

I declare that this thesis is my independent work and that it has been presented in no other program or award other than the Master of Arts in Women's Studies at the Victoria University of Technology. The research undertaken for the thesis was approved by The Human Research Ethics Committee of Victoria University of Technology (HREC 97/341).

Signed:



Date:

15 August '98

~~WER~~ THESIS  
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Towards a feminist  
philosophy of fertility  
consciousness

## Acknowledgments

With sincere appreciation I would like to acknowledge the support and guidance I received throughout this project from Dr Barbara Brook and Ms Finbar Hopkins.

A very special thankyou also goes to the women who participated in this project either directly or indirectly by telling their stories, sharing their lives and for providing the insight and encouragement that enabled this project to come to fruition. Collectively we shared a passion and a vision to make fertility-awareness knowledge more accessible and more widely available to women, and to girls, so that they might experience their body more wholly and revel in its magical powers.

## Glossary Of Terms

**Fertility-Awareness:** This term traditionally applies when barrier contraception is utilised in the fertility-awareness aspect of a Natural Family Planning (NFP) method. In this thesis it refers to having an awareness of the signs of one's fertility.

**Fertility Consciousness:** Refers to a conscious participation in the events of the menstrual cycle.

**Natural Family Planning (NFP):** The term NFP applies when the fertility-awareness aspect of a NFP method is utilised to achieve or avoid pregnancy.

**The Ovulation Method-Billings (OM):** The OM is a method of NFP that was developed under the auspices of the Roman-Catholic Church.

The research that led to the development of the OM began in the 1950s in response to pressure asserted by groups from within the Roman-Catholic Church for Roman-Catholic men and women to have access to more effective NFP methods than were the Temperature and Rhythm methods. The assertion of this demand occurred when the Pill was being promoted around the world just prior to its global release. The Roman-Catholic Church responded to the pressure groups in two ways: firstly, by affirming the Roman-Catholic Churches position on "birth-control"; and secondly, by briefing Dr John Billings with the task of finding an improved method of NFP.

The concept that mucus produced in glands in the canal of the cervix around the time that ovulation occurs might hold the key to the

development of a an improved method of NFP was triggered when Dr. J. Billings found in *The Pathology and Treatment of Leukorrhoea* (Smith, 1855) that there was a relationship between fluid cervical mucus and fertility. In pursuing this lead in the literature, Dr. J. Billings found that numerous other gynaecologists had also noted that there was a link fertility and fluid cervical mucus, but had not developed it.

Armed with this information and with the support and co-operation of hundreds of women and couples in Melbourne (Australia), experiential research in the form of women noting when they had sex in relation to the observance of fluid cervical mucus at the vulva was initiated. Since this initial research which led the development of the OM, the OM has undergone a process of continual refinement as more and more knowledge has been accumulated. Today, the OM is credited as a highly effective NFP method which enables women to accurately identify the fertile days in all phases of reproductive life when it is taught and understood correctly.

While the OM was being developed through women's experiential knowledge of their fertility in Australia, a Professor Erik Odeblad (a Swedish obstetrician and biophysicist) was conducting scientific research on the function of the cervical secretory system and the role it plays in regulating fertility. The work of Professor Erik Odeblad both verified the method principles of the OM and extended scientific knowledge of women's reproductive biology (Odeblad, 1994;1996).

It is the accessibility of the cervical mucus symptom of fertility together with its accuracy in marking the fertile days in all phases of a woman's reproductive life that sets it apart from all other methods of NFP. These same qualities advanced the concept of fertility consciousness because they facilitate a consciousness of the events of the menstrual cycle. Before

the development of the OM, NFP methods (Temperature and Rhythm) were based on empirical medical science applied to the menstrual cycle. It is interesting to note that the Rhythm Method, the first and least effective NFP method, was developed more than eighty years after the first of numerous citations in the medical literature that there was a connection between fluid cervical mucus and women's fertility (which women can observe for themselves) (Billings and Westmore, 1992).

In field trials in different cultural settings around the world the OM has been demonstrated to be around ninety-nine per cent method effective in preventing pregnancy, when the method is correctly understood and applied. (Professor Qian Shao-Zen, China Study Presentation, December, 1997).

Today, the OM is utilised by many millions of women in both developed and developing countries of the world.

## **Acknowledgements**

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## Introduction

In this thesis it is argued that the fertility-awareness aspect of the Ovulation Method-Billings (OM) can contribute towards women's liberation in patriarchal societies because it enables fertility consciousness. Mosse and Heaton (1990) define fertility consciousness as a conscious participation in the events of the menstrual cycle. The Fertility Consciousness Group (1980), Mosse and Heaton (1990) and Valins (1993) argue that until we establish a feminist fertility consciousness our ability to act with self-governance in relation to our fertility will be compromised.

O'Brien (1986), Mosse and Heaton (1990) and Valins (1993) argue that our reproductive consciousness (which includes consciousness of our fertility) has been eroded in patriarchal societies to such an extent that we have come to rely almost exclusively on the medical and pharmaceutical establishments for "birth-control". Our knowledge is consequently rarely found on the shelves in book shops where fertility and reproductive knowledge is coded, commodified, and legitimised for *our* consumption. It is even less likely to be found in the libraries of the nursing and medical practitioners whom we are most likely to consult when seeking this information (O'Brien, 1986; Owen, 1988; Watkins and Danz, 1995). Prior to this situation occurring, a plethora of historical and anthropological evidence suggests that women in various cultures around the world were knowledgeable about their fertility in various ways and "managed" it effectively in accordance with their

cultural norms (see, for example, McLaren, 1990; Billings and Westmore, 1992; Siedlecky and Wyndham, 1990)

Fertility-awareness knowledge is today principally conveyed in Natural Family Planning (NFP) discourse. NFP discourse combines the medical model of the menstrual cycle with the Roman-Catholic Church's moral theology on sexuality and marriage principally to achieve or avoid pregnancy. NFP became a medical science in the 1930s with the development of the Rhythm Method, following the significant discovery by Ogino and Knaus that menstruation always follows ovulation within eleven to seventeen days in the absence of pregnancy occurring. Further scientific investigations into the menstrual cycle gave rise to the Temperature Method in the 1940s and two decades later the OM was developed (Richards, 1982; Billings and Westmore, 1992). The Roman-Catholic Church is the main political advocate of NFP, and over time the Roman-Catholic Church and NFP methods have become synonymous.

Polemic perspectives characterise community attitudes towards NFP. These are vividly illustrated in several recent articles in the Melbourne *Age* newspaper which began with Pamela Bone (an *Age* reporter) criticising the late Mother Teresa for not promoting contraception in her capacity as a carer of the "poor" of India. Dr. J. Billings (a principal author of the OM) responded by saying that Mother Teresa did in fact promote "birth-control" because she and her Order taught the OM. The other respondents either supported or dismissed one or the other view (see *The Age*, 18, 23, 29 October, 1997).

Many feminists have explored the way in which "truth" and "knowledge" claims effect power over women (for example, Bleier, 1988; Haraway,

1988; Martin, 1990; Stanley, 1990; Jacobus, Fox Keller and Shuttleworth, 1990; Spender, 1990; Fouquet, 1992; Hughes, 1995; Heinen and Matuchniak-Krususka, 1995; Stevens, 1996; Gatens, 1996). The central issue of concern for these theorists is the binary system of oppositions which structures and characterises most aspects of western thought and practice, i.e., objectivity/subjectivity, nature/science, knower/known, and the role they play in constructing “truth” or “knowledge claims”. They ask what is “truth”, who can define it and how can it be defined?

These are the questions underpinning this thesis.

### ***Research Objectives***

The objectives of this research are:

to document

- 1a) our knowledge of our fertility prior to learning the fertility-awareness aspect of the OM;
- b) the barriers we experienced in accessing fertility-awareness knowledge;
- c) the benefits we perceive in having fertility-awareness knowledge,

and thus,

- 2 a) to facilitate the development of feminist fertility consciousness programs which will be made available for inclusion in medical and nursing, community and school curricula to expand the knowledge base of these discourses;
- b) to validate our experiences and make them available to other women.

## ***Hypotheses***

The fertility-awareness aspect of the OM can liberate us from patriarchal “birth-control” practices because it enables us to establish a consciousness of our fertility. While most of us learn fertility-awareness to “manage” our fertility privately and autonomously, fertility-awareness also commences a process of redefining our fertile bodies.

Women experience two major barriers to obtaining fertility-awareness knowledge: firstly, there is the medical establishment which operates to favour the distribution of pharmaceutical “birth-control” and also provides an alienating medical model of the menstrual cycle; and secondly, many women outside the Roman-Catholic Church are alienated from this knowledge because of its association with the Roman-Catholic Church. More women would utilise fertility-awareness knowledge if it were detached from these dominant models and made more accessible and available.

