Hormones, Choices and Reproductive Autonomy:

How Dutch Women Navigate in a World of Contraception

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Abstract

While contraception is available to many women nowadays, I argue that it is not a solved issue yet. I have conducted semi-structured interviews with five women to gain a deeper understanding of their lived experiences with contraception and the pill in particular. I deconstruct the notion of 'choice' that surrounds the usage of the pill, by showing how women's contraceptive decision making is structured by wider sociopolitical factors. Women's options and ability to choose are based on a trajectory that society laid out for them, namely to use hormonal contraceptives. Rejecting this path would mean having significantly less options and to break with gendered norms and expectations of contraception. I will link the illusion of choice to reproductive autonomy, and question to what extent women nowadays feel like they have agency when it comes to their reproductive choices. My analysis shows that with regard to reproductive autonomy, being well-protected against a pregnancy is the top priority. Consequently, in a landscape without sufficient effective male contraceptives or non-hormonal contraceptives, women feel the need to let go of their ethical concerns and use hormonal contraception like the pill. Furthermore, I discuss the importance and possibilities of making contraception a shared responsibility, for which trust seems to be a key aspect.

Keywords: *the pill, contraception, choice, reproductive autonomy, gender equality, situated knowledges, feminist research*

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Introduction

Embodied experience

A few years ago, I went to my doctor with a straight goal in mind; I wanted to be sexually active but most certainly didn't want children. He told me that my best option was to go on the pill. He argued that it was a highly reliable form of contraceptive that did not require a painful procedure (such as with the hormonal and copper intrauterine devices, or IUD's). When I asked my doctor about the side effects, he focused on the minor, physical ones. Of course my period would be irregular in the beginning, since my body had to adjust to the new status quo. However, this and other 'little inconveniences' like headaches and mood swings would be gone within a few months. That was it. Fifteen minutes later I jumped on my bike with a prescription in my bag.

I was on the pill for more than three years. During this whole period I never felt comfortable taking it and always had an internal conflict going on. On the one hand, I was glad that I could explore my sexuality without risking a pregnancy. On the other hand, I felt less in touch with myself and my body. I noticed that I started to have more inexplicable mood swings and, even though I initially went on the pill to have sex, my interest in it declined. While I knew that something was off, I did what most women do in situations like these. I told myself that it was all in my head, because it seemed so 'normal' for women to take the pill, perhaps even unavoidable. As a woman, I felt highly responsible for not getting pregnant and since the pill is a very effective contraceptive method, I simply could not afford to question it.

When my boyfriend and I ended our relationship, I decided to put myself first and do what I felt like I could not do before: to quit the pill. I wanted to reconnect with my body without the continuous intake of synthetic hormones. Quickly after quitting the pill, the mental and physical issues that I was dealing with before disappeared. Even though I was glad to find out that the pill likely caused my problems and that not taking it would solve them, I also found myself in a difficult position. My deliberate decision to refuse any synthetic hormones, confronted me with the limits of women's options. All of a sudden, I only had two suboptimal options left, using condoms (which are less effective in preventing pregnancies) or getting a copper IUD (of which the insertion would likely be painful). This makes that the issue of contraception did and still does elicit mixed feelings. I am grateful that I can access different contraceptive methods and protect myself against an unwanted pregnancy, something that I find extremely important since I am eager on getting my master's degree and

starting a career. At the same time, I am also frustrated. I feel like, as a society, we still have a long road to go, especially when it comes to responsibility for contraception. The lack of effective male contraceptives and the societal depiction of contraception as a women's issue refrains men from taking their responsibility. This has a direct impact on women's embodied experience with contraception. For me, it is a matter of choosing between the lesser of evils: getting pregnant or accepting the side effects of contraception. I feel trapped in a system that does not allow me to make the decisions about my body that I want to. This raises the question, how does this system work and how do other women experience it?

Aim of the research and structure

This thesis focuses on other women's embodied experience with contraception, and the pill in particular. I will deconstruct the notion of 'choice' that surrounds the usage of the pill, by showing how women's contraceptive decisions are shaped by sociopolitical factors. In the first chapter, I will give a historical overview of the introduction of the pill. I will explain why there was such resistance towards legal contraception at first, and how the contraceptive market has evolved ever since. I will show that the focus on the development of female contraception has reinforced the idea that contraception is a women's issue. After that, I will touch upon the importance of taking a feminist approach, especially with analyzing personal topics like contraception. In the second chapter, I will show how women's choice for the pill is based on incomplete information, due to the organization of our health care system and a lack of information about the pill's effect on women's bodies. The last chapter centers around reproductive autonomy. This concept refers to women's agency when it comes to their reproductive functions, in this case preventing a pregnancy (Senderowicz & Higgins, 2020). It is about their ability to access contraception, without feeling coerced. I will question whether women really do have agency when it comes to their reproductive needs, and link this to wider expectations on controlling fertility.

In order to keep this thesis specific, I will focus on the Netherlands. This will be the geographical, cultural and historical context in which I will critically analyze the notion of 'choice' and explore women's reproductive autonomy in relation to the pill.

1. Theoretical and methodological chapter

1.1 Resistance towards birth control

I believe that it is important to start with a historical overview of the introduction of the pill, and to acknowledge how birth control has liberated numerous women from their reproductive duties. Until the middle of the 1960's, the Netherlands was conservative when it came to family planning (Ketting, 1982). Sexuality in general was considered to be taboo and was barely discussed within the home, at school or in the media. Within this social context, the use of contraceptives was not accepted either. The church was still an influential institution and rejected the use of contraceptives, saying that it threatened public morality. Contraceptives were seen as jeopardizing the traditional roles that women presumed to fulfill within society and within the home. Women were supposed to be housewives and mothers. Consequently, they could barely access contraception. In 1911, the 'Zedelijkheidswet' was enacted which added contraception to the Criminal Code, making it illegal to publicly advertise and distribute it (Rutgers Stichting, n.d.). Women could only access contraceptives behind closed doors and in special clinics. The act also made abortion punishable by law, which made women's position even more difficult.

How then, would contraceptives pose a threat to women's marginalized position in a patriarchal society? Perhaps there was initially such great resistance towards contraception, because it could deconstruct the link between women and 'their nature'. Contraception allows women to regulate their fertility and their menstruation. This means that it gives women the opportunity to *choose* for motherhood, rather than seeing it as something that is a natural consequence of having a female body. In other words, whereas women were first subjected to their bodily functions such as menstruation, pregnancy and labor, the use of contraceptives meant that they would be able to control them.

This could be seen as a threat, because according to De Beauvoir, women's strong association with nature and the corporeal is what makes them subordinate to men. In her book *The second sex* (1949/1993), De Beauvoir explores the way in which women are prevented from taking control of their own lives and play an active role in society. She argues that women have historically always been defined by nature, by their bodies, more than men. De Beauvoir claims that women's reproductive functions are one of the key factors behind the oppression of women. She says that 'because woman has the greater physical reproductive function, a division of roles emerges: men appropriated the production sphere, i.e., the active conquest of nature, often risking their lives in the process; women remained limited to the

reproductive sphere and the home, or rather to the repetition of life', as summarized on page 27 in Vintges' (1996) book on De Beauvoir. In other words, women's reproductive functions do not only result in the burden of motherhood, but it also refrains women from participating as active subjects in society. Combining motherhood with a career is difficult, especially if men perceive women to be unworthy of one because their link to nature makes them to be seen as less rational. For De Beauvoir, contraception is a form of reproductive control. She says that 'contraception and legal abortion would permit woman to undertake her maternities in freedom.' (De Beauvoir, 1949/1993, p. 518). De Beauvoir argues that contraception gives women the opportunity to reject motherhood and the social roles that patriarchy has laid out for them. Or as birth control activist Sanger (1920) said: 'No woman can call herself free who does not own and control her body. No woman can call herself free until she can choose consciously whether she will or will not be a mother' (p. 94).

1.2 Reproductive autonomy

Political struggles concerning contraception were centered around the fight over reproductive autonomy. This concept can be defined as 'individuals' ability to be fully empowered agents in their reproductive needs and decisions and to access reproductive health services without interference or coercion' (Senderowicz & Higgins, 2020, p. 81). In other words, it refers to women's power to decide when to become pregnant and whether to continue a pregnancy. This means among others, that women can make decisions concerning contraceptives and safe abortions and that they can access it easily.

One of the reasons that feminists advocated for accessible birth control, was because they believed that women should be able to avoid 'coerced reproduction' (Johnston & Zacharias, 2017, S8). Since women were not legally allowed to use contraception, motherhood was not a choice, but something inevitable that was forced upon them. Therefore, the first step in enhancing women's reproductive autonomy lay in securing negative rights and thus be 'free from unwanted or unauthorized medical interventions' (Johnston & Zacharias, 2017, S7). Negative rights in this context refer to women's right to not be forced to reproduce, by not being hindered in their access to contraception and abortion. Therefore, the goal was to increase women's access to medical care, by making contraception and abortion legal.

1.3 Introduction of the pill in the Netherlands

In 1963, the first Dutch contraceptive pill was officially registered under the name 'Lyndion' (Ketting, 2000). Since contraception was still illegal, it was marketed as a medicine against menstrual irregularities, with temporal infertility as a side effect (''Moeders wil is wet, met de pil naar bed'', 2010). However, during the 1960's the public opinion on contraception changed significantly. The Netherlands became a welfare state, in which the state was held responsible for the health of individuals, rather than the family. It also became increasingly more secularized and the church could not dictate personal behavior like before. This change was strengthened by the increasing number of people with a tv and radio. Different political and social viewpoints on sexuality and contraception became available to a wider public. In this way, family planning became less of a taboo subject (Ketting, 1982).

In 1969, the Dutch government had lifted all the legal bans for contraception and family planning became more generally accepted (Ketting & Visser, 1994). The Dutch Association of Family Doctors (NHG) decided that general practitioners, rather than clinics, should be responsible for providing services with regard to family planning and prescribing contraception. As a result, the pill became widely and easily accessible for women, who could just go to their family doctor.

