⁸⁵ Ibid.

³⁸⁶ Ibid., 235-236.

³⁸⁷ *New Our Bodies*, 1984, 235.

³⁸⁸ Ibid.

for pregnancy prevention.³⁸⁹ The authors stress the importance of communicating with other women when learning this method, and that information in textual form is insufficient: “Although a number of books in Resources can be very helpful and are recommended, books (including this one) cannot give you the personal feedback, support, and experience-sharing you need.”³⁹⁰ They go on to list tips for seeking out instruction and support, and questions to ask when considering joining a women’s group dedicated to fertility observation.³⁹¹ Under the subheadings about each type of fertility observation method discussed in this entry (Ovulation Method and Sympto-thermal method), brief historical or contextual information is provided, as well as basic information about how the methods work and the science behind it. Whereas the last edition (despite articulating that fertility observation was a poor choice of method) offered an actual formula and models for charting menstrual cycles, this edition only provides descriptive information and the insistence that readers must thoroughly learn the methods before relying on them. In the section about Effectiveness, the authors clearly differentiate the failure-prone rhythm method from more precise approaches to fertility observation: “Recent studies (based on women avoiding all vagina-to-penis contact on fertile days) indicate that the Ovulation Method or Sympto-Thermal method can be extremely effective when taught carefully, understood thoroughly and used correctly (called ‘theoretical effectiveness’).”³⁹² However, it is explicated that these high failure rates are due to women not fully understanding the methods or not using barrier methods on their fertile days.³⁹³ The entry

³⁸⁹ Ibid.

³⁹⁰ Ibid.

³⁹¹ Ibid.

³⁹² Ibid., 237.

³⁹³ Ibid.

concludes with a brief passage about the future of fertility observation methods: “Numerous machines and devices are being developed to measure hormonal changes and to pinpoint fertility. They are based on the same principles as the Ovulation Method and the STM, but they’re more expensive and more profitable for the manufacturers without necessarily being more accurate.”³⁹⁴

The entry for the IUD in the 1984 edition begins with a brief historical anecdote about the device and goes on to state that about sixty million women worldwide use more than a hundred varieties of IUD.³⁹⁵ Following this, five paragraphs are dedicated to describing the disaster that was the Dalkon Shield which resulted in “a high number of cases of pelvic inflammatory disease (PID) and spontaneous septic abortions (miscarriages). At least seventeen young women have died as a result of Dalkon-Shield related septic abortions.”³⁹⁶ The 1984 edition highlights the problems that had occurred with the Dalkon Shield IUD in the early 1970s that carried into the early 1980s via a class action lawsuit.³⁹⁷ According to Adam Sonfield of the Guttmacher Institute, by the early 1970s, 10% of American women were using IUDs for contraception.³⁹⁸ However, several deaths related to the Dalkon Shield in the 1970s (primarily due to septic miscarriages) resulted in a public relations fiasco and the company bankrupted in the mid-1980s and withdrew its products from the market.³⁹⁹ This shaped perspectives of the IUD in the

³⁹⁴ Ibid.

³⁹⁵ Ibid., 249.

³⁹⁶ Ibid., 249.

³⁹⁷ Ibid., 249.

³⁹⁸ Adam Sonfield, “Popularity Disparity: Attitudes About the IUD in Europe and the United States,” *Guttmacher Policy Review* 10, no. 4 (2007), accessed June 28, 2019, <https://www.guttmacher.org/pubs/gpr/10/4/gpr100419.html>.

³⁹⁹ Ibid.

United States and Canada, but IUDs remained popular in Europe and the UK because other brands and models were available and had better safety records.⁴⁰⁰

The authors explain that the Dalkon Shield was pulled from the market, and numerous lawsuits were pending at the time of publication. The passage ends with the authors urging any readers to have their Dalkon Shields removed.⁴⁰¹ Much of the descriptive language for this entry is very similar to that of the IUD entry in the 1973 edition, but this entry is significantly longer (6 pages vs 3) due to the expanded content related to side effects, warnings, and general safety. More models are described in this edition with a statement about the models that have been removed from the market due to complications. Under “Safety,” the authors reiterate the dangers that they perceive: “More and more studies are documenting serious negative effects suffered by IUD users. Some women have died from IUD complications; others have had serious injury.”⁴⁰² Suffice it to say, the authors are clearly not impressed with the IUD as a method of contraception. This edition offers more detailed instruction on how to check the placement of the IUD than the 1973 edition did, again demonstrating the encouragement of bodily awareness and embodied knowledge. The authors describe what the inside of the vagina should feel like and how IUD users can locate their own cervixes, and also suggest doing a vaginal self-exam with a speculum to locate IUD strings if they can’t be felt with the fingers. They suggest that a medical professional should be consulted if strings cannot be located,

⁴⁰⁰ Ibid.

⁴⁰¹ *New Our Bodies*, 1984, 249.

⁴⁰² Ibid., 251.

implying that readers should trust themselves to identify potential problems with their IUD placement.⁴⁰³

Under “New IUD Design,” the authors again warn readers to remain skeptical: “View *all* new IUDs cautiously, since experience has shown that many of their long-term negative side effects will show up only after they’re put on the market.”⁴⁰⁴ The final section of the entry describes new uses of the IUD as morning-after birth control, but again, the risks are reiterated. Following the disaster that was the Dalkon-Shield and written at the time of pending litigation against the manufacturers, the authors offer readers stern warnings about choosing an IUD as a birth control method and the harm that choice may cause. This makes sense, given that the entire mandate of the Our Bodies endeavor is to ensure that minimal harm is inflicted on women and their bodies in medical contexts.

The authors of the 1984 edition’s entry for birth control pills introduce this method to their readers by offering a contextual background story about how the rapid approval and marketing of this form of contraception without adequate testing resulted in millions of women taking the pill and experiencing harsh side effects and complications. They point to the FDA’s delays in labelling pills with package warnings and pharmaceutical firm G.D Searle’s misrepresenting study findings as examples of how new and continuous information about the pill is emerging all the time.⁴⁰⁵ This bit of background information does not present a rosy picture of pill usage and safety. Following this, much of the description of how the pill works, its effectiveness, and a chart explaining details of a woman’s menstrual cycle remain very similar to those sections in the 1973 edition.

⁴⁰³ Ibid., 254.

⁴⁰⁴ Ibid., 255.

⁴⁰⁵ Ibid., 238.

Countering the statement found in the 1973 edition about hypochondria and encouraging women to resist the urge to attribute all health issues to the pill, the authors clearly state that the pill is dangerous and that women using it should not ignore any symptoms or listen to their doctor's suggestion that said symptoms might just be in their heads: "health workers and doctors...sometimes believe that effects are psychosomatic and that what might happen will influence our perceptions. This attitude is insulting and dangerous. Find out what the risks are before you get a prescription for the pill."⁴⁰⁶ There are also now explicit warnings about pill-related deaths being linked to cardiovascular disease, smoking and older age.⁴⁰⁷ The authors make additions to the list of side effects and also the descriptions of how these side effects manifest

Overall this entry for the pill takes on a much more alarmist tone than the 1973 edition. The authors speak of the pill as though it is still experimental and very dangerous. Discrediting the notion that side effects may just be in our heads, they urge readers to monitor their bodily reactions to the pill very carefully and to be highly informed about any and all potential risks while using it.

The authors of the 1984 edition of *Our Bodies* have no qualms about presenting biases when it comes to birth control information; they state outright that they prefer some methods over others and allow that preference to dictate the structure of the chapter. At this period in time, so many serious health issues affected users of the pill and the IUD that the authors deemed it necessary to include a table of death rates from contraceptive methods, placing IUDS and pills at the forefront of danger and highlighting the fact that

⁴⁰⁶ Ibid., 241.

⁴⁰⁷ Ibid.

barrier and natural methods have, at that time, killed no one.⁴⁰⁸ Accordingly, cervical barrier methods and fertility awareness are described not only as valid choices of contraception, but as the safest, most preferred choices. The way they describe the diaphragm comes off as almost defensive, urging readers to consider this method over the IUD or the pill. Since *Our Bodies* emerged in response to a medical climate that seemed to treat birth control as an ongoing experiment with lax safety regulations that had, at times, severe implications for women, it seems logical that the authors would advocate for the minimization of harm when it came to representing available birth control methods.

5.8 1992 Edition

Overview

The most critical update to the 1992 edition⁴⁰⁹ was a chapter dedicated to the HIV/AIDS epidemic that surfaced as a global issue in the early 1980s. While it is thought HIV had existed in human form since the 1920s,⁴¹⁰ numbers of affected individuals were unknown until the 1980s. AVERT (AIDS Virus Education Research Trust) notes that, “While sporadic cases of AIDS were documented prior to 1970, available data suggests that the current epidemic started in the mid- to late 1970s. By 1980, HIV may have already spread to five continents (North America, South America, Europe, Africa and Australia). In this period, between 100,000 and 300,000 people could have already been infected.”⁴¹¹

⁴⁰⁸ Ibid., 224.

⁴⁰⁹ Eds. Susan Bell, with Suzannah Cooper-Doyle, Judy Norsigian and Felica Stewart Update coordinated by Amy Alpern, Leah Diskin and Judy Norsigian, with Rachel Lanzerotti, Wendy Sanford, Norma Swenson, Laura Weil, and Laurie Williams.

⁴¹⁰ J.M. Mann, “AIDS: A Worldwide Pandemic” in *Current Topics in AIDS Volume 2*, eds. M.S. Gottlieb et al. (John Wiley & Sons, 1989).

⁴¹¹ AVERT, “History of HIV and AIDS Overview,” accessed June 28, 2019, <http://www.avert.org/professionals/history-hiv-aids/overview>.

When the 1984 edition of *Our Bodies* was printing, immune deficiency-related diseases were increasingly found in gay men and injection drug users.⁴¹² By the end of 1981, there were 270 reported cases of severe immune deficiency among gay men, and 121 of these men had died⁴¹³. In September of 1982, the CDC used the term AIDS for the first time⁴¹⁴ and AIDS cases were beginning to be reported in Europe.⁴¹⁵ It wasn't until 1983 that researchers discovered that HIV could be transmitted via heterosexual sex.⁴¹⁶ The AIDS crisis rapidly worsened, and by the time the 1992 edition of *Our Bodies* was printed, 8-10 million people were thought to be living with HIV globally.⁴¹⁷ The 1992 edition addressed the HIV/AIDS crisis by dedicating an entire chapter to the subject, and tailoring it specifically to women. In the chapter entitled "AIDS, HIV Infection, and Women," the authors explain that women are often the invisible faces of AIDS, and that HIV and AIDS particularly affect women of color and poor women. At the time of publication, women with AIDS were dying at rates twice as quickly as their male counterparts, and many were also undiagnosed and becoming ill without knowing why. The authors also describe how women are more frequently the caregivers of AIDS patients and contend that, "AIDS powerfully affects our lives as women. Yet in every aspect of the public response to AIDS,

⁴¹² H. Masur, et. al., "An Outbreak of Community Acquired Pneumocystis Carinii Pneumonia: Initial Manifestation of Cellular Immune Dysfunction," *The New England Journal Of Medicine* 305, no. 24 (1981):1431-1438.

⁴¹³ AIDS.gov, "A Timeline of AIDS," accessed June 28, 2019, <https://www.hiv.gov/sites/default/files/aidsgov-timeline.pdf>.

⁴¹⁴ Centers for Disease Control (CDC), "Current Trends Update on Acquired Immune Deficiency Syndrome (AIDS)," *United States' MMWR* 31, no. 37 (September 24, 1982):507-508, 513-514.

⁴¹⁵ Willy Rozenbaum et al. "Multiple Opportunistic Infection in a Male Homosexual in France," *Lancet* 1(1982):572-573.

⁴¹⁶ Centers for Disease Control and Prevention (CDC), "Epidemiologic Notes and Reports of Immunodeficiency Among Female sexual Partners of Males with Acquired Immune Deficiency Syndrome (AIDS) - New York," *MMWR Weekly* 31, no 52 (January 7 1983):697-698.

⁴¹⁷ J. Chin, "Global Estimates of AIDS Cases and HIV infections: 1990," *AIDS* 4, 1S (1990):277-283.

from research to drug trials, from health provider attitudes to insurance and disability practices, women's experience with HIV and AIDS has often been overlooked. This chapter offers basic HIV and AIDS information for women."⁴¹⁸ HIV/AIDS is contextualized not only as a public health issue, but as a women's health issue. HIV considerations pepper many aspects of this edition, as sexually transmitted diseases have taken on a considerably more deadly tone since the 1984 edition. Accordingly, contraceptive methods are now described not only in their efficacy rates for pregnancy prevention, but also for their efficacy in HIV prevention. New devices designed specifically to address HIV prevention emerge (the female condom is an example).

Again, as with the 1984 edition, the introductory section of the birth control chapter articulates that it plays favorites:

The Collective favors certain methods of contraception over others and has chosen to place them first. Most of us who use or have used birth control chose a diaphragm, cervical cap, or foam and condom, because they effectively prevent pregnancy, are safe and offer some protection against STDs and PID. The *safest* way to control our fertility is to use barrier methods of contraception with abortion as a backup in case of failure. If abortion is an unacceptable option for moral or religious reasons, then the overall safety of these methods, which are, in actual practice, less effective than the Pill and IUD, is reduced by whatever risks pregnancy and childbirth might bring...Beyond safety, we believe far greater use of barrier methods should be encouraged because they offer protection against STDs and HIV. We must seek to change the attitudes and prejudices that kept us from using these methods in the past. Even when women choose the Pill, IUD, or long-acting hormonal method, such as Norplant, barrier methods are important "companions" that help prevent STDs."⁴¹⁹

⁴¹⁸ Boston Women's Health Book Collective, *The New Our Bodies, Ourselves*, (New York: Simon & Schuster, 1992), 327.

⁴¹⁹ *Ibid.*, 264-265.

The statement that barrier methods paired with abortion are a safer and preferred method of contraception over hormonal methods or IUDs sends a strong message to readers about safety and risk. If it is preferred that women undertake a minor surgical procedure rather than use pills and IUDs, this represents a key point in feminist birth control history wherein the products of pharmaceutical innovation are perceived not only with wariness and skepticism, but are also outright rejected. Even more interesting is the assertion that barrier methods should be embraced on a greater scale due to their safety record and the protection against STDs and HIV they might impart. The authors describe a desire to change prejudices about barrier methods and encourage their use alongside hormonal methods; in 1992, barriers were falling even further out of favor, and yet the authors sought a revival because the alternatives, in their view, didn't go far enough to prevent deadly diseases, and were also themselves deadly.

Contents

Table 5:4 Selected Content of 1992 Edition

Method	Cost	Brands	Side Effects	Effectiveness Rate	Page length of entry
Diaphragm	\$20 plus exam and jellies	N/A	Yeast infections, urinary tract infections	82%-94%; 100% achievable if used with FAM	4

Cervical Cap	\$30 plus fitting fee	Prentif (Vimule and Dumas mentioned as not FDA approved)	Toxic shock syndrome, urinary tract infections	82%-94%	2
Pill	N/A	4 listed	Heart attack and stroke, high blood pressure, cancer, headaches, diabetes, depression, change in libido, nausea, fatigue, vaginitis, urinary tract infection, menstrual changes, breakthrough bleeding, breast changes, skin problems, gum inflammation, liver and gallbladder disease, epilepsy and asthma, viral infections, cervical dysplasia, pleurisy, arthritic symptoms, visual disturbances, mouth ulcers,	97%-99.9%	8

			bruising, antagonism with Rifampin, lupus, abdominal cramping, thyroid issues, photodermatitis, alopecia, hirsutism, benign growths, autophonia, cervical ectropion, nutritional deficiencies		
IUD	\$100 initial exam, \$220 - \$300 for a second visit that includes insertion	Paraguard, Copper-7, Shanghai V, Multiload and various other Copper T's, Progestasert, Majzlin Spring, Birnberg Bow and Dalkon Shied off the market	Expulsion, infections, excessive bleeding and cramping, embedding, perforation, ectopic pregnancy, allergic reactions, pain, long-term infertility due to pelvic inflammatory disease	97%	6
FAM/	Free to use, may	N/A	N/A	Ovulation method 97%,	4

Rhythm Method	have to pay for learning materials			Sympto-thermal method 98% with perfect use, high failure rate if used incorrectly. WHO estimates effectiveness at 86.4%	
Sponge	N/A	N/A	Potential link to toxic shock syndrome, allergic reactions, odor, yeast infections	82%-94%, higher failure rate for women who have given birth	1
Female Condom	N/A	Reality Vaginal Pouch	N/A	As effective as diaphragm or cap	1

This edition's entry on the diaphragm is virtually identical to that of 1984's version. The diaphragm is introduced in this edition as a revolutionary innovation; it is described as freeing women from relying on their partners for contraception and placing responsibility in the hands of women for their own reproductive destinies.⁴²⁰ Its decline in

⁴²⁰ *New Our Bodies*, 1992, 265.

use is attributed to pharmaceutical industry proliferation and emphasis on hormonal contraceptives, and then it is suggested that diaphragm use is once again on the rise. There are some minor noteworthy changes in this edition's entry when compared to that of 1984. The authors articulate an increase in research on barrier methods in recent years, but suggest that this level of research nonetheless remains inadequate despite an increase in funding being allocated to diaphragms and caps.⁴²¹ The failure rate of diaphragms jumps from 2% in 1984 to 6% (with ideal use) and 18% (with typical use) in 1992, and it is suggested that, "you can combine the use of the diaphragm with fertility observation. You can achieve almost 100 percent effectiveness with the diaphragm if your partner also uses a condom on your fertile days."⁴²² This suggestion of pairing the diaphragm with other methods is new and reflective of a general shift toward concerns for high efficacy and the rejection of methods with higher failure rates. In previous editions, the diaphragm stood on its own as an efficacious method and by 1992, it was contextualized as a method with a higher failure rate that was not reliable on its own.

The cervical cap was approved for marketing in the U.S. in 1988 after a lengthy FDA review process, as this edition's entry clearly states in its introduction. Much of the text in the introduction remains the same as in the 1984 edition, but an additional paragraph is included:

The National Women's Health Network, feminist health groups and a small number of physicians and nurses spent nearly a decade campaigning for the cap and shepherding it through the long process of the FDA. In addition, much of the research on the cap has been conducted at feminist health centers across the United States. The

⁴²¹ Ibid..

⁴²² Ibid., 266.

availability of the cervical cap today represents a victory for women's health activists.⁴²³

The inclusion of the above paragraph in the entry for the cap signifies cervical caps as feminist birth control method and stands in stark contrast to the 1973 edition, which relegates it to a paragraph and suggests it is outdated and has been replaced by the diaphragm. This is exemplary of how contraceptive methods shift over time in availability, favorability, and contextualization (i.e. going from being outmoded to a modern feminist victory).

Effectiveness is listed as six percent at its lowest and eighteen percent with typical use, which is lower than the 1984 edition's stated two and thirteen percent failure rates. Other than the reduction in efficacy, much of the entry for the cap remains identical to that of the edition from roughly a decade before; what sexually transmitted infections it helps protect against (gonorrhea and chlamydia) is now included,⁴²⁴ and although HIV is not explicitly mentioned in this entry, noting STD protection is novel for the time period.

The description, function and use sections for the sponge in the 1992 version are identical to the 1983 section. However, the efficacy rate is adjusted since the sponge had been on the market for almost a decade at the point of publication. In 1992, the entry for the sponge notes that it is significantly less effective for women who have given birth, and for those who haven't, the effectiveness is similar to the diaphragm. The safety, advantages and disadvantages are all the same for the 1983 and 1992 editions, with the caveat in the latter that it may lead to an increase in yeast infections.⁴²⁵

⁴²³ Ibid., 272.

⁴²⁴ Ibid., 272-273,

⁴²⁵ Ibid., 272.

The entry for “Fertility Observation (Natural Birth Control)” in the 1992 edition is essentially the same as in the 1984 edition, with a few noteworthy updates. More detail is added to the explanation of fertility and how these signs function to determine fertile periods.⁴²⁶ The section entitled “Avoiding Pregnancy Through Fertility Observation” now articulates differences between Natural Family Planning (NFP) and Fertility Awareness Method (FAM), asserting that the former requires total abstinence during fertile periods, and the latter allows for choice between abstinence and the use of barrier methods.⁴²⁷ The remainder of the entry is virtually identical to that of the 1984 edition, although failure rates have been updated to show greater efficacy. Further, the following clause is added: “A recent reinterpretation of the World Health Organization clinical trial determined that the failure rate during typical use is 86.4 percent.”⁴²⁸

As is the case with many other methods discussed here, one of the major changes to the entry for the IUD in the 1992 edition involves discussing its ability (or lack thereof) to prevent sexually transmitted infections and HIV. While the vast majority of the entry is essentially the same as that of the 1984 edition, the IUD’s drawbacks now include its total lack of protection against STDs and HIV.⁴²⁹ Further to this point, women who are at greater risk of HIV exposure are included in the section entitled “Who Is Strongly Advised Not to Use the IUD.”⁴³⁰ The entry takes on the same cautious tone as that of the 1984 edition, and updates information about the class action lawsuits that were pending at the time of publication for the previous edition.

⁴²⁶ Ibid., 276

⁴²⁷ Ibid., 277.

⁴²⁸ Ibid., 279.

⁴²⁹ Ibid., 299.

⁴³⁰ Ibid., 296.

The female condom first appears in the 1992 edition of *Our Bodies*. Although it had not yet received FDA approval at that time, it was expected to pass FDA approval and the authors included an entry for it on that basis. Although the female condom was not yet FDA approved, the authors offer contact information for the manufacturer. In terms of effectiveness, this entry lists the female condom as being at par with the diaphragm and cervical cap but offering greater protection against STDs. It is listed as being highly reversible and a brief description of how to use it is included (placement isn't as important as it is for other cervical barriers and thus the use section is brief). The authors state that the main advantage of using the female condom is its effective STD and HIV prevention. In the disadvantages section, the authors suggest that some women may find the female condom cumbersome, in that the ring that rests outside of the woman's vagina can stick out too far. Additionally, the authors state that to use this method, women must be comfortable with touching their own genitalia.⁴³¹

Birth control pills are again treated with suspicion and wariness in the 1992 edition of *Our Bodies*. The entry contains much of the same information as its 1992 predecessor but updates several topics for currency. The introductory warning about the pill harming women adds information about lower-dose pills being safer, and again points to ongoing research on the topic.⁴³² Content regarding the pill's role in cardiovascular disease has been augmented to include recent studies that show lower risk of cardiovascular events for young, healthy women who don't smoke.⁴³³ Also, the updated entry on the pill clarifies

⁴³¹ Ibid.

⁴³² Ibid., 280.

⁴³³ Ibid.

that the pill does not cause sexual or cardiac side effects in children.⁴³⁴ Also, the differences among the different available pill brands have been updated to reflect the current marketplace.⁴³⁵

Interestingly, while the majority of the birth control methods discussed in this edition benefitted from changes indicating their level of protection against HIV (or in many cases, the fact that some methods offer no protection against HIV or other STIs), the pill in the 1992 edition receives no commentary about the role it may or may not play in HIV prevention. The updates were relatively negligible when comparing this edition from that of 1984.

Overall, much of the information regarding contraceptive safety and efficacy in the 1992 remains quite similar to that of the 1984 edition, with the major exception being augmentations to include STI and HIV-related content. The authors still prioritize cervical barrier methods over hormones and IUDs due to ongoing safety issues at that time, but the lack of STI protection afforded by hormonal methods and IUDs even further erodes their perspective of these options; in an era where protected sex was viewed as a matter of life or death, birth control ideally needed to fill a double role in both preventing pregnancy and the transmission of disease. Because diaphragms, caps, sponges, and now female condoms offered few side effects and some protection against sexual infections, they were contextualized as better methods. Simultaneously, hormones continued to be viewed with suspicion, and IUDs were now marked as dangerous because of their ongoing safety record, and also their potential to increase STI and HIV transmission.

⁴³⁴ Ibid., 284.

⁴³⁵ Ibid., 246.

5.9 2011 Edition

Overview

The 2011 edition was released on the 40th anniversary of *Our Bodies*. This edition was completely revised and the core content that was updated included topics ranging from sexual anatomy, body image and gender identity to pregnancy and birth, perimenopause/menopause, and navigating the health system.⁴³⁶ Reiterating their commitment to reader interaction and having readers help shape each iteration of the text, the writers again incorporate the voices of women:

This edition reflects the perspective and voices of a wide range of women, and their stories are told through new formats. At our invitation, more than three dozen women of all ages and identities participated in a monthlong online conversation about sexuality and relationships; we found their honesty and forthrightness so compelling that the conversation itself became the foundation of a new “Relationships” chapter.⁴³⁷

The convergence of digital and print culture becomes evident here as reader input is solicited via online conversations. Sources and additional resources incorporate both printed and online content.

Trends toward inclusive and globalized feminism⁴³⁸ from the 1990s onward mean that this edition more carefully incorporates cross-cultural content from allies around the globe:

Throughout the book, you will meet members of the Our Bodies Ourselves Global Network and read about their work on issues such as abortion, infertility, HIV education and prevention, and social activism. From distributing posters via canoes in rural Nigeria to setting up interactive websites in Israel and Turkey and reshaping

⁴³⁶ Boston Women’s Health Book Collective, *Our Bodies, Ourselves* (New York: Touchstone, 2011):xi.

⁴³⁷ Ibid.

⁴³⁸ Davis, *Making Of*, 9.

health policy in Nepal and Armenia, their efforts exemplify movement building and the power of voices raised in action.⁴³⁹

The editors touch upon the importance of providing factual, accurate information: “Today, information is abundant, but it is still difficult to find reliable information that encompasses the diversity of women’s experiences and teases apart the conflicts of interest inherent in many issues that affect women’s health.”⁴⁴⁰ The editors suggest that pharmaceutical and corporate interests can influence the quality of research and information on women’s health and lead to unnecessary medicalization of women’s bodies and lives. Further, the profit-centered motivations undergirding many approaches to women’s health can serve to detach women from utilizing one another as informational resources: “This...can also discourage women from questioning the assumptions underlying the care they receive and from valuing and sharing their own insights and experiences.”⁴⁴¹

As the 40th anniversary edition, the editors rearticulate the importance of sharing and privileging women’s voices, which has been the mandate since its very origins.⁴⁴² The authors⁴⁴³ of this edition articulate a commitment to incorporating women’s voices and sharing women’s stories in the Introduction to this edition, and again in the introduction to the chapter on birth control: “By speaking openly, and by carefully comparing experiences and knowledge, we can guide one another to workable methods and good health-care

⁴³⁹ *Our Bodies*, 2011, xii.

⁴⁴⁰ *Ibid.*

⁴⁴¹ *Ibid.*

⁴⁴² *Ibid.*

⁴⁴³ Editorial Team, 2011: Kiki Zeldes, Senior Editor, Christine Cupaiuolo, Managing editor, Judy Norsigian, Amy Romano, Wendy Sanford, contributing editors, additional editors Jackie Lapidus and Heather Stephenson . “Birth Control” chapter revised by Kirsten Thompson, additional contributors Kelly Blanchard, Heather Corinna, Marjorie Greenfield, Mary Ann Leeper, Lisa Perriera, Robin Wallace, Toni Weschler, Carolyn Westhoff, Susan Wysocki.

providers...by talking together, we can also gain an understanding of our more subtle resistance to using birth control.”⁴⁴⁴

Contents

Table 5:5 Selected Content of 2011 Edition

Method	Cost	Brands	Side Effects	Effectiveness Rate	Page length of entry
Diaphragm	N/A	N/A	Entry states there are minimal side effects	84% to 94%	2
Cervical Cap	N/A	FemCap	Allergic reaction to cap material or spermicide	71-86%	1
Pill	N/A	N/A	Risk of blood clots, heart attack and stroke, irregular bleeding and spotting, nausea, breast tenderness, melasma, headaches, mood changes such as depression or decreased sex drive	92-99%	6

⁴⁴⁴ *Our Bodies*, 2011, 203.

IUD	N/A	Paraguard, Mirena	Perforation, embedding, menstrual changes, pain, anemia, spotting, prolonged bleeding, ovarian cysts, headache, mood changes, acne, decreased sex drive	99%	5
FAM/ Rhythm Method	Free, plus cost of learning materials	N/A	No risks or side effects	Perfect use 95-97%; 75- 90% reported in medical literature	1
Sponge	N/A	N/A	Allergic reactions	84-91% for women who haven't given birth, 68%- 80% for women who have	1
Female Condom	About \$12 for a 5-pack	FC2 Condom	Entry states that there are no systemic side effects	79-95%	3

In the introduction to the birth control chapter of this edition, the authors offer some general tips to lower pregnancy risk, including the following: “If you are using a barrier method or nonmedical method, be aware of your fertile time and avoid intercourse or use extra protection during this time.”⁴⁴⁵ This demonstrates the authors’ view that barriers or other methods aside from hormones IUDs are less effective, but also articulates the value of fertility awareness for pregnancy prevention. The specific entry for the diaphragm is briefer than in the previous two editions under analysis. There is no introductory anecdote about how the diaphragm was revolutionary for women of earlier generations. The authors state that, “Though diaphragms have no systemic side effects like those of the Pill, they are not as effective in preventing unintended pregnancy”⁴⁴⁶ and also articulate their lack of popularity in modern-day contexts: “They were once very popular in the United States, but few women use them today.”⁴⁴⁷

The authors warn readers that, “Getting a diaphragm requires a fitting by a health-care provider. Because diaphragms are not widely used, you should call ahead to make sure your provider knows how to fit you for a diaphragm and has the proper equipment to do so.”⁴⁴⁸ They add, “The practitioner should have the diaphragm available right there or will give you a prescription for the proper size.”⁴⁴⁹ There is also a note about how using a diaphragm requires manual dexterity so some women with disabilities cannot use them, and how some women cannot use diaphragms because they can’t be made to fit properly.

Because the 1984 and 1992 entries for the cervical cap both focused primarily on

⁴⁴⁵ Ibid., 209.

⁴⁴⁶ Ibid., 218.

⁴⁴⁷ Ibid.

⁴⁴⁸ Ibid., 219.

⁴⁴⁹ Ibid., 220.

the Prentif cap in terms of description, use, and efficacy, the 2011 entry is notably different due to the discontinuation of Prentif (in 2008) and subsequent emergence of the FemCap in 2009. Accordingly, the entry for cervical cap in the 2011 edition is entirely dedicated to the FemCap. The authors briefly describe its shape (cup-shaped as opposed to the Prentif's thimble shape), and how it works to cover the cervix and, with the assistance of spermicide, prevent sperm from fertilizing eggs.⁴⁵⁰ The entry clearly articulates that the FemCap is the only cervical cap option in the United States, which stands in contrast to the entries of previous editions that suggest the possibility of using brands or models not approved by the FDA. The section "Advantages and Disadvantages" merely directs readers to the entry for the diaphragm.⁴⁵¹ In the section entitled "How to Use," the authors state that "the effectiveness of a cervical cap depends on its fit as well as consistent and correct usage"⁴⁵² and that the FemCap is available in different sizes and needs to be fitted by a medical practitioner. This information conflicts with FemCap's website, which states that FemCap does not require a custom fitting and describes how women can choose one of three available sizes based on their obstetrical history.⁴⁵³ It is worth noting that FemCap's website also lists the effectiveness rate at 92% on average and 98% with perfect use⁴⁵⁴ which is considerably higher than the rates given by *Our Bodies, Ourselves* (86% for women who have never been pregnant and 71% for women who have.)⁴⁵⁵ The entry explains that inserting or removing a cap is similar to using a diaphragm (which may or

⁴⁵⁰ Ibid.