## ***Statement of the Problem***

A feminist philosophy of fertility-awareness knowledge remains to be developed. Until this occurs and is made widely available to women in mainstream education and health services we will continue to experience discrimination and alienation in accessing this knowledge.

# Chapter One

## *Review of the Literature*

The following is a summary of findings made after surveying medical, sociological, general women's health and feminist literature that relate to this field of inquiry.

### **Introduction**

It is estimated that approximately two and four per cent of women in western societies utilise NFP for "birth-control" (Gynaecology: Well-woman Care 1995; Guillebaud 1985; Mosse and Heaton 1990). This figure should be considered as a conservative estimate because many women practise NFP but have not attended a formal education program. A number of NFP texts have been available for several decades from which women can teach themselves. In addition to texts, some women learn NFP from relatives and friends (Daly and Herold, 1985).

Numerous data indicates that more women would utilise NFP if it were made available to them. For instance, a research survey at a family medical practice in England to determine why relatively few women used modern methods of NFP revealed that forty-three per cent of the respondents were interested in learning more about NFP. Of these, twenty-four per cent said they would like to use NFP to prevent pregnancy and thirty-two per cent indicated they would use it to achieve pregnancy. The author found it significant that more non-Roman-Catholic than Roman-Catholic women indicated interest in NFP (Stanford, Lemaire and Fox, 1994). Similar

findings are revealed in the *1995-96 Annual Report of the Australian Catholic Social Welfare Commission* which cited more than an eleven per cent rise in demand for the service in NFP in the same year it was promoted as a reliable, simple, safe and low-cost method of family planning. Half the clients attending this service were from non-Roman-Catholic backgrounds.

Entrenched barriers exist in women's health services preventing women from accessing NFP services. *Why Women's Health? Victorian Women Respond* (1987) reports that women found it more difficult to access information on fertility-management methods that they could control themselves, such as NFP and diaphragm use, than information on any other method. It also reports that women often felt unable to use the contraceptive of their choice because of pharmaceutical bias demonstrated by medical practitioners. Compounding this situation, women reported that there is little opportunity for them to share information or to participate in the planning of services relating to "birth-control". Women in developing societies of the world (Akhter, 1996), Aboriginal women (Women's Business, 1987), lesbians (Stevens, 1996), nursing mothers, young women, women with disabilities, institutionalised women, poor women, and women from non-English speaking backgrounds experience additional discrimination in obtaining information about their bodies and their fertility in health care services (*Why Women's Health? Victorian Women Respond*, 1987; Merkes, 1994).

Medical and pharmaceutical bias in "birth-control" methods is further demonstrated by the allocation of funds for research. Barrier contraceptive and NFP research receive only a fraction of the funds allocated (Richter, 1996).

This situation is occurring despite more than 100 years of feminist activism for reproductive rights and, as Joyce Berkman (1980, pp. 27-28) points out, at a time in history when much disillusionment is being expressed with medical science and technologies which are applied to the various phases of our reproductive lives. Diethylstilbestrol, Human Growth Hormone (hGH), Thalidomide, the Dalcon Shield, silicon breast implants and Depo-Provera are just a few of the technologies that are known to cause iatrogenic (doctor-induced) disease. Renate Klein, Janice Raymond and Lynette Dumble (1991) place the contraceptive Pill and RU486 (a medical abortifacient) in this same category of technologies, and argue that we are encouraged to be consumers of reproductive technologies and drugs under the pretence that they will provide us with greater “control” in our lives by increasing our “choices”. This argument is contradicted, they suggest, when we are given insufficient information about these technologies to be able to choose them freely (see also, Raymond, 1993). Robyn Rowland (1992) uses this argument when she draws attention to the growing list of assisted conception technologies being made available for our consumption, as does Judith Richter (1996) with regard to the contraceptive vaccine currently being developed.

Rebecca Albury (unpub.) writes that, while the notion of “individual choice” is used to promote modern “high-technology” methods of “birth-control”, our “choice” of contraceptive is in fact very much pre-determined by the activities of scientific medicine (which includes scientific research, medical services and the pharmaceutical industry), the state, the mass media and religion. Accordingly, we make our “choice” of contraceptive in relation to prescribed notions of ‘sexuality, the role of experts, the demands of the economy, the authority of the state (...) and definitions of acceptable behaviour for men and women’ (1985, p. 1).

Linda Gordon writes that, while the “birth-control” movement began as a campaign to increase our individual freedom by producing ‘basic social change in sexual and class relations’, under the influence of the medical establishment and the eugenics movement it has become more aligned with the contraceptive industry and world population control campaigns (1978, p. 176). Consequences of this alignment include, abortion services remaining difficult or impossible to access, sex education programs continuing to promote patriarchal values, the birthing of children outside marriage remaining a taboo and poor non-white women continuing to be testing sites for developing newer contraceptives. Gordon’s views are reiterated more recently by a number of writers. (See also, Raymond, 1994; Cook, 1994; Richter, 1996; Akhter, 1996)

Germaine Greer argues that instead of increasing individuals’ ‘rights’ to reproductive destiny, the early twentieth-century “birth-control” movement ‘created the precedent for the invasion of privacy which made reproductive behaviour a public matter’ and placed it in the hands of the medical and pharmaceutical establishments (1984, p. 303). Hence, pharmaceutical “birth-control”, particularly the Pill, provided the means for the thorough medicalisation of “birth-control” and added a further dimension to the struggle for control over our bodies, our sexuality and reproduction (Shapiro, 1987). It is interesting to note that, whilst the Pill was launched on the promise of finally providing us with effective “birth-control”, data on birthing numbers per woman in England, America and Australia between the mid 1800s and 1900s illustrate that they were already in decline (Berkman, 1980; Shapiro, 1987; Mosse and Heaton, 1990).

Susan Bell also describes how medical bias (exerted through government agencies, institutions, language and professional judgements in the name of western science) has contributed towards the regulating of our bodies, our

sexuality and our social power by the applied use of synthetic hormone therapies to all phases of our reproductive lives. She argues that even though ‘tensions, contradictions, ambiguities and uncertainties’ exist in “medical science” it nonetheless ‘reflects and creates gender’, effecting the maintenance of patriarchal order (1995, pp. 492-3).

Susan Owen critically analyses women’s health-care services and writes that they are not necessarily based on logic or even on an understanding of our needs. Owen advocates for women’s health services to be based on feminist philosophies because these would ground health-service practices on our experiences and seek to put us in control of our lives. This could be achieved, she argues, by providing us with a critical knowledge base with which to evaluate “expert” knowledge and to recognise the constraining power of cultural myths and gendered stereotypes. Owen believes that, the ‘acts of claiming and reshaping the alien territory of conventional health care are pivotal functions in feminist health politics’ (Owen, 1990, p. 34). The Boston Women’s Health Collective (*Our Bodies, Ourselves*, 1976) and Leichhardt Women’s Community Health Centre (Stevens, 1995), are two good examples of this utilisation.

In addition to discriminatory practices in women’s health services that favour the distribution of pharmaceutical “birth-control”, we experience discrimination and alienation in accessing fertility-awareness knowledge because it is primarily located within NFP discourse. This view is formed following a content analysis of texts where this knowledge is published for general reading and in the libraries of nurses and medical practitioners women are most likely to consult when seeking this information.

## **NFP Texts**

NFP texts combine the medical model of the menstrual cycle with the Roman-Catholic Church's moral theology on sexuality and marriage. The influence of the Roman-Catholic Church is evident in these texts with such assumptions as all couples presumed to be heterosexual and married, and with numerous omissions of such issues as "withdrawal", non-penetrative sex, barrier and emergency contraception, sexually-transmitted diseases, unplanned pregnancy and abortion (cf. Richards, 1982; Nofziger, 1988; Billings, 1992; Davidson, 1994).

The Roman-Catholic Church developed the concept of NFP specifically to allow its members to have access to a form of "birth-control" within the Roman-Catholic Church's value system. Until *Humanae Vitae* (1968), the Roman-Catholic Church opposed the use of all contraception believing that sex was created for the purpose of procreation, and therefore 'each and every marriage act (...) must remain open to the transmission life' (*Humanae Vitae: Encyclical Letter of Paul VI on the Regulation of Birth*, 1990, p. 19). This view is a core value of NFP discourse promoted by the Roman-Catholic Church (see, also, Fisher, 1997) (unpub.).

