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'We view that as contraceptive failure': Containing the 'multiplicity' of contraception and abortion within Scottish reproductive healthcare

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ABSTRACT

Within contemporary Scottish policy guidance, abortion is routinely configured as evidence of a resolvable problem with the healthcare provision of contraception. This article draws on 42 semi-structured interviews with Scottish health professionals conducted during 2007–2008, in order to explore how, and in what form, realities of contraception/abortion are sustained within abortion practice. In addition to providing empirical insights concerning this sociologically neglected aspect of reproductive healthcare, it demonstrates how a novel conceptual approach could be used to develop existing social scientific analyses of the provision of techniques of fertility prevention. Science and Technology Studies (STS) has highlighted the importance of studying the complex socio-material practices through which realities are enacted (or 'performed'). Mobilising this insight, my analysis illustrates the complex socio-material work required to enact abortion as evidence of a 'problem' with contraception that is resolvable within the healthcare consultation. This work, I argue, renders visible the ontologically 'multiple' (Mol, 2002) nature of contraception/abortion, with important implications for both social science and policy approaches to these techniques of fertility prevention.

Introduction

Policy guidance concerning sexual health services in Scotland positions the provision of contraceptive advice during consultations about abortion as a means through which to reduce the rates of the latter:

> Approximately 1 in 4 women who have a termination of pregnancy subsequently have another termination of pregnancy. Advice about effective contraception following termination of pregnancy is essential to reduce termination of pregnancy rates. (NHS Quality Improvement Scotland, 2008, p. 15)

Accordingly, recent standards for Scottish abortion services require explicitly that:

> 60% of women leave the facility with one of the more effective methods of contraception (hormonal oral contraceptives, intrauterine devices or contraceptive implants). (NHS Quality Improvement Scotland, 2008, p. 15)

Similar framings of the relationship between contraception, abortion and reproductive healthcare are also prevalent in UK sexual health guidance more broadly (for example, Department of Health, 2009; Medical Foundation for AIDS & Sexual Health (MedFASH), 2008; National Collaborating Centre for Women's and Children's Health, 2005). A particularly notable example is the recent guidance commissioned by NICE, which depicts the provision of Long Acting Reversible Contraception (LARC) to women as a revolutionary means to reduce the UK's abortion rate (National Collaborating Centre for Women's and Children's Health, 2005).

In this paper I use Scottish health professionals' accounts of the provision of contraceptive advice during consultations about abortion to explore some of the implications of these forms of guidance. My analysis of health professionals' accounts illustrates the socio-material work that is necessary in order for abortion to be enacted as evidence of a 'fixable' problem with contraception. In illustrating this phenomenon, I have two aims. Firstly, to explore a neglected empirical topic, namely, the provision of techniques of fertility prevention within contemporary Scottish reproductive healthcare. Secondly, to suggest new theoretical directions for broader social scientific enquiry concerning the provision and use of techniques of fertility prevention.

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Background: the differentiation of abortion and contraception through twentieth century medicalization in the UK

For much of the twentieth century, *all* techniques of fertility prevention were deemed illegitimate by the UK medical profession and, more broadly, within public discourse (Brookes, 1988; Hawkes, 1996; McLaren, 1990; Thomas, 1985). As McLaren (1990) demonstrates, the gradual differentiation of contraception and abortion as two distinct techniques was the result of a strategy employed by the early twentieth century birth control movement. In attempt to gain the support of the medical profession, birth control campaigners promoted the use of relatively 'high-tech' pre-coital methods (for example, the diaphragm and cap, and later, hormonal contraceptives and intrauterine devices) whose use could be planned far in advance of sex, and required clinical supervision. In contrast, they explicitly dissociated themselves from methods associated with (hetero)sex, or its aftermath (condoms, 'withdrawal' and abortion).

In spite of the campaigns of birth control activists, their advocacy of the idea that fertility should be 'planned' through the use of pre-coital contraception did not become accepted as a mainstream part of medical practice until the 1960s–70s (McLaren, 1990). McLaren suggests that the availability of a more high-status and 'scientific' (Clarke, 1998) method of contraception in the form of the Pill was critical in the profession's change of heart concerning the goals of the birth control movement. Another important event was that, during the late 1960s, health professionals in much of the UK suddenly became faced with responsibility for the provision of abortion (Aitken-Swann, 1977; Davis & Davidson, 2005; Hawkes, 1996; McLaren, 1990; Thomas, 1985). The 1967 Abortion Act re-classified abortion as a 'medical', rather than a 'criminal' act (Sheldon, 1997) by defining legal grounds on which two doctors could agree that it was necessary in the interests of a pregnant woman's health, or the health of her foetus. In doing so, it gave doctors formal responsibility for the decision about whether or not a particular pregnancy should be terminated (Davis & Davidson, 2005).