⁴⁵¹ Ibid.

⁴⁵² Ibid.

⁴⁵³ FemCap, "FAQ," accessed June 28, 2019, <http://FemCap.com/faq>.

⁴⁵⁴ Ibid.

⁴⁵⁵ *Our Bodies*, 2011, 220.

may not be helpful to readers, depending on their level of knowledge on diaphragms). There is a section, brief in length, entitled “Refitting,” which states that “giving birth can affect the way a cervical cap fits. Three months after a birth, have your medical provider check its fit.”⁴⁵⁶ This again counters the manufacturer’s direction, which asserts that fittings aren’t required and that sizes should be selected based on pregnancy history. The “Health Concerns” section again advises women to consult the entry for diaphragms. Finally, in a section on where to obtain a cap, the authors state that caps aren’t widely available because many practitioners are not trained to fit them, and suggest that readers call their clinic before visiting to ensure that they have caps available and can fit them.⁴⁵⁷ It is worth noting that FemCaps are readily available online in many countries without prescription or need for fitting, although a prescription is required in the US.

In 2011, the entry for the contraceptive sponge is significantly shortened. It contains a brief physical description, and a perfect and typical use rate of effectiveness. The advantages and disadvantages are conflated and suggest that while it can be purchased at the drug store, the benefits and drawbacks are “otherwise the same for diaphragms; see p. 218.”⁴⁵⁸ The use section is fairly similar as the previous editions. The sponge’s availability has waxed and waned since its introduction, disappearing from shelves in 1994 and then returning again in 2005 only to disappear once more in 2008 and returning again in 2009. It was once the most popular form of over-the-counter birth control for women,⁴⁵⁹ but has faced production and ownership issues and thus its popularity has waxed and

⁴⁵⁶ Ibid., 221.

⁴⁵⁷ Ibid.

⁴⁵⁸ Ibid., 221.

⁴⁵⁹ Singer, Natasha, “Contraceptive Sponge Makes a Return to Pharmacy Shelves,” *New York Times* (May 22, 2009), accessed June 28, 2019, <http://www.nytimes.com/2009/05/23/business/23sponge.html>.

waned alongside its availability. It is currently still available in North America, the UK and Europe, both in stores and online (you can even join the Today Sponge's web-based "Spongeworthy Club" in the US to get sponges mailed to you automatically)⁴⁶⁰ but its future may be tied to increasing concerns about the safety of nonoxynol-9 spermicides.⁴⁶¹ Regardless, its most recent representation in *Our Bodies* is fairly curt, possibly due to its lacking popularity.

The authors of the entry for "Fertility Awareness Method (FAM) and Other Natural Methods" in the 2011 edition remove any negative references to high failure rates or misconceptions about the rhythm method and assert, in the opening paragraph, that "FAM is a scientifically validated method of natural birth control that involves charting fertility signs to determine whether or not you are fertile on any given day."⁴⁶² They state that users of this method must be dedicated enough to do their research and keep the required records, and that additional resources are required such as taking a class or reading *Taking Charge of Your Fertility* by Toni Weschler.⁴⁶³ The entry contains a two-paragraph description of how FAM works. They further suggest that natural methods are most appropriate for highly motivated and committed couples.⁴⁶⁴ The section "Advantages" states many of the same ones as in previous editions. The entry ends with a heading called "New Technologies" and describes the emergence of calculators, computer programs, saliva and urine tests to determine fertility. The authors warn that these "high-tech methods are more appropriate

⁴⁶⁰ Today Sponge, "Join the Spongeworthy Club Today," accessed June 28, 2019, <http://www.todaysponge.com/spongeworthyclub.html>.

⁴⁶¹ Singer, "Sponge Makes Return."

⁴⁶² *Our Bodies*, 2011, 248.

⁴⁶³ Toni Weschler, *Taking Charge of Your Fertility: The Definitive Guide to Natural Birth Control, Pregnancy Achievement, and Reproductive Health* (New York: William Morrow, 2015).

⁴⁶⁴ *Our Bodies*, 2011, 248.

for women who are trying to achieve pregnancy rather than avoid it because most of these methods do not give you enough warning of impending ovulation to account for the possibility of sperm surviving for up to five days in the uterus and the fallopian tubes.”⁴⁶⁵

The 2011 edition’s entry for the female condom is roughly twice as long as that of the 1992 edition. This entry gives STI prevention its own subheading and suggests that the female condom provides a similar level of STIs including HIV as does the male condom.⁴⁶⁶ The advantages section of this entry is fairly extensive. In this edition, there is a detailed, step-by-step guide to using the female condom, which stands in contrast to 1992’s two sentence instruction. This edition also offers a brief section on where to purchase the FC2 female condom. The authors also direct readers to AVERT’s site on female condoms for more information about the method itself and HIV/AIDS prevention. An additional feature in this edition’s entry is a short Frequently Asked Questions section that offers key questions that readers may have about the female condom (many of which were covered by the text in the description and use sections).⁴⁶⁷

The 2011 edition’s entry for the IUD is completely overhauled, and the cautious and negative tone towards the method is completely reversed. In fact, in a highlighted blurb entitled “IUD SAFETY CONCERNS, blocked off from the remainder of the entry, the authors make the following statement:

Though the IUD is the second most widely used method of birth control in the world, it has not been popular in the United States. This is largely due to the fact that in the 1970s, one type of IUD, the Dalkon Shield, was found to be unsafe, causing an increase in pelvic infections among users and resulting in the deaths of twenty women. Thousands of women filed lawsuits, and by 1985 the company had

⁴⁶⁵ Ibid., 249.

⁴⁶⁶ Ibid.

⁴⁶⁷ Ibid.

declared bankruptcy. Most of the IUDs were pulled from the market at the time, and the reputation of IUDs was damaged. The IUDs now available are safer and have not been found to increase the risk of pelvic infections except for a small risk right around the time of insertion if a woman has an undiagnosed STI. Talk to your healthcare provider if you are concerned that you might have an STI.⁴⁶⁸

Although the authors do point out the IUD's often dangerous and occasionally fatal history in the US, the language is dismissive. While the major side-effects are discussed here (expulsion is listed as uncommon⁴⁶⁹, uterine perforation is described as rare⁴⁷⁰, and infection is only mentioned in passing, and in relation to existing STIs rather than a serious risk in its own right).⁴⁷¹

In terms of general updates, the authors list two models as being available in the United States.⁴⁷² The clause about not knowing exactly how the IUD works, which was present in the last three editions under analysis, is now replaced with exacting descriptions of how the copper and hormonal IUDs function: "The ParaGard works primarily by releasing copper ions into the uterine fluid; these ions make sperm unable to swim or fertilize an egg...The Mirena IUD works by releasing steady, small amounts of a progestin (levonorgestrel), which prevents ovulation and thickens the cervical fluid."⁴⁷³ Effectiveness is stated as being over 99 percent, and the authors equate the IUD with tubal sterilization in terms of effectiveness.⁴⁷⁴ Several advantages are listed, including the IUDs immediate effectiveness, privacy, allowing for spontaneity, non-interference with

⁴⁶⁸ Ibid., 240.

⁴⁶⁹ Ibid., 241.

⁴⁷⁰ Ibid.

⁴⁷¹ Ibid., 241.

⁴⁷² Ibid., 238.

⁴⁷³ Ibid.

⁴⁷⁴ Ibid.

breastfeeding, allowing a carefree approach to contraception, five-to-twelve year long effectiveness, the non-hormonal aspects of ParaGard, Mirena's ability to decrease menstrual bleeding and cramps, the low hormonal dosage of Mirena, and its affordability relative to other methods.⁴⁷⁵ The 2011 edition's IUD entry lacks the foreboding and deterring tone of the 1984 and 1992 editions and contextualizes it as one of the best methods to consider: "The IUD is now used by more than 160 million women worldwide. It is one of the safest, best tolerated, and most effective methods of contraception available."⁴⁷⁶

Like the entry for the IUD, the 2011 entry for the birth control pill is completely overhauled, with much of the doom-and-gloom tone replaced with repetitive assertions of its safety. A highlighted, six paragraph section explains to readers that the pill is one of the most intensely researched contraceptive methods and is used by millions of women worldwide.⁴⁷⁷ "The early pill formulations raised concerns about blood clots, heart attacks, and stroke," the authors explain, however, they unequivocally assert that "research has concluded that today's birth control pills are safe for most women..."⁴⁷⁸ Not only is the pill safe, according to the entry in the 2011 edition, but it offers a number of health benefits, including protecting against ovarian and endometrial cancer, reducing risk of anemia, lower risk of ovarian cysts, and a decreased incidence of PID.⁴⁷⁹

In terms of how to take the pill and where to obtain them, much of the information is consistent with previous editions, however, the content regarding side effects has been

⁴⁷⁵ Ibid.

⁴⁷⁶ Ibid 238.

⁴⁷⁷ Ibid., 226.

⁴⁷⁸ Ibid.

⁴⁷⁹ Ibid.

significantly altered, whereby what used to occupy over two pages of content is now contained in one paragraph are listed in bullets with no additional explanation for each.⁴⁸⁰

Previous editions listed conditions that warranted not using the pill at all and cautiously using the pill, and these lists also occupied a couple of pages in length. In the 2011 edition, the authors reduce this to one half-page section with mostly bulleted contraindications and a limited discussion of who should not use the pill. A short list of danger signs is included in this entry, and women experiencing severe symptoms while taking the pill are directed to contact a health practitioner or visit an emergency room.⁴⁸¹ The authors of the entry also include a list of drug interactions, which was not present in previous editions. There is also a new section on using the pill as emergency contraception.⁴⁸²

The authors of this edition assert that the *Our Bodies* project is upholding its core values of drawing on experiential knowledge as an information source, and at face value this is both noble and consistent. However, when this core value is concurrently contested in another part of birth control introduction, it comes across as problematic: “One of the greatest obstacles to women’s use of contraception is the fear of possible negative health effects from the use of hormonal methods or the IUD. Some women hear alarming stories that may be based on half-truths, bias, isolated cases, or old information, so it is important to seek out accurate and balanced information before making a birth control decision.”⁴⁸³ Readers are told to simultaneously share information with one another and “carefully”

⁴⁸⁰ Ibid., 228.

⁴⁸¹ Ibid., 228.

⁴⁸² Ibid., 229.

⁴⁸³ Ibid., 210.

compare experiences, whilst being skeptical of any negative information one might hear from peers about hormonal methods and IUDs. This conflicting information and potential bias in favor of the pill and IUD, or at least defense of these methods, tinges the entries for the contraceptive methods under review. The glowing review of the IUD raises some legitimate questions about shifts in the mandate of *Our Bodies* over time, treating pharmaceutical solutions as the ideal and relegating barriers to the realm of inferior or ineffective contraceptive methods.

Tensions between biomedical authority and women's embodied knowledges have manifested over time in the different iterations of *Our Bodies*. While pharmaceutical innovation was treated with suspicion and caution in the earliest versions of the text, in the most recent edition emergent and evolving methods (often hormonal or intrauterine) are lauded. One has to question if these tensions, highly evident in the most recent edition's emphasis on factual, science-based information, serve to counter the mandate of *Our Bodies* to privilege women's voices and use experiential knowledge as an information source. This is interesting given that the editor tasked with revising the birth control chapter in this edition lists the following research interests "Improving family planning access through evidence-based policies and programs, Research and development of new contraceptives, Using new technologies in research and education, Translating scientific findings into lay language and disseminating via new media,"⁴⁸⁴ and has an academic dossier filled with publications about long-acting reversible contraception and IUDs. Bias

⁴⁸⁴ USFC Profiles, "Kirsten Thompson," accessed June 28, 2019, <http://profiles.ucsf.edu/kirsten.thompson#toc-id1>.

can infiltrate information even if is not intentional, although it is the role of the editorial board to ensure content is complimentary to the mandate.

5.10 OBOS Today

The last English-language print edition was released in 2011, and *Our Bodies* maintains an online informational presence. Its online presence is not as comprehensive as the books, and in many cases links to other digital information sources are provided. However, the site is frequently updated blog-style with new developments in women's health issues and also contains a lot of background information about navigating the world of health information and health advocacy. As a digital resource, *Our Bodies* serves as an update blog paired with an archived repository of health information.

An example of its blog-style health information updates is its September 2014 entry about FDA clearance of the Caya diaphragm. Entitled "FDA Clears One-Size-Fits-Most Diaphragm for U.S. Markets," the author explains the research, development, function and use of the Caya diaphragm, and how it will likely be available in the US in the following year despite already being available at the time in Canada and Europe.⁴⁸⁵ At the time of writing, blog updates are ongoing but are inconsistent and can vary from every few days to once a month; Current issues in women's health are still addressed for the website's readership.

In response to the 2016 election of Donald Trump to the American Presidency, feminist media and online groups were (and continue to do so) frantically sharing

⁴⁸⁵ Rachel Walden, "FDA Clears One-Size-Fits-Most Diaphragm for U.S. Markets," accessed June 28, 2019, <http://www.ourbodiesourselves.org/2014/09/fda-approves-diaphragm/>.

information advocating for women to get IUDs and the particularities of obtaining long-acting birth control,⁴⁸⁶ in anticipation that reproductive rights will be even further degraded. The *Our Bodies* site enacted a campaign called “#WriteTheNextChapter” wherein they are solicited not only financial donations, but also asked for readers to share issues that are important for women’s health. The description of the initiative reads as follows:

Our Bodies Ourselves began when a group of young women decided THEY should be the ones in charge of their bodies -- not their male doctors, husbands, or political institutions. Following the 2016 election, we find ourselves at another critical crossroads, where our rights and health are at serious risk. Join our campaign to #WriteTheNextChapter. We’ll battle disinformation, protect access to contraception and abortion, ensure all of our voices – especially those affected by racism, sexism and economic injustice – are heard. There’s no turning back!⁴⁸⁷

This initiative marked yet another example of the contributors of *Our Bodies* drawing on the needs of its readers as it evolves. A letter from the current Executive Director of Our Bodies Ourselves, Julie Childers, regarding the #WriteTheNextChapter fundraising campaign further asserted *Our Bodies* continuing role:

Dear Friend,

As I write this letter, we’re only starting to process what the next four years will mean for women’s health and rights.

Our next president has said women who have abortions should be punished. He pledged to dismantle Obamacare. He called out

⁴⁸⁶ See for example Erica W. Smith, “6 Reasons You Should Get an IUD Before January 20, 2017,” accessed June 28, 2019, <http://bust.com/sex/18545-get-an-iud-before-trump.html>; Gabriella Paiella, “Here’s Why Everyone Is Saying to Get An IUD Today,” *The Cut* (November 9, 2016), accessed June 28, 2019, http://nymag.com/thecut/2016/11/why-you-should-get-an-iud-before-trump-becomes-president.html?mid=twitter_cut.

⁴⁸⁷Our Bodies, Ourselves, “Information Inspires Action,” link no longer active, archived at <https://web.archive.org/web/20180314193510/http://action.ourbodiesourselves.org/page/content/WriteTheNextChapter/>.

immigrants and mocked people with disabilities. And he bragged about assaulting women.

Here at OBOS, we immediately pulled up our sleeves and started brainstorming about what we can do to create an environment where all of us – especially those in communities affected by racism, sexism and economic injustice – feel safe and valued, building on our history of advocating for the well-being of girls and women everywhere.

Thanks to you, we're ready. You came through for us last year when OBOS was in great need. Now we're eager to #WriteTheNextChapter, and we hope you'll help us to grow and respond to the new challenges our country faces.

Access to evidence-based health information that girls and women can trust, especially in this new political climate, is central to our fight. Our most popular website pages, viewed more than 25,000 times per week, concern abortion options. We want to expand these health sections and do more to address reproductive justice.⁴⁸⁸

Childers goes on to explain *Our Bodies'* next informational initiative, which is to launch a website with information about international commercial surrogacy. She also asserts that *Our Bodies* was the only women's health organization to challenge FDA approval of Addyi, a prescription drug under consideration in 2015 to address low sexual desire in women, that despite its approval, maintains a questionable record with regards to its safety and effectiveness.⁴⁸⁹ Around the time of Trump's election, a quick visit to the *Our Bodies, Ourselves* blog showed frequently updated coverage of the Trump administration's assault on women's rights, in addition to other feminist health issues.⁴⁹⁰ Despite these initiatives and revived assertions that *Our Bodies* will continue to play an important role in sharing

⁴⁸⁸ Julie Childers, "A Note From Julie Childers, OBOS Executive Director," link no longer active, archived at <https://web.archive.org/web/20180314193506/http://www.ourbodiesourselves.org/writethenextchapter-fundraising-campaign/note-julie-childers/>.

⁴⁸⁹ Ibid.

⁴⁹⁰ Our Body, Our Blog Contributors, "Our Body, Our Blog," accessed June 28, 2019, <http://www.ourbodiesourselves.org/blog/>.

women’s health information and advocating for bodily autonomy and rights, in April 2018 the board, founders and staff of *Our Bodies* announced insufficient funding to maintain operations and would switch to a volunteer-led structure; this meant no longer publishing print updates of the texts and also to cease new additions regarding health information and turn it into an archive of women’s health information.⁴⁹¹ As mentioned above, the blog is still updated regularly. Many mainstream media outlets covered this announcement and lamented the loss of an important cultural and feminist health information project and much of the commentary suggested that the announcement to cease many operations came at a particularly odd time given the erosion of reproductive rights under Trump. As Jessica Valenti states,

That the foundational feminist text will cease to publish at this particular time seems strange. Trump’s inauguration was dwarfed by millions of women wearing “pussy hats”; abusive men across every industry are being outed by #MeToo; women in film, television and music are embracing the feminist label with gusto. This week, Janelle Monáe released a music video that is rife with imagery celebrating the vulva.⁴⁹²

While it may seem appropriate (albeit somber) to conclude this chapter with the conclusion of the *Our Bodies, Ourselves* project, it would be erroneous, because the baton has been passed on to another organization, the Center for Women’s Health & Human Rights at Suffolk University, who is working in partnership with the remaining volunteers at *Our Bodies, Ourselves*. This partnership has resulted in *Our Bodies Ourselves Today* (OBOST), situated at <http://www.ourbodiesourselvestoday.org>, and maintaining the goal of “building

⁴⁹¹ Our Bodies, Ourselves, “What’s New,” accessed June 28, 2019, <https://www.ourbodiesourselves.org/our-story/whats-new/>.

⁴⁹² Jessica Valenti, “‘Our Bodies, Ourselves’? It’s Shelved,” *New York Times* (April 12, 2018), accessed June 28, 2019, <https://www.nytimes.com/2018/04/12/style/our-bodies-ourselves-book-publishing.html>.

a world-class online platform to provide women with the most up-to-date, reliable and comprehensive information about our health, sexuality and well-being.”⁴⁹³ The plan for the project is to launch in 2020 and cover topics such as childbirth, heart health, menstrual health, abortion, sexuality, gender-based violence, and mental health:

In each area, our experts will combine personal stories with the most current fact-and-science-based information. Above all, we are committed to voicing the perspectives and addressing the needs of women and girls across race, ethnicity, sexual orientation, class, age, ability, immigration status, gender, belief, and all other distinctions.⁴⁹⁴

While the launch date for the informational platform is 2020, the *OBOOST* website is updated with key news and events, one example being a rally to fight the bans and restrictions on abortion that had just recently been announced by several US states at the time of writing. This spin-off project shows that many still value the work that *Our Bodies* has done and see it as labor worth pursuing indefinitely, given that there continues to be a vital need for accurate and updated women’s health information and feminist advocacy for bodily autonomy.

5.11 Implications for LIS

While the impetus for this chapter is to illuminate the experiences of participants by evaluating how contextual factors have affected birth control information over time, some insights can be gleaned about birth control information that may be applicable to LIS researchers and those working in librarianship practice. As this case study of the *Our*

⁴⁹³ Our Bodies Ourselves Today, “What We Do,” accessed June 28, 2019, <https://www.ourbodiesourselfestoday.org/what-we-do>.

⁴⁹⁴ Ibid.

Bodies, Ourselves series illustrates, contraceptive information is influenced by social and contextual factors and evolves in tandem with external influences. The tendency of librarianship and information science to collate like informational sources under specific subject headings makes sense from an ease-of-retrieval standpoint, however, even informational sources that self-label (i.e. “feminist health information”) are not stagnant or located within a vacuum. Despite the fact that the LOC subject headings for the entire *Our Bodies* series has remained constant over time (Women—Health and hygiene., Women—Diseases, Women—Psychology), the nature of this information has been subjected to external social forces and shifting notions of authoritative sources of information.

In the early iterations of the text, biomedical authority was scrutinized and eschewed in favor of women’s stories, women’s experiences, and bodily self-knowledge. Readers were encouraged to arm themselves with information outside of biomedical authority to better empower themselves within interactions with doctors and medical practitioners, and with regard to their general health. These sources of non-mainstream information were exalted as being as valid, if not more so, than traditional biomedical authority. However, over time the privileging of experiential and embodied knowledge began to wane and the inverse privileging of scientific rigor and biomedical expertise began to permeate the text. Women were told to trust research in terms of safety and efficacy and to disregard accounts of other women as valid sources of information. Even though the *Our Bodies* series has consistently considered itself a feminist source of information, how that information manifested has evolved in tandem with external social forces and transitional information landscapes. In this vein, LIS scholars and library

professionals must be mindful that information is unstable while it is simultaneously categorized as the opposite. In their study of how Ontario midwives make claims about interventions,⁴⁹⁵ McKenzie and Oliphant note that, “Far from simply pitting biomedical and holistic forms of knowledge against one another, midwives and women create complex justifications through their talk that show how both forms of knowledge are tied into the structures of local clinical standards and regulated health care.”⁴⁹⁶ In their study site, both experiential and biomedical information were treated as legitimate forms of information that often overlapped and occasionally diverged. They note that while midwifery does indeed at times challenge the discourses of science and medicine, “At the same time, however, biomedical authoritative knowledge was rarely absent even when it was being discounted.”⁴⁹⁷ In this sense, information scholars and library professionals, as well as health practitioners can benefit from, “A recognition of clinical communication as interactionally situated and socially constructed,” which “allows both practitioners and researchers to be alert to the complex discursive environment within which practitioners and clients negotiate informed choice.”⁴⁹⁸

5.12 Conclusion

In 1973, the diaphragm was normalized and encouraged as a safe and highly effective method of contraception that allowed women to more thoroughly know their bodies and their sexual anatomy. There was a strong implication that diaphragms were widely available and easy to obtain. There was also an implied hope that diaphragm fittings

⁴⁹⁵ Pam Mckenzie and Tammy Oliphant, “Informing Evidence.”

⁴⁹⁶ Ibid., 37.

⁴⁹⁷ Ibid., 38.

⁴⁹⁸ Ibid.

would become more commonplace and that the knowledge would be shared with various tiers of medical professionals. In 2011, there is a caveat about potential difficulties in finding doctors to do fittings. It is also clearly articulated that diaphragms are no longer popular. While there is a brief mentioning of the positive attribute of intimacy with one's own body in order to use this method, generally there seems to be much less optimism for this method than in the 1970s. Further, emphasizing the lack of effectiveness is a recurrent aspect of the 2011 entry. Whereas in 1973, efficacy was estimated at 90-98 percent, in 2011 the typical use estimate of about 84 percent was emphasized multiple times.

The marginalization of cervical barrier methods, especially the diaphragm, over time, has serious implications for women desiring or choosing to use this method, or attempting to gain information about it. Still emphasizing its core values of offering factual and women-centered health information, the latest print version of *Our Bodies* accurately represents the climate of dwindling diaphragm availability. Interestingly, the converse occurs with regard to the cervical cap. In 1973, cervical caps were contextualized as outmoded and there was only a short paragraph entry about their use. In 2011, *Our Bodies* dedicated an entire page to the cervical cap, emphasizing FemCap as an available option for American women.

Another dramatic shift in representation over time occurs with fertility awareness methods. In 1973, FAM was ridiculed as an essentially useless method with a high failure rate. As knowledge about cycle tracking increased and new technologies emerged to assist FAM users in accurately tracking their cycles, *Our Bodies*, over time, depicted FAM as an increasingly valid method of contraception. FAM is described as a “scientifically validated

method of natural birth control”⁴⁹⁹ in the 2011 edition, which is a far cry from its 1973 categorization as one of the “birth control methods that don’t work very well.”⁵⁰⁰

When the first version of *Our Bodies* was published, the IUD was contextualized as method to approach with caution due to high numbers of complications, and later, in the 1984 and 1992 editions, as a seriously flawed and dangerous method since many women had significant complications from the Dalkon Shield specifically. However, in 2011, the *Our Bodies* authors omit information about early problems with IUD brands and state that it is one of the safest and most effective methods available. The birth control pill follows a similar trajectory, with warnings about its dangers and risks peaking in the 1980s and 1990s and then in 2011, its safety record being exalted. This may very well represent accurate changes within scientific research and pharmaceutical industry innovation, and indeed studies indicate that modern hormonal methods and IUDs are much safer than their counterparts from forty years ago. However, the way in which these methods are now defended counters the inclusive, woman-centred mandate established in the 1970s and reaffirmed even in the introduction to the 2011 edition: the authors suggest that readers should ignore the experiences of other women regarding negative outcomes with the pill and IUD, which is an assertion that stands in direct opposition to their original mandate.

To put this in perspective, a passage from the 1973 edition reads as follows:

A most valuable source of information is our friends. In the past, women have been embarrassed about birth control and have spoken of it only in whispers, spreading scary stories about Cousin Sally’s gory side effects. But by speaking openly and by carefully comparing experiences and knowledge, we women can learn a great deal to guide us in our own choice of birth-control methods, and we

⁴⁹⁹ *Our Bodies*, 2011, 248.

⁵⁰⁰ *Our Bodies*, 1973, 132.

can also support each other in forcing laws, doctors, clinics and drug companies to make vital changes in practice and attitude.”⁵⁰¹

In 1973, the authors of *Our Bodies* contextualized the experiences and stories of other women as not only an important source of birth control information, but the most important source. In 2011, readers are urged to ignore one another’s experiences and focus on scientific innovation and progress. This is emblematic of how authoritative sources of information may ebb and flow over time. It is also not fully representative of what many women and those seeking pregnancy prevention, especially ones who participated in this project, want in terms of birth control information; online forums, groups and websites that offer the ability to communicate and share with one another desired sources of information. Many of the participants in this study value not only medically accurate, up-to-date sources, but also the experiences and stories of others and this will be further elucidated in the following chapter. The visible shift from exalting diaphragms as a highly effective and feminist method to suggesting it is difficult to obtain and not very effective, and warning women to heed IUDs with caution to hailing them as “the best tolerated and most effective methods of contraception available,”⁵⁰² represents not only the changing climate of birth control information, but also the changing climate of women’s health clinical practice and the pharmaceutical industry over a span of nearly forty years. This changing climate is reflected in the experience of my interview participants, who despite having frequent complications from IUDs and hormonal methods, are told by their practitioners that cervical barrier methods are a poor choice and that hormones and IUDs are safe and effective; this issue among others will be discussed in detail in the following chapter.

⁵⁰¹ *Our Bodies*, 1973, 107-108

⁵⁰² *Our Bodies*, 2011, 238.

The dynamic nature of *Our Bodies* was wholly due to the creators' desire for it to be not only accurate and up-to-date, but also interactive, malleable, and guided by the interests of its readers and this set the tone for feminist health information over the next several decades. While the internet was still in its infancy in the early 1970s when *Our Bodies* was first published, the creators' desire for textual fluidity and reader interaction set the tone for how contraceptive information would be exchanged nearly fifty years later. In our present-day digital world, media scholars talk a lot about user-generated content (which is well-represented in online media, and takes the form of content created by users of platforms such as Facebook, Instagram, Reddit, and other online forums),⁵⁰³ and I contend that *Our Bodies* represented an early form of user-generated content.⁵⁰⁴ Today, women seek informational sources that allow them to interact with and listen to the experiences of others.⁵⁰⁵ Forums, groups, and Facebook pages are first-line informational sources because they are interactive and malleable. Women create the content they need, because often mainstream medical information lacks the experiential and interactive elements deemed highly beneficial in contraceptive decision making. Further, when information isn't readily available, as was the case when *Our Bodies* first manifested in zine format to address a massive gap in the women's health information landscape, women pool together to create it, and sometimes that happens in subversive, underground contexts. This will likely be more apparent in the years to come, under an American presidency with a questionable record on women's rights.

⁵⁰³ José Van Dijck, "Users Like You? Theorizing Agency in User-Generated Content," *Media, Culture & Society* 31 (January, 2009): 41-58.

⁵⁰⁴ *Ibid.*, 41.

⁵⁰⁵ This will be discussed in greater detail in the following chapter.

Sharing information is a central component of this dissertation, and how women seeking barrier contraceptives obtain information and also, in many cases, share it within their online and face-to-face communities in addition to how they navigate healthcare industries in efforts to actually obtain barrier contraceptive devices is of chief concern. Facebook is a highly visible conduit in this context, but other women-centered informational exchanges are fostered in different group formations online. While it seems as though *Our Bodies* is handing the informational baton over to digital communications, and women are now generating their own content via forums, groups, and networks, *Our Bodies* still has a place in the realm of women's health information, and will continue to evolve into different forms and varying projects. The next chapter introduces the participants in this study, outlines their motivations for considering a cervical barrier, and describes the general stages one may navigate through in order to obtain a cervical barrier device.

6 Participants and Stages of Seeking a Cervical Barrier

6.1 Introduction

Our bodies are war zones, and I've taken mine back. – Jamie

The previous chapters provided historical context for the birth control landscape in North America up until the 2010s with a focus on cervical barriers. Fundamental to this project are the accounts of contraceptive seekers and users regarding their own journeys in deciding to use and obtaining diaphragms and cervical caps. Thus, this chapter will draw on the stories shared by women regarding their experiences pursuing cervical barrier methods to describe the participants themselves and present a narrative about their trajectories. Each participant in this study was easily able to identify a motivating factor that caused them to consider or pursue a cervical barrier method. This articulation of a need or desire is the first stage out of four typical stages of seeking a cervical barrier method, with the remainder of these stages being, (2) undergoing a medical consultation, (3) obtaining the actual barrier, and finally, (4) the use stage. These stages and what typically occurs therein will be described on a more general level below.