The menstrual cycle in NFP texts is described in mechanistic linear concepts for control purposes, i.e. achieving or avoiding pregnancy. Some of the more recent texts also include information on related health issues (see, for example, Billings and Billings, 1997; Hilgers, 1991)

### **Medical and Nursing Family-Planning Texts**

A content analysis of medical and nursing family-planning texts published between 1984 and 1994 reveals that fertility-awareness knowledge is conveyed almost exclusively within NFP discourse. Most texts only outlined NFP methods rather than providing full method details (Kovacs and Westmore, 1984; Guillebaud, 1986; Scalone, 1990; Loudon, 1991; IPPHF, 1994)

### **NFP and Fertility-Awareness Handout Literature Distributed by the State and Territory Family Planning Associations of Australia**

A content analysis of the handout literature that is distributed by the state and territory Family Planning Associations (FPAs) of Australia reveals the same restrictive trends. Only the Queensland and Western Australian FPAs provide literature on fertility-awareness, and therefore information on barrier contraception. The Tasmanian FPA does not provide handout literature on NFP or fertility-awareness (see Primary Sources, in Bibliography below).

### **Electronic Publications**

A content analysis of Current Contents, NETSCAPE and FIRSTSEARCH also reveals the same restrictive trends. Most of the material that was surveyed were advertisements for NFP services (see Primary Sources, in Bibliography below).

### **On-line Material**

A content analysis of one hundred and fifty-seven MEDLINE (1983-1996), twenty-eight CINAHL (1982-1996) and thirteen AUSTROM:APAIS (1983-

1996) journal articles in the fields of medicine, nursing and the social sciences also reveals the same restrictive trends. The vast majority of the articles that were surveyed are research findings detailing the efficacy of NFP (primarily the OM) in preventing pregnancy in different cultural settings around the world (see Primary Sources, in Bibliography below).

### **Women's Health Texts**

A content analysis of women's health texts published between 1986 and 1995, and found on the shelves in two of Melbourne's largest book shops (Collins Book Shop and Angus and Robertson) and Options Book Shop (Family Planning Victoria Inc.) also reveals that fertility-awareness knowledge is conveyed almost exclusively within NFP discourse (Kovacs and Westmore, 1986; Khan, 1992; Kahn, 1992; Cabot, 1994; Australian Women's Health Handbook, 1994; Grimwade, 1995; Cooper, 1995).

It is interesting to note that none of the women's health texts surveyed contained sufficient method detail on any of the NFP methods for us to be able to educate ourselves well in any of the methods. This finding is surprising considering the theme of their titles. Titles include: *The Body of Knowledge: Everything you need to know about the female cycle* (Grimwade, 1995); *Australian Women's Health Handbook: All Your Questions Answered From Puberty to Menopause and Beyond* (Gressor, 1994); *Women's Health in Women's Hands: The essential guide to managing your own health* (Cooper, 1995); *Women's Bodies, Women's Wisdom: Creating Physical and Emotional Health and Healing* (Northrup, 1995).

Grimwade (1995) wrote *The Body of Knowledge: Everything you need to know about the female cycle*, in collaboration with two prominent Melbourne doctors in women's health. She writes that if natural methods were effective then 'the world's population would not be increasing at such a significant rate (...) Even though the rules [of the methods] are relatively simple, the female body is not. For starters, one cannot rely on the cycle -- it is simply too unpredictable' (1995, pp. 219-221). Grimwade's comments both reflect and reinforce standard/mainstream views.

### **Feminist Texts on "Birth-Control"**

Only three texts were found on the subject of "birth-control" that explored fertility-awareness in broader terms than NFP. *The Fertility Consciousness Group* (1980), Mosse and Heaton (1990) and Valins (1993) write that, in nearly all circumstances NFP has been adopted without apparent examination of the assumptions inherent in the discourse. They explore fertility-awareness in the context sexuality, self-esteem, health, spirituality, personal power and reproductive self-determination, and advocate for the term fertility consciousness to be adopted to indicate more broadly the implications of fertility-awareness knowledge.

Mosse and Heaton write:

*The trouble with most books on contraception is that they put contraception in perspective only from one point of view -- the technical and medical one (...) how to prevent a sperm from meeting an egg -- a satisfactory technical solution is in deed the end of the story. (Mosse and Heaton, 1990, pp. 19-20)*

Mosse and Heaton argue that, 'It is only when a woman's fertility is seen in the broadest possible terms (...) that we can begin to put contraception into a meaningful context (1990, p.29). They also describe the female body as one

with incredible life-giving powers and experiences that ought to be seen as a resource in our lives.

Reflecting on the medicalisation of “birth-control” Mosse and Heaton assert that the medical view of the female body affects our “choice” of contraceptive method and encourages us to defer our authority to the medical establishment and the social collective. They urge us to reject the largely uncontested hegemony of the medical view of the female body as being inherently problematic, defective and out of control, and in need of constant supervision, regulation and rescuing, as in hormonal regulation. They write that:

*Medical practice encourages a passivity in women regarding their fertility, and that many contraceptive acts may be part and parcel of a denial of the body which has its roots in a basic fear and mistrust of the female body. (Mosse and Heaton, 1990, p. 20)*

Mosse and Heaton quote Mary O’Brien (1986) who writes:

*When we look at these models (medical models of reproductive health care) we learn nothing of the social relations surrounding a woman’s reproductive life, nothing of the internal and external shaping forces, nothing in other words of reproductive consciousness. We need to find a way of drawing together both the biological and the thinking/feeling aspects of human behaviour. (Mosse and Heaton, 1990, p. 24)*

Mosse and Heaton (1990) believe that our ability to reclaim our fertile bodies is dependent on establishing *our* knowledge of our bodies. Mosse and Heaton write:

*This bodily acceptance needs to be rooted in knowledge--not just medical knowledge but an imaginative ‘knowing’, a conscious participation in bodily events, a willingness to explore what sexuality, menstruation, the ovarian cycle, pregnancy and childbirth mean for us in the context of our own particular lives. It is the totality of these events and the meaning that women ascribe to them*

*that is the broadest meaning of fertility. Thus fertility, far from being simply a question of the number of children women have and how long it takes them to conceive, becomes a term for their conscious appropriation of their whole reproductive cycle, which may or may not include children. It is only when a woman's fertility is seen in its broadest possible terms--the totality of the reproductive story of her life so -- that we can begin to put contraception into a more meaningful context. Our fundamental argument is that many contraceptive acts represent an attempt to deny and ignore the body's fertility, to make ourselves in Germaine Greer's unforgettable phrase, female eunuchs. And in so doing we may be doing damage to our bodies capacity to be fertile (by failing to protect it from damaging infections). Moreover in alienating our fertility -- in denying our bodily lives -- we may miss out on a source of fecundity that spills out into the other areas of our lives too. (Mosse and Heaton, 1990, p. 29)*

Valins (1993) writes that western science has in many ways invalidated our history of knowledge, inner knowing, intuition and connectedness with our bodies by encouraging us to regard scientific knowledge as being more valid than our own. Through western science we have been taught to defer our knowing and trust to the producers of “rational” “objective” “truth”, and in doing so we have come to deny many of our embodied experiences. Valins asserts that this kind of knowing disrupts our connectedness with our body, and prevents us from knowing ourselves as whole persons. It also affects how we can know and what we can know, and in turn this determines the amount of power we can assert in our personal and social lives. Valins urges us to come to know our fertile bodies more through personal experience.

*The Fertility Consciousness Group (1980) argue that fertility-awareness knowledge is self-knowledge that is every woman's ‘right’. They also argue that fertility-awareness knowledge can be liberating because it enables us to “manage” our fertility independently of the medical and pharmaceutical establishments and also because ‘we can teach one-another and, in doing so, by-pass the medical establishment altogether’ (1980, p. 72-73).*

## **Feminism and Science**

Many feminists argue that the primary aim of western science in the field of reproduction has been to appropriate the female body and to control it on their terms and in their own interest . Rowland (1992), Bell (1995) and Steinberg (1996) variously describe western science in this way.

Ruth Bleier writes that, western science has ‘played a role in the creation of the mythology of women’s biological inferiority as an explanation of their subordinate position in cultures of western civilisations’ (1984, p. V11). Rather than uncovering “truth” Bleier argues that, western science actually constructs “truth” by ‘determining who can speak, what is or not discussed, what questions may be asked and what is true or false’ (1984, p 194). The assertion of power and oppression through “truth” and “knowledge” claims is described as the “hierarchy of knowledge” because it enables those who create the “knowledge” to have power over those whom the knowledge has been created for, or about.

When science reduces such complex matters as fertility to biological facts principally for the purpose of finding solutions to controlling it, this can be termed reductionism. Lynda Birke (1988) writes that while methodological reductionism has contributed greatly to the success of science, feminists tend to criticise it for two reasons: firstly, because it impoverishes our understanding of the complex whole that actually exists; and secondly, because it tends to imply a degree of biological determinism.