The legislative framework introduced by the 1967 Abortion Act continues to regulate the provision of abortion in the UK (with the notable exception of Northern Ireland, to which this Act has never been applied, and where abortion remains largely unavailable). While it has, arguably, facilitated the widespread provision of safe, legal procedures (Sheldon, 1997) the law nonetheless legitimates abortion only as a last resort course of action necessary to alleviate the suffering of a patient whose unwanted pregnancy constitutes a threat to her mental and/or physical wellbeing (Boyle, 1997; Sheldon, 1997). Negative framings of abortion clearly influenced the incorporation of contraceptive provision into UK healthcare; this was positioned as necessary 'to prevent illegitimacy and abortion rather than to promote sexual freedom' (Thomas, 1985, p. 52). While illegitimacy is no longer an explicit policy concern, the guidance cited above demonstrates that concerns about the prevention of abortion remain significant.

Conceptual framework

The significance of professional practice concerning the provision of contraceptive advice to women seeking abortion was first highlighted by Luker (1975) in her ground-breaking study of contraceptive 'risk taking'. In an exploration of the non-use of contraception by women who request abortion, Luker argued that competing perceptions of the meanings of contraception and unwanted pregnancy/abortion are held by women and medical institutions. She suggested that the latter assume that the most significant 'cost' of (hetero)sex is 'unplanned' pregnancy/abortion. Simultaneously, medical institutions minimise the costs of contraception, and stigmatise women who refuse to bear these costs as either 'ignorant' or 'self-destructive and irrational' (Luker, 1975, p. 140).

The central aim of Luker's study was to destabilise these assumptions by illustrating that, when contraception is situated within the lived context of its use, its non-use becomes an entirely rational act. She argues that:

> risk-taking behaviour which ends in an unwanted pregnancy is the result of a "rational" decision-making chain produced by a person who is acting in what he or she perceives to be his or her best interests, although often in the presence of faulty data. (Luker, 1975, p. 138)

Costs of contraception can include, for example, the side-effects of hormonally-based contraceptives, the routine interactions with clinicians that these drugs necessitate, and costs to identities and relationships. In particular, as Luker points out, to obtain and make use of a contraceptive involves the cost of acknowledging to oneself and others (often health professionals) that one is *planning* to be sexually active. In contrast to these immediate costs of contraception, 'unplanned' pregnancy/abortion represents an unknown future cost which may be 'discounted', or may in some cases be viewed as a benefit, for example, an opportunity to test a male partner's commitment (Luker, 1975).

However, as Paxson (2004) highlights, while Luker's work provides valuable insights, it replicates an important aspect of the institutional discourse which it sets out to critique. As numerous commentators have noted (Ali, 2002; Paxson, 2004; Ruhl, 2002) the medicalization of techniques of fertility control is grounded in a socially specific construction of human subjectivity. Specifically, it reflects Western Enlightenment philosophy's account of subjectivity as contingent upon an individual's ability to abstract themselves from 'time, space, and bodily circumstances' (Ruhl, 2002, p. 644) in order to make rational-calculative decisions that maximise self-interest. In the case of techniques of fertility control, medical institutions view self-interest as maximised when women have control over the timing of conception. While Luker successfully illustrates that this is not the only way in which women can realise their interests, she nonetheless portrays the autonomous, rational, calculation of self-interest as the basis for women's contraceptive (non)use. In other words, she concurs with institutional logics concerning the forms of human agency which it is possible to exert in relation to techniques of fertility control (Paxson, 2004).

In contrast to Luker's analysis, anthropological studies have instead sought to illustrate how cultural norms (in particular, those concerning sexuality and fertility) shape the forms of agency which people exert through their engagement with techniques of fertility prevention. For example, Paxson (2004) demonstrates that, in Greece, women's use of techniques of fertility prevention has historically been oriented towards the maintenance of gender norms concerning masculine dominance/feminine passivity in sexual relations. Women-controlled methods of contraception, which require women to be pro-active in advance of sex, challenge these relationships. In contrast, abortion provides a private, post-hoc means for women to regulate their fertility, which does not impinge upon the norms of heterosexual encounters. Paxson argues that, within the Greek context, the introduction of medicalized models of fertility prevention in the form of 'family planning' initiatives can be understood as burdening, rather than liberating, women. Such initiatives stigmatise Greek women's use of abortion and require them to 'plan' contraception, without acknowledging that contraceptive planning *also* produces stigma because it requires women to transgress local gender norms (Paxson, 2004).