Women and those seeking to prevent pregnancy have particular needs and desires with regard to contraception. Mainstream methods like the pill and IUDs are not ideal for everyone and there are many who seek to use natural methods, non-hormonal methods, or methods with lesser or no side effects. It is useful to hear women's accounts of their own needs and motivations for birth control from a number of standpoints, including policymaking, biomedical, marketing, feminist, sociological, etc. The reasons a woman comes to choose a cervical barrier, as varied as they are, help situate the starting point of this project's inquiry into the contraceptive journeys undertaken by participants in this

study. Acknowledging that many participants used other forms of contraceptives before embarking on their quests for cervical barriers, I use the phrase “contraceptive journey” to describe the entirety of their experiences as contraceptive users and seekers. Individually, participants are able to articulate their own unique requirements and desires with regard to birth control and then, as is discussed in the following chapter, collectivize in order to gain access to information about these methods, and in order to gain access to the devices themselves. This chapter will introduce the reader to each participant, the cause for their interest in cervical barrier methods and the individualized trajectory undertaken by them to pursue a diaphragm or cervical cap. This will help clarify why women and those seeking to prevent conception may select an unpopular and marginalized contraceptive method and some of the hurdles, successes and failures encountered during their journeys.

6.2 Stages of Seeking Cervical Barrier Methods

Each participant’s journey in seeking and acquiring a cervical barrier method was unique, but enough similarities were evident that four key stages of the quest were identified: motivation, medical consultation, acquisition, and use. While some or all of these stages were present in one form or another in the experiences of the majority of participants, they may not have occurred chronologically in the lived experience of the participant, and in some instances, were not present at all. At first consideration, I was tempted to add information seeking as a disparate stage, however, information processes (seeking and sharing) were interwoven throughout each stage (i.e. information seeking happened throughout participant experiences including initial information searches, subsequent information searches, and searches even after using barrier methods for some time). Thus, a more detailed analysis of informational aspects will follow in the proceeding

chapter. Below is a generalized description of the key stages involved in choosing a cervical barrier method:

1) **Motivation** – In this fundamental stage, some factor causes the participant to become interested in using a cervical barrier method or resolve to use one. There is no singular “best” method of contraception and the participants in this study have generally endeavored to find a method most suitable for their own unique physiological, ideological, or preferential needs. Some examples of prevalent motivational factors described by participants are: negative side effects or reactions from hormonal methods, a desire to lead a more natural and holistic life devoid of added hormones, the ability to control one’s own contraceptive method, not transferring hormones through breast milk, and a method that is easily reversible and allows pregnancy to happen quickly if and when desired. While most participants experience one or several motivating factors that drive them toward the realm of cervical barrier methods, a few had them suggested to them by others (friends, relatives or practitioners) causing them to investigate cervical barriers further. Most participants have used hormonal methods before and are seeking cervical barrier methods because other methods were not suitable. Every participant was easily able to describe why they were drawn cervical barriers and what caused them to consider evaluating them as a form of contraceptive.

2) **Medical Consultation** - This stage was a requirement for those seeking a fitted diaphragm and even some participants who sought or used cervical caps or the one-size-fits-all Caya diaphragm underwent some form of medical consultation before acquiring their devices. The medical consultations stage typically involves booking a medical

appointment to find out about diaphragms/caps, obtaining a medical consultation, getting fitted for a diaphragm or cap and prescribed/sold the actual device, or in some cases, getting talked out of using these methods. Many doctors were not supportive and used biomedical authoritative knowledge to reiterate failure rates, ensure participants were in committed sexual relationships, judge participants, and in a few cases, some doctors were hostile or ridiculed their patients. Participants frequently had to advocate for themselves in these situations. Some backed down and then asserted themselves later. Some who were ridiculed were offended or began to question their choice to use a cervical barrier method. Some practitioners were highly supportive and this tended to occur more often at women's clinics with feminist mandates. Male doctors were more likely to not be sympathetic. Also, medical-related trauma manifested for two participants at this stage (trauma from past experiences with other methods or in one participant's case, being raped in a hospital). At this stage, many participants were encouraged to use hormonal methods such as the pill or IUD.

3) **Acquisition** - Once they had secured a prescription for a barrier method or decided on a method that didn't require a prescription (such as a one-size-fits-all cervical cap), participants filled the prescription or purchased a device. Often there were difficulties encountered in actually obtaining the device. For many participants, getting the prescription felt like a victory. Some participants were not aware of issues at pharmacy or with purchasing barrier methods. Some easily obtained their diaphragm/cap directly from their doctor, while others had to search intensively for one. Those who had to search often ended up ordering online or from different country. Some participants opted for the one-

size-fits-all Caya diaphragm, and some gave up on using cervical barrier methods altogether. At the time of interviewing, three participants were waiting to hear back from their pharmacy regarding special orders for diaphragms.

4) **Use** - This stage involves actually using the device, and issues of fit, feel, ease of use, and complications emerge. Participants often faced learning curves, needing to become comfortable with their own bodies. Instances of embodied knowledge often manifest at this stage, with participants focusing on the feel of the barrier method to determine proper fit, as well as learning the position of cervix. At this stage, participants often discuss partner response to the barrier during sexual activity. Many participants expressed feelings of empowerment if using the method was successful, or defeat if it did not work out. Those using a barrier must acclimate to inserting it before intercourse, determining if the fit is correct and comfortable, and leaving it in after sex for a period of time. Participants who faced any level of difficulty in using their barrier often describe being determined to make it work. If participants are happy with their chosen method, they might want to share with others and “get the word out”. If participants have difficulty using a barrier, they may contact a practitioner to ensure proper use and fit or turn online to discuss issues with other barrier users.

While the majority of participants mentioned one or more of these five stages, the presence of any individual stage and the movement from one stage to another varied across participants according to their individual contexts. The following section describes participants and their motivations for using or seeking cervical barrier. Using their own words compiled from the interview data (which is either their own typed text or transcribed

audio), participant accounts of how they became interested in diaphragms and caps are highlighted and paired with descriptive summaries of their cervical barrier journeys.

6.3 Descriptions of Participants

In total, twenty-five participants shared their stories with me about the desire to use a cervical barrier and how that desire played out or may play out in the future (and one participant was a practitioner who advocates for cervical barrier methods). Emphasizing what drew these contraception seekers to cervical barriers in the first place, the following descriptions of participants will offer up generalized narratives of their birth control quests. Detailed thematic analyses will follow in the proceeding chapter.

Participant 1, Liz:

I was (most likely wrongly) diagnosed with high blood pressure and my Dr. recommended coming off the pill and trying a barrier method. I liked the idea as I hated being dependent on pills and Dr. visits. I was also worried about my health in regards to the pill plus it was expensive. I have a latex allergy so generic diaphragms didn't work for me. I was happy to learn that there is a silicone alternative. I love the fact that you don't need a fitting with Lea's Shield. I loved the idea of not altering my body chemistry and the self-determination barrier methods come with. I would have gotten a tubal ligation but was worried about long-term health effects that seem to be downplayed quite a bit in general by the medical establishment, as I found out online in self-help forums.

Liz is 39 years old and lives in the Pacific Northwest of Canada. She uses the Lea's shield cervical cap for contraception. She was recruited for the study via the diaphragms and caps online group. She was first introduced to the cap by a doctor in Europe when she was living there 15 years ago. She was diagnosed with blood pressure issues and encouraged to come off of the birth control pill by that doctor. She didn't experience issues obtaining this

method in Europe, but had difficulty when she moved back to Canada; she feels as though cervical barriers are more accepted by women in Europe than in North America. She was initially nervous about the size of the Lea's Shield but has learned to appreciate the device. She has a latex allergy and needs a barrier method made of silicone. She enjoys the natural aspects of barrier methods and the autonomy that it allows her. She worries about the future of cervical barrier methods and whether or not she'll be able to locate a replacement for her current cervical cap when the time comes to get a new one, because they aren't readily available in Canada. She has turned to online forums to gain more information about replacement caps for when this time comes, and for now is extending the duration of recommended time she uses her current Lea's Shield (which at the time of interview was 10 years old) before replacement.

Participant 2, Poppy:

A personal lifestyle choice of mine is to lead as sustainable life as possible, creating as little waste as possible and removing the possibility of myself leading to pollution. I was on birth control pills from when I was a teenager, until I learned that oestrogen from these pills can lead to water pollution from sewage systems. This ruled out all forms of hormonal contraception for me. I was left with three choices, a copper IUD, natural family planning and barrier methods. I ruled out an IUD as research online alerted me to the fact that there is a small chance of infertility after removal, and we do want children some day. Jointly, myself and my fiancé decided on barrier methods teamed with symptothermal method. Condoms were not an option for me as they are disposable, and this does not fit in with my waste free lifestyle. I also found the idea of being in control of my barrier to be a liberating and empowering idea. I originally wanted a diaphragm, but was unable to find a doctor willing to fit me. With the increase of LARC's and pills, there are less and less doctors with this skill. I ordered my FemCap online without a prescription based on my pregnancy history and learned symptothermal method from books and ACCORD, an Irish Catholic association. I love the idea of being in control of my own barrier, I find this to be very

empowering and allows me to be in control of exactly when I wish to fall pregnant. It is natural, reversible and has no side effects for us as we are not sensitive to n-9.

Poppy is 26 and lives in Northern Ireland. She was recruited via the diaphragm and caps group and uses a FemCap and spermicide paired with FAM. She had difficulty finding a doctor to fit her for a diaphragm in Ireland (she suspects the skill is in decline due to the rise of long acting contraceptives like IUDs), so she ordered her cervical cap online. She was annoyed that despite the fact the NHS pays for contraception, because she ordered her FemCap herself online, she had to pay out of pocket. Doctors she spoke with were not supportive and talked down to her, urging her to choose a method with a lower failure rate, but she ultimately found support and information through the online diaphragms and caps group; while it is comforting to her to know she is not alone in her situation, she finds her own experience and the experiences of others frustrating. Having ordered her diaphragm herself with no practitioner fitting, she had to learn how to insert and use the cap herself, which she says took several weeks to do; online groups were fundamental to her achieving this on her own. She is pessimistic about the future of cervical barriers generally, but hopes that a revival will come in the form of one-size-fits-all methods like Caya.

Participant 3, Evie:

I have been on the pill since I was 15 went on it initially to make my periods more regular. I hate it as it gave me bad acne and other side effects. That's why I didn't want an IUD as it is still hormonal.

Evie is 20 and lives in South London. She was recruited for the study from the diaphragm and caps group and uses a diaphragm. She had minor side effects from hormonal contraceptives and wanted a non-hormonal method. She had negative experiences with the

NHS after being denied fittings by several doctors and ridiculed by one male doctor in particular. She was nervous to go for a birth control consultation and being laughed at made her feel terrible. The first doctor insisted she get an IUD, so she went to a women-staffed contraceptive clinic and again was pressured to get an IUD or birth control pills. She ultimately obtained her diaphragm from the private Marie Stopes clinic where she felt respected and listened to. Unfortunately, she had to pay £100 out of pocket for the consultation and the diaphragm itself. She feels like her young age does not command respect in medical settings. She also feels like only older women use diaphragms and that she is therefore alone in her choice. She understands why pills are more popular with young women since they don't require touching oneself intimately or having an uncomfortable physical exam. She found a lot of useful information in an online diaphragm group and had initially found information about the diaphragm via a pamphlet at an NHS contraceptive clinic (she notes the irony of this given their refusal to fit and prescribe a diaphragm for her). She is frustrated by the medical system in her country, the fact that male doctors can dictate what contraceptive methods women can use, and the fact that diaphragms are becoming harder and harder to obtain. She worries about their future, but notes that one of her friends who accompanied her to her fitting was interested in using the method too after learning more about it.

Participant 4, Stacey:

I've been celibate for most of my life, so I didn't have to worry much about birth control. But at one point I was on Yaz (a birth control pill) and I really hated it. The physical symptoms didn't bother me as much, but it really messed with my emotions--made me feel depressed, disconnected, and just "not me." I was taking the pill for other health issues, not for contraception, so I dropped it, deciding

the pill was worse than the issues it was attempting to address, which were painful periods. I knew then that I did *not* want to go on birth control pills again if I were in a sexual relationship in the future. So fast forward several years, to when I met my husband. He believed in saving sex for marriage, which was fine with me, because, honestly, I didn't trust any birth control method 100%, and I did not want to get pregnant without being married. I knew I didn't want to do a hormonal method; I was uncomfortable with the IUD because it causes cramping, and I already have an issue with painful periods; and I wasn't thrilled with the condom because I wanted something that was more in my control. I had already pretty much decided that I wanted to use a diaphragm, and I didn't mind that it was somewhat less effective because we want to have kids eventually, and it wouldn't be a huge crisis if I got pregnant.

Stacey is 32 and lives in South Dakota, USA. She was recruited for the study from the diaphragm and caps group and uses a FemCap with fertility awareness and condoms on fertile days. Her husband wanted to wait until marriage for sex, and she wanted to be prepared with a non-hormonal method that was fully in her control. She chose a FemCap over a diaphragm because it seemed more accessible to her, even though she had to travel 2.5 hours to see a practitioner who prescribed them. She also has a hard time sourcing the natural spermicide that she requires and has to special order it from a distributor in Canada. When she first obtained the FemCap she was hesitant about placing it properly and joined an online diaphragms and caps group for support from other users. She finds that using a cervical cap has taught her more about her own anatomy and cervix positioning throughout her menstrual cycle. After moving to South Dakota, she found that her local doctor wasn't supportive and urged her to get an IUD. Return checkups from her prescribing doctor are nearly impossible not only due to proximity but also because the original fitting practitioner left that practice. Now she relies on a local midwife for support if needed. She recently took an online course about contraception and found that the course instructor was very dismissive about cervical barrier methods. She finds it frustrating that women are

discouraged from using cervical barriers by mainstream medical practice, however she is hopeful about the future of cervical barriers and sees a grassroots movement of women coming together to support each other in using alternative contraceptive methods, despite what seems to be increasingly lacking practitioner support for these methods.

Participant 5, Dr. Legge: Dr Legge is a practitioner who provides non-hormonal contraceptive options at his specialty clinic in the UK. He was recruited via the diaphragms and caps group as he sometimes advises its members.

Participant 6, Lucy:

I want to avoid hormones and I'm rather scared of the coil. Condoms have worked well for us for a long time but I wanted a bit more sensation and hoped to get this with a diaphragm whilst avoiding hormones. I felt [cervical barriers] would meet my needs, I'm in a steady long term relationship so STI's aren't a worry. They are hormone free and a cheaper alternative to condoms and provide a more 'unprotected' feel during intercourse.

Lucy is 30 and lives in the East Midlands, UK. She uses a diaphragm and a male condom and was recruited via the diaphragm and caps group. She prefers to avoid hormones and is admittedly a bit scared of the IUD. She successfully used condoms for a long time, but thinks a diaphragm is a better way to gain more sensation during sex with her long-term partner; she also likes the affordability of a diaphragm compared to condom usage. She had a positive initial experience getting fitted for a diaphragm. However, after losing weight and needing a subsequent refitting, she is having difficulty finding qualified fitters and keeps getting the wrong size diaphragm, which makes sex uncomfortable for herself and her partner. After waiting a few months for an appointment, she was recently missized

again and is awaiting another fitting appointment. She has also had some issues obtaining diaphragms and has had to order them in a couple of times, but she notes that her one sexual health clinic readily stocks them. She uses the diaphragms and caps group online to gain information about her own proper fit and her partner's comfort in feeling the rim of the diaphragm. This group has been her sole source of information in addition to some parenting forums and acknowledges that online forums seem to be the best place to get information and support in using cervical barriers. She feels that the diaphragm's lack of popularity is causing a shortage of medical practitioners who are knowledgeable about the method and she worries that cervical barriers are on a downward spiral, but she personally finds diaphragms to be an easy-to-use method if a proper fit can be achieved.

Participant 7, Jen:

I have always felt opposed to using hormones as a contraception. However, out of pressure from medical/social influences felt I should try the pill when I first became sexually active (at 25yrs) but discontinued it shortly after starting. I was on two different pills during 4 months but had side effects such as weight gain, breast soreness and mood shifts/depression, and an overall bloated feeling. I was so unhappy with it that I stopped and went back to using condoms. From this point on, condoms were my chosen method of birth control until getting into another serious relationship where they were no longer a desirable option. From this I switched to withdrawal method with the occasional use of condoms during ovulation. I was not satisfied with this, but was not willing to go back to hormones and the Copper IUD was not attractive to me because it seemed intrusive and painful to me (both my mother and sister had used it). I arrived at the cervical barrier method from eliminating other options, and from the knowledge that I was at a high risk of pregnancy with my current method of withdrawal/fertility awareness. It seemed attractive to me to have a method that I could control and I also liked that a cervical barrier was re-usable and environmentally friendly. I also saw the concept of a silicone barrier contraceptive aligning with my experience of the diva cup (a silicone cup to replace tampons and pads during menstruation). Having used

the diva cup for 4 years now I have been so happy I discovered it. I have completely removed chemicals and waste from my cycle that come from tampon and pad use, and have a feeling of independence and freedom now when I have my period. I felt that this feeling of power, comfort and control over my period would be mirrored in the use of a diaphragm in relation to my fertility.

Jen is 29 and lives in Montreal, Canada. She is currently using a Caya diaphragm paired with fertility awareness. She was recruited for this study via the diaphragms and caps group. She was drawn to cervical barriers because she opposes hormonal methods, prefers natural ones, and wants to feel in charge of her own birth control. She was pressured by previous medical practitioners to use hormonal methods, and after a brief period on the pill, decided to use a diaphragm due to some minor side effects. Her initial experiences with her gynecologist were unfavorable as the doctor refused to fit or prescribe diaphragms due to a belief that the failure rate was too high. When Jen rearticulated her desire to avoid hormonal methods, the gynecologist tried to persuade her to get an IUD. Jen called four other clinics and struggled to find a practitioner to help her with a cervical barrier. She finally found a doctor at a university clinic who still did fittings, but since she wasn't a student she was ineligible to attend this clinic. She joined the diaphragms and caps group online and learned that her situation was fairly common and found additional information about cervical barriers that wasn't previously available to her. She ultimately ended up ordering her Caya online and relied on information from group members to ensure proper placement, later having a doctor check the placement for proper cervical coverage. She is very happy with the Caya and also feels a sense of accomplishment having devoted the time into researching cervical barriers and ultimately succeeding in obtaining one and properly using it. She worries that cervical barriers will continue to be marginalized but sees hope in online communities of women and holistically-minded women who don't

want hormonal methods; she thinks that Caya might bring about a rise in popularity, but getting the word out about it will be up to women in online environments.

Participant 8, Cordelia:

[I was] unable to take Pill for medical reasons [and] I wanted reversible contraception under my own control as a woman.

Cordelia is 47 and lives in Scotland. She is currently using the discontinued Prentif cervical cap. She was recruited to the study via the diaphragms and caps group. She initially chose a diaphragm (in the late 1980s) because she wanted reversible contraception that was under her own control. When the diaphragm did not fit correctly, and she became pregnant, her then-partner suggested that she look into a cervical cap instead. She gained additional information about caps through a feminist bookstore. She easily acquired it at a Boots pharmacy and had it regularly checked at a sexual health clinic. She is confident in fitting her own cap now and is also trained to fit a few types of caps in others, although occasionally she has another cap fitter check to ensure proper sizing. Because of her age and experience with cervical barriers, she does not require any assistance from online groups, but enjoys reading the experiences of others learning about and using cervical barriers. She generally believes that cervical barriers are a positive contribution to women's health and offer a solid alternative to being exposed to hormones constantly, however, she sees the medical profession as disagreeing with this belief. She is observing a trend of one-size-fits-all cervical barriers and hopes that these new products will be tailored to offer more STD protection. She notes that there is still demand for cervical barriers, but new products are being obtained over the counter whereas medical practitioners are advocating for prescription birth control methods like pills and IUDs. As

she approaches menopause, she is relieved to not need birth control for much longer as finding a Prentif cap is becoming more and more difficult.

Participant 9, Lynne:

I had tried an IUD (right as they were being taken off the market), and it caused debilitating menstrual bleeding and pain. I tried the pill for a while, but it decreased my sex drive and made me feel “out of it.” I tried a diaphragm, but had an allergic reaction to the spermicide. We used condoms for a while but didn’t like using them and didn’t feel they were reliable enough on their own. So my boyfriend, who’d had a prior girlfriend who used a cervical barrier, urged me to sign up for the study. Finally, after much urging, I did. I still use a barrier today because I feel strongly that I don’t want to mess with my hormones. I ENJOY ovulating, and don’t want to miss it! I think it’s a travesty that in this day and age of natural everything, so many women don’t even think a thing about taking hormones.

Lynne is 44 and lives in the Pacific Northwest, USA. She currently uses a Lea’s Shield cervical cap and was recruited to the study via the diaphragm and caps group. Before the Lea’s Shield, which she began using in 2007, she used a Prentif cap beginning in 1988. She chose a Lea’s Shield because it’s one of the only cervical barriers that didn’t require spermicide, which she had a reaction to when using a diaphragm before discovering cervical caps. Prior to this, she had severe side effects from one of the IUDs discontinued from the market in the 1980s, and also had some undesirable side-effects with the pill. She initially learned about cervical caps from her boyfriend in the late 1980s, as one of his previous partners had used cervical barriers. Lynne heard of a study on cervical barriers (testing the efficacy of the Dumas and Prentif caps in the USA) and joined this study, where she first acquired her Prentif cap. To get replacement caps she contacted her doctor, who was totally unfamiliar with the method, but happy to learn about it and prescribe a replacement. She also had some issues at the pharmacy because caps were not as common

as diaphragms in the 1980s and 1990s. She feels strongly about not interfering with her body's hormones and this is why she prefers cervical barriers to other contraceptive methods. Lynne describes initial difficulty using the Prentif cap especially given her sensitivity to spermicide; she tried honey and lemon juice, and ultimately took the risk of simply using no spermicide at all. She also had some difficulty with proper placement and describes using the Lea's Shield as a significantly easier process. When the Prentif cap was discontinued, she only learned of that information by reading about it online. At that time, she selected the Lea's Shield as a replacement, and now that those caps are also discontinued, she turned to the diaphragms and caps online group to find information about sourcing the discontinued Lea's Shield; she notes that this group has been the best and most reliable source of information for her. She thinks it's a travesty that in a time where so many women seem concerned with natural health products, that they take hormones without giving it a second thought. She is a bit pessimistic about the future of cervical barrier methods since women don't ask for them and doctors don't promote them, but she hopes that a celebrity will endorse them to aid them gaining in popularity; she believes a push in public awareness will encourage more women to try cervical barriers.

Participant 10, Astrid:

My mother is a bit of a 'natural' type person and doesn't like the idea of birth control pills, which she took her whole life. And I have been taking them since I was like 16 and she's always telling me not to take them...but I was always like yeah and do what?? Once my mom stopped taking birth control pills she started menopause with a lot of symptoms. Well, a little over a year ago a friend of my aunt's and her sister came to visit from upstate New York. and my mom was talking to her about menopause and if she had any symptoms and she told my mom that she has no menopausal symptoms after her period stopped. My mom couldn't believe it and said what did you use for

birth control? And she said a diaphragm. I was in the kitchen with them when they were talking about this, so I immediately started asking her a bunch of questions about it, because it wasn't even an option to me at the time; I didn't really know anything about it and she said it worked great for her. She had one planned pregnancy her whole life and that it was easier to get in and out than her contacts. It's crazy, this one meeting with this one woman kind of changed my whole life. I never had terrible side effects or anything from birth control pills. My period and that has always been really easy, I just didn't like the idea of being on constant hormones.

Astrid is 27 and lives in Idaho (but typically resides in the state of Washington, USA). She currently uses a diaphragm paired with Contragel and withdrawal. She was recruited to the study via the diaphragm and caps group. She hopes to start using fertility awareness in addition her current methods but describes herself as currently being "too lazy" to put forth the effort. After hearing about her aunt's friend's success story about using a diaphragm, Astrid began looking up information online, and was a bit discouraged to read about how diaphragms require a spermicide that is irritating for many women. However, she quickly found out about Contragel and decided that the diaphragm was a legitimate option for her. She had a frank discussion with her partner about the risk of pregnancy, but they decided that they were established enough in their lives and their relationship that a baby wouldn't be devastating for them if the diaphragm failed. She found the diaphragms and caps group and found reading the experiences of other women extremely useful in her decision-making process. Astrid was easily able to find a doctor to fit her in Idaho, but the doctor wasn't very supportive and tried to talk her into other forms of birth control before agreeing to fit her for a diaphragm. She notes that her doctor didn't seem very happy about issuing the prescription and was not very supportive with instructing her on usage (she turned online to gain that information). Even now she worries that her diaphragm placement isn't 100% correct, which is where the diaphragms and caps groups has helped

her a lot. Astrid easily obtained her diaphragm from a Walmart pharmacy, but is worried to get a replacement because she's read that they've been discontinued and are more and more difficult to get. She thinks that their decline is related to doctors actively dissuading women from using them, but notes that there seem to be a lot of women still interested in cervical barriers; she has been doing her part to share information and tell her peers about diaphragms to help get the word out. She believes that online communities will be extremely important in keeping information flowing about diaphragms and caps.

Participant 11, Jamie:

I have tried various birth control pills, the Depo shot, and the Paragard IUD and disliked them immensely. I have some mental health issues that hormonal birth control exacerbates and I also felt strange and unnatural when my natural cycle was suppressed. believe it or not, I actually really enjoy menstruation. Being on the pill took away my hormone cycle and thus my creativity/productivity cycle, flattening me out in a way I felt was inauthentic and alarming. In addition, I have a history of anorexia, so my bone density isn't great, and Depo made that a lot worse and also worsened my depression. So that was a bad option as well. Finally I tried the IUD -- The Paragard, which has no hormones. Sadly, this method didn't work for me either. The place I got it was unhygienic and for some reason allowed me and my friend to actually touch the device before insertion (I guess so I'd know what the strings felt like- why they didn't use an office model for this I don't know). I managed to get an intense case of PID and was in crippling pain for nearly 8 months. not to mention I was bleeding profusely DAILY, with no letup. Needless to say, I didn't feel well enough for sexytime while I had that thing in, so it was altogether useless. So: after that I started FAM and using condoms. With Plan B as backup if I had PIV intercourse during fertile times and a condom broke. I will never again use hormones, nor am I interested in an implanted device of any kind- the very idea freaks me out.

Jamie is 31 and lives in Massachusetts, USA. They identify as genderqueer/nonbinary and thus reject gendered pronouns, but they were born with and currently possess female

genitalia and are actively avoiding pregnancy. They use FAM and condoms as birth control and were in the process of getting a diaphragm to use in conjunction with FAM at the time of interview. They were recruited via the diaphragms and caps online group. They are a rape survivor and have sexual and contraceptive-related trauma. They have had abortions in the past and seek an effective method. They have had problems with hormonal methods as well as the IUD and are drawn to barrier methods as a catalyst for increased self-knowledge and self-love. They had a generally favorable patient experience because they went to a women's clinic to get the diaphragm, but they strongly advocated for themselves; they were still misgendered despite the otherwise empathetic and respectful medical interactions. They had some issues getting the diaphragm from the pharmacy, but the women's clinic intervened and ordered the device directly from the manufacturer. They believe that the self-knowledge necessary for using barrier methods is a radical act and are optimistic that diaphragms will gain in popularity.

Participant 12, Lindsay:

I didn't want to use any hormonal methods. After 10 years on the pill, it was enough.

Lindsay is 39 and lives in New York. She currently uses an Ortho All-Flex diaphragm and was recruited to the study via the diaphragms and caps group. After a decade on the pill, a friend who had used a diaphragm for years recommended the method to her and she decided to pursue it. She contacted her OB-Gyn and easily obtained prescription and then readily picked it up her diaphragm at CVS, a North American drugstore chain. She was able to test the sizing at her doctor's office and describes the process of insertion and learning how

to use the diaphragm as being very simple. She has been using it for over seven years at the time of interview. She uses the diaphragms and caps group to ask questions about fit and comfort, as in some sexual positions she can feel the diaphragm and wants to make sure that it's being used correctly. However, in her 7 years of use she's never had an issue with effectiveness and she states that she's very happy with the method and uses it daily. Two of her friends at her gym also use diaphragms and she occasionally discusses the method with them. She has not refilled her prescription since obtaining the initial device, but based on things she's read in the online group, she is anticipating issues. Lindsay believes the phasing out of diaphragms is horrible and but is hopeful about the Caya; she is optimistic that it might initiate a rebirth of cervical barrier methods. She sees online communities as being instrumental in sharing information about cervical barriers and hopes that that the Caya will take off with a boost from online communities.

Participant 13, Jocelyn:

I did not want to use hormonal methods after hearing many stories of women suffering from nausea, fatigue, and loss of libido. I also heard several women say they lost their monthly bleeding altogether, and that did not sound appealing to me. I typically choose my foods and hygienic products with lower amounts of synthetic chemicals, so the idea of routinely ingesting synthetic hormones for potentially years at a time clashed with the more natural lifestyle I attempt to lead. My mother was on a birth control pill for many years, switched off to use a diaphragm, and then had horrible swelling in her limbs when she tried to go back on the pill for a second time. She also has had an experience with a blood clot (unrelated to the pill). I felt that her experiences might mean I am more at risk for adverse effects of the pill.

Jocelyn is 24 and lives in Northeastern USA. She uses FAM, condoms, a diaphragm and a FemCap depending on where she is in her cycle. She was recruited to the study via the diaphragms and caps group. After eschewing hormonal methods, she used the internet to

obtain information and ultimately found that the diaphragms group to be extremely helpful. She notes that while she enjoys research and found it easy to obtain information, others might be put off by the amount of conflicting information regarding effectiveness, use of spermicide, and so on. She had favorable interactions with medical practitioners, describing her doctors as being open-minded to the idea of non-hormonal methods. Jocelyn states that she had a much easier time getting a diaphragm than she anticipated; reading other women's experiences online prepared her for the worst, but because she is in a liberal city, her doctor was happy to fit her and called the (Milex) diaphragm prescription into a nearby CVS without issue. However, Jocelyn's experience getting a FemCap was entirely the opposite; the receptionist and nurse at her clinic did not know what cervical caps were and several back-and-forth messages and interactions didn't seem to clarify the situation. She finally obtained a prescription and ordered a FemCap online. For Jocelyn, getting spermicide was more difficult than the actual cervical barrier, as she had to order Contragel from the UK, and finding it cost-prohibitive, decided to make her own using a recipe found on the diaphragms and caps group. She states that the diaphragms and caps group was vital in informing her about how to use these methods and ensure proper fit, as well as finding difficult-to-source information about alternative spermicides and how to use them. Jocelyn finds it problematic that the medical industry pushes hormonal methods so much that women aren't even aware of alternatives, as is the case with many of her peers. She believes that for now, the internet and online groups are the only sources of valid and accurate information regarding cervical barriers, and views sharing of this information as vital in order to keep the method alive. However, she thinks that once women find out that non-hormonal alternatives exist, methods like diaphragms and caps will become more

popular; she notes that she has some friends currently seeking non-hormonal methods of birth control.