In an attempt to understand and subvert women’s oppression in patriarchal societies, feminists in recent decades have turned their attention to

exploring the links between method, methodology and epistemology. They argue that the binary system of oppositions upon which western scientific knowledge is based obscures the reality between those who have the power and those who do not. For this reason, they argue for what they term “unalienated” knowledge (rather than “alienated” knowledge which is the kind typically produced by western science), because “unalienated” knowledge aims to account for the conditions of its production thereby making it available for criticism and change (Harding, 1983; Stanley, 1990; Fonow and Cook 1991; Reinharz, 1992; Fouquet, 1992).

Donna Haraway (1988), Dorothy Smith (1988) and Evelyn Fox Keller (1990) look beyond the notion of making one kind of knowledge claim over the other and envision what they term “successor science”. Haraway describes “successor science” ‘as politics and epistemologies of location, positioning, and situation where partiality and not universality is the condition of being heard to make rational knowledge claims’ (1988, pp. 575-589). They argue that women can benefit from western science and that this is more likely to occur when it is motivated by women-centred values. They also argue that western science can coexist with more holistic accounts, such as those provided by social scientists. Two examples of “successor science” in this field of inquiry are provided by D. Blake, D. Smith, A. Bargiacchi, M. France and G. Gudex (1997) and Professor Erik Odeblad (1994)

Blake et al. (1997) found in social science research conducted in a New Zealand assisted conception centre that some women may be receiving assisted conception treatment but not be infertile in a medical sense. Professor Erik Odeblad utilised the principles of methodological reductionism in his research of the cervical secretory system to explain how it regulates fertility. His work validated the OM as a highly effective method of NFP which can be utilised by women in all phases of reproductive life

(Odeblad, 1994; Odeblad, 1996), (see, also, J. Brown, P. Harrison, M. Smith and H. Burger (1982). Methodological reductionism was also utilised in research that found that we can identify the fertile days of the menstrual cycle utilising the OM as accurately as the most advanced clinical and laboratory technologies available for determining these days ( i.e. ultrasound and urinary hormonal markers of fertility) (J. Brown, P. Vigil, L. Blackball, NFP Conference, Melbourne, April, 1997).

### **Feminist Theories on the Body**

The theory of “power-knowledge” has been utilised extensively by feminist theorists in recent years because it provides an analytical framework with which to explain our oppression without succumbing to notions of biological determinism (McNay, 1991). Our biology (rather than social conditioning) has been long promoted in western male thought and practice as the cause of our oppression. O’Brien (1986) points out that this view has also been shared by such influential feminist writers as, Simone de Beauvoir and Shulamith Firestone.

Elizabeth Grosz (1990) analyses the nineteenth-century philosophies of Nietzsche, the work of twentieth-century writer Foucault and the more recent work of Irigaray, Lyotard and Lingis and explores the notion of “knowledge-power”. Grosz contends that these writers in different ways challenge the widely held view that power is effected through ideological systems, and argue instead that power is primarily mediated through inscriptions or writings on the corporeal (body), for example, through medicalised observations and regulation of sexuality. They argue that our subjectivity is constructed by these practices, and that we in turn ‘internalise’ these concepts of ourselves which lead us to acts of self-regulation to conform to the dominant paradigms. Self-knowledge, in other words, is contradictorily acquired from sources without rather than from

within and its repressive nature leads us to collude and contribute to our subordination without consciously knowing it. Grosz describes this as being disembodied from the core of our being and ‘internally lived, experienced and acted upon by the subject and the social collectively’ (1990, p. 65).

Because the body is a site of political appropriation, Grosz argues that, it can also be a site for political intervention by disrupting the “knowledge-power” that appropriates us. Grosz writes:

*As well as being the site of knowledge-power, the body is also a site of resistance, for it exerts a recalcitrance, and always entails the possibility of a counter strategic reinscription, for it is capable of being self-marked, self-represented in alternative ways. (Grosz, 1990, p. 64)*

Moira Gatens also shares the view that our liberation is dependent on establishing an alternative philosophy of the body, because, as she points out, the phallogentric philosophy on which the female body is promoted as “lack”, as ‘deformity’ or deficiency’ has remained a constant utilisation throughout history for disqualifying our active participation in public life where power and discourse is made (1996, p. i). Gatens grounds our liberation in a feminist philosophy of the body that is based on what is unique for us and our bodies. By grounding our knowledge in our actual experience we become ‘situated beings’ with a language that attempts to articulate our specificity and disrupt our silencing in patriarchal society. O’Brien (1986), Martin (1989), Braidotti (1994), Diprose (1994) and Cranny-Francis (1995) also argue this view.

In response to the argument that postmodern theories on the body privilege specificity over the broad category of ‘woman’ or ‘women’ to the detriment of a united movement, Carol Bignal (1991) utilises Merleau-Ponty’s philosophy of the phenomenology of the body to argue that, between the

nature/culture divide we have a 'body givenness' that unites us as to some extent across class, culture and sexual identity while allowing at the same time for difference.

Janet Wolff (1986) concurs with post-modern theorists and drawing on the work of Kristeva, Irigaray and Cixous, she discusses the concept of writing from the body (this is writing that is grounded in women's experience of the body, sexuality and reproduction) as a means of constructing feminine writing. According to Wolff, this writing would emanate from the semiotic (that is in Freudian/Lacanian psychological terms the pre-Oedipal; pre-Symbolic) and would therefore escape the patriarchal influences of language and symbolism. Whilst supporting this approach, Wolff also entertains Parveen Adams' argument, 'that we never have an unmediated experience of a pre-given body' as subjects in patriarchal societies (1986, p. 133). As Wolff (1990) questions:

*Can there be such a thing as women's writing? More specifically in a culture, in which institution, language, and regimens of representation collude in the marginalisation of women's experience and in the silencing of women's voices. (Wolff, 1990, p. 68)*

Wolff (1990) also reminds us that we must not repeat the mistake found in western science and claim one true correct knowledge for all women, as the category of 'women' or 'woman' is fragmented across race, class, ethnicity, identity, sexuality, etcetera. The closest one might get to a women-centred knowledge, Wolff believes, 'is by exposing the ideological limitations of male thought', thereby creating space for 'women's voices and women's experience' so that the process might begin for establishing our own writing in the context of 'alienating cultural systems' that mediate against it (p. 82). Harding also argues this perspective and points out that it is 'problematic to undertake the task of articulating women's experience, silenced as it has traditionally been in patriarchal culture, in the categories, concepts, and

language available' (1990, pp. 81-2). (See, also, Heinen and Matuchniak-Krasuska, 1995; and Markens, 1996)

### **Summary**

In summarising, the review of the literature suggests that pharmaceutical “birth-control” is developed, promoted and distributed in a culture of patriarchal politics which contributes to our oppression by defining and medicalising our reproductive processes. It also suggests that fertility-awareness knowledge could subvert our oppression in patriarchal societies by facilitating our own reproductive knowing, definitions and voice, if it were made accessible and made available.

## Chapter Two

### *Research Method and Methodology*

#### **Introduction**

There is general agreement among feminists that while there is no such thing as one actual feminist research method or methodology, feminist research is none the less characterised by several defining features. In essence it is research on women, by women, and especially for women in order to bring about desired changes that will reduce or eliminate the social inequalities we experience as a category of people.

Essentially what drives the feminist research process is the desire to produce knowledge that validates our subjectivity so that our human experience is more fully and therefore more accurately represented. This perspective privileges our understanding of how the larger social structures affect our daily lives and points to sites for political intervention. Political intervention or change can take numerous forms, including the empowerment of individual women, community action, or changes in policy or law. The situation-at-hand frequently determines the subject of feminist research.

What distinguishes much feminist research is its consistent reflection on the links between methods (tool) and methodology (theory and philosophy). This emphasis is what some writers term 'praxis' (see, for example, Harding and Hintikka, 1983; Lather, 1988; Harding, 1987; Stanley, 1990; Reinharz, 1992; Wadsworth, 1993).

## Research Methodology

Ethnographic research methodology is utilised in this thesis. Ethnographic research appears congenial to feminist researchers because it is grounded in phenomenological experience, and as such includes the feeling, intuition, empathy and relationship aspects of being human. These aspects of our humanness are validated in the research process and utilised as a valuable resource.

Reinharz (1992) describes feminist research as one that attempts to dissolve the binary system of oppositions that characterise most aspects of western thought and practice by:

- 1) recording our private experiences for public knowledge and locating them within their associated historical, economic, political and social perspectives for them to be analysed;
- 2) supporting the notion of self-help and community primarily through consciousness-raising;
- 3) drawing on the subjectivity of both the researcher and the researched and attempting to place them on the same critical plain to co-produce and co-consume knowledge; and,
- 4) actively problematising the research process so that both the process and its end product “knowledge” is made available for criticism and change.