The feminist activist group Dolle Mina contributed to making contraception not only more accessible, but also more affordable. Between the period of 1970 – 1978, this group actively campaigned for equal rights for women (Atria, n.d.). By demonstrating in a playful manner, the members aimed to improve women's position within society on different levels, such as education, equal payment and abortion rights. On October 10th 1970, protesters from Dolle Mina (the so called 'Dolle Mina's') walked through the center of Amsterdam advocating affordable contraception. In their hands they were holding signs saying 'Met de pil meer mens' and 'Slik een pil en doe wat je wil'[1] to support their argument. The main goal of the protest was to include the contraceptive pill in the national public health insurance system (''Moeders wil is wet, met de pil naar bed'', 2010). The Dolle Mina's propaganda parade contributed to the inclusion of the pill, as well as the IUD and diaphragm, as part of health insurance in 1971. Now women did not only have access to contraception, they were also able to get it for free (Ketting & Visser, 1994). This caused the number of women on the pill to grow exponentially. In 1976, more than 40% of the Dutch women between the age of 15-44 regulated their fertility by taking the pill.

[1] Translated in English: 'With the pill more human' and 'Swallow a pill and do what you want'.

1.4 Contraceptive market

The introduction of the contraceptive pill, and the acceptance of contraception in general, enhanced Dutch women's reproductive autonomy significantly. It transformed them into empowered agents by providing them with the opportunity to control their fertility. For the first time, women could fulfill a specific reproductive need: practice sex freely without automatically risking getting pregnant. However, reproductive autonomy is continuously subject to changes. Senderowicz and Higgins (2020) argue that 'threats to reproductive autonomy can arise from interpersonal relationships, as well as from health systems and other structural sources, including sexism and systemic racism' (p. 81). A good example is the reimbursement of the pill. As I mentioned before, the Dolle Mina's managed to include the pill in the basic health insurance package. However, since then this has continuously been threatened by political decisions to cut spending. In 2011, contraception was taken out of the basic health insurance package again, because it was considered not to be a medical necessity (''Anticonceptie is een Politieke Speelbal geworden'', 2021). Currently, women from the age of 21 have to pay for contraception themselves. This makes it less accessible and diminishes women's reproductive autonomy, especially for women who are financially unstable.[2] This shows that reproductive autonomy is never stable, especially not in a capitalistic, patriarchal society like ours. It also makes us understand how women's reproductive choices are actually not solely individual ones that they make independent of their environment. Instead, these choices are structured by social systems that places more value on some choices and preferences than others. This raises the question, to what extent do women really *choose* to be on contraceptives, in this case the pill?

According to Hartmann (1995) two cornerstones in reproductive technology are choice and information. By gaining more information on how reproduction works, more choices can be created in the form of new contraceptive methods. However, Hartmann (1995) argues that sexist practices have led to biases in contraceptive research. 'From top to bottom, men dominate the contraceptive research field, and many of them hold the view that reproduction is basically a woman's concern.' (p. 335). In other words, patriarchal systems and

[2] Luckily, there might be light on the horizon. Law firm Bureau Clara Wichmann and civil movement DeGoedeZaak filed a lawsuit against the state to make contraception covered by health insurance again. The verdict of the hearing that happened on July 12th 2021, will be announced on October 6th 2021 (Bureau Clara Wichmann, 2021).

stereotypical ideas on femininity have made the female reproductive system to be the center of contraceptive research. Hartmann (1995) argues that pharmaceutical companies and research institutions have misdirected the contraceptive revolution that started with the introduction of the pill. Rather than researching male and female reproductive systems equally, the focus lay on the latter.

In a sense, it can be argued that this has contributed to women's reproductive autonomy. Nowadays, women can choose between a wide variety of effective birth control options. The most popular one remains the contraceptive pill, but one can also opt for other methods such as the IUD, implant, patch, injection, vaginal ring or female sterilization (Thuisarts, 2021). The extensive amount of information on female contraceptives and the way it can easily be accessed, does provide women with a wide range of options.

However, Rothman (2018) aptly notes that 'while technology opens up some choices, it closes down others' (p. 325). The emphasis on female contraceptives has led the focus away from the development of male contraceptives. Currently men can only choose between condoms and a vasectomy (Johnson, 2020). Condoms are helpful for the prevention of sexually transmitted infections, but it is not as effective in preventing pregnancies as female hormonal contraceptives. The efficacy of condoms highly depends on the right use and is subject to mistakes such as rupture. Furthermore, putting on a condom can be experienced as an interruption and the condom itself could negatively affect the sexual pleasure for both parties. A vasectomy concerns a surgical procedure during which the vas deferens (the tube that transports the sperm for the semen) is cut. This is a permanent procedure, which makes it not suitable for men who would like to have children at a later point in their life.[3]

This gender inequality with regard to contraceptives raises the question to what extent women actually have a choice. The development of technologies predominantly for women, reinforces the idea that women should take responsibility for pregnancy prevention. This is justified by giving them different options, so that they can make the needed choice (Rothman, 2018). In other words, contraception is passed off to women as a 'choice', but it might not be perceived by them as such. Information may expand the opportunity for choices for women, but it does not necessarily mean that their reproductive needs on an individual level are respected and honored. By focusing on women, the option to develop male contraceptives is lost. This means that at the same time, the option to approach contraceptives as a shared responsibility is lost. If we understand this, we can also start to understand how women's

[3] Part of this paragraph is taken from a paper (no title, January 26th 2021) that I wrote on male contraception for the course Somatechnics.

choices for contraception is structured by society and the contraceptive market. If a man and a woman both want to engage in sexual activity without risking a pregnancy, they have a different position when it comes to contraception. The numerous female options open up the possibility for men to practice sex safely without carrying the costs of contraception. Since so many women are on effective birth control, many men do not feel the need to use a condom (unless it is a case of prevention against sexual transmitted diseases). However, if a woman wants to have sex without risking a pregnancy, this automatically means that she has to be the one to use contraception and accept the physical, mental and financial burden that comes along with it. She can choose between different methods, but the lack of effective male options means that she cannot choose to leave the responsibility with men. This raises the question to what extent women nowadays can be considered to be 'fully empowered agents in their reproductive needs' (Senderowicz & Higgins, 2020, p. 81). Can their choice to collectively use contraceptives like the pill be considered a free one or more as choosing between the lesser of two evils?

1.5 Pill most popular form of contraceptive

In 2017, de Graaf et al. conducted a study on sexual behaviour among young people in the Netherlands on behalf of Rutgers Stichting and Soa Aids Nederland. It is called 'Seks onder je 25e' and was funded by the Dutch Ministry of Health, Welfare and Sport. The goal of the study was to gain more knowledge on the sexual behaviors of this age group. It aimed to find out which positive developments were present and which topics required more attention and perhaps intervention. One of the chapters is focused on reproductive health and explores the use of contraceptives. De Graaf et al. (2017) argue that, even though there is a wide variety of contraceptive methods available to young women nowadays, the pill clearly remains the most popular one. In total, 64% of women between the age of 15-24 are taking the contraceptive pill. This shows that the pill, even though it was introduced almost 60 years ago and there are currently many alternatives available, still plays a significant role in the majority of women's lives.

While the published report contains extensive information on different themes related to sexual health, such as sexual orientation and gender identity, prevalence of STD's and sexual harassment, there are two important remarks to be made when it comes to contraception. First of all, the data concerning the use of contraceptives focus solely on women. Each option, such as the pill, IUD, implant, patch, ring and condom, is followed by a

percentage of women using it. There is no information on men's use of contraceptives, even though they also have the option to use condoms. This again reflects the inequality that, even in today's society, exists when it comes to preventing pregnancies. The focus on the female reproductive system and all the options that are available for women, make contraception to be considered a female issue. It is seen as something that women are responsible for.

Secondly, women's motivations for using a certain type of contraceptive is missing. Even though it is important to gain knowledge on women's use of contraceptives, it is even more important to understand why they use it in the first place. The pill allows women to regulate their fertility and explore their sexuality freely, but this does not come without a cost. Research psychologist Hill highlights in her book *How the pill changes everything* (2019), the role that sex hormones play in women's embodied experiences and how the pill affects this by changing their hormonal balance. She argues that there is a tendency to downplay the importance of hormones, as if there is a version of women without hormones. 'Although many of us think of hormones as something that ''happen'' to us, that isn't quite right. You *are* your hormones. They help to form your very identity, the beliefs that you have about yourself, and your behaviors' (p. 7). In other words, hormones matter. Therefore, it is important to understand how the pill, and its synthetic hormones, affect women on a physical and mental level.

Women have two types of sex hormones, estrogen and progesterone, which are both designed to fulfill different tasks (Hill, 2019). Broadly speaking, women's menstrual cycle consists of 28 days and can be divided into two phases. In the middle of these phases ovulation occurs, which means that a mature egg is released and that there is a possibility of reproduction.

The first phase of the menstrual cycle starts on the first day of a woman's period, and centers around conception. The brain knows that there is no pregnancy going on and thus tells the ovaries to mature a new egg for another round. This stimulation of the ovaries goes along with a rise in estrogen, which gradually increases. The moment that it peaks, the brain knows that the egg can be released and as a result ovulation occurs. The second phase of the menstrual cycle starts after ovulation and centers around implantation and pregnancy. This period is characterized by high levels of progesterone.

Women who are taking the contraceptive pill, do not have a biological[4] menstrual cycle anymore and have a different hormonal profile than women who are not on the pill. The core task of the pill is to prevent ovulation, so that women are able to be sexually active without risking fertilization and consequently a pregnancy. The synthetic estrogen and progestin (a synthetic progesterone) that the pill contains, mimic the second phase of the menstrual cycle. 'Rather than having dynamically changing hormones across the cycle like naturally cycling women do, pill-taking women get the *same* hormonal message delivered every day.' (Hill, 2019, p. 78). The message that Hill points at here, is that by keeping the levels of estrogen and progesterone high, the pill tells a woman's body that there is no need to mature an egg. The body thinks that ovulation has just occurred, and that it is waiting for a possible conception. As a result, there is no release of FSH (follicle-stimulating hormone) and LH (luteinizing hormone), which are meant to stimulate the maturation of a new egg.

In other words, the pill protects women from getting pregnant by changing their hormonal profile. Hormones like estrogen and progesterone do not only regulate bodily processes but, more importantly, they also affect how women think, feel and what they do. They are 'a key part of what creates the experience of feeling like ourselves.' (Hill, 2019, p. 36). This illustrates that if women choose to go on hormonal contraceptives like the pill, that they automatically also have to choose to expose themselves to not only possibly physical, but also mental side effects. However, are women educated about this? Especially in light of the effects that synthetic hormones can have on female bodies and the lack of male options on the market, it is crucial to gain more insight in the context in which women make choices regarding contraception.