Participant 14, Maggie:

I didn't like taking the pill as it gave me bad side effects, also my partner is away a lot working and I didn't want to pump my body full of hormones for the sake of it. I thought about having a Mirena put in but again that is hormonal. I didn't want to take a pill each day, it was hard to get into a routine of taking it at a set time each day.

Maggie is 20 years old and lives in the southeast UK. She currently uses a diaphragm and was recruited via the diaphragms and caps group. While on the pill she developed acne and breast tenderness, and she found it difficult to remember to take each day. She and her partner used condoms for a while, disliked them, and then began using female condoms. Maggie actually liked female condoms, but they're one of the few birth control methods not covered by the NHS. She learned of the diaphragm through her forty-year-old co-worker (her younger friends were all on the pill) and decided to pursue it as a method. Her initial interaction with a doctor was negative; she laughed at Maggie and asked her why she wanted to use a diaphragm if her goal was to not get pregnant. Maggie notes that the NHS has a mandate to push hormonal methods and IUDs due to high rates of teenage pregnancy, and her doctor's reaction was likely due to the fact that she was 19 at the time of the consultation. She then went to a family planning clinic, and although the practitioners were more sympathetic than the first doctor, they still wanted to give her hormonal birth control. She began researching online (her friend had directed her to the diaphragms group as a research tool) and later booked a consult with the private health provider BUPA, for which she had to pay £138. At the private clinic Maggie described

feeling respected and not pressured to get hormonal methods. The doctor listened to her and thoroughly explained all the options including cervical barriers. The center didn't have any diaphragms on hand to do a fitting, but Maggie had a return appointment the following week at which she received a fitting and a well-woman exam (what the NHS calls a physical to evaluate women's reproductive and sexual health). She was able to take the diaphragm home that day. Her fee also included a follow-up exam to ensure that she was using the diaphragm properly. For Maggie, inserting the diaphragm is akin to putting in contacts, and using it is fairly simple. However, because the method is "retro," she was initially embarrassed about using it and didn't want her peers to know. She is more willing to discuss it now and has two younger friends that are interested, although she says that most friends her own age have Mirena IUDs or are on the pill. She thinks that the internet will continue to be a major source of information for women seeking diaphragms and hopes that it catches on in popularity so that she won't have a difficult time when she needs to replace her diaphragm; if she has difficulty in the future, she will return to using female condoms.

Participant 15, Esther:

For religious reasons, a lot of people use natural family planning. But like, in my religion people don't really use it as much. But I heard...it's like more common in Christian circles, one of my friends was telling me. I'm Orthodox Jewish. But my good friend is Methodist I believe, and her pastor kept telling everyone like, 'before you get married, you have to do natural family planning cuz it's the only way.' So I started looking into it with my friend actually, and we found that it is possible to use even with Orthodox Jewish laws, because our laws...we have like different laws I guess, about that. They're called like family purity laws. But the nurse had no clue that like I could still be able to use that with our family purity laws, because she really didn't have any knowledge of natural family

planning. I thought about the pill and I went to a gynecologist at my school actually, like my university, and they kept trying to get me to get an IUD, which was really annoying. Because it's like, I want to like conceive in like a year or two, not 12 years, which is what they were trying to get me to get. So I kept telling that and they, like, the gynecologist literally looked at me like I was crazy, and then told me I should take the pill or the NuvaRing. And I was like 'I'd really rather not do hormones cuz I have bad reactions to hormones'.

Esther is 20 and living in the East Coast, USA. She is recently married and an adherent to Orthodox Judaism. She plans on starting a family soon and is using natural birth control methods so that she can easily get pregnant when the time is right for her. She experienced some difficulty with practitioners respecting her desire to use non-hormonal methods and with finding practitioners knowledgeable about fertility awareness methods. She also had difficulty finding someone to do a diaphragm fitting for her, and had several practitioners encourage her to use an IUD despite her explicitly stating that she wanted a diaphragm. She found misleading information online from sources like Planned Parenthood's website that implied getting a diaphragm would be straightforward and easy, which was counter to her experience. At the time of the interview, she was still trying to obtain a diaphragm and having some difficulty, as pharmacies could no longer order diaphragms from their major distributor, Ortho, following their discontinuation of the Ortho All-flex diaphragm. She is currently waiting for a special order through another pharmacy for a Milex diaphragm. She remains skeptical about the future of cervical barriers and natural family planning due to the profit-seeking nature of the pharmaceutical industry but remains hopeful that diaphragms may have a dramatic rebound as women become wearier of hormones. She also sees a lot of technological innovation with regard to fertility awareness and is hopeful that it will flourish as a method.

Participant 16, Alicia:

I had been using the IUS for many years since I was 21, but my husband and I are going to want to start a family within the next year. Once the IUS has been removed it can take a while for your body to settle down. So I wanted to be hormone free so decided to use the diaphragm as my main contraceptive and a female condom on other days. If I did get pregnant by accident at present it wouldn't be the end of the world. I am a flight attendant as my day job and the pill isn't really an option due to the long hours and the time zones we cross, and depending on what airline you work for many offer their female staff a free IUS fitting. Just over a year ago I had the IUS removed as we decided we would try for a baby when I am 30. We initially decided that we would use condoms but my husband struggled to get and maintain an erection with them so we tried the female condom but they are difficult to obtain at times. A friend who had just had a baby had a diaphragm and we talked a lot about it and I had one fitted.

Alicia is 29 and lives near Manchester, UK. She currently uses a Caya diaphragm and the female condom and was recruited to the study via the diaphragms and caps group. As a flight attendant, frequently changing time zones meant that the birth control pill was a poor option and an IUD was a perfect solution for her. She was quite happy with the IUD and had no health issues while using it, but had it removed in preparation to conceive. Through her work, she has access to free health care at specific private clinics, and at her first appointment to get a diaphragm she was able to obtain one that same day. She admits that she was quite lucky in this regard, as reading other women's experiences online gives her the impression that getting a diaphragm can be quite an arduous process. She sometimes has issues getting spermicide to use with the diaphragm and has to order it from pharmacies. She has issues with the NHS and feels lucky to be able to use private health care services. After initially discussing diaphragms with her friend who uses one, she conducted research online for more information and realized that the diaphragm is a "retro" method and "modern" methods all seem to be hormonal or IUD based. The doctor that

fitted her told her that diaphragms are “delightfully old-fashioned,” and that she hadn’t fitted one for a while. Alicia describes her doctor as being supportive, and notes that her doctor asserted a woman’s right to choose her own contraceptive. She did question Alicia about her relationship status and desire to start a family, but Alicia doesn’t believe this had any bearing on her willingness to prescribe a diaphragm, as her friend was single when she obtained one from the same doctor. Alicia discovered the diaphragms and caps group when researching homemade spermicide; ultimately she decided that DIY spermicide was too risky to use and is continuing to purchase it at pharmacies. She hasn’t contributed to the group or asked any questions and says that she feels guilty reading posts because her experience was so smooth compared to those of other group members. Alicia says she is quite confident at using her Caya and never had any issues with fit. Before the Caya she used a Reflexions diaphragm for nine months and was fitted by the same doctor who fitted her Caya, but she switched to the Caya after losing weight. She notes that the Caya feels more comfortable than the Reflexions, and in each fitting instance her doctor ensured that the fit was proper and that Alicia was comfortable with insertion and removal. She sometimes prefers to use female condoms because they are less messy but switches up the methods fairly regularly. She believes that diaphragms are wonderful birth control methods and is happy to discuss them with her friends, whose reactions range from “wow!” to “yuk!”. She’s shown her Caya to friends and colleagues and even gave a visual demo for insertion to one interested friend. While she says that it was embarrassing for her, she stresses the importance of sharing information and states that diaphragms and female condoms are a strong statement of feminism because women can control their own methods.

Participant 17, Chloe:

My other options are limited for a number of reasons. My mother had a deep vein thrombosis and all of the men on my dad's side of the family have died of strokes and heart attacks so I couldn't have oestrogen. I had briefly [taken the pill before] but it made me bleed very badly and spot. It also brought on my Hypermobility Syndrome and I struggled to walk for 18 months. My Hypermobility is a life long disability. I had an IUD after hormones were no longer an option but that slipped after 4 days and shifted upwards and twisted and after 6 attempts at extractions I had to have surgery to remove it. When I went for the IUD (while I was at university in Essex) I actually wanted the diaphragm.

Chloe is 27 and lives in Hampshire, UK. She currently uses a diaphragm paired with spermicide and was recruited to the study via the comment section of a feminist news page on Facebook. Chloe was made aware of diaphragms via the UK's sexual education program in schools, but also from her mother who used one and openly discussed it. When she went to ask for a diaphragm at a health clinic several years ago, the contraceptive nurse urged her to get an IUD instead. The nurse told Chloe that she was too young and had not been with her partner for long enough to use a diaphragm, and that the IUD would be more reliable and less of a hassle; Chloe notes the irony of this given the complications that resulted. Chloe had daily bleeding with the IUD and recounts it slipping during intercourse only four days after insertion. From the first day of insertion to the day of extraction six months later, she was in constant pain. Her hypermobility disorder was exacerbated by progesterone, so in addition to pelvic pain she had widespread bodily pain. She saw her doctor every few weeks and there were several attempts to remove the IUD, but each time it failed and the doctor wasn't convinced the IUD was even still inside Chloe until an ultrasound months later showed it lodged deep inside her uterus. She was finally able to

have removal surgery; Chloe notes that she has trauma from her contraceptive history and cries every time she has to recount it to a doctor. After the IUD removal, she used condoms for a while. Later, her current partner urged to try methods that increased her own pleasure, which she struggled with due to childhood sexual abuse. She returned to the contraceptive clinic again, and when the nurse suggested an IUD again, she became emotional and vividly described her contraceptive history; this nurse saw her desperation and was supportive and reassuring. The nurse fitted her for a diaphragm on the spot, gave her the device and a sixth-month supply of spermicide. Chloe states that she loved this particular nurse and visited her several times for rechecks and replacement diaphragms. When she switched clinics after a move, she was issued a different model of diaphragm and that's when she became aware of the phasing out of diaphragms. At the new clinic, only one nurse could fit them and this particular nurse wasn't as friendly or experienced as the previous one. The nurse told her that practitioners aren't being trained to fit diaphragms anymore, and suggested that Chloe look into the Caya diaphragm to avoid having to get fit in the future. At the time of interview, Chloe was also having issues sourcing spermicide and had to order it online. Chloe is skeptical about one-size-fits all diaphragms, but says that she'd consider it over IUDs or pills. She currently gets most of her birth control information online, via clinic pamphlets, and directly from practitioners, and says that she doesn't talk with her peers much about birth control other than the fact that they all mostly use the pill. She has a decent stockpile of diaphragms and hopes that when she'll need a replacement, she'll be ready to have children. She enjoys using diaphragms and says that they've taught her more about her own body. She worries about the future of the diaphragm given that they're harder to get and health systems seem to push hormones and IUDs, but

she thinks there may be hope with the Caya diaphragm if they're taken up by the NHS. Chloe says the main message she gets from the NHS now is that diaphragms are a risky method that shouldn't be trusted, and that women need to stand up and fight for what's best for their own individual needs.

Participant 18, Lisa:

When my husband and I were getting married, previously we had used condoms. But we had hoped to try to find something besides condoms to use after we were married, and I didn't want to use any hormonal options. My mother passed away of breast cancer and she was 33 when she was diagnosed with it. When I had originally spoken to a doctor at one point about possibly going on the pill or something like that, he had cautioned me to be careful because in some studies they found some links between hormonal birth control and breast cancer rates or something like that. Since I was already highly at risk because she was so young and they think it's most likely genetic, he didn't think I should do anything else to increase my risk. However, I've spoken since to other medical – doctors and midwives and stuff, and they don't think there's any relation between the two and stuff. But that was my original decision not to choose any hormonal methods. So when we were looking for a non-hormonal method, the diaphragm seemed to make the most sense.

Lisa is 31 and lives in Maryland, USA. She was recruited to the study via the comments section of a feminist news page on Facebook. In her initial consult for a birth control method other than condoms in 2008, the doctor who suggested a diaphragm for her wasn't able to fit her and she had to see a different doctor to get a fitting. She used the Planned Parenthood website to do research on contraceptive methods, and one of the reasons she had narrowed down the diaphragm in her own research was its low cost; she didn't mind that it had higher failure rates because she intended to get pregnant fairly quickly in her marriage. She recently had a baby and has used a diaphragm to successfully space 3 pregnancies over the past 7 years. She is currently breastfeeding and wants to start using it

again but is in need of a replacement and is having a difficult time getting a pharmacy to fill the order; she and her husband use condoms in the meantime. She last purchased a diaphragm three years ago and wants to continue using it until her husband has a vasectomy. Her midwife was supportive of the method, measured her and wrote the prescription for a replacement, but couldn't find it on the list of prescriptions that their partner-pharmacy carried. Lisa took the prescription to CVS, and the pharmacy staff said they'd order it and it would be available in two days. However, they later called her to say it was unavailable. Her midwife wrote a prescription for a different model and called it into CVS, but CVS couldn't get it from their suppliers. Lisa notes that the customer service rep at the CVS told her that he hadn't sold a prescription for a diaphragm in over 20 years. She was told to contact a small, independent pharmacy, and at the time of interview she was waiting for her diaphragm to come in. She was surprised to face such difficulty in obtaining a diaphragm replacement given her previously smooth experiences as recent as three years ago. She is relying on her midwife's office for information and support and hasn't looked online for additional information, however if she faces further issues she will use the internet to find a solution. Her midwife also mentioned the Caya, but expressed skepticism about the one-size-fits-all aspect and urged her to continue using the fitted diaphragm. Her midwife is very pro-diaphragm and is discouraged by the fact that women no longer consider it as a method; the midwifery clinic even brought in students during one of her fittings to show them how to fit diaphragms because fittings are so rare nowadays. Lisa was happy to contribute to the teaching of that skill. Lisa considered a Mirena IUD after her most recent pregnancy, but ultimately decided against it since she is breastfeeding and doesn't want any hormones leaching into her breastmilk. Her friends

express skepticism about the diaphragm due to low stated effectiveness rating, but it's always worked for her and she's happy to continue using it if she can get a replacement. She is hopeful about the future of diaphragms, especially with the emergence of Caya and other one-size-fits-all options; she thinks that publicity will be the deciding factor for whether or not they take off and that women need to start talking about diaphragms to ensure their future.

Participant 19, Tara:

I was looking to get off hormonal birth control and looking for a better option than a condom. I've used the Nuva Ring in the past and liked it but it gave me sinus infections. I liked the pill but I had a friend who had a stroke – it was determined hormonal bc was the reason and that worried me. I started researching and kept coming back to diaphragm. It seemed to be what I was looking for.

Tara is 33 and lives in Tennessee, USA. She currently uses the Caya diaphragm and was recruited to the study via the comments section of a feminist news page on Facebook. After seeing her friend have a serious health issue from the pill, she booked an appointment with her gynecologist to get a fitting for a diaphragm. She was easily able to get an appointment, but the intake nurse was confused about what she was requesting and offered other birth control options; this nurse told her she had never discussed diaphragms with other patients before. The doctor told Tara that he was happy to fit her for a diaphragm but cautioned her that getting one from a pharmacy would be difficult, and then he kept emphasizing a high failure rate, seemingly discouraging its use and even offering an IUD instead. Ultimately, he respected her decision and wrote her a script after dusting off his old diaphragm fit kit and fitting her. Tara began researching online to find out more about obtaining a diaphragm and kept coming back to Caya as a more readily available option (“I googled

the heck out of it. I watched YouTube videos - if it's about Caya and it's on the internet, I read it"). She tried talking to other women she knew, but nobody had used a diaphragm; older women thought she was crazy for wanting one, while her peers were fascinated by the device. Having her cervix measurement from her diaphragm fitting gave her more confidence with the sizing parameters of the Caya (which comes in three sizes), and she ended up ordering it online from the UK. She didn't have any issues inserting or using the Caya, although she was surprised to learn she had to order spermicide separately and ended up ordering Contragel online. She did not go back to her doctor to ensure proper fit because it felt comfortable for her, but she is considering going back to show him how it works and fits so that he can be better informed in case other patients ask about it. Tara thinks women need to be more informed about what's available for them and worries that young women are pushed onto pills and hormonal methods because it's the status quo. She enjoys using the Caya and says the only minor issue is that her boyfriend can occasionally feel it during sex. Even though she initially wanted a traditional diaphragm she will stick with the Caya because it is so user-friendly. She is optimistic about the diaphragm's future and thinks devices like Caya will gain steam as more women switch to menstrual cups and look for non-hormonal birth control. She also tries to spread the word about Caya when the topic of birth control arises.

Participant 20, Anya:

I liked the fact that there were no side effects or systemic risks. I carry a higher than average risk of heart-related illness such as heart attack and stroke, and have poor circulation. I also smoked for many years, including the years when I started the pill through when I

started using the diaphragm, which I knew compounded that risk. It was a mental relief not to have to worry about those side effects.

Anya is 46 and lives in Ohio, USA. She is not currently using a method of birth control, and was recruited to the study via the comments section of a feminist news page on Facebook. She went on the pill when she was in high school and got engaged right after college. She wanted to get off the pill at that point and began using the diaphragm from 1992 to 1997. At that time she easily obtained a diaphragm from both her doctor and the pharmacy, but she notes that she knew no other women who used it and that it was not a popular method then. Her doctor likened its effectiveness to the pill when used properly, and she felt that that level of protection against pregnancy was sufficient, and also the fact that it had no side effects. However, the messiness, the bad flavor of spermicide, and occasional discomfort with long wear meant the diaphragm was not an ideal method of contraception for her. She tried to go back on the pill many years later but found she could not tolerate even the lowest dose of hormones. It gave her headaches, breast pain and a diminished libido. She started using the NuvaRing at that time and loved using that for many, many years. For her, NuvaRing was perfect but it has caused many problems for other women and carries high risks, and as middle aged and divorced woman, Anya feels as though she has no birth control options. Now she is single and would consider using the diaphragm again if it weren't for the negative aspects of the required spermicide. She views non-hormonal options as being limited and having a number of drawbacks, and wouldn't recommend cervical barriers to other women unless they could be designed to be highly effective without requiring spermicide; cervical barriers need to have better design elements if they're to catch on again in the future. She believes that fertility awareness and

cycle tracking should receive greater advocacy and that women should know more about their bodies.

Participant 21, Isabel:

When I had gone off of the pill, I had my two children pretty close together. Like within two years of each other, so I hadn't really ever gone back on the pill between the two. And so I realized that I kind of liked staying off of it just because I had some side effects and I wanted to switch to something that was non-hormonal. So I switched to that after my second son was born. So that's about a year and a half ago. And then I've used that until pretty recently, actually about six months ago. Then I started noticing that my skin was breaking out like more and more, and then, so then I actually went back on the pill for a couple months just to clear that up. And then when I went back on; I had temporarily kind of gone back on it after my first son, and then I went back off to have my second son a couple months later and that's when I realized that when I went back off of it all of that got a lot better. So then after my second son I thought 'well maybe I'll just stay off it and look at some non-hormonal methods.'

Isabel is 35 and lives in Pennsylvania, USA. She has used a diaphragm off-and-on but is currently not using any birth control method because she is trying to conceive. She was recruited to the study via the comments section of a feminist news page on Facebook. She had been on the pill before conceiving her son but had her second child shortly after her first. After a short stint on the pill after her second child, she noticed some side-effects like vaginal dryness and reduced libido and decided to investigate non-hormonal methods. She initially looked into IUDs but read that even the non-hormonal version had some pretty severe side effects, and also the idea of insertion didn't appeal to her. The majority of her research was conducted online, but she also talked to her friends about birth control, many of whom were on the pill. She also looked at a forum for new mothers and describes it as a helpful resource for women sharing their birth control experiences after having children.

When she decided on a diaphragm, she booked an appointment with her OB, who expressed surprise at the request. While Isabel asserted that she did want to try the diaphragm, the doctor kept mentioning the Mirena IUD and also said she wanted to discuss other options with Isabel for when she decided in a few months that she no longer wanted to use a diaphragm. Isabel found it strange that the doctor assumed she would discontinue using a diaphragm after a few months. Her doctor stressed that some women have difficulty with insertion and that the failure rate is high with incorrect usage but was also informative and ultimately supportive after Isabel insisted that she wanted a diaphragm. She was able to have her diaphragm fitted at the same appointment and easily obtained one at her pharmacy. She was actually surprised by her own smooth experience, because she had read the stories of other women who had a lot of difficulty getting fitted or obtaining a diaphragm. While she liked the diaphragm, she's not sure if she'll continue to use a diaphragm after her next child or will go back on the pill for her skin issues. However, she's interested in Caya and may ask her doctor about it in the future. She wishes there were more non-hormonal options for women and isn't certain about their future but acknowledges that women will always want non-hormonal methods and more options need to exist for that demographic.

Participant 22, Christina:

I've been on birth control since I was like 16 years old. One of my first methods of birth control was the birth control patch, which was the transdermal hormonal one. It was extremely expensive and I used to pay for it every month. I was in high school and I was literally paying like \$50 a month. That's huge. And that I was on the NuvaRing for a while as well, and then I've also done the pill – different types of the pill. I'm currently on the pill. I've also had episodes in my life where I wasn't on any birth control pill because I wasn't in a situation where I was needing birth control necessarily. The first reason [I'm considering a diaphragm] is because I'm in a

monogamous relationship with someone, which I feel makes it, like in case anything does happen, there's just more responsibility and there's more security, I think is also part of it. Like if I knew I couldn't rely on my partner necessarily, I think I would stay on hormonal birth control. But because there's now this partnership, then it's like, you know, since the diaphragm does have a slightly less...the odds are a little less in your favor. So it's good to have that. So that's part of the reason, and then another reason I'm considering it is not too much because I've had any adverse effects to the hormones, thankfully, because that hasn't been the case, but it's also because I am currently working on my PhD in women's studies and I'm just approaching a time in my life where I'm trying to embrace more holistic forms of living in general, with the understanding that a hormone that I take every single day has probably created some pretty epic shit in my person. So that's another factor that's pushing me to consider it and to look into it as an option for me.

Christina is 29 and lives in Texas, USA. She is currently on the birth control pill and was recruited to the study via the comments section of feminist news page on Facebook. She is interested in using diaphragms but has no experience with the method. She's been on hormonal methods since the age of 16, starting with the patch, moving to the NuvaRing and currently using the pill. She is interested in the diaphragm because she's in a long-term monogamous relationship and is trying to embrace more holistic forms of living. She had no side-effects from hormonal methods but wants a more natural method. She is hoping to talk to a gynecologist at her university soon to pursue the method.

Participant 23, Susanna:

I am so slow to make any decision about birth control, however! I have not been on any form of hormonal bc post pregnancy and I am hesitant to get another hormonal form. I have a lot of sex now so I know that I should get bc, but again I am relying on the pull out method. Which is silly, I know. But I am also tracking my cycles so that is useful. the hesitation stems from three things I think: Not wanting the hormones. I guess I think it is probably not good for me. I can tell things about my body so much better now than I had ever before, like when I am ovulating. I have more instinctual feelings, I

think. Not wanting to gain weight. I lost 50lbs over the last year so I don't want hormonal bc cause I think it would make body changes. The IUD scares me. Mostly the fact that it can make my cycle worse. Or that it can perforate my cervix/uterus.

Susanna is 31 and lives in New York, USA. She is currently using cycle tracking and withdrawal following the birth of her child and is considering a diaphragm in order to avoid hormones and be better protected from pregnancy. She was recruited to the study via the comments section of a feminist news page of Facebook. She was on the pill for over a decade and then switched to NuvaRing for a short period of time. After deciding she wanted to live a more holistic life, she began using condoms but became pregnant six months later after one episode of unprotected sex with her husband. She was finishing her PhD at the time and about to move to Singapore, but she notes that for some reason she didn't actually think she'd get pregnant so easily. She now has a toddler, and uses the withdrawal method to avoid pregnancy, but notes the risks involved in this method. She felt a lot better when she went off hormonal birth control and is hesitant to go back on the pill, and also notes condom failure as a problem she's experienced a few times (and thus a desire to avoid condoms). She contacted her doctor to discuss IUDs and also looked at mommy forums to read other mothers' experiences with them. She describes the encounter with her doctor as being somewhat informative, but she felt like there wasn't enough push from them to get her to use any method of birth control. When Susanna mentioned the diaphragm to her friend, her friend laughed at her (and also thinks she's a bit weird for using a Diva cup). She hasn't yet consulted any medical practitioners about a diaphragm but will be talking to her sister who is a nurse practitioner. She had briefly discussed diaphragms with her friend who used to work at Planned Parenthood, and it was this friend

who tagged her in a Facebook article about Caya. Susanna describes hearing about the experiences of postpartum women from marginalized groups having birth control pushed on them after birth, and expresses genuine surprise that doctors seem indifferent to her own situation. She notes that the passivity of her doctors paired with her own passivity is not ideal and articulates a need to actively pursue some method of birth control. She states that following her interview, she will pursue a diaphragm, although needs to do a lot of additional research since she is uninformed about how and where to get them (she was convinced she could get them at the drug store on the same shelf as the Today Sponge).

Participant 24, Camila:

I didn't start having sex until I was 22. In my high school years I was very shy and I didn't see the need or point of getting into the whole young relationship thing because it never works out. I wasn't in any kind of serious relationship when I was 22, I just wanted to be an adult and have sex. I had a few casual boyfriends but I wasn't having sex much so I would always use condoms because I heard so many things about the pill and I didn't want to go on it. So I always used condoms and a couple of times I used spermicide as backup to the condom cuz I was so scared of getting pregnant, and I got a really bad UTI infection and it lead to a kidney infection. I was peeing blood and I went to a doctor and they were trying to convince me...these two men were like 'oh you silly girl, why aren't you on birth control?' Like 'you're sexually active and you're not on birth control??' they were very judgey. And then they were trying to convince me that I was on my period, and believe me, I was not. And then I took a pee test and then they were like 'oh yeah, it is a UTI, and here's some medicine, and goodbye.' So then I started dating for a couple months this one guy who turned out to be a real asshole, but anyway, the first time we had sex there was a condom mishap, like he said it came off, so I had to get the morning after pill, and then I was kind of freaked out from that. So then I was like, well maybe I should go on the pill, you know, like after all this, maybe I should do the responsible adult thing. So I went on it for a month and a half or so before we broke up, and I had really really bad side effects. Like nothing crazy, but I always had really clear skin and I had intense acne; I looked like I had boils all over my face. It was bad

and painful. They always say it's gonna make your skin clear. Nope. These were boils and people would gasp when they saw me. I had other issues like nausea, I would get so nauseous that I would have to leave work. So that's no good. My boyfriend and I broke up and I was like 'I'm not crazy about him or the pill.' So then when I met my late husband, I was 23 and he was 22, and we started getting serious, and we always used condoms and then after we'd been serious for a while, we had the big talk about what to do about contraception and he's like me, like I'm very natural and holistic-minded and he was even more extreme than me. He took it to a whole 'nother level. So he too was not crazy about birth control, the idea of me being on birth control.

Camila is 27 and lives in Florida, USA. She is widowed but in a new relationship and currently using fertility awareness methods that include tracking cycles with basal temperature, checking cervical fluid signs, and using ovulation tests purchased from the store to confirm ovulation. She and her late husband experimented with fertility awareness (he initially purchased CycleBeads for her) and then started using a diaphragm on fertile days. She notes that if she had continued using CycleBeads rather than cycle charting with daily temperature, she'd have inevitably gotten pregnant since counting beads is not an efficacious method of contraception. She had trouble finding a doctor to do the fitting initially, having to call around several different practitioners' offices before finding a doctor who could do diaphragm fittings. When she finally found a doctor who could fit the diaphragm, she describes having a positive experience, stating that he was very nice, and interested in fertility awareness methods, and even requested to see her CycleBeads and called in the nurses to show them the beads. Her doctor also asked if the nurses could observe her diaphragm fitting since they were performed so infrequently in his office and the nurses were very curious; Camila was happy to oblige and was fitted with the now-discontinued Ortho All-Flex. She was able to get the diaphragm easily. However, she is

physically too small for diaphragms to work properly, and also couldn't get a Caya to fit properly. She feels like the sizing parameters of fitted and one-size-fits-all diaphragms need to be updated to accommodate the diversity in female anatomy. Camila expresses relief that her current partner is amicable to fertility awareness because not all men trust it as a method and describes an ex-boyfriend before her current partner urging her to go on the pill; she notes that trust is an important element of using fertility awareness methods. She observes the upsurge of fertility awareness apps (citing Kindara as one that she enjoys) and is optimistic about the future of that method and the barriers that pair well with them; however, she worries that women will rely too heavily on them without thoroughly learning their own cycles. Camila's fear is that women will not bother learning how to chart, will get pregnant while using the apps, and then say that fertility awareness isn't an effective method; she sees the rise of fertility awareness apps as a positive for the future of the method, but worries that using method while ill-informed can also harm the method as a whole.

Participant 25, Beth:

I think years and years and years and years ago, I started with condoms, and then I was with a fiancé, we'd been together for a really long time, and I tried birth control pills; I was also having really tough periods, like passing out and stuff from the pain, and we tried birth control and it made me crazy. Like nuts. Suicidal thoughts, like nuts, so we discontinued those. And the doctor I had at the time suggested a diaphragm, and I was creeped out by the idea of it cuz it seemed so strange, but I got one, and after a while it was just the easiest thing in the whole wide world, especially if we did the condom and the diaphragm situation. And yeah, that's what I did for the longest time.

Beth is 49 and lives in Massachusetts, USA. She currently uses a diaphragm and condoms but notes that she has sex very rarely. She believes that using those two methods means that each partner is contributing something to the interaction, but says that in her experience, it doesn't always work that way in practice. She used a diaphragm paired with condoms for a long time, but later was celibate for an extended period and when she needed to replace her diaphragm years later, was surprised to see the lack of availability of spermicide. Beth notes that experts deemed spermicide as irritating to tissues and suggests that its irritating nature may be why she experienced discomfort when using it years ago. Since she last used a diaphragm paired with spermicide and has recently replaced it (within the last five years), she is unsure about how to actually use her replacement in the absence of spermicide. However, she states that acquiring a replacement diaphragm was quite easy the last time she did it. She speculates that diaphragms are not profitable because they do last for a long time before needed to be replaced. Beth says that she doesn't know anyone else who uses a diaphragm and that all of friends use IUDs; she expresses discomfort with the idea of a foreign body inside of her and also describes negative feelings towards contraceptive implants like Implanon. As a college student in the early-to-mid-nineties, she was a pro-choice activist working in support of Planned Parenthood and Rock for Choice; this activism followed a pregnancy termination after being raped. Around the time she obtained a second abortion after a condom breaking with her boyfriend, the Brookline Clinic shootings occurred, which inspired Beth to raise money for Rock for Choice benefits. She is currently single and perimenopausal and anticipating she won't need birth control for much longer, but she describes having some difficulty navigating the singles terrain since many men her age have vasectomies and don't want to use condoms. She also

notes that her age group and geographical locale are not hospitable to openly discussing sex and sexuality, and despite trying to discuss sex with her peers, is often shut down by friends; however, she expresses a desire to move to Seattle where she believes her “tribe” of women is more forthright and open-minded. Beth thinks it is “insane” that medical professionals advocate for hormonal methods and IUDs despite them having significant side effects in women but is hopeful that more women will embrace barrier methods and eschew hormonal ones.