While many feminists evince ethnographic methodology as ideally suited to feminist research, Judith Stacey draws on Ann Oakley’s classic work *Interviewing Women: A Contradiction in Terms* and argues that some

inherent contradictions exist between ethnographic method and feminist principles. While the characteristic features of ethnographic research -- 'authenticity, reciprocity and intersubjectivity'-- are espoused on the grounds that they will 'end the exploitation of women', Stacey argues that it is precisely these same research qualities that put women at 'greater risk of exploitation, betrayal, and abandonment' (1988, p. 25).

Cathleen Armstead (1995) also describes the difficulties that can exist between the principles of feminist research and the actual doing of the research, particularly in the writing-up phase when it can be very difficult to write a coherent article which is accurate, accessible and clear, but which accounts for the contradictions.

Dale Spender (1980) and Liz Stanley (1990) write that while feminist research works toward eliminating power inequalities, power nonetheless ultimately rests with the producer of the written text who will be influenced by associations with institutions and particular philosophies.

### **Standpoint Theory and the Researchers Standpoint**

The development of standpoint theory was a major breakthrough for the construction of feminist epistemology. Succinctly, feminist standpoint epistemologies produce a visibility of women in social inquiry, both as a broad category and as marginalised groups. Stanley and Wise critically analyse the work of Sandra Harding (Harding and Hintikka, 1983; Harding, 1986a, 1987a) and Dorothy Smith (1988) and argue for the notion of multiple feminist standpoint positions and "successor science", as advocated by Smith. They argue that it is possible to have multiple feminist

epistemological positions without invalidating the broad category of women 'because all women share, by virtue of being women, a set of common experiences' (p. 21). They write that, a feminist research standpoint is both 'located in (and) proceeding from the grounded analyses of women's material realities'(p. 25). Standpoint positions enable us to articulate our specificity and become speaking subjects from a politically activating perspective.

In this field of inquiry I have numerous standpoints which I draw on and include in the thesis as part of the feminist research process.

My interest in this field of inquiry began around thirteen years ago when I became disenchanted with the range of pharmaceutical contraceptives available. The Pill caused me to feel generally unwell. Each time I consulted a medical practitioner to discuss using a less invasive form of contraception I left with another script for the Pill.

I had heard of NFP but knew nothing about it. Rather than something I could relate to, NFP to me was a mystical Roman-Catholic practice. With hindsight, I realise I didn't even consider requesting NFP education from the medical practitioners I consulted, nor was it offered.

In the early 1980s I learnt the OM of NFP by reading *The Billings Method* (1980). Whilst I established an effective working knowledge of the OM from the book I didn't feel entirely confident using it to avoid pregnancy. Confidence developed several years later after discussing the method with other women who also used it for contraception.

In the early years of using the OM for contraception I remember being amazed that it actually worked. Conversely, when I wanted to become pregnant I was able to achieve this in the first cycle I “tried”, and knowing the date of conception enabled me to estimate my own birthing date. The fertility-awareness aspect of the OM initiated a whole new way of thinking about my body, my fertility and the menstrual cycle, and facilitated a physical and psychological well-being I had not previously experienced. The personal power of having fertility-awareness knowledge was profoundly reinforced more recently, when I initiated specific medical investigations for an abnormal mucus pattern of fertility which led to a diagnosis of adenocarcinoma of the cervix. Adenocarcinoma of the cervix is a cancer of the mucus secreting glands in the canal of the cervix which regulate fertility. The Australian Institute of Health and Welfare (Canberra), conservatively estimate that around fifty Australian women die annually from adenocarcinoma of the cervix (telephone conversation, 8 January 1998). Adenocarcinoma of the cervix is life threatening: firstly, because it tends to spread beyond the cervix in its early stages; and secondly, because it is not routinely screened for. Its very early diagnosis in my case resulted in a surgical cure rate of ninety-seven per cent.

Not so long ago I met socially a medical practitioner in student health, who angrily rejected the notion of women wanting to record menstrual cycle symptoms for “birth-control” reasons. She said that “women cannot identify when they ovulate”, that “women have more to do with their time than observe mucus,” and that my suggested involvement in facilitating the early detection of adenocarcinoma was “dangerous” because she had only ever diagnosed one herself. These assertions were challenging confrontations leading me to consider more fully the difficulties women experience in holding on to their realities and believing in themselves.

In 1988 a state and federally funded family planning service invited me to present the NFP lecture in sexual and reproductive health courses for nurses and medical practitioners. In the nurses' course it was not uncommon for nurses to disclose that they were using, or had used NFP, for contraception but did not discuss this openly because comments like, "it doesn't work", undermined their confidence. Course evaluations indicated that this session was very well received with many nurses stating that it was both personally and professionally useful. Around the same time I began teaching NFP in the clinic setting where I experienced enormous pleasure sharing fertility-awareness knowledge with other women. Comments like, "I have wanted to learn this for such a long time", "I should have been taught this at school", "I feel cheated that I was not given this information before", were frequently made, as were derisive comments by some colleagues disputing NFP as an effective method of "birth-control". On several occasions nurses undertaking clinical supervision reported that other practitioners in the clinic had successfully talked women out of their request for NFP education.

In 1991 I became a trained teacher of the OM by the Ovulation Method References and Research Centre of Australia (OMRRCA). Through my association with this centre I gained both an appreciation for, and a critical analysis of the Roman-Catholic Church's doctrine on NFP.

In 1995 I began to consider the possibility of becoming an independent nurse practitioner of fertility-awareness education when the management of the women's health service I was working in decided to restrict first consultations for NFP education to thirty minutes and follow-up consultations to fifteen minutes. It was/is my view that effective education of this kind is not possible within these time frames. It was also decided around this time to reduce the NFP lecture in the nurses' and medical practitioners' course from a one and a half hours to half an hour. Consequently, in 1996 I established myself as a consultant in this field

under the business name of Wise Woman Business, and since then I have been exploring the concept of feminist fertility consciousness. This project will be utilised to aid in the development of such programs.

In exploring my history in this field, multiple standpoints can be seen both as a user and educator of NFP. Cook and Fonow (1991) describe the multiple standpoint situation as having 'outsider within status' and suggest that there are a number of benefits to having this status when producing knowledge because it can facilitate 'greater objective ability to see patterns insiders are too immersed to see' (p. 3).

### **Research Method**

Twenty-six out of a possible twenty-nine women who had attended fertility-awareness education in the previous fourteen months with the researcher were invited to take part in this project.

Eleven women responded to the invitation and seven agreed to participate. Two respondents were later unable to attend for family reasons and another asked if her sister could attend with her because she was interested in learning about fertility-awareness. This request was agreed to following consultation with the other participants.

Two group interviews based on a set of pre-determined open-ended questions took place at The Women's Clinic on Richmond Hill, 366 Church Street, Richmond. This setting was chosen because of its central location and accessibility by public transport. The set questions were tested in a pilot study and amended accordingly. Only very minor alterations were made (see, Appendix Three).

Research data was collected in four ways: firstly, by tape-recording the interviews; secondly, by amending and extending our interview transcripts; thirdly, by completing an evaluation form; and fourthly, by the author writing a reflective diary throughout the research phase.

### **Group Interview Format**

The interviewer is present in the group interviews in the dual capacity of interviewer and interviewee. The interviews began with a group forming activity and with discussion ranging over the research objectives and design. In the first interview a collective working agreement was established (covering such issues as confidentiality, listening and supporting one another to speak), the Informed Consent Forms were signed and each participant made their choice of pseudonym under which the research will be published. A debriefing exercise concluded each session.

Tape-recording began with actual interviewing. The tape-recorded interviews were transcribed and distributed back to each participant so that they could be amended for accuracy and extended if we wished to do this. This exercise served several functions. It enabled us to write what we did not feel comfortable discussing in the group situation, it served as a consciousness raising exercise to extend our stories if we wished to, and it validated our experiences and thoughts by making them seem more real. All data were verified for accuracy before excerpts were made. No corrections are made, for example to grammar. The stories are located within their historical perspectives so that an analysis of their respective economic, political and social conditions can be made. And as far as is possible our active voices are used to support the analytic arguments. The near to final draft of the analysis was accepted by all participants before the conclusion

of this project, conferring shared authority in authorship. The observations made on the group characteristics and how they affected the group interview process are documented in chapter six. They include reflections on ‘non-verbal behaviours, affect, communication processes, rapport and power ‘dynamics’ and serve to ‘contextualise the interview data, verify congruence of verbal and non-verbal communication, record personal reflections, and analyse interview techniques’ (Stevens, 1996, pp. 28-9).