1.6 Case study

Studies like the one conducted by de Graaf et al. (2017) remain superficial by focusing predominantly on general data about the number of women that are on and off the pill. Too little is known about women's individual experiences with contraceptive decision making. Therefore, this thesis will explore the paradoxical relationship between the opportunities that female contraceptives like the pill offer and Dutch women's reproductive autonomy.

[4] To remove the normative element, I deliberately write 'biological cycle' instead of 'natural cycle' when I talk about menstruation without synthetic hormones. There is no such thing as a natural cycle, because every cycle is personal.

Research question:

How can a feminist approach to reproductive autonomy deconstruct the narrative of choice that surrounds the usage of the contraceptive pill?

Sub questions:

- How does access to information influence women's choice for contraception?
- Can contraception for women be considered a choice?
- How does the pill affect women's relationship with their body?
- Which affective responses does the pill evoke by women?
- How do women understand and value reproductive autonomy?
- Which role does trust play in the choice for contraception?

1.7 Feminist research

Contraception is not only a medical tool to regulate fertility, but it is also political and embedded in power relations. The choices that are presented to women, the side effects that are marginalized and the pressure on women to be responsible for contraception are all part of wider social relations, such as medical professions and the pharmaceutical market. Research like the one that has been conducted by de Graaf et al. (2017), is not adequate enough to go beyond contraception as a medical tool and see how it can also be oppressive and undermine women's reproductive autonomy. By solely focusing on the use of contraception and its trends over the years reflected in quantitative data, it neglects women's personal, embodied experiences. It is curial to take a feminist perspective, because it concerns critically analyzing gender inequality and the practices that reinforce this. Feminist research does not solely focus on one aspect, like gender, but also takes into account cultural systems, power relations and patriarchy as a whole. It questions and deconstructs the status quo, which is exactly what this thesis is about. Only by approaching today's contraceptive options and its use as something that is the result of social expectations and wider institutional decisions, can we understand the marginalized position that women are currently in.

<u>Situated knowledges and positionality</u>

In order to take a feminist point of view, it is important to change what we usually consider to be knowledge. Haraway (1988) explains that 'feminist objectivity means quite simply situated knowledges' (p. 581). She rejects the Western thought on objectivity and knowledge, which assumes that a researcher can be fully objective by detaching itself from its object of study

and in that way obtain ‘true knowledge’. Haraway claims that there is not an objective way in which a certain topic can be studied. Researchers study certain topics and make decisions throughout their work for a reason. People have different ways of perceiving the world and the most valuable thing is to understand these situated knowledges by taking lived experiences as a starting point. Only then will we be able to understand how people are affected differently (Haraway, 1988). In other words, each body is a source of knowledge and from that you are valid to make a point, including me. Women’s lived experiences with contraception should be brought to light, because together it can form collective knowledge.

Personally, I feel frustrated by the way in which contraception for women is so normalized and almost seen as part of their identity. I feel upset by the way in which the physical and emotional burden that women accept in the name of pregnancy prevention is barely seen or acknowledged. And I feel hopeless when I see that even today, new, stricter laws on contraception and abortion are introduced in countries like the United States, that undermine women’s reproductive autonomy. My personal experiences and the conversations that I have had with women around me, make that I feel determined to deconstruct dominant discourses that surround the pill. I take this standpoint because, as a woman, I have first-handed experienced how the pill can be liberating and enchaining at the same time.

Even though this strong opinion of mine has been the reason that this research is here in the first place, it does make positionality and reflexivity important. In the process of writing my thesis and obtaining the data, I continuously reflected on my own positionality and the way in which this affected my research. I will elaborate on these moments of reflection throughout the chapters.

1.8 Research method

Since the aim of my research is to deconstruct the narrative of choice that surrounds the pill by gaining a deeper understanding of women’s lived experiences, I considered semi-structured interviews to be the most suitable research method. It allowed me to prepare the interview by creating a topic-list that could give the interviews direction, without making it feel unnatural. The benefit in comparison to a fully structured interview, is that the interview could feel more like a conversation. The less rigid format would make the interviewee more likely to open up (Hermanowicz, 2002), while at the same time leaving room for the participants to shape the interview. The interviewees could elaborate on certain topics if they felt the need to or they could have their own input and steer the interview in a new direction. In my opinion, this type of method would give me the opportunity to gain a deeper

understanding of their lives and how they relate to contraception, without creating a strong hierarchy between me as researcher and them as interviewees.

I interviewed five cis, white, heterosexual, middle-class women between the age of 21-25. There are three reasons for choosing this group of women. First of all, I am focusing on the pill as a means to prevent a pregnancy rather than for example as a solution for heavy periods or acne. Heterosexual women are more likely to use the contraceptive pill for birth control than queer women. Secondly, I decided that the women should be at least 21 because from that age, insurance companies do not fund the contraceptive pill anymore. This makes the issue of who pays for the pill relevant. Lastly, I decided to interview solely white women because I focus on the right to prevent a pregnancy, rather than the right to have children in the first place. Davis (1982) explains that in the 20th century, for white women from the US the fight over reproductive autonomy was one over contraception and being able to prevent a pregnancy. Black women however, fought for the freedom to actually have children. Eugenic movements focused on eliminating 'unfit' participants of society, resulting in racial minorities like black women to be compulsory sterilized. It is clear that reproductive autonomy and its politics are linked to racists practices, and thus that black women's experience with reproductive autonomy differs from those of white women. This is an extremely important and valuable angle to explore, but in this thesis I focus specifically on reproductive autonomy and the right to prevent a pregnancy. Consequently, it felt unjust to interview black women because I believed that my research design was not apt to fully understand their specific lived experiences.

I conducted the interviews in spaces where the participants felt comfortable and safe. Two of the interviews took place online via Zoom and the other three interviews took place at the participant's home. Duncombe and Jessop (2002) stress the importance of rapport between the interviewer and the interviewee, because it makes the interviewee more likely to open up. Since all of the interviewees were friends or acquaintances, this rapport was already naturally there. However, I was aware of the fact that my emotional connection with the interviewees could also be ethically challenging. Duncombe and Jessop (2002) mentioned that 'with deeper rapport, interviewees become more likely to explore their more intimidate experiences and emotions. Yet they also become more likely to discover and disclose experiences and feelings which, upon reflection, they would have preferred to keep private form others' (p. 112). I wanted to prevent that my interviewees shared information with me because I am their friend, while they actually did not feel comfortable sharing it for research purposes. Even though interviewees can never give fully informed consent because they do not know how the

interview will evolve, I stressed in the beginning that they should only share what they feel comfortable with sharing. All the participants agreed with having the interview recorded and after transcribing the interviews, I deleted the audio files in order to protect their privacy. The data were exclusively used for this research.

Structure and analysis

The interview consisted of three blocks of questions which touched upon three different themes, namely 'knowledge', 'reproductive autonomy' and 'responsibility'. The first block was mainly descriptive and aimed to give more information on the context in which the interviewees decided to start the pill. I focused on their motivations for starting the pill, the moment in which they made this decision and the social context in which they did so. I also asked how they have been informed on contraceptive options and tested their knowledge on the workings of the pill. In the second block of questions, I researched how the pill and contraception in general affects them on a more affective and emotional level. I wanted to know where their priorities lie when it comes to reproductive autonomy, and whether they feel like the current landscape matches this. The last block was focused around responsibility for contraception and how this is linked to notions of femininity. I researched how responsibility is currently enacted and whether this differed from how they would like it to be. The full list of interview questions can be found in the appendix.

After the interviews, I transcribed them and looked for similarities and differences between the answers that I received. I linked these primary sources to relevant feminist literature in order to place them in a wider discourse on choice and reproductive autonomy. Especially *How the pill changes everything* (Hill, 2019) is an important book that has allowed me to approach the topic of contraception in this specific way. It explains hormones on a biological level and how synthetic hormones can affect women's behavior with regard to stress, libido and interpersonal relationships. But more importantly, it also addresses wider issues like competition in the research field, sexist practices and politics. The book made me understand how the pill specifically works and gave me an insight in the dynamics of the pharmaceutical market. Another secondary source that has been helpful is the article *De-constructing 'choice': the social imperative and women's use of the birth control pill* (2010) by Granzow. According to her, taking the pill is presented as an act of individual agency, while it actually is an act of repetition encouraged by social expectations. She argues that it places women in a difficult position, since they are considered to be 'choosing reproductive subjects', while her respondents were ambiguous whether they experienced using the pill as a

choice. This ambiguity could be seen as a form of resistance and opens up the possibility to critically analyze ‘choice’ in this context. I took her interesting argument as a starting point and developed it further by linking it to reproductive autonomy.

In order to answer the research question extensively while keeping this thesis structured, I have decided to discuss my findings in two main chapters: ‘The illusion of choice’ and ‘Reproductive autonomy’. Throughout these chapters I will analyze my interviewees’ answers with regard to the themes knowledge, reproductive autonomy and responsibility.

2. The illusion of choice

2.1 Introduction

It is clear to say that the pill has opened doors for women that were closed before. Nowadays women can deliberately choose to not get pregnant, in contrast to 60 years ago when women were more left to their fate. The fact that women can plan their pregnancy has made them to be more active agents in their life and has contributed significantly to women's emancipation. However, even though there are many positive things that can be said about the pill and contraception in general, there is also a critical note to be made here. It seems as if contraception is 'a solved problem', only because women can choose between different contraceptives. But, as I already mentioned in the theoretical chapter, women's choices cannot be seen as existing independent from social structures and political factors. Does the mere presence of different female contraceptives and the option to 'choose', automatically exclude a predetermined trajectory for women? In other words, does it exclude that they are pushed in a certain direction? Women's options are limited and the extent to which women can choose, is shaped by external factors. In this chapter, I will dive into these factors by sharing Dutch women's embodied experiences with contraceptive decision making, a concept mentioned by Donnelly et al. (2014). It refers to the considerations that women and their provider of contraception make when they are in the process of choosing a contraceptive. My aim is to critically analyze the notion of 'choice', by addressing how contraception can be enabling and limiting at the same time. Using the pill should be considered a social and political matter, instead of a matter of women's choice. First, I will touch upon women's motivations for starting the pill. Then, I will show how a lack of information on contraceptives and the absence of male contraceptives shape women's contraceptive decision making.