Participant 26, Marina:

In general, I eat very healthily. I like buying organic, and I like taking care of my body. So the thought of artificial hormones didn't sit well with me. On top of that, I was concerned that because I have a predisposition to dealing with mood problems (undiagnosed depression/anxiety symptoms), I didn't want to take something that could trigger a depressive episode or something like that. I was also concerned that since I deal with acne, the BC could aggravate it. All in all, I felt that my body already had some issues of its own, and rather than masking them with birth control, I wanted to get my body working on its own through better diet, stress reduction, etc. So I have never used any hormonal contraception (except for Plan B). I never liked the idea of putting artificial hormones in my body.

Marina is 20 and lives in Massachusetts, USA. She currently uses fertility awareness paired with a FemCap and was recruited to the study via the diaphragms and caps group. She started out using condoms for contraception, then began using withdrawal, and later a very conservative rhythm method. She discovered Fertility Awareness via the Kindara app and was led to a Fertility Awareness group on Facebook. Thereafter, she decided she wanted to have a back-up method to withdrawal to increase effectiveness, so she obtained a FemCap to pair with withdrawal during high fertility days. She sometimes also uses FemCap alone (without withdrawal) during low fertility days. She describes being

fortunate to live in a state where schools offer comprehensive sexual education, and so she was aware of a number of options and did not need to consult with a doctor upon initial sexual activity at 16. However, her boyfriend urged her to go on the pill because it was the method all of their peers used and seemed easier than condoms, fertility tracking and withdrawal. Once she became better at tracking temperature changes, he was more open to using non-hormonal methods. She considered taking birth control pills, and at one point had a consultation for a Paragard IUD, but ultimately decided that fertility awareness and a cervical barrier were her preferred choice. Marina had positive interactions with a nurse practitioner who she felt truly listened to her regarding her fears about hormones; although the nurse initially prescribed a low-dose birth control pill, she was happy to prescribe the FemCap when Marina later expressed a desire to not take the pills. Although the nurse practitioner wasn't super knowledgeable about the FemCap, she conducted research on Marina's behalf to try to find a distributor, although Marina later had to source the cap herself by contacting the manufacturer directly. Marina notes that this is the best experience she's ever had with a medical practitioner because she felt as though the nurse actually trusted her. She describes other practitioners interacting with her in a condescending manner, ultimately causing her to withhold information from them and even lie because she felt like they demanded specific answers. Marina obtained the majority of her birth control information online and describes conducting extensive online searches. She found the diaphragms and caps group link in another discussion forum and has used the group to ask questions about wearing routines for long distance relationships. In terms of using the cap, she found it easy to insert and comfortable to wear from day one. She feels empowered using fertility awareness as her primary method and supporting it

with withdrawal and the FemCap. Marina is optimistic about the future of fertility awareness due to a great deal of attention being given to technological innovations like fertility tracking apps and devices, and she sees a possible upsurge in cervical barrier usage as a result since fertility awareness requires a backup method on fertile days. She is hoping to spread the word about fertility awareness and is hoping to become a part-time fertility awareness instructor to promote the method further.

6.4 Overarching Narrative and Conclusions

While it cannot be said that every participant had difficulty obtaining a diaphragm, the majority had some type of complication or hiccup during the process, whether it was in the motivation stage, in the medical consultation stage, in the acquisition stage, or in the use stage. The experiences of older participants who began using cervical barrier methods in the 1980s and 1990s reflect a shift in not only the accessibility of diaphragms and caps over time, but also the informational landscape that undergirds these contraceptive methods. Some participants in a higher age bracket recount their experiences of obtaining a diaphragm or cap as unremarkable – the mainstream nature of these methods meant that the process of getting one was fairly straightforward. They were not met with resistance by medical practitioners given that the method was both widely available and still considered scientifically legitimate, nor were there any issues in obtaining these methods, save for having to special order some cervical caps. Some older participants have reached menopause and thus ended their contraceptive journeys, but are able to describe in some detail what it was like to obtain and use a diaphragm; for some participants in this demographic, the diaphragm was not looked upon fondly and was thought of as messy or cumbersome. However, given that the pill and other hormonal methods were also widely

available in the 1980s and 1990s, most participants in this demographic chose the diaphragm or cap specifically because they had some issue with hormonal methods (bad reactions, etc.). Access to contraceptive information for these older participants was also markedly different from that of younger participants – most obtained their birth control information directly from their doctors, via word-of-mouth, from medical pamphlets in a clinic, or at feminist bookstores. This was largely due to the fact that the worldwide web was not yet existent in the 1980s or commonplace in the 1990s, whereas in later years the internet became the primary tool for contraceptive information searches. As described in the previous chapter, due to broader forces including changes in the pharmaceutical industry and biomedical science, cervical barrier methods became displaced in favor of hormonal methods and intrauterine devices. This meant that for younger participants, or participants who started their contraceptive journeys more recently, access to diaphragms and caps differed dramatically when compared to those obtaining these methods in previous decades.

For younger participants, or those who started their journeys in pursuit of cervical barrier methods more recently, the trajectory, although in no way standardized, often followed a similar pattern: identifying the need for non-hormonal methods, conducting research about them to gain more information, consultation with a medical practitioner, acquisition or attempted acquisition (as some participants had, at the time of interview, not actually yet obtained cervical barrier methods), and use. The initial identification of a need for non-hormonal methods was often due to previous bad experiences with hormonal methods (mild reactions or serious medical crises), preconceived beliefs about them, or religious reasons. Most participants used the internet as a precursory research tool in

conducting searches for information about cervical barrier methods. Some visited clinic or medical websites (i.e. Planned Parenthood's website), some became involved with online forums as observers, participants, or both, some watched videos on sites like Youtube, and some used the communities that have emerged on Facebook as information resources. Many consulted medical practitioners for information about contraceptive methods, while some sought the advice of friends and family. After information searches were conducted, most participants made appointments with medical practitioners (typically doctors or nurse practitioners). Here, participants received varying levels of support; a large number of participants were faced with resistance from their practitioners ranging from a minor attempt at dissuasion resulting in participants ultimately gaining a prescription for a non-hormonal method, to outright refusal and the insistence that they stick with long-acting methods like IUDs or hormonal methods. In a few extreme cases, participants were ridiculed by their practitioners for their request; many who weren't ridiculed were viewed with perplexity or confusion.

In many cases participants would have to advocate for themselves and essentially insist upon non-hormonal methods; some had to switch to different practitioners in order to achieve this. Some participants were fortunate to have supportive practitioners, but some of these more supportive doctors and nurses were at times misinformed or unaware of the presently marginalized status of cervical barriers. A few participants did have a smooth journey throughout, but those experiences were relatively rare overall. Not all participants made it to the use phase, but those who did describe the learning curve for insertion, the need to learn their own anatomy to properly use the method, the pros and cons (natural but messy, etc.). Some talk about liking cervical barriers so much that they'd want to share

information about them with their friends; others express embarrassment at the fact they are using an unpopular method and choose to keep it from their friends. The above descriptions of participants only briefly touch upon their journeys in seeking and using cervical barriers. The following chapter will explore, in-depth, participant experiences as they relate to the research questions that drive this study; evident instances of authoritative knowledge, collaborative information behavior, embodied knowledge, and subversive information sharing and will be discussed at length in the context following chapter. Additionally, the next chapter analyzes participant experiences and narratives in detail, identifying and explaining themes, and linking them to theoretical perspectives that can help better illuminate them.

7 Participant Experiences

I contacted multiple doctors and nurses. I contacted my usual clinic and asked if it was possible to get fitted for a diaphragm. I was very much talked down to during that conversation. I was told it was an irresponsible method of contraception, I was told it had a “pathetic failure rate”, and I was encouraged to take hormones again. Other doctors ignored me and refused to return my calls. Every conversation I had with doctors and nurses disparaged cervical barriers, and encouraged hormonal contraception. – Poppy

The above quote exemplifies the challenges many women seeking a cervical barrier may face while navigating the systems of medicine in westernized countries; there are typically roadblocks, be they informational, medical, or pharmaceutical. Thus, the impetus for this chapter is further interrogating this ordeal as well as the informational and medical landscapes that undergird it. While the general stages encountered when endeavoring to use a cervical barrier method as a form of contraception were briefly outlined in the previous chapter, detailed descriptions of how of participants in this study embark on becoming informed about these methods, how they interact with medical practitioners to begin the process of obtaining these methods, and ultimately, the ways in which they must come to know their bodies in order to use diaphragms and caps will be chronicled here. The research questions guiding this study center on informational encounters and access, authoritative knowledge, information sharing and subversive information practices.

Explicitly stated, the research questions guiding this chapter are as follows:

- 1) How have women’s knowledges (embodied and otherwise) been subjugated and repressed by a climate of patriarchal, science-dominated medicine? Are women actively circumventing the idea of authoritative knowledge in favour of women-centred communities of information sharing, and if so, how?

- 2) How do women interested in the diaphragm as a contraceptive method gain knowledge about their methods, and how do communities of women work collaboratively to facilitate the sharing of knowledge about this form of contraception?
- 3) Does the marginalization of women's knowledge facilitate strategies that women undertake to challenge the boundaries to accessing this information, and if so, do these strategies constitute acts of subversion?

In applying these questions to participant experiences throughout their contraceptive journeys, it becomes clear that the medicalization of women's bodies and lives has very concrete implications for women seeking cervical barriers, and that the informational landscape therein is a rugged terrain that requires very specific informational strategies in order to navigate.

7.1 Becoming Informed: Learning, Sharing and Generativity

The ways women became informed about cervical barriers, how they navigated difficult or inaccurate informational terrain, strategies they undertook to circumvent information barriers, and their views or interactions with information sharing are key aspects of this study. Access to health information is essential to making informed and empowered choices about one's own health. As Frances D'Souza states, "Of course, information alone is not enough; women also need access to services in order to act upon their choices. But it is the information--when it is accessible, comprehensible and unbiased--that makes the crucial difference between services that are designed to promote societal goals, however well-intentioned, and services that empower women to make their

own choices.”⁵⁰⁶ What is evident from participants’ informational experiences while seeking cervical barriers is that an informational realm that tells women they have contraceptive choice and that there is empowerment in acting on this choice fails to deliver its message in practice. A marketplace of options described in contraceptive literature is not quite as well-stocked as women in western societies have come to believe. And while D’Souza implies that empowerment derives from the ability to exercise choice (and I certainly tend to agree with this assertion), an odd outcome is that sometimes the inhibition of choice via informational barriers advances even greater empowerment through alternative strategies and subversive acts.

Information seeking happened throughout participants’ pursuits of cervical barrier methods, and thus represents a continuing and ongoing process interwoven into all aspects of contraception seeking. Throughout, processes of becoming informed, information sharing, and navigating and circumventing information barriers play key roles. Participants sought information about contraceptive methods in general, cervical barriers in particular, and engaged in information seeking with regard to formal medical channels (i.e. how to get fitted for a diaphragm) and pharmaceutical (i.e. where to purchase a diaphragm) networks; information about efficacy and use was sought in the majority of participant experiences.

All participants conducted various informational searches regarding cervical barrier methods. In the cases of participants who sought diaphragms or cervical caps before the internet had mainstream accessibility, these methods were recommended to them by

⁵⁰⁶ Frances D’Souza, "Preface" in *The Right to Know* ed. Sandra Coliver (London: Article 19, 1995), xiv

their practitioners or friends and family, and additional information was gathered via womens' groups or pamphlets. For Liz, it was her gynecologist who recommended the Lea's Shield cap fifteen years prior to being interviewed and provided her the bulk of her information. Liz notes that "I had no internet back then. But I've been reading a lot about barrier methods later, mostly out of curiosity." Internet searches proved vital later on when she had trouble finding spermicidal jelly. Further, Liz notes that internet searches assisted her in buying the last local stock of her discontinued contraceptive device:

I read forums when I was searching for Lea's Shield in Canada and learned about all the restrictions and difficulties to obtain it. That was 10 years ago. But I managed to buy the very last Lea's Shield at a women's clinic in Toronto (which I found through the internet). I joked about Seinfeld's 'spongeworkiness' episode with the nurse who held it for me after I had called the clinic so I could buy it. Sad times. I am also interested in spermicides to use with my shield and did a lot of research on that.

Cordelia sought information about cervical caps at a feminist bookstore in the late 1980s and drew on information pamphlets and a face-to-face discussion group to learn more about the method. She joined an online cervical barrier group later on, not to gain additional information for herself, but to interact with other women using the method. Lynn learned about cervical caps in the late 1980s as well, when her boyfriend told her about his ex-girlfriend's experiences with cervical barriers. She participated in a study on cervical caps to actually obtain her barrier, and describes acquiring much of her information "in the form of xeroxed articles from the women's health group who ran the study I participated in." She later used the internet to discover that the Prentif cap was no longer available in the US, and then subsequently to discover that the Lea's Shield was discontinued as well.

Even if participants did not end up acquiring a cervical barrier, either informal or formal research was conducted at some point. Formal and informal informational searches

were conducted online, among peers, and in medical consultative scenarios, and the aforementioned sources are conceptualized in this study as mainstream channels, as they are accessed in primary information seeking. More explicitly, participants conducted online searches, read pamphlets and other medical/health literature, and discussed contraception with others (friends, family, co-workers). In many participants' experiences, information about cervical barriers could only be sourced online. Poppy echoes this sentiment: "There is a lack of information on cervical barriers as it is not a popular method of contraception. I found all of my information online, from sites such as the American organisation for Planned Parenthood, and the UK Family Planning Association. I had received no information on cervical barriers as part of my sex education in school, and none of my friends use this method so could not give advice." While Poppy did not receive comprehensive sex education in school, Chloe's experience was the opposite: "Sex ed in the UK is excellent. I was told about all methods available at the time I was in education." Some participants went straight to a medical practitioner for first-line information. Many participants began their online informational journeys with a simple Google search. Tara describes her online information process after searching for information about actually obtaining a diaphragm and finding that they are no longer easy to get in the US. After reading as much as she could online about the Caya device, she ultimately ended up ordering one from the UK. Jen also conducted research in medical journals to learn more about the efficacy of the Caya diaphragm, as well as comparative efficacy data between the cervical cap and diaphragm.

Many participants had issues actually obtaining a diaphragm or cap because practitioners themselves or other informational resources were misinformed about their

availability. Tara was fitted for a conventional diaphragm but ended up ordering a Caya device because she couldn't find a diaphragm locally: "I did call around to pharmacies once I got the prescription, but nobody knew how to/could order one." Even though Milet diaphragms were still being manufactured and could be special ordered, Tara "just assumed since everywhere I called, even my regular mom and pop pharmacy, that they weren't available at all. A lot of my internet reading said the same." For Jen, the misinformation online about diaphragm accessibility made her more determined to get one:

As soon as I found out that it was going to be difficult to obtain a fitting for a diaphragm, I became even more determined to do so. I had feelings of indignation that this method, which was advertised on government websites etc. as a reliable form of birth control was not easily available to me.

Beth expresses frustration over not being able to purchase spermicide anymore and states that she doesn't "know where to find anything." She says her doctor told her to use a general lubricant, but that is counter to what her doctors told her to do in the early 1990s when she first started using a diaphragm. She expresses frustration at the lack of clear information regarding whether diaphragms need to be used with spermicide or not, and given that most stores have stopped carrying spermicide, she is unsure of where she can actually obtain it if it should be used. Like Tara, Jen ended up ordering a Caya because a traditional diaphragm didn't seem within reach. The availability of one-size-fits all diaphragms and cervical caps helps fill a marketplace void for women who cannot find diaphragm fitters or traditional diaphragm devices locally, however, it does not mitigate the issue of misinformation online.

If mainstream channels failed to convey the desired information, more obscure informational sources were sought, such as very specific online contraceptive forums, and

in the case of sixteen participants, via a closed online group dedicated solely to the topic of cervical barrier methods. Jamie believes that the informational landscape surrounding reproductive health issues is rife with bias and inaccuracies, and therefore those seeking this type of information must make a concerted effort to find it: “I think this is why people who use menstrual cups and diaphragms tend to be somewhat fanatical—we can’t afford to be blasé about something that is politically and personally powerful. We have to basically fight for accurate, unbiased information, and we have to fight to discuss and disseminate our personal experiences.”

Information behavior in the context of cervical barrier seekers and users is not limited to information-seeking; in many instances, sharing information and hearing and reading experiential accounts of cervical barrier use are important facets of participants’ contraceptive journeys. While most participants did some preliminary research on barrier methods after identifying a need or interest in these forms of contraception (or alternatively they went straight to medical practitioners for information), additional information was often sought throughout different stages in the contraceptive trajectory. Many participants conducted additional information searches after disappointing or frustrating medical consultations, after finding barrier methods difficult to actually obtain, or after becoming confused or wanting confirmation of proper use when actually beginning the use stage. Instances of serendipitous information were also present, as several participants subscribed to a feminist news page on Facebook saw an article about Caya diaphragms and began to engage with others in the discussion proceeding the article. For a few of these particular participants, seeing this article prompted an interest in cervical barriers and a desire to learn more.

In this study, themes of sharing and generativity manifest when participants want to share information with others about cervical barrier methods or gain information from their peers. This may include telling friends about diaphragms, posting in forums, showing friends how to use/insert diaphragms, or even allowing medical students to observe their cervical barrier consultations as patients in medical consultations. Some participants stated a desire to spread the word about alternative contraceptive methods and share information with others. Others describe hearing about diaphragms and caps from other friends or relatives. Because diaphragms and cervical caps are uncommon contraceptive methods in present day, turning to peer networks to discuss, for example more common methods such as oral contraceptives or IUDs, was often not an option for participants. If they wanted to hear personal accounts of other women using cervical barrier methods, they would typically have to go online for accounts from strangers. Sixteen participants were able to locate and join a closed online discussion group dedicated to cervical barrier methods, where they were able to gain experiential accounts of diaphragm and cap usage, as well as share information about their own experiences.

Poppy's difficulty in locating information about cervical barriers led her to the closed diaphragm and caps group online. For her, the group provided not only important information about how to find an experienced fitter and obtain a cervical barrier, but it also assisted her in feeling as though she was not alone in her journey:

This has been a great support to me, as I now realize I am not the only woman to be treated poorly by doctors when trying to obtain a cervical barrier. It is both comforting and frustrating to know that my situation is not unique. All women should be able to choose the method of contraception which fits their lifestyle best, but it not easy to get this information and service from doctors. So, we help ourselves and pool or knowledge in these groups and forums.

After being treated poorly by her doctors, Evie joined the online group when she “lost faith in the NHS.” The group made her feel “that I wasn’t alone in wanting to use the diaphragm,” however, she still feels like an outlier as “most of the women in the group are 30+ and I am only 20”. For Evie, the group was the only source of accurate and up-to-date information about cervical barriers, and she notes the irony of the fact that her NHS clinic stocked leaflets about the diaphragm despite not offering fittings for them. Stacey describes looking at a number of online sources, including Planned Parenthood, Scarleteen, blogs and forums that discussed natural birth control methods. In her experience, information was widely available, but its availability was incongruous with the actual contraceptive marketplace:

I think what’s most frustrating is that there’s this mythology of ‘choice’ when it comes to birth control – that there are so many options – which is true on one level. But in reality, the majority of hormonal-base methods work on the body in the same way, leaving fewer options than it seems if you don’t want or can’t do hormones. Perhaps that disconnect is what is most frustrating. We learn the methods exist and then have trouble obtaining them!

This mythology of choice Stacey describes was something several other participants alluded to when they conducted their informational searches about cervical barrier methods, found a wealth of information but then realized there was difficulty getting fitted or obtaining a cervical barrier device. For Stacey, the online diaphragms and caps group was an invaluable source of information. She states that the group was the most useful, because “the group is active, and questions usually get answers – so rather than hoping to find an answer somewhere on the internet based on searches, you can ask real people your exact question. It’s definitely the best resource I’ve found for practical reasons.” She suggests that this real-time support network allows women considering cervical barrier

methods to be more persistent in locating practitioners who support these methods as well as the devices themselves: “The group arms women with a lot of information which they can take with them to be firm about what they want when they’re actually at the clinic. Plus, all the online resources the group has aggregated really helps people like me who don’t live near metropolitan areas.”

Lucy turned to the diaphragms and caps group after searching online and not finding much information. She had looked at parenting forums but found a generally negative representation of cervical barriers and ended up at the dedicated group for more detailed information. She has used the group to ask questions about fit and says that it “seems to be the only place to get good information and your questions answered.” Jen also used the internet as her sole source of information for diaphragms and caps and also found the group to be the best resource available. She states,

I did little to no research before visiting the gynecologist, but when I learned that she would not offer this as an option, my curiosity was peaked to say the least, and I started to do more focused research. I discovered the diaphragm discussion group, which was the most valuable source for experiential discussion. Official websites about birth control offered only minimal statistical information but not much about who else was using this form of birth control, what it was like to actually use one, etc.

After learning that both the Prentif and Lea’s Shield caps were discontinued, Lynne turned to the group for more information and describes it as being an “invaluable” resource: “I believe that’s how I found out about the place in Germany that sells the Lea’s Shields and other barrier methods. I would have been hesitant to order from them (as they have different ordering protocols in Europe than we do here – they ask for a bank account number!), but many other group members have done so successfully.”

As outlined above, many participants describe hearing the experiences of others as beneficial to their decision-making processes. One participant, Astrid, learned of the diaphragm through a friend of her aunt's through casual conversation. Hearing of this older woman's experiences piqued her interest in the method, and she gained a great deal of information by simply asking questions in an informal setting. Despite not seeking out information on cervical barriers, and sort of stumbling across it, Astrid set on a path to obtain a cervical barrier: "it's crazy, this one meeting with this one woman kind of changed my whole life." Astrid notes that while she does talk to many peers and other women about birth control, her aunt's friend was the first person she'd ever discussed diaphragms with. Following that conversation, she conducted an online information search that ultimately led her to the group. Astrid had no problems finding general information online, but states that, "the group is a little different because it is actual women and their experiences and it is a constant stream of info. Even now it helps me keep going with it or hear about updates." For Astrid, general online information and experiential accounts of diaphragm use were both useful, but the ability to interact with other users and ask questions makes the informational experience "more real, rather than reading medical sites or brands trying to sell things." She notes that in the group, "people are pretty supportive and quick responding and most people are very frank about opinions and answers; I don't feel weird asking anything because everyone is there for the same reason."

Jen's experience with the diaphragm and caps group demonstrates/indicates a desire to hear the experiences of other women:

I found the forum to be a wealth of information. It was interesting to hear of other women having the same struggle and looking for the same option I was. I was connected to some valuable on-line resources through the group, and it was also useful to hear of real life

experiences of women trying different methods in order to discover the one that worked best for them.

Like Jen, many participants describe reaping some benefit from reading or hearing the experiences of other women with regard to contraceptives. Thus, in many cases forums, discussion groups, or social media were consulted. Poppy notes that, “There is a wonderful online support in these communities, and it is important that we share our knowledge so it is not forgotten.” Jen says that she tries to share information about cervical barrier methods in person to her peers, but contends that online communities such as the closed group play an important role as well given that “many people turn to the internet for more private or sensitive topics (such as sexuality and birth control) when they can remain anonymous and keep more of an observing role.” Cordelia feels that online communities will continue to play a huge role in facilitating information exchange about cervical barrier methods because “these are becoming the main method of exchange of information, at least in the developing world.”

Although Lynne is confident with her cervical barrier usage, she participates in the group so that she can share information about it and give an honest list of pros and cons to interested parties. She states that,

It’s an uphill battle for most women wishing to use a barrier...especially when switching from another method. As I mentioned earlier, there can be a learning curve as well, and the support and encouragement you can receive through a group is invaluable. I see the stories of the women on the group, and figure most of them would have given up if not for the group!

Beth expresses frustration that women her age (in their 40s and 50s) in New England are modest and don’t talk openly about sex with one another: “I try! And they don’t talk” However, she notes that in Seattle she has a “tribe of women” who talk about anything and

love to share information with one another. For Beth, the need to share information is vital: “If I don’t talk about it, I might die. So I’m going to talk about it while I have the chance!” Astrid believes that groups like the diaphragms and caps group will continue to be utilized by women as production continues to cease for these methods: “I think women will take to groups or looking online, which leads to groups, to find out where other people are getting them from. Or what other people have done. Or just to share when they run into a major problem or have some sort of success.” She also tries to share information about cervical barriers to her face-to-face peers:

I know that I try to encourage people when they talk about changing birth control because with everyone looking at you like you’re crazy for wanting this ‘outdated’ method, it’s nice to know that there are still people out there that use it. I’ve started talking to people about it a lot. The longer I go without getting pregnant the more I’m like YES, DO IT.

Jamie asserts that the only way to keep cervical barriers alive is to share information about them:

Sharing information is the only way to keep it accessible. I have high hopes that we may see an uptick in popularity. The menstrual cup has exploded in popularity (in a small way) and more and more people have heard of it. It’s in many grocery stores even. I think they go hand in hand. Genital knowledge, environmental consciousness, DIY mindset.

However, Jamie also contends that there may be an equity issue at play. They state that, “I do however think that knowledge sharing is almost entirely dependent on internet access, so there is a major digital divide that is pretty much on class/race lines.”

Tara is happy to share information about her Caya to any interested parties but jokes that she doesn’t “want to be that crazy friend who won’t shut up about her birth control!” Some participants also expressed a desire for privacy and a preference to not talk about their cervical barrier methods with their peers; these participants tended to be younger and have

friends who mainly used hormonal methods and who were unfamiliar with diaphragms and caps.

A few participants describe allowing their own bodies to become informational sources about cervical barriers by allowing themselves to be examples for other parties, be them curious women or unfamiliar practitioners. In Jamie's experience, their doctor was accompanied by an intern who was in her final week of pelvic rotation, had never seen a diaphragm fitting before, and was very interested in observing Jamie's appointment. Jamie was happy to help educate the intern and made sure to explain their previous medical trauma and boundaries before the fitting: "The intern had never worked with a survivor, so I felt really good about explaining that to her. Like maybe my patient explanation will help her to be a great doctor to other survivors who might not be as articulate or able to advocate for themselves." Jamie describes the process of learning how to insert the diaphragm under the watchful eye of the doctor and the intern: "Strangely, I didn't feel embarrassed at all. The doc and her intern were in the room watching with interest while I was squatting and bleeding [Jamie was menstruating at the time] and talking excitedly about my cervix. It actually felt really empowering and fun." The intern requested to feel the diaphragm inside of Jamie to get a sense of what proper placement felt like, since she had never seen or touched one before, and Jamie was happy to oblige: "I was feeling really comfortable and really liked the idea of helping this new professional be great at her job, so I said sure. She had some trouble finding my cervix (it feels odd when covered by a sheet of silicone!) so I wiggled my behind and helped her reach it. And then her face got that 'aha' look. It was awesome."

Tara is confident in the fit of her Caya diaphragm and doesn't require a professional fitting, but the lack of practitioner knowledge about the device has led her to consider bringing it to appointments to show her doctor: "I have considered showing it to him at my yearly appointment so if anyone else ever asks he can give them some sort of answer. I just think women need to know what's out there. I was put on the pill at 14 for endometriosis symptoms with no real discussion...I look back now and think, huh, there could have been a lot of other options."

Cassandra is quite fond of combining cervical barrier methods and FAM. While she uses an app now (Kindara), at the time of her diaphragm fitting she was using Cycle Beads. Her doctor had his nurses come into the room to learn more about Cycle Beads and she also showed them her Diva menstrual cup since many of them hadn't seen one before. Her doctor then told her, prior to her diaphragm fitting, that "a lot of the nurses, they're really curious about this. So they want to know if they can come in for the fitting." Cassandra was okay with this since the nurses were all women, and she says she isn't shy. The nurses observed the diaphragm fitting since it represented a rare opportunity to observe the process in action.

Another participant, Jessica, offered her friends and colleagues the opportunity to observe her body in the context of a Caya diaphragm insertion, after showing them the device and hearing their comments that it looked uncomfortably large. Jessica offered to show them how she used the Caya and they expressed interest and were more open to the method after seeing how easy it was to put in. Jessica explains that, "After I put it in, I told [my friend] to wash her hands and see if she could feel inside of me and she couldn't. She washed her hands again as [my coworker] offered to see if she could feel her IUS strings

and she said the Caya is more discreet than the IUS.” Jessica allowed her own body to become an information source for her peers, allowing them to imagine Jessica’s embodiment as their own. These participants who allowed their bodies to be observed by others all express a desire to share information and to propagate knowledge of barrier methods; as Jessica states, “knowledge is like money – share it around and it will grow.”

Many participants in this study describe a desire to spread the word about cervical barrier methods and propagate information about them. For Marianna, sharing knowledge with other women is a powerful act: “I share info on [two online groups] all the time about Fertility Awareness. I’ve converted a few! I love the power of the internet. The power of communities. The power of sharing knowledge.”

7.2 Negotiated Interactions

Modern western medicine advances the notion of practitioner as expert,⁵⁰⁷ and contraceptive consultations typically involve a practitioner offering the final say as to which method is best suited for the patient in question. While, as Rivano Eckerdal⁵⁰⁸ notes, birth control consultations are negotiations between practitioner and patient, participants in this study frequently describe being ignored or minimized within medical interactions. In a negotiated power dynamic, a practitioner might listen to their patient’s concerns and then work with the patient to determine a mutually agreed upon best outcome. In this

⁵⁰⁷ Renee Gravois Lee and Theresa Garvin, “Moving From Information Transfer to Information Exchange in Health and Health Care,” *Social Science and Medicine* 56(2003): 449-464.

⁵⁰⁸ Johanna Rivano Eckerdal, “To Jointly Negotiate a Personal Decision: A Qualitative Study on Information Literacy Practices in Midwifery Counselling About Contraceptives At Youth Centres in Southern Sweden,” *Information Research* 16, no. 1 (March, 2011), <http://www.informationr.net/ir/16-1/paper466.html>.

consultative scenario, the patient articulates her motivations, concerns and any specific requests, and the practitioner would work with the patient to explain, in detail, what outcomes can be achieved and strategies for achieving them. If a patient, for example, has a particular request for birth control, in a negotiated scenario, the practitioner's role would be to ensure no contraindications (i.e. high risk of stroke would contraindicate hormonal contraceptives), prescribe the requested method of contraception and thoroughly explain its efficacy and best practices for efficacious use. Personal bias against specific methods have no place in a negotiated contraceptive consultation.