### **Method of Data Analysis**

All data was collated and organised into categories by content analysis. The themes that emerged are interpreted in the context of the literature reviewed and experience the researcher has in this field.

### **Limitations**

Whilst every effort was made to adhere to the principles of feminist research outlined, inherent limitations will nonetheless be evident: for example, notwithstanding the effort that was made to create a space to facilitate our voices, some of us may not have said all we wanted to say or could have said for numerous reasons. I hope that the collaborative model of story telling and the chance to extend the interview transcripts helped to negate this limitation to some extent. Limitations will also exist in the language we used to describe our life experiences and the level of consciousness within the group.

## Chapter Three

We have turned away from our bodies. Shamefully we have been taught to be unaware of them (...) There are still so few women winning back their bodies. Helen Cixous, *The Newly Born Woman*. (cited in *The Fertility and Contraception Book*, Mosse and Heaton, 1990)

### *Amended And Extended Interview Transcript*

#### **Group Interview One**

This interview was attended by six women who had undertaken fertility-awareness education sometime in the previous fourteen months with the author of this project. The author is present in the dual capacity of interviewer and interviewee. Our ages range between twenty-five and forty-one years. We are of Australian and Greek cultural identity, heterosexual and lesbian, and in a range of paid employment. None of us are Roman-Catholic.

The following questions were asked: “What factors influenced your choice of contraceptive method in the past?”; “Can you describe how you came to your decision to learn fertility-awareness?”; and, “Can you describe your experiences in accessing fertility-awareness information?”

Our responses to these questions are recorded in full.

**Heather:** *At school we had a volunteer group take a special class on contraceptives. They covered condoms, IUDs and the Pill. It was very informative. Looking at it now they should have expanded another class with*

*girls to explain our fertility as a means of contraception. After the class, at home after dinner, Mum managed to introduce our class to Dad and my younger sister. I explained what was covered which was OK. The conversation ended with Dad saying basically, "So now you think you know all about contraception then, don't ever come home and say you're pregnant!". Needless to say, my first relationship with a male had me almost instantly going to the doctors for the Pill.*

*It's the wrong way about, we should know about our fertility before we are given the Pill. No-one tells you about it. There's no where to go to get the information.*

*Later, I was quite happy in my own little world until one day a woman came in when I was doing Chinese Medicine and she asked how much fertility she had left. She said she was forty years and wanted to have a baby. I wondered, what the hell am I going to say to that? So the Professor came in and he said, "A woman has twenty-eight years after she gets her first period". How the hell could he say that! The mathematics of it all, and the general approach of it all was really wrong. It stuck in my mind.*

*I had been thinking about going off the Pill for some time but I thought that I wanted to know what my body was going to do when I did go off it. My husband said it was OK. He was fully supportive. I didn't want to fall pregnant though. I wanted to go off "The Pill" for me and I am doing it for me. I made phone call after phone call. I went to a chemist and there was a woman there who I asked if there was something I could test myself daily with, so that I could know what my body was doing...*

*(Roberta: Like Clear-Plan?)...*

*Yes basically, and that had about 5 things in it that cost about \$80.00. Look I said, I don't care if it costs me \$200.00 if its going to give me what I want to know. And she said, "I think I might know what you are looking for". She made several phone calls for me and I rang Family Planning, and they gave me Kerry's phone number. That was terrific. She said that several other women had been in and asked if there was something they could use as well. So I took some of Kerry's brochures and gave them to her....*

*(Cheree: I have no doubt that more women are asking!)...*

**Roberta:** *I remember I got out of the bath and I saw blood running down my leg, and I thought this is it, oh no, how am I going to tell Mum...*

*(Cheree: Yes. Exactly !)...*

*That was my first thought. Then I thought well I'm going to have to tell her. I was only eleven. She took me to a room. She didn't show me how to put those things on. It was really strange. I was her daughter I was only eleven for goodness sake! And yet, Mum had always tried to be open but still she and I know now she wasn't very comfortable with the whole thing, so she couldn't pass anything on.*

*What's really sad is that women as a whole, as a group have no feeling of a sense of a mystery, of a whole art of being female and of who we are. And, we don't celebrate the major mile-stones in our lives. There's no celebration when a girl has her first menstruation. I had exactly the same situation as you. I was the first person to get my period. I was horrified., I just wanted to hide it. I just didn't want to know about it. I didn't go to school on the first day at that time in the month. I sat at home worried. I was ashamed. I was frightened it would show and all kinds of things. This is not the way it should be. So I think what we need to do is for women to take pride in those things*

*that make us essentially women; our hormones, our fertility cycle and menstruation. I think we need to take pride in who we are and what we have, and loving ourselves for our own reasons rather than trying not to be women and ignoring ourselves and not talking about these things...*

*It should be a wonderful thing; And now you are becoming a woman! We should be talking about these things. And for mothers and aunts and grandmothers and schools to celebrate these things too. And to educate girls not in the same room as boys as they have their own thing to go through. They can learn to value their body, learn about how their body works.*

*I was maybe nineteen or twenty and an older friend of my mothers who had three or four children and couldn't go on the Pill. She mentioned something about mucus. I thought that's weird. I never considered it as an option. It was such a strange thing to think about taking note of your mucus...*

**Cheree:** *When you are a teenage girl the last thing you want is to be different. So if you wanted to be normal then you go on the Pill, because that is what everyone else is doing. If you try and watch your mucus patterns then that is something that would separate you from everyone else and there are so many other things that would do that.*

*There is no-one around collectively that says that this is a great thing that is happening to you. There is nothing like that that communicates positively about the changes that are happening. I remember being so scared when I first got my period. Perhaps for a couple of months, I can't remember for how long that when I got blood on my "undies" I wrapped them up and put them in the bin. Finally I thought this can't go on. I wonder what my Mum thought and if she ever noticed...*

*(Roberta: And if she did, why she didn't say anything!)*...

*I would find public bins to put them in. I look back on it now and it still hurts me because I still don't have a very good relationship with my mum. I remember when I first told her that I got my period, she said, "Are you sure?", which was really unhelpful because I thought don't question me. There was no affirmation and I still find there is hurt there.*

*I remember my Mum giving me a book. I remember Dad hassling her a bit. So Mum gave me a book which I was probably really glad about because I was really too embarrassed to ask. And the other thing I remember reading was Dolly magazines and their contraception specials. It was all picked up in the school yard and kind of what-ever I could get my hands on. And it was all pretty secret, you couldn't just talk to any one about it.*

*I suppose I've always been pretty anti-drugs and into natural things, so I've never been on the Pill. A doctor did want to put me on the Pill once to make my periods regular but I didn't want to do that because I thought that it didn't tell me why my periods were irregular. I was twenty-five at the time and I wasn't in a relationship so I had the time to work my cycles out. I later found out that I have polycystic ovarian syndrome (PCO) which causes you to naturally have irregular cycles.*

*I had heard friends talk about Billings babies. I read the Council of Adult Education Course Guide and I saw your [Kerry's] course. I felt pretty excited about learning about my cycles and about my fertility.*

*It's only been relatively recently that I've chosen to use contraception. I felt no peer pressure to use a certain method, although my doctor and gynaecologist wanted to prescribe me the Pill. Being a bit older was good because I felt more confident about thoroughly checking out all my options. I grew up in a small country town and had I wanted to get contraception when I*

*lived there then I am sure I would have gone on the Pill - It's simple and discreet and fairly standard!*

*I originally decided to learn fertility-awareness as a way of feeling a bit more "in control" of my cycle -- which is by no means regular. I was told by my gynaecologist that my hormone levels are irregular because I have got PCO [instead of ovulation occurring cyst form on the ovaries] and the best way to control my cycle would be to go on the Pill. I didn't necessarily want to control my cycle but I did want to know what my body was doing. I didn't go on the Pill because my hormones are already all over the place and I didn't want to add synthetic hormones into the picture...*

**Marie:** *I didn't know any thing about mucus. I went to the doctor because I didn't want to get pregnant and he gave me the Pill. He didn't offer anything else and I didn't know to ask. When I decided not to get pregnant I went off the Pill and got pregnant straight away. However, I had a miscarriage at three months. I found out about mucus when I contacted The Women's Clinic on Richmond Hill looking for someone to talk to because I was very upset about the miscarriage. They referred me to Kerry and she told me about mucus. I used this information to get pregnant again but I've had another miscarriage. I wasn't told anything about this [mucus] at school and Mothers can only tell you what they know...*

(Roberta: Mothers only know what they have learnt!)..