2.2 Background of the interviewees

For this research I interviewed the following five women: Lotte, Ilse, Noene, Vivian and Amber. The reason that I selected these women is that they are all sexually active and, even though they might have started it for different reasons, they currently take the pill predominantly as a form of birth control. These women have their own story and personal experience with being on or off the pill. Lotte for example, started the pill when she was 13 due to menstrual problems. She got her period very irregularly and if she did, it was so heavy that she could not function properly. The pill has changed the relationship with her body in a positive way, by relieving her from extreme cramps and back pain. Since a few months she

has a boyfriend and is starting to wonder how her menstruation would be without the daily intake of synthetic hormones and whether it has changed. However, she currently feels like she cannot try this because she finds male contraceptives not effective enough.

Ilse got her first boyfriend at the age of 15 and started the pill to protect herself from getting pregnant. Even though this relationship did not last, she continued the pill out of habit and because it enabled her to regulate her period. She was content with it, until she started to have problems with high blood pressure and the pill was mentioned as a possible cause. Ilse delved more into the side effects and realized that these were more extensive than she assumed. On top of that came her mother's personal experience with the pill. After years of being on the pill she got thrombosis in her leg, which is known to be a side effect of pill-use. These factors made that Ilse decided to quit hormones, but it turned out not to be as easy as she imagined. The only option that would protect her just as much as hormonal contraceptives is the copper IUD. The copper wire that is coiled around the IUD produces an inflammatory reaction that is toxic to sperm and eggs. Sperm can hardly reach an egg and if an egg is still fertilized, it cannot implant itself (NHS, 2021). Ilse has had it for two years now and even though she feels safe because it protects her well, she also questions it. She experiences more emotional instability, heavier periods and inexplicable weight gain.

Noene started the pill when she was 17, because she wanted to regulate her menstruation. On her 21st, she found out that she had a uterine fibroid[5]. This is also known as a myoma, and concerns a non-cancerous tumor that grows in or around the uterus (NHS, 2018). The pill provided relief during the medical treatment of her fibroid by reducing the bleeding. In this way, it allowed her to keep doing her tasks as a student and employee. After the surgery, the gynecologist told Noene that she should listen to her own hormone balance, so Noene quit the pill. However, she currently has a boyfriend and decided to start the pill again as a means of birth control. The copper IUD was not an option for her, because it requires a surgery-like treatment and she finds this mentally and physically challenging due to her medical history. Therefore, the pill seems to be the best option. Noene feels like she lost sight of her body without hormones, but also finds peace in the idea of being well-protected.

Vivian was not keen on using the pill because she considered it as something unnatural, but promised to herself to start it as soon as she would become sexually active. This moment arrived when she was 21 and she has been on the pill ever since. Vivian is

[5] 'Vleesboom' in Dutch.

currently not in a relationship but has, as she calls it, ‘casual contacts’. She feels responsible for taking care of contraception and thus takes the pill every day.

Amber started the pill on at the age of 14 as a way to make her periods more doable. Only when she quit it five years later, did she realize how it had impacted her mental and physical health. While being on the pill, she felt like everything was out of balance and she experienced a distorted self-image. Amber had gained weight and started to develop an eating disorder. At the same time, she was dealing with depression and emotional instability. It took half a year of being off the pill before she started to feel like herself again. She currently uses a combination of the pull-out method (in which a man pulls back his penis before ejaculation), the calendar method (meaning that she tracks her ovulation and thus fertile period) and condoms (The society of obstetricians and gynaecologists of Canada, 2021). Amber is aware of the fact that these methods are more risky than hormonal contraceptives, but she feels like there is no good alternative available that will not give her the side effects that she experienced before.

It was interesting to see that these five women hold similarities as well as differences. They are all sexually active, most of them in a heterosexual relationship, and in the same stage of life. They are either at the end of their study or at the beginning of their career, and believe that an unplanned pregnancy would threaten this. This feeling particularly surfaced when I asked them about reproductive autonomy and what it means to them. Even though they are all focused on not getting pregnant, the way that they approach this differs significantly. Especially with regard to the contraceptives that they use and the road that they have taken to get there. Lotte for example, started the pill and never went off it. In general, she is content with it, especially because it also allows her to regulate her menstruation. Ilse and Amber on the other hand are in a more difficult position. They cannot take in hormones due to a medical history and are still asking themselves whether a copper UID or a combination of more natural methods and condoms are the best option.

Since these women are in a similar stage of life as me, I noticed that during the interviews I could easily understand their point of view. In the next sections I will dive deeper into the answers that my interviewees gave me and analyze them from a feminist perspective.

2.3 ‘Choosing’ for the pill

In general, the interviewees started the pill either for regulating menstruation or pregnancy prevention. These motivations were subject to changes in the interviewees life, meaning that the reason for being on the pill could shift over time, and often coincided.

I got my period when I was 12. I menstruated very irregularly and heavy. On the first day I was practically sick and could not go to school due to cramps. It was also inconvenient because I was afraid to use tampons, so for example going swimming with school was complicated. Many of my friends had not started their period yet either. My mother proposed to go to the doctor and I started the pill on my 13th. All my problems were solved. I barely had any pain in my stomach and back and my period only lasted for three to four days, instead of seven. (Lotte)

In a sense, through using the pill Lotte has taken control back. Whereas her menstruation first impacted her life, and could even prevent her from living it fully, she can now determine when she will get her period. This means that she does not have to adjust her activities to her menstruation anymore. Granzow (2007) suggests that controlling bodily processes like menstruation and reproduction is linked to a sense of freedom. She assumes an 'association between control over the body, that is, over reproduction, and increased choice in life(style)' (Granzow, 2007, p. 47). In other words, controlling the body with the mind is considered to give women more agency. However, Granzow also problematizes this by claiming that there seems to be a shift from the *wish* to control bodily processes to an *obligation* to do so. I think that this is where there seems to be a difference emerging between using the pill as a means of controlling menstruation like Lotte, or as a form of birth control.

As I mentioned earlier, women's reproductive functions were considered to be the main thing that inhibited women from participating fully in society. Controlling these processes, meant that women could also be seen as rational beings worthy of a place in the public realm. The pill could enhance women's freedom by allowing them to regulate their menstruation and in that way, reduce the impact it can have on their body and life. In Lotte's case, her heavy and irregular period prevented her from going to school as a child. There are also many other, daily situations thinkable in which menstruation can be perceived as a limiting factor, such as going to work, exercising and social activities. It is completely understandable that for women like Lotte, the pill can feel like a godsend.

However, there is an important difference between using the pill as a solution to heavy menstruation and using it as a means of birth control. Heavy menstruation is something that only affects you and is only caused by your own body. In this way, taking the pill is a choice solely made by yourself and for yourself. A pregnancy, on the other hand, always includes at least two actors, namely a man and a woman (or more, in case you cannot conceive

biologically). Even though these two actors have in theory equal responsibility when it comes to preventing a pregnancy, often women are the ones that are expected to take care of it. Using the pill can feel more like an obligation, rather than a wish. This was also reflected in my interviews. I saw a different narrative emerging if the interviewees used the pill predominantly as a form of birth control.

I always thought that you shouldn't go on the pill, because it is unnatural and it has side effects. But I knew that if I was going to be sexually active, that it would be the best option. If I only used a condom I would be stressed out. (Vivian)

I really don't want any hormones. But there just comes a time that you have to choose. You can be fundamentally against something, but you also don't want to get pregnant. (Noene)

These two answers display a similar story. Vivian and Noene explain that they always had a strong resistance towards the pill. They did not like the idea of synthetic hormones changing their biological menstrual cycle and exposing themselves to possible side effects. However, the desire to be sexually active makes that they felt like they have to choose. The choice is between starting the pill even though they might not want to, or risking a pregnancy. As Vivian indicates, this choice is influenced by the absence of effective male contraceptives. She says that she would be 'stressed out' if she only used a condom, which means that she does not see it as sufficiently effective for preventing a pregnancy. The only way to protect themselves from an unwanted pregnancy, is if they use contraception themselves (which practically all include hormones). Vivian and Noene are currently both using the contraceptive pill, which implies that the costs of getting pregnant seem to outweigh their ethical considerations. Their lived experiences tell us that choosing for the pill, could require you to put your own personal beliefs aside.

2.4 Access to information

If you want to make a conscious choice, it is crucial that you have sufficient information on the different options. Donnelly et al. (2014) researched which kind of information women value the most when it comes to contraceptive decision making. Their results show that women's number one priority is knowing how a contraceptive works, followed by its safety (e.g. whether it increases the risk of specific health issues) and its side effects (e.g. weight gain). This is the kind of information that women are meant to receive during a doctor's

consult, which all women have since you need a doctor's prescription to get the pill. The experiences of the interviewees show that getting a prescription was not a problem, the lack of information however was.

If I wanted it, I could get it. Especially when I started the pill for the second time it was no problem. I only had to call the receptionist and then I had it again. (Vivian)

You go there with a targeted question and they kind of can't refuse you. So yeah, it's easy. Perhaps too easy. Doctors give too little information. There should be some sort of disclaimer, like 'Hey, did you actually think about your choice and do you know about the side effects?' (Noene)

Of course, it is a positive thing that the pill is perceived to be an accessible contraceptive method. It is important that, regardless whether women want to make use of it, the option is at least there. However, and Noene's answer already suggests it, the ease of getting a prescription does seem to come at a cost. Even though a doctor's consult is meant to educate women properly on contraception, the majority of doctors consults in the Netherlands only lasts approximately ten minutes (Irving et al., 2017). Is this short period of time enough to provide women with all the information needed to make a conscious choice for the pill?