In Rivano Eckerdal's analysis of contraceptive consultations between midwives and patients, she describes a tendency for encounters to follow a similar trajectory:

When the topic of contraceptives was brought into the conversation, midwives would ask the young women if they had any idea of what kind of contraceptive they would like to use, or similar questions. Midwives often followed up the answers by asking young women why they were interested in this or that contraceptive. Young women then explained their interest by referring to their information sources: *'those I know that have used it and it works really well for them'* (Young woman in meeting 1). Already at this point the choice can in retrospect be said to have been made in all the meetings in the study. The contraceptive that young women put forth in the beginning was the contraceptive to be prescribed at the end of the meeting unless a medical reason for avoiding it came up during the meeting.⁵⁰⁹

Rivano Eckerdal's case studies represent a place and ideologically specific type of contraceptive encounter, occurring in the strong socially democratic country of Sweden and demonstrating a women-centered medical perspective via midwifery. Being more egalitarian and women-driven, the midwife encounter in Rivano Eckerdal's study is

⁵⁰⁹ Ibid.

typically a negotiated one. She notes that the midwives in her study emphasize the importance of patient choice and reject their own roles as ones of agenda imposition:

Midwives avoided giving explicit advice concerning what to choose, a main goal being that the young women chose a contraceptive and that the choice was formulated as their own. One midwife put it like this: *'I want them to feel like they are the ones who chose it, with me as a consultant. Because otherwise they won't use contraceptives, if they don't feel like they chose it themselves.'* (Interview with midwife 9). They strive to formulate the choice as the young women's own choice, a work that was done both by the midwives and by most of the young women, reflects the high value given to decision-making as an important expression of identity creation in late modernity.⁵¹⁰

While a large percentage of participants in my own study encountered resistance, pushback, ridicule or refusal in their consultations with practitioners, a number of them also experienced fruitful and negotiated exchanges. Those incidences are described below.

Liz had a positive experience with her doctor, who was the one to recommend a barrier method for her initially, several years ago in Europe. Suggesting it as an alternative to hormonal methods after a diagnosis of high blood pressure, Liz's doctor worked with her to find an appropriate contraceptive method. After Evie's initially negative experiences with authoritative practitioners, she went to a private Marie Stopes clinic and experienced better engaged practitioners: "It was great, I was treated like a person and not a number. She discussed why I had been on the pill and why I wanted to come off it, and explained how the cap works rather than dismissing it." Evie feels annoyed that she had to go to a private clinic to "get heard," but is happy that she ultimately got what she wanted. She also notes that the instruction on using a diaphragm was very thorough: "I had a good hour with

⁵¹⁰ Ibid.

the Dr. practicing how to insert it and remove it.” Stacey describes a fairly positive encounter with her practitioner when obtaining her FemCap: “The woman who prescribed my FemCap was supportive of that choice because she could tell I was clear about wanting to use it. When I had the follow up appointment with the local midwife, she told me to use the FemCap but to take folic acid supplements ‘just in case.’ She also encouraged me to learn about fertility awareness, which I had already planned to do.” Lucy’s initial interaction with a practitioner was very positive -- her practice nurse was able to properly fit her for a diaphragm without any issue and the nurse even remarked that she had used a diaphragm in the past. Although her nurse commented that the method wasn’t as popular anymore, Lucy felt comfortable in this interaction.

Jamie has had mixed interactions with different practitioners but describes one fruitful and negotiated encounter with a practitioner who truly listened to their concerns and made suggestions based on Jamie’s needs. In this encounter, Jamie was about to undergo tubal ligation surgery and had a panic attack before the procedure. This particular doctor wanted to ensure that Jamie’s mental health was addressed before any permanent decisions were made going forward, so she and Jamie were “strategizing together about options,” and the doctor suggested that Jamie talk to their therapist before going through with surgery or choosing an alternate form of birth control. Jamie notes that there was nothing “paternalistic” about this doctor and that she truly worked with Jamie’s best interests at heart; it is a great example of a negotiated interaction in practice.

Jocelyn also describes a positive encounter with her physicians when seeking a diaphragm:

My doctors (both primary care practitioner and GYN) were very welcoming to the idea of non-hormonal forms of birth control and

FAM. This may be because they are located in a city which has a reputation of being more liberal and also more open to natural/holistic lifestyles. The diaphragm was simpler than I expected to obtain. I had heard stories of practitioners fitting diaphragms incorrectly, receptionists not even knowing what one was, or doctors unsure of where to obtain a diaphragm. My experience was very easy. My doctor understood what I wanted and she fitted me correctly.

Anticipating difficulties based on other stories, Jocelyn attributes her smooth experience to living in a region with liberal values. Indeed, a negotiated experience requires practitioners to embrace feminist approaches to medicine.

Like Evie, Maggie too had initially negative experiences with the NHS and a positive, negotiated encounter with a doctor at a private clinic in the UK: “I was treated like a person and not some disillusioned kid.” She notes that her doctor was impressed with her contraceptive history and “seemed to think I knew what I was talking about and said if I wanted a diaphragm I could have one.” The doctor was thorough in explaining her options, but ultimately worked with Maggie to get her the method that she wanted. Ensuring that Maggie knew how to properly use the diaphragm, “she was very thorough, put it in and withdrew it a couple of times then made me do the same.”

Alicia has private coverage through her employer in the UK, and her quest for a diaphragm went smoothly from start to finish. Deciding to remove her IUD and use a diaphragm temporarily before trying to start a family, she was able to walk out with her cervical barrier 30 minutes after her initial appointment. Noting that she was very lucky in her experience based on things she’d heard from other women, she also describes her doctor as being supportive: “The doctor said it was delightfully old fashioned and that she hadn’t fitted one for a while, but she did say that a woman should be free to choose her own contraception and if I wanted one I could have one.” This echoes the assertions of the

midwives in Rivano Eckerdal's study -- a negotiated encounter means that the patient's choice is respected and interventions are only made if medically necessary.

Anya describes the importance of having a practitioner who enacts mutual trust. The diaphragm was suggested to her by her practitioner in 1992 after she encountered side effects from the birth control pill. Her practitioner at the time described the diaphragm as having an efficacy rate close to that of the pill with "correct usage," and this helped Anya feel confident in using it. She states that "I had a wonderful and special gynecologist for many, many years who was very honest with me about every aspect of my care. She was a trusted confidante for many years until she had to retire early due to Parkinson's." Anya contends that she is very lucky in her experiences with medical practitioners, and even though her favorite gynecologist is retired, her current one "is not judgmental and is factual and forthcoming, which I appreciate." For Anya, the notion that a doctor might attempt to impose a contraceptive trajectory onto a patient is "ridiculous."

Mariana too has had mixed experiences with medical practitioners, but describes an encounter with a nurse practitioner who respected her decision to use a cervical barrier and worked to ensure that she was able to get the type of contraception she wanted:

So the doctor (actually Nurse Practitioner) at the university health center was a VERY good listener. She was impressed at my knowledge about contraceptive options. She heard me when I said I was wary of hormones, and she gave me the lowest dose pill that was available and said that if I didn't like it, I wouldn't have to take it. She was also the person that, when I went back to the health service crying about not wanting to take the pills anymore because they didn't align with my values, prescribed me my FemCap!!!

While the nurse practitioner was not very knowledgeable about FemCaps, she researched on behalf of Mariana to locate pharmacies that carried the product and messaged Mariana back-and-forth through her clinic's online health portal. Ultimately, Mariana had to locate

her own FemCap by contacting the company directly, but she acknowledges the importance of a positive practitioner-patient relationship: “The best thing about the experience was that I felt she trusted me. She was very supportive.”

The above experiences of participants depict negotiated practitioner-patient interactions wherein patient needs and desires are respected and their contraceptive of choice, unless explicitly medically contraindicated, is what is ultimately prescribed. These encounters are described favorably by participants, and whenever participants did have smooth and positive contraceptive consultations, they indicate that this was a pleasing and desired outcome. Many participants who experienced negotiated consultations note their “luck” in such scenarios; this is because their peers have told them about medical interactions that do not go quite so smoothly. There seems to be a common feeling among women in this study that not all doctors and practitioners are there to listen and support, and that, contrarily, they may be more imposing or judgmental with regard to prescribing contraceptives. Encounters more reflective of this -- ones I’ve deemed “authoritative encounters” -- will be explicated below.

7.3 Authoritarian and Authoritative

While the participant encounters described above reflect positive, negotiated consultations with medical practitioners, these experiences are not reflective of participant encounters as a whole. The notion of a negotiated medical interaction is unfortunately an idealized one, and often does not reflect reality. Participants in this study describe their doctors or nurse practitioners at times imposing an agenda that includes hormonal or long-acting contraceptive methods, which are usually described in consultations as having higher efficacy rates than cervical barriers. While some participants had the ideal

“negotiated” experiences with practitioners wherein they felt legitimately listened to and respected, there were repeated accounts of the opposite; this is indicative of authoritative knowledge in action. Thus, authoritative knowledge in the context of participant experiences typically refers to encounters with medical practitioners that reflect the notion that their doctor or practitioner knows best; in some cases, the practitioner implies that the participant lacks intelligence for inquiring about cervical barrier methods.

Some participants describe what they perceive as positive interactions with their practitioners, but upon reflection realize that their doctor or nurse advocated for a hormonal method or IUD in an effort to dissuade away from cervical barriers; even in scenarios where participants felt as though their concerns were legitimately being heard, efforts to impose methods they explicitly stated that they did not want were enacted by practitioners.

As Poppy’s quote at the head of this chapter shows, her practitioners approached her request for a barrier in different ways, arguing poor efficacy, irresponsibility, or outright ignoring her request. Poppy was pressured to take hormonal methods instead of getting the method that she was seeking. Evie experienced ridicule by her doctor in her first consultation for a cervical barrier: “My Doctor laughed and said if I give you a cap you will be back in 3 months for an abortion, and wasn’t interested. We have things called family planning clinics here which are also free and specialise in contraceptives for men and women. They didn’t want to know and suggested I went for an IUD.” She describes feeling as though her concerns weren’t being addressed: “he wanted me to have what he wanted, not what I wanted.” She felt embarrassed to be discussing contraceptives but felt even worse when her doctor laughed at her. After this she went to a family planning clinic with the hope that the predominately women practitioners would be more empathetic to

her concerns but she felt dismissed here as well since the practitioner she saw encouraged her to get an IUD and to use condoms. She says the staff listened to her concerns but still refused to prescribe a diaphragm. She ultimately went to a private clinic to obtain a diaphragm fitting and the diaphragm itself.

Despite Stacey's initially positive medical interactions (see above), future consultations were less negotiated and more authoritative: "When I moved to South Dakota, I asked whether they did diaphragm fittings at the women's clinic, and the doctor told me yes -- but then tried to talk me into getting an IUD after I'd had children instead." She notes that she felt the most resistance with this particular doctor in South Dakota, but that because she was just inquiring about the hypothetical future use of a diaphragm, she didn't feel the need to push back. Stacey also mentions recently taking an online course about contraception, and finding it troubling that the instructor heavily pushed hormonal methods and "was quite dismissive of women's concerns with hormones and cervical barriers for contraceptive use," which she finds "troubling, because the majority of people taking the class were future practitioners." While Stacey describes her initial consultation in positive contexts, her doctor's suggestion that she take folic acid in case of unwanted pregnancy hints at a lower efficacy rate and passively implies that pregnancy is a possible outcome. Several participants in this study also describe having to insist that pregnancy wouldn't be the end of the world for them if they were prescribed a barrier and it failed.

While Lucy didn't have a negative experience with a practitioner attempting to dissuade her from a diaphragm, she has been having difficulty finding a practitioner who can accurately fit her. A recent fitting was "rough" and caused her to tense up, which

resulted in a diaphragm that was too small. She attributes her difficulty in finding an experienced fitter to the lack of popularity of the method.

Jen has always personally felt opposed to hormonal methods of contraception, but “out of pressure from medical/social influences, felt [she] should try them when [she] first became sexually active (at 25 years) but discontinued it shortly after starting.” Ultimately deciding on a diaphragm, she visited a new-to-her gynecologist who refused to offer diaphragms or caps because the “failure rate is so high that they don’t make them anymore.” This practitioner, despite Jen stating that she did not want hormonal methods, went on to offer a NuvaRing, and then an IUD. Ultimately, she suggested Jen visit an “alternative clinic.” Jen, after calling four different clinics, finally found a doctor working out of a university clinic in Montreal, however she was unable to see this doctor because she was not a student at the time. Finally, through a naturopath, Jen was able to find a doctor that did diaphragm fittings. Jen notes that, “Even when speaking with the nurses during my appointment, they had to double check that they even had the resources necessary for the fitting. The doctor was very surprised when I told her how much trouble I had in finding someone to fit me. Her assumptions were that all her peers were able/willing to offer fittings.” Jen’s difficulty in locating an appropriate practitioner is demonstrative of lengths some women have to go to obtain a cervical barrier method; further, her experiences indicate that within the medical sector, practitioners may erroneously assume that even if they do not offer the service of barrier fittings, their peers will do so readily. This lack of practitioner awareness on diminishing cervical barrier practice puts women at a disadvantage and places the onus on the patient to persistently advocate and source her own care.

Cordelia sought a cervical cap in the late 1980s, researched on her own, and purchased her Prentif cap from a Boots chemist; it was not a popular method and she had the fit checked “reluctantly” by nurses at a sexual health clinic. She would intermittently have her fit checked there and ordered her own supplies directly from pharmacies or manufacturers. She notes the limited number of practitioners who currently possess the skill to fit barriers and adds that many of them place “a lot of pressure on you to take a pill or other hormones instead.”

Throughout Cordelia’s cervical barrier journey, she faced resistance and reluctance in finding practitioners to fit her, and their tendency to suggest hormonal methods instead represents the increased marginalization of barriers. Again, it was through her own persistence and self-empowerment that she was able to use the barrier of her choice until menopause, but mainstream medical practice did little to facilitate a smooth journey on her behalf.

Lynne’s experience was similar to Cordelia’s, also occurring in the late 1980s and involving cervical caps (Prentif and then later, Lea’s Shield). Like Cordelia, Lynne had to source her own caps and often faced practitioners who were unfamiliar with that method. She states that, “I did have my primary care physician prescribe me a couple of Prentif caps. I think I had to explain what it was and spell it out for her (and explain how it worked and how I knew about it) because she was not familiar with it. However, she did prescribe it for me without complaint.” Lynne’s experience meant a great deal of self-advocacy, but she was not met with resistance in the same way other participants were. In her case, being empowered with information about her desired method allowed her to communicate her

needs to her practitioner, who despite not being entirely familiar with the method, was still willing to prescribe it.

Astrid was easily able to find a practitioner to fit her for a diaphragm and was also able to obtain the actual device quite easily. She “didn’t have all the trouble that I’ve read about from other people,” but notes that her practitioner tried to dissuade her from the method:

She was surprised and she wasn’t very supportive, I guess is the word. She asked me if I had used condoms before and how good I was at using one every time. Because she said that while it is effective, there is a lot of ‘user error’ as in, people don’t always get it in and therefore it becomes ineffective. And she tried to talk me into some other forms of birth control, like had I thought about the IUD. She didn’t really want to do it [the fitting]. And had I not been so sure that this is what I was doing, I probably would have caved. She was always asking me, ‘You know what you are going to do if you get pregnant?’ That abortions weren’t a form of birth control...and I needed to be prepared. Honestly she scared the shit out of me. I was thinking ‘great now I’m getting pregnant because I want to try something different.’

Astrid describes feeling like her gynecologist was trying to make sure she knew what a big responsibility it was to have to insert a diaphragm each time before sex. Despite being frightened by what she heard. Astrid was assertive and told her doctor, “I am doing this and I want to do this. And thanks for the warning but I’m prepared for the consequences and I want to try.” Astrid’s doctor “wasn’t happy” and despite ensuring that Astrid was able to insert the diaphragm on her own a couple of times to make sure it felt comfortable, Astrid notes that, “I didn’t feel like she gave me all the information I wanted or that I even knew I needed until later. She barely even talked to me about using spermicide. The pharmacist is the one that told me, you must use spermicide. I don’t remember the doctor talking about it at all.”

As described above. Jamie's diaphragm consultation was a pleasant and negotiated one wherein Jamie's doctor respected their desire for cervical barrier and worked with them to achieve a good outcome. However, Jamie has had numerous experiences being misgendered by mainstream medical practice that is still working to understand the needs of transgender and gender non-binary patients:

On my first visit, I told them my preferred name, gender, and pronouns. They quickly changed my chart to reflect my name, but seemed unable to understand the gender/pronouns part. They kept misgendering me and actually called me 'girl' a few times, like in a cutesy way trying to build rapport – 'Hey girl, how are you?' kind of thing. It wasn't worth it to me to insist or overexplain. I won't have to see them ever again. If we were going to have an ongoing relationship, I might gently educate them. But at that point, I was pretty desperate to just get my birth control.

For Jamie, authoritative knowledge came not in the imposition of undesired contraceptive methods or a criticism of the desire to use a cervical barrier, but rather in a more overarching structural way. Because Jamie was assigned female at birth and desires pregnancy prevention, mainstream medical practice imposed its notions of normative gender identity upon them despite Jamie's explicit assertion of their own non-binary identity. This is oppositional to Jamie's own experience and knowledge of their bodily existence.

Maggie, like Evie, was laughed at by her practitioner when she requested a diaphragm in consultation. "First I went to see my GP and she laughed and said that she thought I wanted to avoid getting pregnant, so why use the diaphragm? I felt silly. There is a lot of pressure on doctors here to give LARC (long acting reversible contraception) such as the IUD/injection/implant as the UK has a high rate of teenage pregnancy and I was 19 at the time." Maggie told her practitioner that she would think about it and went to

a family planning clinic instead. She notes that the staff were more sympathetic there but still suggested hormonal pills and injections. Maggie felt like she was not taken seriously by the doctors she visited and ultimately went to a private health care center to obtain a diaphragm. While she is happy that she was finally able to get what she wanted and felt as though her needs were respected, the fact that she was laughed at by a physician is wholly problematic and showcases authoritative knowledge in action.

Esther experienced pushback from her physicians when she articulated that she had recently married at the age of 20 and was planning on conceiving within a couple of years; also, as an Orthodox Jewish woman, there were certain contraceptive methods that she could not use according to rules of her faith and she also preferred to not use hormones.. Despite these factors, doctors and nurses continually tried to persuade her to get an IUD or go on birth control pills:

I thought about the pill and I went to a gynecologist at my university, and they always kept trying to get me to get an IUD, which was really annoying. Because it's like, I want to like conceive in like a year or two, not 12 years, which is what they were trying to get me to get. So I kept telling them that and the gynecologist literally looked at me like I was crazy, and then told me I should take the pill or the NuvaRing. And I was like 'I'd really rather not do hormones because I have bad reactions to hormones.' So then I convinced her to give me the mini pill, which she really didn't want to give me. Because I didn't want to do estrogen and progesterone.

Esther had to see several practitioners before she found one who would prescribe a diaphragm for her. In each consultation, the IUD was recommended to her despite her insistence that she wanted to have children soon. At one consultation, her fiancé accompanied her and she states that his presence made her feel more assertive in refusing a hormonal method: "I was just really happy that my fiancé was there at that point because I felt like, kind of pressured and I would have just...I would have never gotten an IUD but

I would have just left without something I wanted.” She struggled to find a practitioner who could fit diaphragms and after contacting several clinics and practitioner offices, she finally went to Johns Hopkins for a fitting. Esther highlights the importance of going to Johns Hopkins because it is a large research institution and she felt as though if anyone could help her, this institution could. However, even here the gynecologist insisted that Esther get tested for STDs despite her very recent onset of sexual activity with a partner who had also been a virgin prior. Esther’s insistence that this testing was not required was met with resistance by the doctor.

Five years prior to being interviewed, Chloe was persuaded by a contraception nurse in the NHS to get an IUD fitted instead of getting the diaphragm she had asked for. The nurse didn’t think Chloe was old enough to safely use a diaphragm (she was 25 at the time) and was concerned that she hadn’t been with her partner for a long enough time. While Chloe had gone in for a diaphragm, the IUD was represented as an easy and effective method and so she agreed to get one; the IUD unfortunately moved out of place and caused her chronic pain and frequent bleeding for nearly 6 months until it was removed. It also aggravated a painful chronic condition called hypermobility. Chloe notes that “every time a health professional asks for my contraceptive history, I cry.” Despite her prior issues with the IUD, she returned to the contraceptive clinic and demanded a diaphragm. She was offered another IUD, and after asserting that she did not want one, was finally able to get fitted for a diaphragm. It took a traumatic contraceptive history and strong assertiveness for Chloe to finally get a cervical barrier, but she states that at this point in time she connected with a nurse practitioner who could see her desperation and obliged to listen to her needs and treat her with respect. The initial imposition of an IUD on Chloe despite her

requesting a diaphragm is counter to a negotiated consultation and fully demonstrative of authoritative knowledge at play.

Tara was able to get fitted for a diaphragm fairly easily; however, other methods were suggested to her and her doctor discouraged its use due to low efficacy rates:

When I got there the intake nurse seemed a little confused and asked if I was interested in any other options. Nope, here for a diaphragm. Anyway, the Dr. comes in and explains that he's happy to do a fitting, however, you can't get a diaphragm at a pharmacy anymore, you have to order it online. He additionally discouraged its use citing only an 86% effective rate. I had made up my mind though so I figured I would figure out how to get one later. He literally dusted off the samples to fit me, wrote me a script in case I needed it and sent me on my way. The nurse seemed to think I was a little nuts. She had never had a patient discuss one at all. The Dr. was initially a bit discouraging and after some serious searching brought me a pamphlet from the 80s citing the 86% effective rate, etc. I pulled up the latest numbers on my phone showing 94% and we discussed it, which was nice. I don't think he'll be suggesting it to other patients but he did ultimately respect my decision. Sidenote: It was actually my first time seeing this Dr. since my regular gyno just retired. I think he felt obligated to chat with me about it and discuss my options. I am also certain he will remember me my next visit.

Although she does note that the doctor ultimately respected her wishes, his attempt to dissuade her from a diaphragm with statistics, paired with the nurse's suggestion of other methods shows that authoritative knowledge creeps in even when it seems like patient needs are being respected by practitioners.

Isabel's gynecologist was surprised by her request for a diaphragm and willingly fit and prescribed one for her, but continually insisted that Isabel would decide she didn't like the method later on.

So I just scheduled an appointment with my OB and then I went in and told them, you know, what I was looking for and then actually was surprised because she said that not that many people come in

and ask for them. So she just wanted to know my reasons why and she was trying to talk to me about like Mirena and the other one but I just kept telling her like, I wasn't interested in those. But I did notice...it was funny because I kept saying like 'well I just at least want to try a diaphragm' and then she kept saying 'well...okay you can try it but, you know, pretty much when you decide you don't want to use it anymore let's look at these other things' [laughs]. It was just so weird because she kind of just assumed I would be back in a couple months like, not wanting to use it anymore. She was just kind of like 'well, if that's what you want, okay.' And she certainly was like, 'I'll go through, you know, everything you need to help you get one,' but there was like a preconceived like, 'okay, but when you want to switch this let's look at some other things.'

To suggest that a patient is making a wrong choice and will regret it, even if the practitioner is going along with the request for a cervical barrier, is entirely problematic and implies that the patient, in this case Isabel, is misinformed and better suited to other contraceptive methods. The gynecologist's suggestion that Isabel pre-emptively look at other methods for when she inevitably discontinues use of the diaphragm is yet another example of authoritative knowledge enacted.

Mariana describes feeling "judged" by her primary care doctor, an experience counter to the one described above with the practitioner at her university clinic. In addition to being judged, she felt that her doctor wanted specific answers from her rather than truly listening to her needs:

She was constantly staring at her computer screen, not taking the time to have a conversation with me. She posed "leading" questions. The types of questions that I feel warrant a specific answer that she's looking for. So even though I do not use condoms with my boyfriend anymore (because I've been in a monogamous relationship since I was 17), I told her that I did use condoms, all the time. I felt uncomfortable "admitting" that I used withdrawal, even though withdrawal is 96% effective with perfect use (contrary to what sex ed classes and doctors want you to believe). I knew she would tell me that it "wasn't a birth control method at all." I didn't have faith in her ability to listen to me or trust me.

The desire to be trusted and respected by practitioners was mentioned by several participants and reflects the reality that many seekers of contraceptives feel as though they can ascertain what is best for their own unique bodies; however, the fact that many practitioner encounters described in this study counter the characteristics of a negotiated interaction demonstrate that authoritative knowledge is frequently employed by practitioners.

Revisiting Jordan's concept of authoritative knowledge is a crucial exercise when considering the above experiences of participants in this study; two types of knowledge are at play in participant encounters with medical practitioners – mainstream medical knowledge, and embodied and experiential knowledge of the self. While these two types of knowledge are not necessarily in opposition to one another, as is evidenced by the negotiated interactions described by Rivano Eckerdal, in many cases mainstream medical knowledge is positioned as superior and more valid than the self-knowledge participants bring to their practitioner encounters. Again, Jordan's work on authoritative knowledge is pertinent to experiences of cervical barrier seekers and users; seekers of these methods in present day are typically relying on their own experiences of their bodies to guide them in their contraceptive decision making. Some have had bad reactions to hormones, others have religious considerations, and some simply want a method that offers them a greater connection to their own anatomy. Still, this self-awareness and embodiment that provides guiding information is generally dismissed by participants' care providers; the scientific data that doctors rely on regarding contraceptive efficacy trumps women's own experiences and embodied knowledge. Authoritative knowledge is the rule; negotiated

interactions that draw on participants' unique perspectives about their bodies are the exception.

In McKenzie's study on cognitive authority and the discursive information strategies of pregnant women, she notes that "Pregnant women used several forms of personal positioning to validate or contest the authority of information sources. They sometimes relied on themselves as cognitive authorities, using their own reasoning, bodies, or experience as evidence against which to test the authority of another source."⁵¹¹ Despite the authoritative informational positioning of medical practitioners, pregnant women adopted strategies to either accept or reject the information being given to them in consultative scenarios. At times they relied on their own experiences and bodies to determine which information they would accept and which information they would reject, similar to the participants in this study. As an example, one woman in McKenzie's study drew on past experiences with an ultrasound technician to discredit information about her current pregnancy; another pregnant woman in the study reduced her levels of physical activity based on what her own body was telling her.⁵¹² One of my research questions posited whether or not authoritative biomedical knowledge was serving to marginalize the unique embodied and experiential knowledge of seekers of cervical barrier methods; the answer to that question is unequivocally yes. However, some participants in this study adopt counterstrategies and enact subversive tactics to circumvent any subjugation of their own bodily knowledge systems by structural systems that privilege objectivist biomedical approaches; these strategies are discussed further below.

⁵¹¹ McKenzie, "Justifying Cognitive Authority Decisions," 281-282.

⁵¹² Ibid.

7.4 Embodied and Experiential Knowledge

Due to the intimate nature of cervical barrier methods, participants in this study often have a strong desire to know their bodies more thoroughly and are frequently able to articulate a sense of what is right for their own bodies; they rely on both experiential and embodied knowledge to guide them into finding a contraceptive method that works best for them. Marsha Schubert and Thomasina Borkman⁵¹³ define experiential knowledge as “based on wisdom and know-how gained through reflection upon personal lived experience.” Borkman differentiates experiential knowledge from the understandings of professionals (“professional knowledge”) and of individuals who have not gained knowledge through specific experiences (“lay knowledge”).⁵¹⁴ McKenzie describes experiential knowledge as being “transferred through the sharing of individual stories, often in self-help or mutual aid groups. Experienced peers can offer some specific forms of help.”⁵¹⁵ Embodied knowledge refers to the use of one’s own body as a source of information. As mentioned in Chapter 2, the notion of embodied knowledge is derived from the phenomenology of the French philosopher, Maurice Merleau-Ponty, who described the concept by using the example of touch typing.⁵¹⁶

As described in Chapter 2, the notion that living through the body imbues one with knowledge about the body has been drawn upon by feminist scholars, who view women as having unique embodied experiences via biological, psychological and social processes.

⁵¹³ Marsha A. Schubert and Thomasina Borkman, “Identifying the Experiential Knowledge Developed Within a Self-Help Group,” in *Understanding the Self-Help Organization: Frameworks and Findings* ed., Thomas J. Powell (Thousand Oaks, California: Sage, 1994):228-29

⁵¹⁴ Thomasina J. Borkman, “Experiential, Professional, and Lay Frames of Reference,” in *Working With Self-Help*, ed. Thomas J. Powell (Silver Springs, MD.: National Association of Social Workers Press, 1990),.3.

⁵¹⁵ McKenzie, *Cognitive Authority*, 279.

⁵¹⁶ Merleau-Ponty, *Phenomenology*, 144.

Utilizing this view to evaluate women's approaches to selecting and using contraceptives is fruitful, as the unique physiological needs of contraceptive users tend to dictate which methods are suitable. Further, some methods of contraception require a more nuanced knowledge of and interaction with the body, and the participants in this study offer many insights into how both experiential and embodied knowledge serve their contraceptive information seeking processes.

Fertility awareness methods are a prime example of embodied knowledge being applied to contraceptives; the menstrual cycle itself, temperature fluctuations and changes in cervical fluid as different hormonal processes occur can tell a woman a great deal about when she's ovulating and thus more likely to conceive. Several participants use fertility awareness methods in conjunction with a cervical barrier, and all describe enjoying being closer to their bodies' natural rhythms. For Mariana, using fertility awareness gives her a sense of empowerment: "I'll tell you right now that I feel extremely empowered by Fertility Awareness, I don't think it's hard anymore, I love it, and [my boyfriend] is on board now too. He loves that I love it and that I know my body so well."