**Heather:** *In wanting to get off the Pill, it is a very hard decision to make. At school I didn't have many friends at all, and girls don't really talk about fertility, or your bodily experiences while on the Pill. So when your hormones play havoc who do you talk to? It's really wrong. You seem to plod along with everyone else but the deep down feelings are more of segregation. You almost feel an alien while menstruation is taking place. But I now know this*

*[menstruation] is normal. It's a shame no-one tells you this when you're younger. One common thing I have noticed more recently is that women who have given birth talk more openly about their body, the changes happening, and they ask people for explanations and advice...*

**Marie:** *No-one actually tells you when you are trying to get pregnant the days when that can happen in your cycle. That was really good when I found out. It was a great help. I never realised. I've got it now. So I thought I'm going to tell everyone. I'm like that. If I think something is good I'll tell everyone about it..*

**Josie:** *Mum was there. She was pretty good about it...*

*(Cheree: That's really nice!)*...

*I was late getting my period. Everyone else had theirs and I was wondering why I hadn't got mine. I thought there must be something wrong with me. When I got it I was so excited...*

*(Roberta: That's good. That's the way to go!)*...

*I remember Mum telling everyone in the street, and they all said, "Well done!" They were all very happy. I was also very lucky because I have my older sister who was helpful too. I was only on the Pill for one month and that was when I was on my honeymoon, and I thought I didn't want to get pregnant then. After that, I went off it to get pregnant. We tried to get pregnant for about a year or so, and when it didn't happen my husband had a test and it was found that he didn't have a "Vas" [tube through which sperm pass from the testes to the penis during ejaculation], so we are now on IVF [in vitro fertilisation]. We've had one go, but it didn't work...*

(Kerry: “When you were trying to become pregnant and before you found out about your husband, did anyone tell you about cervical mucus and its relation to fertility?”)...

*No, no-one told me about mucus. My sister told me about mucus more lately though. I didn't know anything about mucus before that...*

**Kerry:** *My mother was shy and seemed easily embarrassed. She didn't tell me any thing about how my body works. Instead, she gave me a book which I can't remember much about. Nor can I remember much about the film I saw at school, except for pictures of the reproductive system.*

*I remember feeling a sense of fear to the point of almost feeling immobilised when I first got my period. I knew I had to tell Mum but actually doing this filled me with a sense of fear and confusion, which confused me even further.*

*I think my mother's reaction to my first period sent me a powerful message, that was that I couldn't go to her for personal information or support for such matters.*

*One day many years later, she visited me when I was training as a nurse. She specifically visited to tell me that a family friend, my age, had become pregnant and was going to be married.*

*I had a boyfriend at the time and Mum said that if I needed to do anything that prevented this from happening to me, she would understand. Without her actually saying so, I believe that she was giving me permission to go on the Pill. I could tell that she found this situation very difficult and it seemed that we both knew this. I didn't need the Pill for contraception but some months later I consulted a doctor to it ask if the Pill would relieve the extreme period*

*pain I was experiencing at the time. After the doctor prescribed the Pill he warned me that it would not work as a contraceptive. I knew he was lying and wondered why he would bother. I took the Pill on and off over the next several years. Throughout most of this time I didn't like the idea of taking it, nor did I feel entirely well whilst I did. When I consulted doctors regarding this, their solution was to try another brand of the Pill; non-invasive alternatives were never canvassed. Many years later I read The Billings Method and that was when I started to learn about my fertility and about my body. A comment Heather made earlier reminded me that I also experienced a fear about going off the Pill because I wasn't sure if I could manage my fertility without it and I had a fear about my cycle that I could not have articulated then.*

## **Group Interview Two**

This interview was attended of six women who had undertaken fertility-awareness education sometime in the previous fourteen months with the author of this project. The author is present in the dual capacity of interviewer and interviewee. Josie and Marie are absent and Thalia and Rebecca have joined us. Our ages range between twenty-two and forty-one years. We are of Australian cultural identity, heterosexual and lesbian and in a range of paid employment. None of us are Roman-Catholic.

The following questions were asked: “What do you perceive were the barriers that prevented you from receiving fertility-awareness knowledge?”; and, “What do you consider are the benefits of having fertility-awareness knowledge?”

**Roberta:** *The first time I heard about this idea of charting your fertility through mucus signs was through my mothers' friend. Then somehow along the road I must have heard more about it, but I can't remember when. But I do remember mentioning to someone who was trying to get pregnant, "Oh you should try the Billings Method." I didn't need to use it myself until I wanted to get pregnant. I read the book Natural Fertility by Francesca Naish and after I had charted it for six months I thought I wanted to speak to someone, and that's when I found you [Kerry]. If I hadn't learnt it to get pregnant then I perhaps would have learnt it as part of that time of questioning that occurs around the thirties.*

*The obstetrician I saw is a "big wig" with IVF and I felt he was very good. But, he said and I quote, "Don't take notice of mucus." I said, "But I've heard that this mucus is important." And he said again, "No don't worry about it." I got the distinct impression that he didn't believe mucus had anything to do with fertility. He didn't bring the subject up, I did. A friend of mine who conceived triplets on IVF was never told about mucus at all. She was told to buy and use the Clearplan ovulation prediction kit each month...*

**Rebecca:** *I probably learnt the basics of the cycle when I did biology at school. I learned about the 28 day cycle and that there are different stages in the cycle. But that was very basic knowledge. We weren't given information about hormones or mucus. That was at school when I was in year nine or ten. Then nothing much else was said after that unless you go looking for it. Even when you go to the doctor and get put on the Pill they don't go through anything like that. They just say, "Here take these Pills, and they will do it all for you really..."*

**Heather:** *I'm much about the same, I had basic sex education at school. You have a 28 day cycle and this [ovulation] happens in the middle, and that's it. So, I basically didn't have a sex education. They should segregate the boys*

*from the girls. Boys should learn about their fertility too. Both the boys and the girls should learn about their fertility. Like Josie's story, they always think that when something goes wrong with fertility then there must be something wrong with your fertility. Its never them. We had three little letters at home that we put on the calendar...*

(Kerry: And they indicated when your period was to come.)...

*Yes....*

**Rebecca:** *We should be taught about our own natural cycles before we are put on the Pill. Basically, all I learned at school was that the lining of the uterus built up over the cycle and then came away at the end of it..*

**Roberta:** *There is nothing about mucus...*

(Rebecca: You're right, there was definitely nothing about mucus.)...

*And nothing about PMT or the emotional side, or how a woman relates to the cycle. There was nothing about how we personally relate to our cycles. Mind you, the people teaching this probably didn't know this either. I think that girls and boys need to be segregated to learn these things at school because they're too embarrassed, they're too shy, and it just makes it too threatening...*

(Rebecca: They should come together after they have had their separate times. Once they know what's going on they would feel a lot more comfortable.)...

*Yes. That's right! That would be good for boys and for girls. The boys want to talk about these things as well but it is different for them...*

(Kerry: Do you think boys should be encouraged to have an understanding and an awareness of their own fertility?)...

*Oh, absolutely...*

(Rebecca: Yes. At least girls have got to be aware of their cycle at least once a month. Whereas boys don't even have to think about their fertility at all.)...

*And also because women get pregnant. And if you get pregnant it's your body. He's not going to grow it in his stomach. Men have this sort of luxury that they can just choose to walk away; What is that? I think that there needs to be a really strong education for boys about the responsibility of it. It's not that you just do as you please and that's the end of it. And, you have got to get boys really young for that, and lots of families don't think about that attitude at all...*

**Heather:** *My husband was given a book...*

(Kerry: What did the book contain?)...

*I don't know because he burned it. 'Here read this. This is what it's all about.' That's it. No discussion. No talks. The first time he had sex with a girl she got pregnant. That really scared him. He says that if we have kids they're going to know about everything. I can imagine that if we have a daughter then he will tell her everything. That would be good.*

*It's just such a shame, you know, when you are learning about it yourself, you're not necessarily in a position to teach someone else. That's where I think it's difficult on parents. You might be looking for further information and that can be difficult too. Even when you are in hospital and you give*

*birth, someone could say this is the way your body is going to work in the next six months and this is your network of people you can contact. This would include a variety of people such as district nurses, other mothers...*

**Heather:** *In school you should get the mothers together and talk about reproduction and what it means to be female Then if you didn't want to talk to your Mum you know that you could talk to another Mum who had attended the same talk and would say the same thing, except that you didn't live with that Mum...*

(Roberta: You could talk to the mothers first)...