According to my interviewees it is not. Even if the doctor had explained the different options, health risks, or possible side effects, this was done very briefly. This lack of knowledge came to light when I asked my interviewees whether they know how the pill prevents them from getting pregnant. Especially since this is the 'number one priority' for women to know (Donnely et al., 2014), I expected my interviewees to understand how the pill works. As I told before, the pill prevents ovulation so that women cannot get pregnant. One swallows synthetic estrogen and progesterone for 21 days, followed by seven pill-free days that causes a bleed (sort of a 'fake' period). Ilse only knew that it had hormones, saying 'it has estrogen and that other thing… testosterone?' Vivian believed that you still have a biological period and that there is an ovulation, 'but less than usual'. Lotte came somewhat closer, saying hesitantly after a long pause: 'I think there is no ovulation?'. Only Noene and Amber were confident that the pill stops ovulation and that the bleed is not the same as if you have a biological cycle. Nevertheless, Noene remained critical and said: 'But I don't know well enough how it further affects my body to choose for the pill'. She refers here to the side effects that the pill can have on women's physical and mental wellbeing. When I started to

ask my interviewees about their knowledge on the pill, e.g. how it works and how it affects your body besides making you temporarily infertile, I noticed that my interviewees felt uncomfortable. I think that especially this interview question served as a moment of reflection for them. Knowing how the pill works is not a prerequisite for being able to start it, and I think that my own level of knowledge on this topic made them question their own. They felt 'bad' or 'awkward' for not knowing what they had been or still were taking in on a daily basis. Perhaps my interviewees realized that they were not as informed as they thought they were. Possibly not even informed enough to understand what they really choose for.

The problem here is that, even if doctors did share all their knowledge, that we still do not know everything. We do not know exactly how the pill affects women's bodies, because that information is simply not there. 'We live in a world in which women's hormones, sexuality, and fertility are politicized in ways that men's are not. And this politicization makes it difficult to talk about nuanced research that looks critically at the pill' (Hill, 2019, p. 229). Women have been systematically excluded from medical research, which led different dimensions of women's health, such as the pill, to be an understudied topic. Furthermore, and that is what Hill points at here, studying women's hormones or birth control is politically challenging. Scientific results can easily be misinterpreted by the mass media or, even worse, used as an anti-statement for women's access to contraception. Even women themselves find it a charged topic, since their hormones is what made them to be seen as irrational and thus not unworthy of rights in the past. However, at the same time refusing to study the pill critically due to its politically charged nature, causes women to make major decisions about their lives without having access to enough information.

Paradoxically, the extensive list of accessible female contraceptives gives women different options, but the organization of our health care system and the lack of research make that they cannot be informed about these options properly. This means that women cannot choose to go on a contraceptive like the pill with their eyes wide open.

2.5 Embodied experience with being on the pill

Sometimes only going through something and experiencing it yourself, can make you fully understand what a decision means. Ilse experienced how the pill affected her more than she initially thought and the constraints that she felt when she wanted to quit it.

In 2019, after being on the pill for multiple years, Ilse went through different medical examinations because she was having problems with her heart. Her blood pressure and

heartbeat did not slow down enough at night, and a specialist told her that this could be a side effect of the pill. Ilse started to reevaluate being on the pill and realized that she was unaware of how the daily intake of synthetic hormones affected her body.

I thought, what does it actually do to you? I put hormones in my body every day but yeah, I don't even know what it exactly does to me. I started to feel an increasing urge to quit hormones and experience my own bodily processes again. There are not that many options that are left then. Only natural methods and the copper IUD, which feels like a surgery. (Ilse)

Ilse mentions that she felt like she had two options left: natural methods and the copper IUD. Natural methods are forms of contraception that 'do not involve medications or devices to prevent pregnancy but rather rely on behavioural practices and/or making observations about a woman's body and menstrual cycle.' (The society of obstetricians and gynaecologists of Canada, 2021). Women for example, could determine their fertile period based on their basal body temperature which rises during ovulation (temperature method), or track their menstrual cycle in an app which calculates their date of ovulation for them (calendar method). As soon as women start to understand their body and feel confident that they know when they are fertile, they can have unprotected sex in their infertile period. A natural way in which men can prevent a pregnancy is with coitus interruptus (withdrawal). The largest advantage of such natural methods is that there are no hormones involved and thus no side effects. However, even though these methods are in theory reliable, the typical-use rate shows otherwise. It requires a high level of self-control and commitment from both sides, as well as a lot of practice. Consequently, natural methods are often less effective in preventing pregnancies. Of every 100 couples, 24 couples that use fertility awareness-based methods and 22 that use withdrawal still gets pregnant within a year (The society of obstetricians and gynaecologists of Canada, 2021).

Since natural methods are known to be unreliable, Ilse decided to go for the copper IUD. While she was sitting at the gynecologist for the insertion, he tried to convince her to switch from the copper IUD to one with hormones.

I was like, I choose consciously to not take in any hormones and he still sort of tries to convince me to take it anyways. I didn't like that at all and thought it was weird. My mum said that she got thrombosis due to the pill, and he replied: 'Yeah, but it's better to have no period

for ten years straight and maybe get thrombosis than having your period every month right?' (Ilse)

Due to medical reasons, Ilse wants to stop taking hormones. This is easier said than done, since the majority of female contraceptives contain hormones. Constraints that were not visible before, become real in its consequences. As long as women comply with taking in hormones there is a wide variety of options. They could take the pill, patch, ring, injection and so on. The moment that women refuse to take hormones but still want to be well protected, only one option is left: the copper IUD. This option is not only less common, it also requires more emotional and physical labor. It needs to be inserted, which is often a painful procedure, and the copper makes women's menstruation heavier.

The way that the gynecologist still tried to steer Ilse in the direction of the IUD with hormones, indicates how hormonal contraceptives seem to be the norm. Ilse's experience shows the consequence if women resist this norm. If women refuse to take in hormones, all of a sudden the options that they are presented with is extremely limited. Accepting synthetic hormones and the side effects that it can have, seem to be a precondition for the illusion that women have a choice. In other words, women's contraceptive decision making is not only structured by the absence of effective male contraceptives, but also by absence of effective hormone-free alternatives. Ilse's choice was one of choosing between the lesser of evils, in this case getting pregnant or accepting the discomforts of the IUD.

2.6 Conclusion

In this chapter, I have aimed to contextualize women's decision to use the contraceptive pill. During the interviews, I noticed a clear difference in lived experiences between using the pill predominantly as a way to regulate menstruation (like Lotte) or using it as a form of birth control. For Lotte it is felt as a way of taking the power back, by not letting her heavy menstruation get in her way of living life to the fullest. She talked about in in a positive way. However, Noene and Vivian, who both use it to prevent themselves from getting pregnant, responded differently. They seemed frustrated, which could be explained by the fact that they would rather not take the pill. They are both morally against taking it, but feel obligated to do so because they do not want to get pregnant. It seems as if for women, the decision to be sexually active automatically means that they also have to make a decision with regard to contraception. This decision is not about whether they need to use contraception themselves or not, it is about which kind they have to use. This is caused by a lack of effective male

contraception and strong societal pressure on women to be responsible for pregnancy prevention. The ‘choice’ that they have forces them to put their ethical beliefs aside and go to the doctor to get informed on different options.

These options turn out to be limited and focused on hormonal contraceptives. This was illustrated by Ilse’s experience, who refuses to take in hormones. She only had one suitable option left, namely the copper IUD, and even just before its insertion she was steered into the direction of an IUD with hormones by her gynecologist. Serious side effects of hormonal contraception like blood clots seem to be dismissed in the name of pregnancy prevention or menstrual regulation.

Getting well informed on options also turns out to be easier said than done. I was shocked when I found out that Ilse, Lotte and Vivian barely knew how the pill works. Vivian for example, thought that women on the pill still ovulate. How could she understand what she takes in every day, if she does not even understand the most important thing that the pill does? Namely preventing having fertilized egg by making sure that there is no egg at all? I believe that this is an important finding, because it illustrates that women are not aware of how the pill affects them physically and mentally. According to Hill (2019), this is partly caused by a wider trend of women’s systematic exclusion from medical research. If we consider being informed on different options to be a key prerequisite for making a choice, can women’s contraceptive decision making be considered a matter of choice?

3. Reproductive autonomy

3.1 Introduction

In the previous chapter I critiqued the notion of 'choice' that surrounds the usage of the contraceptive pill. I argued that women's choice to start the pill, and contraception in general, is socio-politically constructed and embedded in power relations. It is shaped by the absence of alternatives (effective male contraception and effective hormone-free contraception), lack of information on the side effects and it requires letting of personal, ethical beliefs. If we start to see women's 'choice' for contraception as one that is socially and politically constructed, we can also start to critically analyze women's reproductive autonomy. As I explained before, reproductive autonomy can be defined as 'an individuals' ability to be fully empowered agents in their reproductive needs and decisions and to access reproductive health services without interference or coercion' (Senderowicz & Higgins, 2020, p. 147). In this chapter, I will examine to what extent women nowadays can actually be considered 'fully empowered agents in their reproductive needs'. What are my interviewees' 'reproductive needs' exactly? And how are these met in the current system, if they even are? First, I will elaborate on what reproductive autonomy means for my interviewees. After that, I will approach using contraception from different angle, by linking controlling fertility to wider expectations around femininity. In the end, I will elaborate on the conceptualization of contraception as a mutual responsibility.

3.2 Embodied experiences with reproductive autonomy

After giving my interviewees Senderowicz and Higgins' (2020) definition on reproductive autonomy (which is stated above) and explaining to them what it entails, I asked about their own experiences. I wanted to know how their reproductive autonomy is given shape in their lives and what it means to them.

I think that especially the pill gives me the right to self-determination. I can protect myself against a pregnancy, while before women just got pregnant. I'm very glad that I don't have to trust condoms and stuff. And if I'm not happy with the pill, I can just go to the doctor and ask for different options. Without the pill I would panic every month, thinking 'I hope I'll get my period'. (Lotte)

Lotte explains that protecting herself from an unwanted pregnancy gives her a feeling of self-determination. An interesting thing to note in this excerpt, is the comparison that Lotte makes between the pill and 'condoms and stuff'. She seems to be glad that she does not have to trust condoms and can rely on the pill instead, which has a 99% efficacy rate when taken every day (Planned Parenthood, 2021a.). Effective contraception with a minimal risk of getting pregnant, seems to be a pre-requisite for having the feeling of self-determination. For her, reproductive autonomy means having practically no chance of getting pregnant and thus not having to 'panic every month'. This also illustrates the limitations of male contraceptives like condoms. Even though condoms are presented as a good alternative to female hormonal contraceptives, it is not as effective in preventing pregnancies. In theory, the condom is 98% percent effective, but in reality this often is 85% since it has to be used correctly. A condom could also break and if that happens the woman still needs to take in synthetic hormones in the form of a morning-after pill. Therefore, Planned Parenthood (2021b) says that 'It's a good idea to use another form of birth control, like the pill, ring, shot, implant, or IUD, along with condoms'. Their advice illustrates that when your main reproductive need is to have practically no risk getting pregnant, solely condoms do not suffice as an alternative to hormonal contraception.