With regard to cervical barriers, embodied knowledge is necessary for a woman to be able to precisely insert her barrier and ensure proper cervical coverage. Participants in this study who managed to obtain a cervical barrier method and actively use or previously used these methods rely on embodied knowledge to know if the method is not only working for them, but is a right fit, literally and figuratively. Liz describes initially being unsure of a proper fit for her Lea's Shield: "I was not entirely sure if I had inserted the device correctly, though, as it is so extremely easy. You can't really make a mistake, but I didn't know that at first." Poppy, having no professional guidance for her FemCap, also expressed

concern about proper placement: “I never received a professional fitting for my FemCap, I bought it myself online. This means I also never had a professional consultation. I had to teach myself completely. It did take me several weeks to learn how to insert my cap properly.” Poppy asked for guidance from the diaphragms and caps online group and was able to learn how to obtain a proper fit with the insights of other users. The diaphragm encourages learning more about one’s own body, but for some participants, there is a level of uncomfortableness in this regard. Evie wasn’t entirely comfortable with the bodily awareness and intimacy required for diaphragm use: “Taking a pill is easy, using a diaphragm means having a vaginal examination, touching yourself down there each time you use it or to take it out. Certainly when I had mine fitted it was the first time anyone other than my boyfriend had seen me naked. Sitting on that chair with my feet in those footrest things, I felt very exposed.” So even though embodied knowledge manifests when one chooses to use a cervical barrier, it is not necessarily a welcomed process in the beginning for all participants, even though the majority do eventually come to appreciate this greater knowledge of the body and its sensations later on. Many participants in this study demonstrate embodied knowledge in practice when they describe why they went off hormonal birth control. Stacey mentions how being on Yaz gave her side effects and altered her sense of self: “The physical symptoms didn’t bother me as much, but it really messed with my emotions—made me feel depressed, disconnected, and just ‘not me’.” For Stacey, a type of embodied knowledge was knowing how her body normally felt and being able to establish that hormonal contraceptives had altered that. After obtaining her FemCap, Stacey learned more about her bodily anatomy as well: “I was fairly comfortable with it before then, but I learned a lot more about my cervix---finding it, the changes it

goes through during a month, why it's easier to touch sometimes than others, etc.” Lynne describes having a great deal of difficulty learning how to use a Prentif cap, but then subsequently having zero difficulty in learning how to use the Lea's Shield:

Oh boy, did I ever have problems with my Prentif cap at first! I came home with my cap very hopeful, but seeing that the manufacturer recommended that it be used with spermicide, I first tried to use it with honey and/or lemon juice. (I already knew I had allergies to typical chemical spermicides.) Not only was this messy and irritating to my tissues, but it caused the cap to not seal or be seated well. The Prentif cap depended partly on suction, and it seemed like putting anything inside the cap interfered with suction. There were times after intercourse that I found the cap totally dislodged, or even turned inside out! I became very discouraged for some time. I remember we went back to condoms for a while. Again, my very supportive and encouraging boyfriend urged me to try again. Finally I took the leap, and tried using it without spermicide (the women's health center who ran the study claimed they found no difference in effectiveness either way.) Finally I became confident and had much less problems with the cap dislodging. So there was definitely a learning curve. I had almost no problems learning to use the Lea's Shield, because it's a different type of barrier that covers the entire vaginal canal and not just the cervix. For this reason it's easy to position, and dare I say, virtually impossible to dislodge. The downside is that it's quite large and this can be a problem for either partner. A lot of men can feel it and don't prefer it for that reason. And because it's one size fits all, it could be difficult to insert for some women who have small pelvic anatomy. Since I am “medium boned” and have fairly large pelvic anatomy, it fits me well. But I also think my prior experience with the Prentif gave me lots of experience with inserting barriers.

For Lynne, the learning curve of coming to know her own anatomy in conjunction with the proper placement of her cervical cap took time, but that experience and embodiment ultimately allowed her to use a different model without issue. Several participants describe “getting a feel” for inserting their cervical barrier and ultimately coming to know if it fits correctly after doing it enough times. Maggie likens the act to “putting contacts in” and states that “once you have the knack, it's easy.” Alicia echoes this sentiment and notes

that, “To me it’s no harder to use than a non-applicator tampon. Although I had to put it in and remove it a few times before the doctor let me go home with it. I did practice a lot before I used it.” Alicia “practiced” inserting her diaphragm before trusting it as a contraceptive, ensuring that she knew how to place it properly. Beth too offers an analogy about using a diaphragm: “It’s like putting on a pair of earrings. And not even pierced earrings – clip on earrings!” Beth uses this analogy to compare the diaphragm to hormonal methods and IUDs, which alter body chemistry or require an invasive procedure. Chloe likens using a diaphragm to using a menstrual cup, noting that “You have to be prepared to deal with what is ‘up there.’” She also draws a comparison to masturbation: “You have to be comfortable with touching yourself and knowing your body.”

Astrid states that she always “felt unsure about if it [her diaphragm] was in the right spot or not,” and turned to the online diaphragm and caps group for guidance. She explains,

I guess that’s what I’ve felt most insecure about, is doing it ‘correct.’ It’s easy to get up there and it seems like it’s in the right spot and it feels good...but I’m just not 100% comfortable I guess. With the pill I never worried, or even thought about it. But sometimes with this it’s like...did it shift? Or was it quite right? Or did he move it while we were having sex? Or is there supposed to be more suction or something?

In this sense, it is the lack of embodied knowledge that concerns Astrid. Her lack of knowledge about her anatomy, how her diaphragm should feel, and whether it’s placed correctly is something that concerns her and that she requires reassurance about. However, she anticipates that using a diaphragm and fertility awareness will serve to teach her more about her body: “...One of the reasons I kind of like the diaphragm – there’s nothing wrong with knowing and getting more familiar and comfortable with your own body. It’s crazy what I didn’t know before. I also feel like doing more with the FAM will help me to get to

know my body even better. Also, not being on birth control...I don't know if this is just my perception but I just feel like I just FEEL differently. Or notice changes more or maybe I'm just paying more attention to it."

Anya wishes that she had been taught more about her own body when she was younger. She states,

I honestly believe if more women were taught how to understand their cycles, charting, temping and watching cervical mucus, that would be more effective than what most youth do now, which is nothing. If I had been told when I was a teenager, you don't need to NEVER have sex, but there are three days a month you need to not have intercourse and only oral, and here's how to determine what those days are, I would have done it. Young women should be told this shit when they start puberty. This is how your shit works, learn it.

Anya believes that bodily knowledge is empowering and she promotes fertility awareness methods as a means of fully woman-controlled contraception that relies on tracking the body and its naturally occurring hormonal shifts.

While Susanna has yet to choose a method of contraception following the birth of her child, she describes tracking her cycles as useful and not wanting hormones because they interfere with her ability to interact with her own body: "I guess I think [taking hormones] probably isn't good for me. I can tell things about my body so much better now than I had ever before, like when I am ovulating. I have more instinctual feelings, I think." Beth also describes realizing that hormones affected her body negatively when she began having suicidal thoughts as a student. Beth knew something strange was happening with her body: "This doesn't make sense." She stopped taking the pill after feeling that something very wrong was happening in her body. Several other participants describe

knowing that something was wrong when they were on hormonal birth control or using an IUD.

Participants in this study described different types of embodied knowledge in several different ways: some described a strong sense of knowing their own bodies and what felt right or wrong for themselves. Often a feeling of sickness or discomfort when using hormonal methods or IUDs was articulated, and later, the need to know their own anatomy to ensure diaphragms and caps were inserted properly. Several participants describe an active use of or interest in fertility awareness methods because it brings them greater knowledge of their bodies and allows them to use their own bodies as informational tools in conceiving or preventing conception.

In 1980, the Fertility Consciousness Group operating out of the Women's Community Health Center asserted that "Information regarding our fertility is self-knowledge basic to all women and is every woman's right. It is information that has been lost through the isolation of women from one another and the medicalization of women's reproductive functions."⁵¹⁷ Here, they are explicitly referring to fertility awareness methods, and the bulk of their piece goes on to describe the ways in which tracking one's own body to prevent conception (or generally) is a feminist act that leads to empowerment. Further, they go on to state that,

Keeping women ignorant about our bodies is another way to control women, to decrease our ability to make choices, and to create dependence on the medical establishment. This can be countered by learning to examine and understand our own bodies; by learning that there is a range of variation, rather than one standard norm; by

⁵¹⁷ "Women-Controlled Birth Control," 71.

validating our experiences through sharing them; by exploring what we all have in common.⁵¹⁸

Knowledge of the self and of one's own body as important, empowering, and useful sources of information manifested numerous times in participant accounts.

7.5 Subversive Information Strategies

The process of seeking cervical barrier methods involves a continual quest to become more informed. Participants did not merely conduct singular initial information-seeking sessions and leave it at that. Rather, encountering difficulties in obtaining desired bits of information at nearly every stage of the contraceptive journey resulted in continual and ongoing information seeking acts. In every case, multiple informational sources were consulted. Information sharing was a crucial component of the informational process for the majority of participants; they articulated a desire to interact with peers to gain experiential knowledge and first-hand accounts of all aspects of cervical barrier methods. Some participants also articulated a desire to share information with others about cervical barrier methods. Several participants discuss feeling more motivated or persistent when encountering informational blockades and working to gain more information about cervical barriers and how to obtain them in spite of these difficulties. McKenzie's notion of communicative counterstrategies as circumvention is relevant here, as women seeking health information in formalized settings will overcome barriers to obtaining information by enacting strategies to free this information; I would argue that seekers of cervical barrier methods not only enact communicative counterstrategies to obtain otherwise unavailable

⁵¹⁸ Ibid., 75.

or marginalized information, but often these counterstrategies are subversive informational acts.

As mentioned in Chapter 2, LIS research lacks explicit discussions of subversion, with the notable exception of Hope Olsen⁵¹⁹. Others such as Chatman,⁵²⁰ Ross and Dewdney,⁵²¹ and Rothbauer⁵²² talk about resistance and strategies to circumvent informational barriers, which could be interpreted as subversive information behavior. In the context of feminist resistance as it applies to this project, Saskia Wieringa offers a useful description of subversion:

Women's acts of resistance, or self-affirmation, as social actors in their different historical and political contexts, are already in themselves subversive to existing power relations; but women have been 'sub-versive' also in another sense: in circumventing, uncoding, and denying the various, distinct and multi-layered verses in which their subjugation is inscribed and replacing them with their own verses. Sometimes literally...at other times by creating their own cultures of resistance, re-shaping and transforming their surroundings.⁵²³

In the process of seeking information about cervical barriers, participants in this study encountered authoritative forms of information that positioned them in an informational hierarchy below the "expert" medical practitioner. The informational landscapes of medicine generally, and reproductive health specifically, are often imbued with patriarchal overtones that privilege scientific statistics and diminish experiences and embodiment. Thus, those seeking information about cervical barrier methods often faced

⁵¹⁹ Olson, "Patriarchal Structures."

⁵²⁰ Chatman, "Life in the Round."

⁵²¹ Ross and Dewdney, "Negative Closure."

⁵²² Rothbauer, "Beyond a Signpost."

⁵²³ Saskia Wieringa, "Introduction: Sub-Versive Women and Their Movements," in *Subversive Women: Women's Movements in Africa, Asia, Latin America and the Caribbean*, ed. Saskia Wieringa (New York: Zed Books, 1995), 1-2.

challenges and blockades to acquiring greater knowledge about these types of contraceptives and had to enact informational strategies that circumvented the insufficiencies of mainstream informational sources; I argue, given the patriarchal and authoritative nature of reproductive health information, the imposed hierarchy of expert over patient, and the marginalization of accurate cervical barrier information within mainstream informational channels, that efforts of participants to counter, challenge, and circumvent these blockades constitute subversive acts. So in what ways did participants in this study display subversive acts? They worked to obtain information that isn't available to them, as is evident with locating more obscure online informational sources like closed groups. They shared information to ensure others can benefit; they learned and taught one another how to fit their own diaphragms, how to make spermicide, share a list of doctors who fit them, etc.; they created (primarily online) spaces where, despite their desire for marginalized information, the information flows freely and strategies that defy mainstream medical practices' marginalization of cervical barriers were shared.

When Stacey had difficulty finding a practitioner to fit her, she took matters into her own hands, quite literally: "Well, before I joined the group, I ordered my own speculums so I could try to have a look myself." Jocelyn also took a DIY approach when she had difficulty locating a spermicide she was comfortable with:

The diaphragm and caps group has a few natural spermicide recipes, so I chose to make one at home. I picked the one that contains glycerine, corn starch, salt, lemon juice, and water. These ingredients were cheap and easily accessible, and it has worked well for me with my diaphragm and cap so far.

Liz states that when she was in Europe, she could easily get a Lea's Shield, but that "In Canada it's a different story. I have actually used my shield much longer than

recommended for that reason.” This persistence in using her chosen method rather than switching to something more readily available is indicative of an act of resistance.

Jen feels a sense of power knowing that she isn’t putting chemicals in her body or lining the pockets of large pharmaceutical firms. Tara, like Jen, believes in a bright future for natural birth control methods as women become more aware of the potential dangers of hormonal contraceptives; she also believes that people are becoming more concerned with what they put in their bodies and in the power of sharing information: “I think hormonal birth control is one thing that they’ve started to look at. I think the more women talk about it the more they may want to try it.”

Liz sees ample opportunities for greater resistance, and that actions can convey strong messages to those in power: “I think there might be opportunities to use our voting dollars wisely. Women should order from Europe, reject all that dubious high-tech hormonal stuff, and keep sharing info about caps and co. Someone will notice eventually, I’d hope.”

Many participants, like Poppy, are hopeful that new innovations in cervical barriers will offer women more choice for contraceptive options and free them from medical authority: “Unfortunately, I think cervical barriers are an endangered species. They will disappear in time. However, I hope that one size fits most products like the FemCap and Caya diaphragm will reverse this, as there is no need for women to be undermined by doctors as they seek a fitting.” Mariana is also optimistic because a number of startups have recently released or are developing new hardware and apps for fertility awareness. These types of technologies can help disrupt the pharmaceutical industry and give women more choice in using natural contraceptives. Chloe’s act of resistance came in the form of

simply asserting herself in medical consultations: “Ultimately I know what I want. When necessary I’ve stood up for myself and fought for what I want.”

For Jamie, embracing their body amidst a rejection of binary gender also serves as a powerful act of resistance:

For me, getting to know my body was a radical political action for many reasons. First, I’m a survivor and had layers of fear and uncertainty about my body, and learning FAM and practicing self care was a way to defeat some old spectres and really feel empowered. Understanding the intimate rhythms of my body is the ultimate “fuck you” to my rapists. Second, as a non-binary person, getting to know my body and be comfortable with it is fairly radical. Being able to understand and even enjoy the parts that are “sexed” while still rejecting innate gender is a powerful thing. My sexed anatomy is not gendered, it’s mine. If that makes sense. Finally, being thoroughly educated about my body—and through DIY consciousness raising to boot—is a strong stance against patriarchy. The personal really is political and being comfortable and aware of my body is the first step to dismantling the system. Or at least pushing back against it, and helping educate others. Our bodies are war zones, and I’ve taken mine back.

Beth sees power in knowing our own bodies and using contraceptive methods that are less harmful. She states, “At some point we need to stop being guinea pigs. We’re paying to be guinea pigs for the medical industry and it’s just not cool. We are beta-testing their devices and paying to do it.” For her, resistance comes in the form of rejecting methods that are profitable for the pharmaceutical industry and embracing safe and natural methods that we can control ourselves. Jamie notes that small actions with regard to reproductive freedom can make large impact: “Every little pocket of reproductive resistance is pretty powerful in terms of discursive authority. We are experts on our own bodies.”

The online diaphragm group through which the majority of participants in this study were recruited serves as an alternative space for which marginalized communication

can flow. Because many participants were unable to obtain the information they needed about cervical barriers through mainstream channels, they effectively went “underground” into a somewhat obscure digital space to obtain and share information. Parallels can be drawn to Rothbauer’s ⁵²⁴ observation of LGBTQ library users establishing their own alternative spaces within dominant societal forces is applicable here; when mainstream spaces and information channels fail to meet the needs of users with specialized needs, they use the systems and resources available and create their own means of ensuring informational flow.

In terms of actively subverting mainstream informational channels, mainstream medical practice tends to contextualize practitioners as experts who, despite generally having the best interests of their patients in mind, ultimately have the final say in medical consultations. This means that if patients disagree with their practitioners’ suggestions or conclusions, they must advocate for themselves to either get second opinions from other practitioners, or in the case of this study, work around the medical system to obtain their desired method of contraception. Unlike the Pill or an IUD, which always requires a prescription and/or expert medical intervention, cervical barriers such as caps and the Caya diaphragm can be ordered and used without medical supervision; because these devices can be accessed outside of traditional medical and pharmaceutical channels, they allow for strategies and subversion that other contraceptive methods don’t. In some cases,

⁵²⁴ Paulette M. Rothbauer, “Locating the Library as Place Among Lesbian, Gay, Bisexual and Queer Patrons,” in *The Library as Place: History, Community, and Culture*, ed. John E. Buschman and Gloria J. Leckie (Westport, CT: Libraries Unlimited, 2007): 101–15.

participants had to order cervical barrier methods online and troubleshoot insertion and use solely using online communities and relying on advice from strangers, because in their own locales they could not access the tools and resources they needed to readily actualize their initial contraceptive plan. This effectively constitutes going underground for information and resources, and subverting the boundaries imposed by modern medical practice. The fact that women are willing to share their own experiences and advise others about cervical barrier acquisition and use when they encounter others experiencing difficulty means there is a community of subversive information sharing.

7.6 A Practitioner's Perspective

When asked about why women seeking cervical barriers may encounter resistance or even ridicule from practitioners, the practitioner in this study who advocates for cervical barrier methods states the following: “The reason is two-fold: firstly because most of these practitioners are not trained to fit barriers, they will steer patients away from wanting this method by using (incorrect) statements about the efficacy of barrier contraception. Secondly, even if they can fit barriers the amount of didactic and practical teaching needed in addition to the fitting time to assure that a woman can use her barrier effectively is around 1.5 hours which, in many of today's clinics would be unheard of; even if it was possible, the costs would be prohibitive.” Hormonal methods are fast and easy to prescribe and don't require specialized training. While practitioners may hold strong views about efficacy of barrier methods, their refusal to prescribe them may often stem from inadequate or non-existent training in fitting the devices; it is easier to dismiss a method as inefficacious than it is to admit lack of knowledge or experience with the method.

7.7 Different Bodies

In *Diagnosis: Difference*, Abby Wilkerson notes that in addition to depicting authoritative, biologically deterministic and gender-driven tendencies, mainstream medicine also “conceptualizes the woman patient as white, heterosexual, middle class, able-bodied, young and HIV negative,” and that anyone who may depart from this norm “may find themselves patronized, controlled, neglected, punished, dehumanized, and even criminalized by the institution of medicine.”⁵²⁵ Participants in this study frequently identified differences within their own bodies that made seeking or using a cervical barrier challenging. Mariana describes feeling as though her intelligence is often undermined in medical settings because she is Latina, and that she must advocate for herself and showcase her intellect in order to be taken seriously:

So I consider myself a smart person. I was 13th in my class of 360. And I do soooo much research and thinking about my contraceptive options. A doctor who can *trust* me and trust my ability to use my contraception effectively will be received infinitely better by me than a doctor who assumed I'm not capable of doing so. I'm also a person of color (Latina) who grew up in a town with a large Caucasian population. I also have some insecurities about being stereotyped as not being capable or not being smart. I don't want to be seen that way. And as a feminist I also want my capacity as a smart woman to be acknowledged.

Esther was surprised that her practitioners knew nothing about natural contraceptive methods that are often sought by Christian and Jewish women. Jamie identifies as gender non-binary and frequently faces challenges in medical settings asserting their gender identity; because they have female anatomy, medical staff are quick to impose the gender

⁵²⁵ Abby L. Wilkerson, *Diagnosis: Difference: The Moral Authority of Medicine* (Ithaca: Cornell University Press, 1999), 14.

identity of woman upon Jamie, and have difficulty understanding the non-binary identity. This reflects Wilkerson's assertion that different bodies may be treated poorly by mainstream medical practice. Several participants have experienced trauma in different forms -- rape, medical trauma, or sometimes both -- and medical practice also has difficulty dealing with traumatized bodies. Chloe's disability, hypermobility syndrome brought on by oral contraceptives, creates challenges for mainstream medical practice that seeks to offer quick and easy contraceptive solutions; different bodies require negotiated interactions, not quick and easy ones. Jamie's past experience of sexual assault in a clinical setting has contributed to medical trauma and thus they are open with practitioners about the anxiety they face in healthcare settings; a traumatized body must be approached differently than the normative one. Several participants identified some sort of anatomical variant outside of the norms of cervical barrier measurements and suggested that cervical barriers did not fit because of their own anatomical differences; even diaphragms, which come in a range of sizes, are not suitable for all female pelvic anatomies. Chloe thinks that her IUD migration and the subsequent pain and bleeding it caused for months is due to her being "unlucky in terms of the shape of my body." And given that the majority of participants sought cervical barriers due to an intolerance to or ethical qualm with hormonal contraceptives, the very bodies seeking non-hormonal methods are by definition outside of the mainstream.

In the spirit of openness and transparency, I meet all of Wilkerson's criteria for the normative female body. I am white, heterosexual, middle-class, of reproductive age, able-bodied, and free of any chronic health conditions. Perhaps slightly chubby, but not clinically obese. I am in a long-term relationship with a male partner. My interaction with

my prescribing doctor, once finally scheduled, was smooth. She listened to my needs, and when I met her criteria for prescribing a cervical barrier, she was happy to fit me and issue the script. I heard no concerns about ensuring diaphragm use within a monogamous relationship -- I was already in one. I didn't have to warn her of previous medical trauma. I didn't have to request that she not misgender me. No physical disabilities or abnormalities impaired my ability to be fitted for or use a cervical barrier. My plan -- to use a cervical barrier in conjunction with fertility awareness and abstaining from sex during fertile days -- was not challenged in any way. Knowing that I was completing a PhD program made her feel confident that I would successfully be able to avoid pregnancy. If we consider my experience among those of my participants, I am definitely one of the lucky ones. One participant, Susanna, noted that in her own academic research, she often read about marginalized women having birth control imposed on them; she wonders if since she is white, educated and fairly affluent, her doctors seemed indifferent about her lack of birth control as though her getting pregnant was always a favorable outcome, or simply thought that she would take the initiative to aggressively pursue a contraceptive if she desired one. Even after an unexpected pregnancy, her postpartum medical consultation for contraceptives was fruitless: "They answered questions, but didn't really try to sell me on it. Not that they should, but they didn't seem proactive to get me to do anything either way." She continues, "I never considered them [my doctors] lax, but I knew they weren't overly concerned about getting me on something. I assume they think I know 'better,' which I obviously do not!" Susanna demonstrates an expectation of authoritative knowledge on behalf of her practitioners, but experiences something else entirely -- indifference.

In *Fit to Be Tied*, an analysis of reproductive rights in America between 1950 and 1980, Rebecca Kluchin describes the tendency of doctors to trust white middle-class women with their own reproductive destinies and impose contraceptives on marginalized women:

Women across race and class demanded the Pill, but doctors preferred to prescribe it to white women, especially middle-class women, those deemed reproductively “fit” on the basis of their race and class status and, as such, sufficiently “responsible” to take this female-controlled method of birth control. Physicians advocated the use of the IUD--a device controlled by physicians that women could not remove--as an appropriate contraceptive for “unfit” women, both in the United States and abroad.⁵²⁶

While race was not specifically addressed in questions posed to participants in this study, based on self-identifying information, the majority of participants are white and educated. However, rather than class and racial bias imposed upon patients by practitioners, age and relationship status tended to dictate how much a participant was trusted in a consultative setting; young participants tended to have IUDs or hormonal methods pushed on them by doctors, with cervical barriers being eschewed because they rely too much on the user’s consistent and reliable use for effectiveness and limited practitioner involvement after the fitting. The same goes for women in casual relationships -- practitioners preferred to prescribe cervical barriers to women in long-term monogamous partnerships due to the notion that the pregnancy rate would be higher with barriers than with hormonal methods or long-acting contraceptives.

⁵²⁶ Rebecca M. Kluchin, *Fit to be Tied: Sterilization and Reproductive Rights in America, 1950-1980* (New Brunswick, N.J.: Rutgers University Press, 2011), 53.

7.8 Conclusions

This chapter was guided by three key research questions, interrogating ideas of knowledge marginalization, embodied knowledge, and subversive information practices. As to whether or not women's knowledges are marginalized by expert-practitioner discourse, in many cases of this study's participants, the answer is, often, yes. Occasionally, the medical practitioner is unfamiliar with cervical barrier methods and this lack of knowledge impacts the participant's ability to acquire a diaphragm or cap. Often, participants experienced their doctor suggesting other methods and in some instances the doctor outright refused to fit/prescribe diaphragm. While a number of participants describe generally positive interactions with medical staff wherein they felt respected and as though their voices and concerns were being heard, a trend emerged indicating the opposite with regard to medical interactions. Participants shared their experiences of feeling belittled, ignored, or even at times ridiculed, for their desire to pursue non-hormonal contraceptive methods. Many participants describe experiences with doctors ridiculing their request for a cervical barrier method. One participant describes simply "going along" with what her doctor said because she felt so uncomfortable in the interaction that she didn't want to persist in discussing non-hormonal methods. In the cases of participants who were marginalized in favor of authoritative practitioners seeking to impose their expertise rather than negotiate ideal outcomes articulated by their patients in the consultative setting, participants generally turned to online communities and social networks to validate their choices and gain their desired but previously inaccessible information from other cervical barrier users.

In terms of questions about accessing marginalized information, participants in this study frequently do gain information via mainstream channels, and then when these channels fail them due to inadequacy, they turn to the experiential knowledge of other women to fill in the informational gaps. These firsthand accounts and ability to interact and share information are typically accessed online, via specific designated communities/forums or social media groups (i.e. Facebook). When making any type of medical decision, numerous information processes are at play; those navigating medical decision-making may conduct their own research (via online and other textual sources), discuss their issues with peers or relatives, or engage with strangers via social media and online forums. Medical practitioners are usually consulted at some point as well. After an initial need or motivating factor materializes, mobilizing participants to learn more about cervical barrier methods, preliminary processes of becoming greater informed about these methods typically follows.

Women have to circumvent a challenging informational sphere to obtain knowledge about cervical barrier methods. Because they are not as mainstream as pills or IUDs, information is often harder to locate. As the previous chapter illustrated, women often prefer experiential accounts of birth control use, as well as interactive platforms where they can communicate with others about contraceptives; *Our Bodies, Ourselves* attempted to provide just that, but the limitations of print resulted in informational lags and the inability of readers to communicate in real time. In the age of the internet, a desire for interactive and experiential information not only continues, but thrives. Thus, forums and Facebook groups are key informational resources for women seeking birth control methods generally, but also less common methods such as cervical barrier methods. Further,

cervical barrier method information is quite niche and correspondingly, as are the online groups that privilege these methods.

Even more compelling is the fact that medical practitioners are often not well-versed in prescribing or fitting cervical barrier methods or the current pharmaceutical marketplace that marginalizes them, and will frequently try to dissuade women from using them in favor of hormonal methods or IUDs. Self-advocacy in medical consultation settings becomes paramount, as many practitioners ignore requests for cervical barriers and insisted on hormonal or long-acting methods.

The stories of the participants in this study show different trajectories in a journey with the same end goal. They reveal biases in the medical industry that can also be hinted at in Chapter 6. They illuminate the perseverance and subversive strategies of women seeking marginalized information. Most significantly, they show that women come together as communities to share information, embodied or learned, with others.

8 Conclusions and Implications for Future Research

8.1 Discussion

The impetus for this project was to examine how certain forms of marginalized birth control information are accessed, challenged and subverted. Fundamentally, this research was concerned with how those seeking and using cervical barrier methods navigate medical informational landscapes, pharmaceutical informational landscapes, and ultimately, online community informational landscapes, and what actions and strategies manifest out of these navigations. Further, my guiding research questions sought greater insight into issues of authoritative knowledge, embodied and experiential knowledge, and how information sharing might occur in scenarios where once mainstream contraceptive information is no longer readily available.

Chapter 1 offered a brief introduction to the issues at play in this dissertation – how cervical barriers have steadily declined in popularity over the past 40 years, how this is problematic because they are still sought as a non-hormonal method of contraception for myriad reasons, and how information about cervical barriers is often inaccurate or difficult to find. This chapter touched upon some of the guiding theoretical perspectives including authoritative knowledge, embodied and experiential knowledge, and information marginalization and subversion. Chapter 2 provided a detailed literature review, describing previous LIS research in information behavior and everyday life information seeking, as well as birth control information in LIS contexts, and informational strategies of resistance and subversion. Prior works evaluating authoritative knowledge, embodied knowledge, and gender theory were also described in hopes that they would further illuminate the issues at play in this project. Chapter 3 detailed my methodological considerations in

conducting a feminist digital ethnography as well as outlined the methods I implemented for data collection and analysis. In Chapter 4, I briefly summarized the historical conditions leading to the development and proliferation of cervical barrier methods; their development, popularization, and later, decline, are important facets that undergird the current medical and pharmaceutical climate of diaphragm and cap marginalization. Chapter 5 extends this initiative, providing a detailed case study of an explicitly feminist women's health reference guide (*Our Bodies, Ourselves*) and tracking the representation of cervical barriers therein over the course of nearly four decades in four iterations of the text, concluding with the 2011 edition and leading up to the current informational realm for contraceptives, and the impacts this informational realm may have on participants. The participants of this study are described in Chapter 6, with their motivations for using or seeking a cervical barrier highlighted. Further, this chapter summarizes several key stages encountered by the majority of participants in this study while seeking a cervical barrier. Finally, Chapter 7 explicates participant experiences within their contraceptive-seeking journeys; here, overarching themes of authoritative knowledge, negotiated interactions, embodied and experiential knowledge, and informational strategies of resistance and subversion are evaluated in the context of participants' lived experiences seeking and using cervical barriers. Using participants' own accounts to provide a cohesive narrative of the issues facing those who desire a cervical barrier, this chapter ultimately concludes that informational communities are paramount in freeing marginalized information, and that strategies to circumvent information barriers are enacted on both individual and collective levels.

The theoretical perspectives and prior research that guided this project have helped weave an interdisciplinary underpinning that facilitated my telling of this story and the stories therein. Belenky et al.'s study helped illuminate the ways in which women come to know things and how they view and conceptualize different types of information and authority sources; they articulated a theory of subjective and connected knowing and differentiated the ways women gain knowledge from the ways men do.⁵²⁷ However, the authors were at times guilty of gender essentialism. My own work has helped show that what it means to be a “woman” or having the anatomy required to conceive indeed has implications for how one navigates the world around oneself, interacts with information and knowledge, and is treated by informational authorities, but also that there is no universal womanhood that dictates a specific result. Jamie's experiences navigating the realm of contraceptive information within a body capable of conception were in many ways similar to the other participants in the study who accepted the gender assigned to them, but were also different in many ways. However, because binary thinking often positions Jamie as a woman despite their rejection of gender binaries, I was able to observe a commonality of experience even in the absence of universality.

This commonality could in many instances be isolated to embodiment; regardless of differences in race, class, ability, or gender, contraceptive-seeking in a body capable of pregnancy has some consistencies; knowing what contraceptive is best for oneself means knowing one's anatomy, what feels “right” or “wrong” for the body, and knowing one's own views on contraceptives (be they religious, ethical, health-conscious, etc.). Further, to

⁵²⁷ Belenky et al, *Women's Ways*.

use a contraceptive means to know some aspect of the body, and to use a cervical barrier means to know a very specific aspect of the reproductive body. This embodied knowing was conceptualized by Merleau-Ponty⁵²⁸ and many feminist researchers have built upon this concept. My participants, through their stories, have helped demonstrate the importance of the body as an information source in medical and contraceptive contexts. This embodied information is also meaningful when examining contraceptive information-seeking and biomedical authority. Jordan's⁵²⁹ work on authoritative knowledge helped shine light on the reality of medical practitioner knowledge being valued over patient knowledge and how this derives from patriarchal power structures. This project highlights that reality; many participants told me that despite them articulating a clear reluctance to or refusal of certain contraceptives, their practitioners insisted they knew what was best. In some instances, as in Rivano Eckerdal's study of contraceptive consultations with midwives,⁵³⁰ interactions with practitioners were negotiated and participants were able to easily obtain a cervical barrier without resistance from their doctor or nurse. Negotiated interactions were the exception rather than the rule. However, participants in this study also came up with tactics and strategies to circumvent authoritative knowledge, which often meant sharing information in non-mainstream channels and accessing information that wasn't readily available. McKenzie's view that women in medical consultative scenarios enact counterstrategies to gain the information they desire⁵³¹ is relevant here, but in my view these strategies also constitute acts of subversive information behavior. If we

⁵²⁸ Merleau-Ponty, *Phenomenology*.