This feeling, that effective pregnancy prevention is at the core of reproductive autonomy, was also reflected in the other interviewees answers. Vivian and Noene explain why this is so important to them.

For me reproductive autonomy means being free to leave a partner, without being hindered by an unwanted pregnancy. There used to be more of a power dynamic, in which the woman was subordinate to the man. If you got pregnant unintendedly, it became harder to work and you became dependent on a man. Now, women want to make a career and a child costs money, time and energy. Contraception gives you the possibility to decide when you want to have a child and with whom. (Vivian)

Vivian says that she finds controlling her fertility extremely important, because it gives her more agency when it comes to choosing and leaving a partner. Before contraception became widely accessible, there was an ongoing risk for women to get unintendedly pregnant. Having a child often meant that women had to give up their career and stay home to take care of their family. Vivian says that she feels like the pill has changed women's subordinate position to men. In her eyes, contraception has allowed women to be more independent and make a

career. This idea is supported by Kolbert (1989), who argues that reproductive rights (such as access to contraception) is crucial for women's empowerment. 'Women's ability to control whether, when, with whom, and under what conditions they will have children, in short, women's power to control their fertility, is essential if women are to participate fully and equally in society. Only with the freedom to control their fertility are women free to learn and grow.' (p. 292).

The pill is really a first need. Women want to make a career and having a kid is then the least thing you want. No one is going to take synthetic hormones of which you don't even really know what it does to your body, without having a huge advantage. Not getting pregnant has to give you so much peace that you voluntarily swallow that pill. (Noene)

Noene emphasizes the importance of contraception for making a career as well. She describes the pill as 'a first need', because it allows women to develop themselves professionally without risking an unwanted pregnancy. She says that the desire to make a career is so strong, that women 'voluntarily' take synthetic hormones without actually knowing how it can affect you physically as well as mentally. Similar to when women are actually against the pill, the advantage of taking it has to outweigh the costs (in this case the lack of information). The point that Noene makes here is an important one, because it relates to a blind spot that Hill (2019) mentions in her book *How the pill changes everything*. She says that 'we are willing to turn a blind eye to all the ways the pill can change women because we simply can't entertain going back to living in a world where women don't have control over their fertility (p. 233). This relates to a more general resistance by the medical establishment to critically analyze the pill, but it can also be applied to a more individual level. Women cannot afford to question the pill itself, because it would automatically mean that they would question the use of it. And this is something that they cannot afford either, because they find it extremely important to be well-protected against a pregnancy and not that many other options can fulfill this need. This protection is not only crucial for feeling free to choose and leave partners (like Vivian), but also for being able to pursue professional dreams (like Noene). The result is that women have created a certain blind spot. 'Women never think to question the wisdom of the pill, and instead question the wisdom of their own bodies' (Hill, 2019, p. 232). This is something that I experienced myself as well. For a long time I simply did not want to accept that my mood swings and loss of libido were caused by the pill, because I was so eager to be sexually active without risking getting pregnant. I thought that my own body was the problem, and was

frustrated that it did not work the way that I wanted it to. In other words, being well-protected against pregnancies seems to be extremely important to women, but this does not come without a cost.

3.3 Agency and being steered into a certain direction

Reproductive autonomy implies that women are 'fully empowered agents' when it comes to contraceptive decision making. This means that they are free to choose which contraceptive they want to use and that they do not experience any difficulties while accessing it. In the first chapter I illustrated that, luckily, contraception is legal and accessible in the Netherlands. As long as you have a doctor's prescription (which seems to be no problem), you can practically receive any contraceptive you want. However, I also showed that women are still pushed into a certain direction, namely hormonal contraceptives. This feeling also surfaced, when I asked Ilse whether she considered herself to be a 'fully empowered agent'.

I think it is fifty-fifty. I think we can determine more about our uterus than before. I feel like there are many options for women. So that's your own choice, if you want it or not. But if you don't want any hormones then you still feel limited. Measuring your temperature is too tricky and I don't want a condom either. So in that sense I feel pressured to have my copper IUD. (Ilse)

This excerpt perfectly illustrates women's difficult position. On the one hand, they could be seen as agents navigating in a landscape filled with possibilities. The contraceptive options are simply there, and they can decide themselves whether they want to use it or not. In a sense, this is empowering of course. They can *choose* to take control over their menstruation and reproduction. On the other hand, it is only a choice as long as you go along with what or society wants you to choose, in this case hormonal contraception. The moment that you refuse this, all of a sudden you are limited. You have to choose between a higher risk of getting pregnant or accepting the only alternative: a copper IUD. Since we live in a society in which women are focused on making their own decisions professionally and personally and not being hindered in that, the first one is not an option. Consequently, women like Ilse opt for the copper IUD. And as Ilse already indicates, this decision is not really a choice, but one that is made while being pressured.

A similar narrative emerged when I asked Amber what reproductive autonomy means to her.

It's about making your own decisions over your own body and not being pushed back by a lack of options and resources. Self-determination is a constitutional right. (Amber)

According to Article 11 of the Dutch Constitution, 'everyone shall have the right to inviolability of his person' (Ministry of the Interior and Kingdom Relations, 2018). It is about bodily integrity, neither the government nor other people should be able to make decisions about your body without your consent. Furthermore, according to the international Convention on the Elimination of All Forms of Discrimination against Women[6], being able to decide when to have children is a fundamental right (Overheid.nl, n.d). This indicates that for women, access to contraception is indeed a constitutional right. However, contraception for men should be a fundamental right as well.

When I asked Amber how the feeling of self-determination plays out in her own life, she seemed frustrated. She said that she feels societal pressure to take the pill, but that she does not want to. Due to her history with depression and borderline and the link between hormones and an increase in mood-swings, she is determined to stay away from any synthetic hormones. Therefore, she currently uses a combination of condoms and the calendar method. She tracks her menstrual cycle with an app to make sure to use a condom when she is fertile. Amber explains that it feels like a 'plan b', caused by a lack of other hormone-free options. I believe that her experience shows that there is no 'inviolability' of a body. In the current system, women's reproductive needs cannot be met and they feel pressured to take contraception and affect their body in a way that they rather not to. In other words, the embodied experiences of Ilse and Amber deconstruct the idea that women can be considered 'fully empowered agents'. It seems as if they are, as long as they comply with taking hormonal contraception. As soon as you refuse to take this, your freedom of choice immediately decreases and your reproductive autonomy is undermined. Even though contraception and bodily integrity might be considered constitutional rights by law, these experiences also show that there are limits to it. Therefore, it is important that we include men in the picture as well.

3.4 Controlling fertility as part of identity: social expectations

In the first chapter I critiqued the article on sexual health by De Graaf et al. (2017) because it solely focuses on women's use of contraceptives. Ironically, we can see how many women

[6] Also known as the 'VN-Vrouwenverdrag' in Dutch.

use condoms, but we cannot see how many men use condoms. I argued that the absence of data on men's use of contraceptives contributes to the idea that contraception is a female issue. However, I believe that there are more factors involved in reinforcing the idea that women should be the ones responsible for contraception. In the following part, I will dive into these factors.

During the interviews I felt like my interviewees had an internal conflict going on in which they felt a clash between two different needs. On the one hand they understood that, since they are the ones that get pregnant, that they had to think about contraception. Noene said that 'women can't just walk away if they're pregnant', referring to the fact that a pregnancy holds more consequences for women than for men. Amber confirmed this, saying that women should think about it more because men do not take it serious enough. Lotte talked about gender equality in our society and said that a pregnancy 'should be considered as risky as for women'. However, she believed that this is currently not the case because eventually, the burden is always on women. If they get pregnant, they are the ones that need to make a decision to carry the child and give birth to it, or get an abortion. This decision is extremely hard and both options have a tremendous impact on women's lives. My interviewees were well aware of this, which perhaps explains why they accept side effects and move aside moral complains in exchange for the effectiveness that the pill offers.

On the other hand, my interviewees also felt frustrated. It seemed like what frustrated them the most was not necessarily the fact that they felt responsible for choosing contraception because they can get pregnant, but mostly that they are *expected* to make that choice. Ilse explained that during sexual intercourse, not a single guy had asked her whether she used protection or proposed to use a condom. In other words, if Ilse had not intervened herself, she would automatically have risked getting pregnant. Perhaps not only the fact that women are the ones that get pregnant make them feel responsible for contraception, but also men's lack of initiative and responsibility. Noene thought that it is ridiculous that women's use of birth control is so normalized. 'The society wants us to desire children and give birth, but at the same time we are pressured to take something that prevents that.' Lastly, Amber described the expectations of women to use contraception as 'unfair'.

Interestingly, and in contrast with my other four interviewees, Vivian thought contraception should indeed be a women's issue.

You're a woman of course and part of your identity is that you have a cycle and can get pregnant. So it's logical that the woman takes the pill. (Vivian)

The moment that she said this, I noticed that I did not agree with her and immediately felt the urge to change her mind. Rather than seeing pregnancy as something that requires two people, she shifted the focus only to women. Instead of finding it problematic that men can walk away in case of an unwanted pregnancy, she believed that women are the ones that should prevent it in the first place. Especially the word 'logical' triggered me, as if taking the pill is part of being a woman. I reflected on my own as well as her position and concluded that I do understand where she is coming from. In the end, the fetus grows in a woman's body so a reasonable argument could be that women should be the ones to use contraception. Why though, do we feel like women's use of contraception is logical? I think that this is an interesting starting point for critically analyzing social expectations.

Wigginton et al. (2014) researched agency and responsibility with regard to women's access to contraception. They argue that the use of the pill, and contraception in general, has been feminized, meaning that women are depicted as the primary consumer. One of the areas that they situate this in, is the context of gender theory. They quote Butler (1995) and their notion of intelligible genders, which is defined as 'those which in some sense institute and maintain relations of coherence and continuity among sex, gender, sexual practice, and desire'' (cited in Wigginton et al., 2014, p. 182). Cream (1995) then, applies this to the use of contraception. She argues that using contraception is an integral part of women's gendered script and an enactment of femininity. Controlling your fertility and the idea of freedom that is attached to it, has contributed to the definition of what it is to be a heterosexual, middle class white woman.

It is important to understand that we are talking about gender (femininity) here, not sex (female). It is clear that women have female reproductive organs and that they have the capacity to give birth. This means that if a woman does not want to get pregnant, that either she or her partner has to use contraception. However, and this is what the researchers above criticize, the approach to contraception and the language that is used is gendered. Women are taught from a young age that they are the ones that should predominantly be responsible for contraception and men are kept out of the picture. This was also evident in the report 'Seks onder je 25e' (De Graaf et al., 2017), in which men's use of contraceptives was not even mentioned. In other words, contraception is still considered a women's issue. As long as we keep seeing depicting it that way, we lose the opportunity to approach it as a shared responsibility. I believe that this is what frustrates my interviewees (and me) the most.

3.5 Shared responsibility

In a context in which women are seen as responsible for contraception, the continuous development and improvement of female contraceptives is perceived as something positive and as empowering women (Wigginton et al., 2014). It is about promising women reproductive autonomy and more agency over their life by enabling them to control their fertility. The downside of this gendered approach to reproduction is that it does not allow men to take their responsibility. Wigginton et al. (2014) argue that 'the feminisation of contraceptive use has limited the discursive space for heterosexual men to be involved in contraception and stagnated developments into reversible forms of male contraception' (p. 182). In other words, by specifically targeting female consumers and developing female contraceptives, we lose the possibility of approaching contraception as a shared responsibility. The result is that responsibility for contraception currently is divided unequally. Since so many women are on the pill, men are often able to practice sex freely without carrying the burden of contraception. Women, however, cannot enjoy the benefits without also having to face the costs.

There are limited options. And with this I mean that there is not the options to take nothing, that the man is responsible for it. So choosing to be protected without having the side effects. I feel like that is actually the biggest constraint. (Noene)

Noene's answer shows light to something that is difficult to see in a landscape in which contraceptives are depicted as empowering women and increasing agency. There is actually a specific reproductive need that women have, but that cannot be met in the current system. I am talking here about having the option to let men be responsible for contraception, without automatically expose yourself to a higher risk of pregnancy (as it is with using condom). Lotte, Ilse, Vivian and Amber expressed this desire as well. The fact that it is a shared desire indicates that it might be shared amongst a larger group of women with similar demographics. How then, could we see women as 'fully empowered agents', if contraception is still their responsibility and not a shared one?

Nevertheless, there is an important side note to be made here. In 2020, Rutgers Stichting conducted another research, this time among men and women between the age 18-30 on contraception and responsibility. The report written by Van Ditzhuijzen and Coehoorn (2020) shows that the majority of the women (91%) finds it important that their partner feels responsible for preventing a pregnancy. Paradoxically, 78% of the women also say that they

want to use contraception themselves and stay in control. I found a similar contradiction in my interviewees answers, and I feel like trust is the key issue here. They expressed that they would highly appreciate it if a man would use contraception, as long as the contraceptive is just as effective as the ones that they are currently using (like a pill for men). However, they would only be able to give it out of hands if there is a certain level of trust (such as in a long-term relationship).

One-night stands can lie and can go away easier. But I trust my boyfriend, maybe more than myself. (Amber)

I think women find an unwanted pregnancy worse than men, especially with casual contacts. Men just don't dwell on it, because there is no baby growing in their body and this makes that they feel less responsible. I think that this changes if you're in a relationship. (Ilse)

Trust is important. I do not trust a friends with benefits, because we all say stuff on a moment like that and do not realize the consequences. And these consequences are always harder for women. (Noene)

These answers indicate that trust in a partner is essential for making contraception a shared responsibility. However, this is not enough since male contraceptives are still underdeveloped. Even if there is a relationship of trust, men are currently not in the position to contribute because there simply are not that many options for them. This shows how the decision made by pharmaceutical companies to focus on developing female contraceptives, does not only affect women but also men.

3.6 Conclusion

My interviewees were clear that, with respect to reproductive autonomy, being well-protected against a pregnancy is their number one priority. Lotte explains that especially the pill gives her that feeling of self-determination, because it is highly effective. Other methods like condoms would not suffice for her, which indicates that women's experience with reproductive autonomy is also dependent on the type of contraceptive that they use. Vivian explained that for her, the pill does not only give her agency about her body and future, but also the way in which she experiences interpersonal relationships. She calls it 'being free to leave a partner', by preventing an unwanted pregnancy which otherwise would tie her to that

partner. However, does a pregnancy really tie you to the other parent though? In many ways it does, but there is always the possibility to leave the father and even though it might be more difficult, to make a career. I believe that Vivian's answer is also about (hetero)normative ideals about what we consider to be family, namely a mother, a father and a child (or more). Perhaps for her, single parenthood is not an option because it means that she will not be able to live up to those normative ideals.

Noene calls the pill 'a first need', especially if women want to make a career. This touches upon a different angle of single parenthood, namely unmarried mothers that are left by the father of the child. In the Netherlands, fathers that are not married to or do not have a registered partnership with the mother, have to actively acknowledge the child (Rijksoverheid, n.d.). In contrast to motherhood which is not up to discussion, fatherhood requires an extra procedure for it to be acknowledged. Men need to go to the townhall and make it lawfully known that they are the father and thus take on the responsibilities and financial costs that come along with it. The fact that fatherhood requires an extra procedure also opens up the opportunity for men to reject it at all. Perhaps this explains why women have a blind spot, as Hill (2019) calls it, when it comes to the pill. They are aware of their more vulnerable position compared to men, and thus simply cannot afford to question the pill.

Perhaps the specific position that women hold, meaning that they are the ones that carry the child and the fact that men have to actively accept fatherhood, also explains why they find it difficult to let go control over contraception. Even though the interviewees expressed a strong desire for making contraception a shared responsibility, they also emphasized that they would find it difficult to make men solely responsible for contraception. Feelings of trust in a partner seem to be a precondition, indicating that emotions and affect are important elements of reproductive autonomy. This also explains why situated knowledges are so valuable when researching contraception. It allows us to gain a deeper understanding of those emotions.

Discussion

This thesis is focused on deconstructing the narrative of choice that surrounds the usage of the contraceptive pill by taking a feminist approach to reproductive autonomy. In order to do this, there were two chapters which both critically analyzed different themes. The first chapter was about 'the illusion of choice'. In this chapter I have elaborated on the context in which women decide to start the pill. The most important finding was that they seem to make this decision without feeling well-educated on the possible side-effects and other options. Even though this does not refrain them from starting the pill, it does affect them emotionally. They felt 'bad', almost ashamed even, for not knowing how the pill works. This lack of knowledge can be explained by the systemic exclusion of women in medical research, which has made the pill itself to be an understudied topic. Another cause is that studying birth control is politically challenging, since it could also backlash and be used as a way to limit women's access to the pill. Nevertheless, women have the right to know what they put in their body on a daily basis and which alternatives there are. There should be more research on the effects of synthetic hormones on women's bodies and women should be more informed about other contraceptive options.

My interviewees explained that they start the pill because they feel pressured by the desire to be well-protected and the absence of other good options (such as hormone-free alternatives and effective male contraceptives). This pressure to be well-protected is so strong, that my interviewees deliberately let go of their moral beliefs. Even though they did not want to use the pill, since it contains synthetic hormones and affects your body more than you might be aware of, they did it anyways because it is a highly reliable form of contraception. This was an important finding, because it brings light to the difficult position that women are in. It shows how far women are willing to go and which things they are willing to give up in order to prevent a pregnancy effectively. What would happen if they decided to stay true to themselves, and to choose not to take in any hormones? In order words, refusing to accept the path that society has laid out for them, as women? It would mean that they would have significantly less options, namely the copper IUD, a condom or more natural methods. This means that for contraception, they could only choose between undergoing a painful procedure for the insertion of something that could still affect their body and even worsen their menstrual period, or accepting a higher risk of getting pregnant. Especially the last one is something that women just cannot afford. Having an abortion or a child if you are not ready for it, affect women tremendously on a physical as well as on a mental level. To be short, the

choice that women have is not a free one at all. It is a choice between the lesser of evils, with the benefits (not getting pregnant) outweighing the costs (such as side effects and feeling responsible for taking the pill daily).

The second chapter was about reproductive autonomy. The introduction of the pill enhanced women's perceived reproductive autonomy significantly because for the first time, they could protect themselves against unwanted pregnancies. However, that introduction is almost 60 years ago. It is time to understand how women feel today, in a society in which contraception is widely accessible but mostly focused on the female reproductive organs. My interviews showed that women highly value their reproductive autonomy and that the most important aspect of it is having practically no risk of getting pregnant. In this sense, they are glad that they can easily access highly effective contraception like the pill. It allows them to pursue their professional dreams and choose when (or not at all) they want to have a child and with whom. Nevertheless, my interviewees also showed that they struggle with the 'responsibility'-aspect of it. They want to be well-protected, but it frustrates them that they should always be the ones to take care of it and face the physical and mental costs of contraception. This is caused by two things. First of all, using contraception is seen as part of the gendered script for women. They are the ones who can get pregnant, so they should be the ones to be responsible for contraception. This idea is mostly reflected in the abundance of female contraceptives. This does not only reinforce the idea that women are the ones that should be responsible, it also limits their options by not enabling men to play their part. Men could propose to use condoms, but these are less effective and could be seen as interrupting an intimate moment. In other words, if women nowadays do not want to get pregnant their only 'choice' is which contraception they will take.

The notion of choice and reproductive autonomy are strongly linked to each other. On the one hand, the development and improvement of female contraceptives is a positive thing. I believe that the option to choose contraception has and still does empower women on so many levels. They can finally express their sexuality more, take control over their menstruation if needed and develop themselves professionally without feeling afraid that an unwanted pregnancy jeopardizes this. On the other hand however, I argue that there is still inequality when it comes to contraception. Women, just like men, should also be able to be sexually active without carrying the burden of contraception. As long as women feel like they need to do something that they are morally against or accept feeling not in touch with their body, I believe that we cannot call their choice a free one. We should move away from societal

expectations and talk about consent. It is time that we approach contraception the way that we approach sex itself, as something that you do together.

In this thesis I have started to pinpoint what is needed to make birth control a shared responsibility. Trust in a partner seems to be crucial for women to be able to let go of control. Nevertheless, I can also imagine that the type of male contraceptive could play a role. A pill, for example, would require a daily intake and thus a high level of punctuality. Other more long-term options, like a gel that blocks the production of sperm, could be more accessible. Since the contraceptive market is driven by capitalism, it is crucial that future research identifies which male contraceptives would be widely used and thus profitable. Therefore, it could focus on understanding what characteristics male contraceptives need for men in order to use it and for women in order to be able to let go control. Only then will they be developed and expand men's, as well as women's, options. Another interesting strand for future research might be to delve deeper into the relationship between gender and contraception. Having more male contraceptives is not enough, they also need to be used. In other words, how could the link between femininity and contraception be deconstructed? And how does this provide opportunities for a wider acceptance, or perhaps even encouragement, of male contraceptives?