⁵²⁹ Jordan, *Birth in Four Cultures*.

⁵³⁰ Rivano Eckerdal, "To Jointly Negotiate."

⁵³¹ Pamela J. McKenzie, "Communication Barriers."

define subversion as “circumventing, uncoding, and denying the various, distinct and multi-layered verses in which their subjugation is inscribed and replacing them with their [our] own verses. Sometimes literally...at other times by creating their own cultures of resistance, re-shaping and transforming their surroundings,”⁵³² then the strategies and tactics the participants in this study have employed to free marginalized information and share it with others is indeed subversive. Karlyn Kohrs Campbell argues that the “key element in the erosion of the myths that justify women’s subordination and the ideological barriers that retard social change” is subversion, or “using the master’s tools to undermine, even sabotage, the master’s house.”⁵³³ For Campbell, subversion occurs through the use of discourse, as language is a crucial instrument in allowing those in power to subordinate others; if we extend this idea to women’s rejection of authoritative practices in mainstream medicine, can this rejection constitute using the master’s tools to undermine or sabotage the master’s house? I would argue that learning how to fit one’s own diaphragm, acquiring a diaphragm from alternative purveyors, making one’s own spermicide, and sharing information that mainstream medical practice restricts or marginalizes indeed constitute an undermining of the master (authoritative mainstream medical practice) and thus are legitimate forms of subversion.

My research goals could not have been attained without the accounts of 26 participants, who graciously shared their stories, experiences and perspectives on the issues in question; these personal narratives helped document the ways in which, as described above, authoritative knowledge can supersede experiential and embodied knowledges, but

⁵³² Wieringa, *Subversive Women*.

⁵³³ Karlyn Kohrs Campbell, “Inventing Women: From Amaterasu to Virginia Woolf,” *Women’s Studies in Communication* 21(1998): 112.

that even when facing informational and knowledge marginalization, strategies can be and often are enacted to free information from gatekeepers (i.e. medical practitioners who refuse to fit diaphragms can be circumvented by learning how to fit one's own diaphragm). My research approach was ethnographic in that I was a member of the online communities and recruited participants as their peer – I fundamentally rejected any notion of research hierarchy and made it clear that I too had traversed the informational terrain they found themselves exploring. The feminist approach to conducting digital ethnographic work that I embraced allowed me access to an understandably private and intimate community; while I had initially feared that cervical barrier users would prefer to not speak about their experiences due to the personal information they would need to divulge, this fear was not borne out given the peer-based, lateral relation between researcher and interviewees. However, bearing this in mind, recruitment was difficult; while women and contraceptive users are often willing to share information about their own experiences and bodies, limiting the type of contraceptive to cervical barriers meant severely restricting the pool of interviewees. While I was able to recruit from a dedicated online community, that community is niche and it did take a considerable amount of time to recruit and interview the 25 cervical barrier users and seekers and the one practitioner. Due to varying geographic locales and the goal of ensuring participant comfort, a variety of interview modes were offered, including questionnaires, textual online chat, video chat, or telephone. While interviewing in real-time yielded the richest data and the most detailed participant narratives, questionnaires offered participants with time constraints or concerns about being interviewed a way to write their own accounts in whatever level of detail they felt appropriate and comfortable with. Upon reflection, I do feel that this “choose your own

interview style” approach allowed me to maximize the number of participants given the subject matter; however, in the context of utilizing a thorough interview approach to conduct a digital ethnography, the real-time interview formats admittedly yielded more nuanced data.

Other potential limitations of this research are consistent with the niche aspect of the subject matter – accounts and experiences of cervical barrier users and seekers very likely cannot be extrapolated to the contraceptive seeking populace on a general level. Someone seeking an IUD or a birth control pill is likely not met with resistance or concern the way that those interested in cervical barriers might be. In fact, many participants were eagerly offered these types of more mainstream methods by their practitioners, and prior use of these methods is what often drove them to seek something more natural. However, burgeoning interest in fertility awareness methods means more women and people with uteruses seeking pregnancy prevention are contacting their practitioners for more information, and despite a booming technological sector for these methods (apps and fertility calculating devices), mainstream medical practice also tends to eschew FAM in favor of hormonal or long-acting methods; it is thus fair to assume that this research may offer useful insights in contexts of other marginalized contraceptive methods.

8.2 Conclusion

A few years ago, I obtained a diaphragm. It was a challenging feat. Upon further investigation, I learned that these challenges were not unique to me. Women and persons capable of becoming pregnant across the world want the ability to control their fertility and they seek options that include hormonal methods and long acting methods, but also natural and reversible methods in their own control. They want options when it comes to

contraceptives, and unfortunately, those options are becoming increasingly fewer. The mythology of choice convinces us that because there are several brands of oral contraceptives, hormones in the form of patches and vaginal rings and injections, and IUDs of different materials such as copper and plastic, that we have an abundance of options. But in actuality, all hormonal methods are just that. There are different delivery systems for the same chemicals. Cervical barriers help to extend the menu of contraceptive offerings, but they are increasingly hard to obtain.

We are currently living in a time of increased paternalism and mistrust of women. Governments across the globe are seeking greater restriction and criminalization of abortion while simultaneously targeting contraceptives like the morning after pill; Planned Parenthood in the US faces a relentless, targeted assault from the Trump administration; CDC guidelines now suggest that any women of fertile age begin taking folic acid supplements whether they intend to get pregnant or not,⁵³⁴ arguably reducing women to vessels with breeding potential rather than individuals with different reproductive goals. Even in Ontario, Canada where abortion has been off the table for discussion for over forty years, the newly elected provincial government seeks greater control of pregnancy termination, seeking to change parental consent laws for minors seeking abortion.⁵³⁵ Women are increasingly reduced to their wombs. The Trump presidency brings these issues into further question, with policy initiatives that seek to limit access to contraception and abortion. At the time of writing this, several US states have announced either full-on

⁵³⁴ CDC, "Folic Acid," accessed June 28, 2019, <https://www.cdc.gov/ncbddd/folicacid/about.html>.

⁵³⁵ CBC News, "Doug Ford Says 'We've Got to Consult Parents' When it Comes to Minors' Access to Abortion," (March 5, 2018), accessed June 28, 2019, <https://www.cbc.ca/news/canada/toronto/ford-abortion-debate-pc-leadership-1.4562035>.

abortion bans, or aggressive abortion restrictions.⁵³⁶ While beacons of hope occasionally emerge, such as the referendum in Ireland which, after decades of an abortion ban, showed that the majority of citizens believe in women's reproductive freedom, the outlook on women's reproductive rights on the global scale is fairly grim.

We are living in an environment of abundant information that is easily accessible via the internet; previously unavailable or carefully controlled information is now readily available at our fingertips. However, we simultaneously face increasing issues accessing accurate information, filtering useful information, or encountering censorship. There is glut of information available, but sussing out its usefulness can prove difficult. Further, we are losing the ability to determine between information that is accurate and truthful, and misinformation (with an agenda or otherwise).⁵³⁷ Women are increasingly turning to groups and communities online to discuss and share information and identify accurate and experiential information that isn't available from mainstream channels.

Paternalistic practices in medicine also bring about questions of agency. Often in discussions of birth control, men control the narrative, and women are removed entirely from the picture. CDC guidelines do not mention men's involvement (i.e. use a condom when having sex with women if you don't want to become a father), and US states banning or restricting abortion do not suggest that men's child support payments should start at conception. But also, factually it is women and those with female reproductive systems

⁵³⁶ Mara Gordon and Alyson Hurt, "Early Abortion Bans: Which States Have Passed Them?" *Shots: Health News From NPR* (June 5, 2019), <https://www.npr.org/sections/health-shots/2019/06/05/729753903/early-abortion-bans-which-states-have-passed-them>.

⁵³⁷ Y. Chen., N. J. Conroy, and V. Rubin, "News in an Online World: The Need for an 'Automatic Crap Detector,'" in *The Proceedings of the Association for Information Science and Technology Annual Meeting (ASIST2015)*, Nov. 6–10, 2015. St. Louis.

who bear the brunt of pregnancy prevention, and arguably, we should be able to say if and when we want to become pregnant. This is why so many participants articulated that they want to have total control over their birth control method, and this is what Sanger sought when she first attempted to democratize birth control. Our assertions should be respected.

But a real challenge to reproductive agency is that authoritative knowledge dominates the medical landscape - doctors think they know better than us, and we tend to agree. Scientific efficacy is more important to the medical establishment than helping patients find something that jives with their needs and individual bodies. Without access to information, and without the assistance of like-minded virtual communities, navigating this realm of authoritative knowledge can prove challenging and at times, impossible. Again, the ability to access sharing communities (digital or face-to-face) is paramount as either supplemental or primary sources of experiential information.

Diaphragms are increasingly marginalized likely due to a lower profitability (as compared to hormonal methods and IUDs) and declining practitioner training for fittings, but women still want options. There has been a shift over time from diaphragms being THE innovative and modern method of choice, to them being considered old-fashioned and ineffective. While cervical barriers may be an imperfect method, it is one that allows women to fully control their own birth control without side effects. Interviews with participants show that contraceptive seekers often know what they want, that experiences within their own bodies guide their decision-making processes, and that in the wake of authoritative knowledge, there is a real need for patients to be able to advocate for themselves in clinical settings. But self-advocacy does not have to be an individualistic pursuit: communities of like-minded people can and do embolden and empower members

to stand up for themselves and achieve their health objectives. These communities operate as networks of sharing and are essential in climates of reproductive health oppression.

I make the argument that these communities can facilitate subversive information sharing, but the truth is that subversion has been women's forte for a long time, with suffrage, Sanger's birth control movement, and the *Our Bodies, Ourselves* project serving as key examples. If the onus is placed on us to advocate for ourselves and others in terms of birth control access, then we must share info with each other even if it is through underground means. We have done this in the past and will continue to do so utilizing digital technologies in addition to face-to-face interactions. Informal activism and small actions can lead to empowerment and resistance, and the ability to collectivize has been imperative in the past and is imperative now; how this collectivization occurs may look slightly different than in the 1970s, but it is a powerful tool whether online or in person.

The twenty-five participants in this study who took the time to share their stories with me have taught me several key truths: we fight paternalism and we can advocate for ourselves and our own bodily autonomy, but we need to do it collectively. Taking into account the rejection of essentialism is crucial in this regard: women's experiences are not monolithic, and occur on racial, cultural, economic levels. Even gender experience is not a universal; there are biological females rejecting an essential womanhood and gendered labels who still need access to contraception or pregnancy care, and there are also men who require pregnancy prevention and care. Regardless of our differences, we need to advocate for each other; reproductive freedom should be a universal right, even if there is no universal woman.

8.3 Implications for LIS

This study has implications across a number of areas, including policy, R&D, education, and information provision. LIS specifically would benefit from taking into account ways people may circumvent or bypass mainstream informational barriers by forging their own informational communities. Subversive information strategies, which in this case involves sharing marginalized information via somewhat underground channels online and ensuring access to knowledge that is not given out by medical professionals (i.e. how to fit your own diaphragm and make your own spermicide), may be particularly noteworthy to LIS professionals. As information purveyors, how can we best facilitate this sharing? If our databases and catalogues lack information that is necessary to improve people's lives, how can we enable the sharing of this information within communities, or how can we transfer it into mainstream channels? Further evaluating the strategies and subversive tactics people seeking marginalized information employ can elicit a number of fruitful outcomes for LIS researchers and practitioners.

Another noteworthy consideration for LIS is to consider the ongoing nature of information seeking behavior. For the participants in this study, the goal is acquiring and being able to use a cervical barrier method, but once participants have done so it's not the end of their contraception-related informational activities; many continue to follow cervical barrier topics in the media or participate in online communities because new questions, issues and experiences emerge over time. Many models in LIS⁵³⁸ assume an

⁵³⁸ See D. Ellis, D, "A Behavioural Approach to Information Retrieval Design, *Journal of Documentation* 45, no. 2 (1989), 318-338; T. D. Wilson, "Human Information Behavior", *Informing Science* 3 no. 2,

instrumental information need with an endpoint when that “need” is met; that is not the case here and likely is also not the case in many other information-seeking scenarios.

8.4 Other Considerations

A current trend in the birth control marketplace indicates that those wanting to prevent pregnancy seek to merge technological innovation with nature. Many contraceptive users and seekers are eschewing hormonal methods and seeking methods of birth control that don't alter their own body chemistry. The manifestation of this trend is evident in the rising popularity of Fertility Awareness Method (FAM). The technological innovation surrounding FAM is significant at the time of writing. Apps that track periods and fertility are commonplace (at present I have one on my own phone). Different brands of smart basal thermometers are being marketed, and digital fitness trackers are also now targeting fertility as a trackable bodily process (the Ava bracelet, Bellabeat Leaf, and iFertracker are just a few examples). Portable fertility computers with built-in basal thermometer are also popular (Lady Comp, Daisy and Ovacue, among others). There is a somewhat seamless pairing of FAM with cervical barrier methods. Many who use FAM reject hormonal contraception and also seek to control their own methods. Pairing FAM with a barrier method ensures a higher level of efficacy and self-reliance. A casual observance of a FAM Facebook group (with over 24,000 members) indicates FAM users are often also barrier users. It is somewhat ironic that the newest trends in digital culture

(2000)49-55 ; Carole Collier Kuhlthau, *Seeking Meaning: A Process Approach to Library and Information Services* (Norwood, NJ: Ablex, 1993).

and the quantification of the self are pairing with what has been contextualized as an old-fashioned method. Modernizing birth control digitally and without augmenting the body in some way has the potential to revitalize what has until recently been considered grandma's birth control. In this study, participants also frequently articulated that cervical barrier methods leave something to be desired. There can be some discomfort using cervical barriers, as fit is important. It can also be messy. It is safe to say that the market is ripe for innovation in barrier methods that pairs with digital applications. The desire to quantify women's bodies and subsequently increase efficacy of contraceptives has been a longstanding feature in the birth control landscape over the last century, but the desire for contraceptive users to take these matters into their own hands is increasing, and these new fertility apps and tracking devices allows one to monitor their own fertility without using hormones or chemicals. While those in power may seek to disempower us, we can stand against authoritative misogyny by standing and innovating together.

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Appendices

Appendix A: Ethics Approval

	Western Research	Research Ethics	
Western University Health Science Research Ethics Board NMREB Annual Continuing Ethics Approval Notice			
Date: June 03, 2015 Principal Investigator: Pamela McKenzie Department & Institution: Information and Media Studies/faculty of Information & Media Studies, Western University			
NMREB File Number: 003585 Study Title: Strategic or Subversive? The Case of the Disappearing ID applications and Women's Information Sharing Process Sponsor:			
NMREB Renewal Due Date & NMREB Expiry Date: Renewal Due -2015/12/31 Expiry Date -2016/01/05			
The Western University Non-Medical Research Ethics Board (NMREB) has reviewed the Continuing Ethics Review (CER) form and is re-issuing approval for the above noted study.			
The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), Part 4 of the Natural Health Product Regulations, the Ontario Freedom of Information and Protection of Privacy Act (FIPPA, 1993), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.			
Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.			
The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.			
			
Ethics Officer to Contact for Further Information			
Erika Basile ebasile@uwo.ca	Tara Kelly tara.kelly@uwo.ca	Mia McKel mckel@uwo.ca	Yvonne Linn ylinn@uwo.ca
<i>This is an official document. Please retain the original in your files.</i>			
Western University, Research Support Services Building, Room 1010 London, ON, Canada N6G 1G9 519.861.2036 519.850.2488 www.uwo.ca/research/ethics			

Appendix B: Ethics Extension



**Western University Non-Medical Research Ethics Board
NMREB Amendment Approval Notice**

Principal Investigator: Pamela McKenzie
Department & Institution: Information and Media Studies/Faculty of Information & Media Studies, Western University

NMREB File Number: 103583
Study Title: Strategic and Subversive? The Case of the Disappearing Diaphragm and Women's Information Sharing Process
Sponsor:

NMREB Revision Approval Date: September 01, 2015
NMREB Expiry Date: January 05, 2016

Documents Approved and/or Received for Information:

Document Name	Comments	Version Date
Other	Requesting permission to increase the number of women participants from 15-20 to 25-50. Number of health care providers will remain the same.	

The Western University Non-Medical Science Research Ethics Board (NMREB) has reviewed and approved the amendment to the above named study, as of the NMREB Amendment Approval Date noted above.

NMREB approval for this study remains valid until the NMREB Expiry Date noted above, conditional to timely submission and acceptance of NMREB Continuing Ethics Review.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS2), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IR00000941.



Ethics Officer to Contact for Further Information

<input type="checkbox"/> Prita Basile pbasile@uwo.ca	<input checked="" type="checkbox"/> Grace Kelly grace.kelly@uwo.ca	<input type="checkbox"/> Mia McKillop mmckillop@uwo.ca	<input type="checkbox"/> Vicki Tam vicki.tam@uwo.ca
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Appendix C: Ethics Renewal



Research Ethics

Western University Non-Medical Research Ethics Board NMREB Annual Continuing Ethics Approval Notice

Date: January 05, 2016
Principal Investigator: Pamela McKenzie
Department & Institution: Information and Media Studies/Faculty of Information & Media Studies, Western University

NMREB File Number: 103583
Study Title: Strategic and Subversive? The Case of the Disappearing Diaphragm and Women's Information Sharing Process
Sponsor:


NMREB Renewal Due Date & NMREB Expiry Date:
Renewal Due -2016/12/31
Expiry Date -2017/01/05

The Western University Non-Medical Research Ethics Board (NMREB) has reviewed the Continuing Ethics Review (CER) form and is re-issuing approval for the above noted study.

The Western University NMREB operates in compliance with the Tri-Council Policy Statement Ethical Conduct for Research Involving Humans (TCPS2), Part 4 of the Natural Health Product Regulations, the Ontario Freedom of Information and Protection of Privacy Act (FIPPA, 1990), the Ontario Personal Health Information Protection Act (PHIPA, 2004), and the applicable laws and regulations of Ontario.

Members of the NMREB who are named as Investigators in research studies do not participate in discussions related to, nor vote on such studies when they are presented to the REB.

The NMREB is registered with the U.S. Department of Health & Human Services under the IRB registration number IRB 00000941.


Ethics Officer in Charge: Faculty Information Ethics Board Nursing Care Ethics King Medical Vita Tran

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Western University, Research Support Services Dept., Rm. 5150
London, ON, Canada N6C 1C9 | 519.661.3036 | 519.880.2466 | www.uwo.ca/research/ethics

Appendix D: Letter of Information

Strategic and Subversive? The Case of the Disappearing Diaphragm and Women's Information Sharing Practices

University of Western Ontario

Sherilyn Williams (xxx) xxx-xxxx or xxxxxxxx@uwo.ca &

Dr. Pamela McKenzie (xxx)-xxx-xxxx ext. xxxxx or xxxxxxxxxxxx@uwo.ca

Introduction: Thank you for your interest in this study of information and cervical barrier contraception. I, Sherilyn Williams, am a doctoral student in the Faculty of Information and Media Studies at the University of Western Ontario under the supervision of Dr. Pamela McKenzie. The information I am collecting will be used in my doctoral thesis. You may keep this letter even if you do not choose to participate.

About the Study: You are being invited to participate in a research project that seeks to examine how women interested in using diaphragms or cervical caps acquire information about these methods and use online groups and forums to access and share information. The purpose of this letter is to provide you with the information you require to make an informed decision about participating in this research. This study will draw on approximately 15-20 women who are actively seeking, or have previously sought information on cervical barrier methods and are active or past members of online groups dedicated to discussing contraceptive methods. Your participation is requested to assist in identifying trends and themes in the field by offering your insights and experiences.

Participants: If you choose to take part in this study, you will be asked to engage in an interview of approximately 60 minutes at a time, location and delivery mode convenient to you. The interview questions ask you about your experiences seeking information about diaphragms and caps, acquiring the actual devices, using them as a contraceptive method, and engaging in discussions with others online about these methods. Interviews will be conducted via structured email interview, online textual or video chat (i.e. Skype), or audiotaped telephone conversation. Follow-up interviews of approximately 30 minutes in length may be required after the initial interviews

Risks and Benefits: There are no known risks to participation in this research. You will not benefit directly from involvement with this study but your participation will contribute to an understanding of how women seek and share certain types of information.

Withdrawal: Participation in this study is voluntary. You may refuse to participate, refuse to answer any questions or withdraw from the study at any time. There are no consequences if you choose to decline participation or withdraw.

Confidentiality: Your identity will be kept confidential. Pseudonyms will be used in all reports and any publications that may result from the study. Your identity or the information you have provided will not be released or published without your specific consent to do so. All transcripts, notes, email records and any additional materials will be kept by the researcher on a password protected computer and destroyed/deleted within 5 years after the completion of the study, with the exception of those materials which you have provided and request for your own records.

Contacts: If you have any questions or concerns about this study, please contact Sherilyn Williams at (xxx) xxx-xxxx, Dr. Pam McKenzie at (xxx) xxx-xxx ext. xxx or xxxxxxxxxxxx@uwo.ca or the UWO Office of Research Ethics at (xxx) xxx- xxxx.

Appendix E: Consent Form

Consent Form

Strategic and Subversive? The Case of the Disappearing Diaphragm and Women's Information Sharing Practices

PARTICIPANT CONSENT FORM

Participant's Name: _____

In agreeing to be a participant in this study, "Strategic and Subversive," I have read the letter of information and all questions have been answered to my satisfaction. I also understand the purpose, general nature and procedures of this study, as explained by the researcher.

I understand that unless I indicate otherwise, all identifying information resulting from my participation will be kept confidential by the researcher.

I further understand that I may withdraw from this study at any time and for any reason without repercussions.

I hereby give my permission:

1. to participate in interviews in person, via e-mail or online chat, or telephone; and
2. to allow the researcher to use the data, including interviews and other information resulting from research, for educational, research and publication purposes.

After reading this form, consent will be given by participating in the interview.

Appendix F: Letter to Group Gatekeeper Requesting Access

Dear XXXX

First and foremost, I want to express my gratitude for providing a forum for women to discuss and share information about diaphragms and caps; this group has been immensely helpful to me since I decided to give up the pill after 12 years in preference of a non-hormonal method, and was having difficulty getting information about diaphragms locally. Without this group, I would probably still be on the pill, or begrudgingly looking into obtaining an IUD.

Secondly, I would like to get your opinion on something. I'm a doctoral student in Library & Info Science at the University of Western Ontario. My primary research focus is women's information sharing in community settings, with a focus on subversiveness. Up until now, I have been researching women in handicraft groups (knitting, crocheting, quilting, etc.) and how they exchange information about and through their crafts. However, since experiencing issues with obtaining a diaphragm (and realizing this was a huge problem in Canada for women), and subsequently discovering your group, I'm thinking of changing my case study from handicrafts to diaphragms and caps. I am currently in the process of writing my dissertation proposal, and was hoping to focus my research on the information that women are being given about cervical barrier methods by mainstream consumer health organizations or practitioners (i.e. Planned Parenthood, general practitioners, OB-GYNS) and how this information is often inaccurate or lacking, as well as the barriers women face to obtaining cervical barrier methods, and then the tactics they use to ultimately find accurate information and access to diaphragms and caps. I'm hoping to interview women about their experiences in considering cervical barrier methods, obtaining them, and using them, in addition to interviewing practitioners that offer fittings (or as seems to be the case more recently, refuse to offer fittings) to get a sense of the how diaphragms and caps are contextualized as contraceptives in modern and alternative medicine. Further, since the community of diaphragm users is dispersed geographically, and seemingly linked via online communication tools such as forums or groups, I would

like to extend my research to interviewing members of online communities and, possibly, to analyze their online posts.

As the person who knows your group best, how do you think the members would feel about this? What kinds of info do you think they'd be willing to share, and what concerns might they have? Do you think they might be okay with someone analyzing their posts if identifying info was removed? Could you offer any suggestions as to how this research might be undertaken? In order to conduct such interviews, I must go through a fairly rigorous ethical protocol that ensures participant confidentiality and that nobody is identifiable in the final report.

I think that lack of access to or information about diaphragms and caps is an important issue affecting women. My goal with this study would be to bring awareness to the fact that women are being denied access to a reliable and women-controlled birth control method, and also, to show that a community of women exists who refuse to have their needs and desired be denied by medical professionals and the pharmaceutical industry. I'd be absolutely delighted if you could offer some insights on the potential of this research, or the best ways to approach this community. Please let me know any thoughts or concerns you may have.

Sincerely,

Sherilyn Williams

Appendix G: Recruitment Tool Posted to Group

Participants Sought for Online Interviews about Diaphragm & Cap Experiences

Study: Strategic and Subversive? The Case of the Disappearing Diaphragm and Women's Information Sharing Practices

Hi everyone! I'm a doctoral student in Library & Info Science at the University of Western Ontario. My primary research focus is women's information sharing in community settings. Since experiencing issues with obtaining a diaphragm (and realizing this was a huge problem for women in Canada), my dissertation will be focusing on women's information sharing about diaphragms and caps. I'm hoping to interview women about their experiences in considering cervical barrier methods, obtaining them, and using them, in addition to interviewing practitioners that offer fittings (or as seems to be the case more recently, refuse to offer fittings). Since the communities of diaphragm users are dispersed geographically, online communication tools such as forums or groups, along with interviews seem likely ways to find out about women's information sharing. In order to do this research, I have, of course, prepared a rigorously vetted ethical protocol that ensures participant confidentiality and that nobody is identifiable in the final report.

Here is a link to my student profile which explains a little bit about my research:

xxxxxxxxxxxxxxxx.com

If you might be interested in participating, please contact me for more information about the study at:

xxxxxxx @xxxxx.com (preferred)

or

xxxxxx@uwo.ca (alternate)

Appendix H: Interview Questionnaire/Outline – Participants

Interview Questionnaire

Strategic and Subversive? The Case of the Disappearing Diaphragm and Women's Information Sharing Practices

Please answer questions 4-16 with as much detail as possible.

- 1) How old are you? (leave blank if you prefer not to answer)
- 2) In what region are you located?
- 3) What method(s) of birth control are you currently using?
- 4) What factors caused you to decide on this/these methods?
- 5) Why did you consider cervical barrier methods as an option?
- 6) Can you explain how you went about finding information about diaphragms/caps? Were there any difficulties?
- 7) Did you contact a doctor or other medical professional about acquiring this method? If so, what was your experience like?
- 8) Could you easily locate/obtain your chosen method? Can you explain a bit about what that was like?
- 9) Did you use the internet to gain information?
- 10) How did forums/groups function in your search for information about diaphragms and caps?
- 11) Did you have any problems learning how to use these methods?
- 12) Did you seek advice from other diaphragm/cap users (for information about diaphragms/caps, where to get them, how to use them)?
- 13) What are your thoughts on the increasing difficulty of obtaining diaphragms and caps?
- 14) Do you think sharing information in online groups/forums about this issue is important?
- 15) What role do you think women's online communities will play in the future for information on birth control methods such as diaphragms and caps?

16) Where do you see the future of cervical barrier methods heading?

Appendix I: Interview Questionnaire – Practitioner

Interview Questionnaire

Strategic and Subversive? The Case of the Disappearing Diaphragm and Women's Information Sharing Practices

Please answer the following questions with as much detail as possible.

- 1) Can you tell me a little bit about the philosophy of your practice?
- 2) Why have you chosen to be a vocal advocate of cervical barrier methods? Do you also advocate more “popular” methods such as birth control pills?
- 3) Does your practice prescribe hormonal contraceptives and/or IUDs? Why or why not?
- 4) How long have you been fitting diaphragms and caps?
- 5) In Canada fewer and fewer practitioners have the skill to fit diaphragms and caps. Do you feel that fewer practitioners have the knowledge/skill to fit diaphragms in the UK as well? If yes, why do you think this might be?
- 6) Many of my participants have stated that when they sought a diaphragm from a medical practitioner, they were either ridiculed or told that it was a poor method, and then steered in the direction of hormonal contraceptives or IUDs. Why do you think general practitioners are so dismissive of diaphragms and caps?
- 7) Have any of your patients described difficulty in obtaining diaphragms or caps before they came to your practice?
- 8) Do you see many patients interested in cervical barrier methods? Is the number of interested women rising or shrinking?
- 9) Is there anything that distinguishes women that specifically seek diaphragms as their contraceptive method from women that want more common methods such as the pill?
- 10) I recently went about acquiring a diaphragm for contraception and found that the process was a bit difficult. Practitioners that prescribe them are difficult to find. Do you think women in my position will have increasingly difficult times trying to locate practitioners and the actual devices?
- 11) What are the best options in your opinion for women who do not want to use hormonal contraceptive methods?
- 12) Will you continue to prescribe diaphragms?

- 13) Do you think the newer generation of practitioners (doctors/nurse practitioners/midwives) will acquire the skill of fitting diaphragms, or will it become obsolete?
- 14) What is your hope as a practitioner for the future of cervical barrier methods?

Appendix J: Facebook Comment Posted to Caya Article

I'm researching the decline of diaphragms and the women who still use them for my PhD dissertation. It's actually a really interesting story (I think!) of why they declined (mostly pharmaceutical profit-seeking because the diaphragm is inexpensive and lasts 3-5 years before needing to be replaced) and a group of women dedicated to their use fighting to keep them afloat. If anyone is using a diaphragm currently, or thinking of using one, shoot me a message. I'd love to talk to you!

Curriculum Vitae

Name: Sherilyn Williams

Post-secondary Education and Degrees: Wayne State University
Detroit, MI, USA
2002-2006 B.A.in Journalism

The University of Western Ontario
London, Ontario, Canada
2006-2008 M.A.in Media Studies

Honours and Awards: Province of Ontario Graduate Scholarship
2017

Related Work Experience Teaching Assistant
The University of Western Ontario
2006-2015

Research Assistant – Library & Information Science
The University of Western Ontario
2012-2016

Research Assistant – Visual Arts
The University of Western Ontario
2011

Publications:

Williams, Sherilyn. "Get Down Tonight: Birth Control and the Modern Woman," *Missy/Ink Magazine* 14, Summer 2014.

McKenzie, Pamela J., Elisabeth Davies and Sherilyn Williams. "Information Creation and the Ideological Code of Managerialism in the Work of Keeping Track." *Information Research*, 19(2) paper 614. [Available at <http://InformationR.net/ir/19-2/paper614.html>], June 2014.

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