These questions are extremely important, because the development and widespread use of effective male contraceptives would give women the ultimate form of freedom. It would allow them to be well-protected, without going against their own moral beliefs or expose themselves to side effects. Lastly, it is important that future researchers that study contraception pay attention to the political field that they navigate in and the possibility of a backlash for women's rights. Women's (and men's) access to contraception should never be questioned or jeopardized. Therefore, the aim of future research should be to improve current contraceptive methods, develop new ones and inform people properly about the options that they have.

For now I would like to end this thesis with another quote of birth control activist Sanger. In her book *Woman, morality and birth control (1922)* she said that 'birth control is the first important step woman must take toward the goal of her freedom' (pp 3-4). We have been able to take the first step by legalizing contraception and developing female contraceptives. However, almost 100 years after her statement, women are still not completely free. They should not feel trapped in a system or feel alone when it comes to preventing a pregnancy. We need to take the second step towards complete freedom for women *together*, and make contraception really a shared responsibility. Because gender equality should be achieved in all aspects of our lives, also in the bedroom.

Bibliography

Anticonceptie is een politieke speelbal geworden. (2021, July 12). *NOS.* https://nos.nl/artikel/2388995-anticonceptie-is-een-politieke-speelbal-geworden

Atria. (n.d.). *Dolle Mina tijdbalk.* Retrieved July 4, 2021, from https://atria.nl/nieuws-publicaties/feminisme/feminisme-20e-eeuw/dolle-mina-tijdbalk/

Bureau Clara Wichmann. (2021, July 12). *Rechtszitting gratis anticonceptie: staat discrimineert.* https://clara-wichmann.nl/nieuws/rechtszitting-gratis-anticonceptie-staat-discrimineert/

Cream, J. (1995). Women on trial: a private pillory? In S. Pile & N. Thrift (Eds.), *Mapping the Subject: Geographies of Cultural Transformation* (pp. 158-169). Routledge.

Davis, A. (1982). Racism, birth control and reproductive rights. In R. Lewis & S. Mills (Eds.), *Feminist Postcolonial Theory: A Reader* (pp. 353-367). Routledge.

De Beauvoir, S. (1993). *The second sex*. (H. M. Parshley. Ed & Trans). Alfred A. Knopf. (Original work published 1949).

De Graaf, H., Van den Borne, M., Nikkelen, S., Twisk, D., & Meijer, S. (2017). *Seks onder je 25e: seksuele gezondheid van jongeren in Nederland anno 2017.* Rutgers Stichting & Soa Aids Nederland. https://seksonderje25e.nl/files/uploads/Onderzoeksboek%20Seks%20onder%20je%2025e%202017.pdf

Donnelly, K. Z., Foster, T. C., & Thompson, R. (2014). What matters most? The content and concordance of patients' and providers' information priorities for contraceptive decision making. *Contraception*, *90*(3), 280–287. https://doi.org/10.1016/j.contraception.2014.04.012

Duncombe, J., & Jessop, J. (2002). Doing rapport and the ethics of faking friendship. In T. Miller, M. Birch, M. Mauthner & J. Jesspop (Eds.), *Ethics in Qualitative Research* (pp. 107-122). Sage.

Granzow, K. (2007). De-constructing ‘choice’: the social imperative and women’s use of the birth control pill. *Culture, Health & Sexuality, 9*(1), 43-54. https://doi.org/10.1080/13691050600963948

Haraway, D. (1988). Situated knowledges: the science question in feminism and the privilege of partial perspective. *Feminist studies*, *14*(3), 575-599. https://doi.org/10.4324/9780203873106-18

Hartmann, B. (1995). Reproductive rights and wrongs. In A. M. Jaggar (Ed.), *Living with contradictions: controversies in feminist social ethics* (pp. 330-340). Westview Press, Inc. https/doi.org/10.4324/9780429499142-51

Hermanowicz J. C. (2002). The great interview: 25 strategies for studying people in bed. *Qualitative Sociology, 25*(4), 479–499. https://doi.org/10.1023/A:1021062932081

Hill, S. E. (2019). *How the pill changes everything*. Orion Spring.

Irving, G., Neves, A. L., Dambha-Miller, H., Oishi, A., Tagashira, H., Verho, A., & Holden, J. (2017). International variations in primary care physician consultation time: a systematic review of 67 countries. *BMJ Open*, *7*(10), 1-15. https://doi.org/10.1136/bmjopen-2017-017902

Johnson, T. C. (2021, March 31). *Male birth control options*. https://www.webmd.com/sex/birth-control/male-contraceptives
Johnston, J., & Zacharias, R. L. (2017). The future of reproductive autonomy. *Hastings Center Report, 47*(6), S6-S11. https://doi.org/10.1002/hast.789

Ketting, E. (2000). De invloed van orale anticonceptie op de maatschappij. *Nederlands Tijdschrift voor Geneeskunde, 144*(6), 283-286. Retrieved from https://www.ntvg.nl/artikelen/de-invloed-van-orale-anticonceptie-op-de-maatschappij/icmje

Ketting, E. (1982). Contraception and fertility in the Netherlands. *International Family Planning Perspectives*, *8*(4), 141–147. https://doi.org/10.2307/2948134

Ketting, E., & Visser, A. P. (1994). Contraception in the Netherlands: the low abortion rate explained. *Patient Education and Counseling*, *23*(3), 161–171. https://doi.org/10.1016/0738-3991(94)90032-9

Kolbert, K. (1989). A reproductive rights agenda for the 1990s. In A. M. Jaggar (Ed.), *Living with Contradictions: Controversies in Feminist Social Ethics* (pp. 292-297). Westview Press, Inc.

Ministry of the interior and kingdom relations. (2018). *The Constitution of the Kingdom of the Netherlands 2018.* https://www.government.nl/ministries/ministry-of-the-interior-and-kingdom-relations/documents/reports/2019/02/28/the-constitution-of-the-kingdom-of-the-netherlands

Moeders wil is wet, met de pil naar bed. (2010, June 25). *Trouw.* https://www.trouw.nl/nieuws/moeders-wil-is-wet-met-de-pil-naar bed~b57bcb75/?referrer=https%3A%2F%2Fwww.google.com%2F

NHS. (2021, March 30). *Intrauterine Device.* https://www.nhs.uk/conditions/contraception/iud-coil/

NHS. (2018, September 17). *Overview fibroids*. https://www.nhs.uk/conditions/fibroids/

Overheid.nl. (n.d.). *Verdrag inzake de uitbanning van alle vormen van discriminatie van vrouwen, New York, 18-12-1979.* Retrieved August 11, 2021, from https://wetten.overheid.nl/BWBV0002909/1991-08-22

Planned Parenthood. (2021a). *How effective is the birth control pill?* https://www.plannedparenthood.org/learn/birth-control/birth-control-pill/how-effective-is-the-birth-control-pill

Planned Parenthood. (2021b). *How effective are condoms?* https://www.plannedparenthood.org/learn/birth-control/condom/how-effective-are-condoms

Rijksoverheid. (n.d.). *In welke situatie kan ik een kind erkennen?* Retrieved August 2, 2021,

from https://www.rijksoverheid.nl/onderwerpen/erkenning-kind/vraag-en-antwoord/wanneer-kind-erkennen

Rothman, B. K. (2018). The meanings of choice in reproductive technology. In A. M. Jaggar (Ed.), *Living with contradictions: controversies in feminist social ethics* (pp. 325-329). Westview Press, Inc. https/doi.org/10.4324/9780429499142-51

Rutgers Stichting. (n.d.). *Seksualitijdlijn.* Retrieved July 15, 2021, from https://tijdlijn.rutgers.nl

Sanger, M. (1922). *Morality and birth control*. The American Birth Control League, Inc. Retrieved from https://collections.nlm.nih.gov/ext/dw/02610550R/PDF/02610550R.pdf

Sanger, M., & Ellis, H. (1920). *Woman and the new race*. Brentano's. Retrieved from https://ru.on.worldcat.org/oclc/1047666607

Senderowicz, L., & Higgins, J. (2020). Reproductive autonomy is nonnegotiable, even in the time of covid-19. *International Perspectives on Sexual and Reproductive Health*, *52*(2), 81–85. https://doi.org/10.1363/psrh.12152

The society of obstetricians and gynaecologists of Canada. (2021). *Natural methods.* https://www.sexandu.ca/contraception/natural-methods/#tc1

Thuisarts. (2021, February 2). *Ik wil voorkomen dat ik zwanger word. Wat kan ik kiezen?* https://www.thuisarts.nl/anticonceptie/ik-wil-voorkomen-dat-ik-zwanger-word-wat-kan-ik-kiezen

Van Ditzhuijzen, J., & Coehoorn, J. (2020). *We doen het samen: resultaten peiling over gedeelde verantwoordelijkheid bij anticonceptiegebruik (m/v).* Rutgers Stichting.

Vintges, K. (1996). *Philosophy as passion: The thinking of Simone de Beauvoir*. Indiana University Press.

Wigginton, B., Harris, M. L., Loxton, D., Herbert, D., & Lucke, J. (2014). The feminisation of

contraceptive use: Australian women's accounts of accessing contraception. *Feminism & Psychology*, *25*(2), 178-198. https://doi.org/10.1177/0959353514562802

Appendix

Interview questions

Knowledge

1. Why and when did you decide to use contraception?
2. How did your parents respond?
3. How have you been educated on the options that are available?
4. How did you make your decision to use the pill?
5. Do you know how the pill prevents you from getting pregnant?
6. Have you experienced or are you still experiencing side effects?

Reproductive autonomy

7. Which feelings do you have towards the pill?
8. How would you describe the relationship with your body? Has the pill changed this?
9. What does reproductive autonomy mean to you?
10. Do you feel in control over your body?
11. Are you content with the options that are presented to you?

Responsibility

12. Who pays for the pill?
13. Who do you feel should be responsible for contraception? And how is this in reality?
14. Would you trust your partner with the responsibility of contraception?