*Yes, you could talk to the mothers first, alone, and without the children. That would be a really good idea. Because the children would then have somewhere to go. I think that that's really important...*

(Kerry: In our discussion on Monday night a number of us expressed a profound disappointment that we were unable to talk to our mothers about personal body matters. Do you think mothers also need support and education in this area... [All responded affirmatively])

**Thalia:** *Having the "Pill" as the answer to contraception, you grow up thinking everything will be dandy. Then you realise that things aren't the way you thought they were. When I grew up and started doing research I began to realise exactly what it was. But then I was given no other options. And so rarely do you get this information. So having fertility-awareness gives me an understanding of what it is to be a woman. I know much more about myself and I understand myself more too. I find that I'm coming to know where I am*

*in my cycle, so when I have that sense that I'm feeling really tired today, I know why I am when I am at the end of my cycle, so it doesn't matter. So I just take time out. I feel now that I know why I feel the way I do. My body seems to make much more sense. So rather than fumbling through; in the past I would feel PMT but I wouldn't know exactly what was going on. I'm more aware of it now and more accepting...*

**Roberta:** *It's like sometimes when you are feeling a bit tired, and you think, "Why am I feeling tired today?" I should be able to just keep going. I think we are just expected to behave just like men in the sense that you have to be able to do exactly the same thing at exactly the same level all of the time. And not to take into account the whole cyclical way females are and appreciating that for what it is. I think that we don't do that most of the time. You might be feeling under the weather and you just soldier on...*

**Heather:** *I just walk into work and say; "Sorry guys, I've got PMT so just leave me alone." That's it. I'm not hiding it. I've got no reason to snap at people normally and all of a sudden I start doing it so I just let people know. Then all of a sudden someone will say, "Yes I'm going to be that way in a couple of days too!" So, it goes around like that...*

**Cheree:** *If I know that I'm expecting my period on a certain day then I know that around then I'll be feeling very agoraphobic and I won't want to go out. So I'll try not to do too much on that weekend or during the week before. In the past I've not turned up at parties so many times. Now I'm beginning to realise that I won't say I will go and then not turn up...*

**Roberta:** *Talking about how menstruation is viewed. In other cultures a long time ago I've read that menstruation was seen as a positive experience. I don't know if this still is the case but women were seen as powerful at that time. It is a time when women were more introspective. After I read this I realised that I feel differently at that time too. You feel pain and you feel sluggish at that time but it is also a time through reflection that women have power. It could be seen as dangerous, as a way of controlling us...*

**Cheree:** *Talking about the barriers. I was thinking about this today. It's not just the inaccessibility of fertility-awareness information. It's also the mass dominance of the pharmaceutical industry. A lot of women said last week that when they went to the doctor to get contraception they weren't given choices. It was presumed that if you want contraception then you want the "Pill". It was as though we have no ability to learn when we are fertile and are encouraged to have comfort in the magic "Pill" that will take care of everything. All we have to do, is remember to take it. It's insulting in many ways!*

*I wonder if this is partly because fertility-awareness is seen as a bit freaky or a bit scary. And because we don't need to purchase any special products. Some people talk about it as if it is dangerous.*

*It's a great feeling to have fertility-awareness knowledge. My cycle is still not regular and rather than being constantly be worried about where I'm up to. Now I look out for all the signs of ovulating and expect my period two weeks later. I actually enjoy my period more. This has something to do with using cloth pads too. It's like I'm revelling in my womanhood. It's definitely a confidence builder to feel like I know what my body is doing...*

**Thalia:** *Actually, I've have that reaction from people...*

**Roberta:** *Yes, like you can't know your own body well enough to be able to manage your fertility...*

**Rebecca:** *I think it frightens or intimidates some men to think that women could know their own bodies that well. I think they see it as an issue of power. It gives us the choice and knowledge about the conception of life. The only thing they can never take away from us, and for us to be in control of that may be perceived as dangerous...*

**Thalia:** *I have had that kind of response from people who don't actually understand. Of course there are times when your not sure where you are in your cycle, so you safe guard yourself and take precautions accordingly, but that's not all the time. But it's amazing. It's such a strong reaction sometimes. Some people warn me and say, "I hope you know what you are doing!"...*

**Rebecca:** *I agree with Thalia. Having this knowledge gives you so much more power over who you are and an awareness about where you are in your life. Fertility-awareness probably didn't give me any more body awareness than I already had but it enabled me to put the changes into place, and give it some sort of logic and meaning...*

**Roberta:** *I agree with Rebecca. It is knowledge that is empowering. And, it also makes you appreciate your body and the way it works. You come to know it as an amazing thing really. It gives you a sense of being positive...*

**Thalia:** *We had a woman come to our work to talk to us about stress relief and she was talking about the mind and the body as being one thing. She was really pushing this as a way of reducing stress. I felt like saying to her, "I am*

*aware of what my body is doing". With this information I feel like my body is me. It makes me feel like a whole being and that's empowering...*

**Cheree:** *In relation to that [fertile-awareness information] it helps me deal with things that perhaps otherwise would be seen as a negative thing better. Like, I was talking before about feeling agoraphobic. In the past I felt that I don't want to go out, but perhaps I should. Whereas now I think that it's okay if I don't go out. I can go out at another time. Tolerance isn't the quite the word I'm looking for. It's more a freedom to accept who I am at a certain time...*

**Rebecca:** *Talking about noticing certain things in the cycle, I find that now when I'm coming into that time in my cycle I wear different clothes because I feel bloated and I do just literally want to hide under something, so I've got particular dresses that I wear at that time that have no shape...*

(Kerry: Being inward in your cycle)...

*Yes absolutely hiding away and being really introverted and no-one really knows...*

**Kerry:** *One of the things I found exciting about having fertility-awareness knowledge was being able to reinterpret a number of things about my body that are generally considered a negative. When I trained as a nurse and a midwife we never talked about cervical mucus. All fluids that came from the vagina were called "discharge". This word has very negative connotations and it affects the way we think and feel about our bodies. Like it's something dirty that you need to get rid of, and you certainly wouldn't admit to having it.*

*So one of the most powerful things for me when I learnt fertility-awareness through knowing about mucus patterns was the actual power of the mucus. It is very powerful in the way it facilitates pregnancy. And, having this knowledge and power felt quiet spiritual at times. Observing it meant that I could know exactly when I was fertile in my cycle, when I was about to ovulate, and when I had ovulated. And knowing its functions in relation to fertility enabled me to see my fertility in very positive terms rather than fearing it because I didn't understand it...*

*(Rebecca: That's so true!)*...

*(Roberta: That's very true. I can relate to that!)*...

*Sometime after I had learnt about the cervical mucus, I had a flash-back. I remembered sitting on the toilet once not long after I first got my period and seeing a string of mucus come away. I wondered if it was normal, what it meant, and if I should be worried about it. I was too embarrassed to ask anyone, so it was many, many, years later that I learned its significance.*

*In addition to enabling me to "manage" my fertility, fertility-awareness knowledge enabled me to understand the physical, psychological and spiritual changes that occur in the menstrual cycle in relation to ovulation and to menstruation. So rather than viewing these experiences as negatives that I didn't understand, they became additional information that guided me as to where I was in my cycle. And, understanding the different needs I had throughout the cycle enabled me to look after myself better than I had been able to before. Understanding normal cycle patterns also enabled me to be certain that I was producing cervical mucus at a time in my cycle when I should not have been. This knowledge led to an early diagnosis of*

*adenocarcinoma of the cervix which may not have been detected otherwise. Fertility-awareness knowledge therefore contributed to saving my life...*

**Rebecca:** *Women must have talked about this before. They must have known...*

**Roberta:** *Somewhere along the line it seems that it became not all right to talk about our bodies and about its functions Somewhere along the line this knowledge must have been wiped out.*

## Chapter Four

There is no closure of discourse, discourse only ever being a compromise (...) between what is legitimate to say, what one would like to contend or argue, and what one is forced to recognise. Michele Le Doeuff, *The Philosophical Imaginary* (Gates, 1996, p. vii, cited in Athlone, 1989, p. 19)

If a woman is to consider herself a real knower she must find acceptance for her ideas in the public world. (Belenky et al., 1986, *Woman's Ways of Knowing*)

### ***Content Analyses and Discussion of Interview Data***

#### **Introduction**

With hindsight, we identified that we *should* have received fertility-awareness knowledge from three specific sources: from our mothers in the years leading up to menarche; in the school sex education programs we attended; and when we consulted medical practitioners for contraceptive advice. We did not receive this knowledge from any of those sources however, primarily we believe, because they did not have the knowledge to pass on to us, and also because they reflected and reinforced dominant mainstream values held by the wider community.

Without fertility-awareness knowledge we assumed that “fertility management” relied upon the involvement of the medical and pharmaceutical establishments, and this reliance in turn led us to take responsibility for our partner’s fertility as well as our own.

Conversely, fertility-awareness knowledge enabled us to assert self-governance in the “management” of our fertility and therefore to be able to resist pharmaceutical “birth-control” processes. Fertility-awareness also

began a process of grounding our knowledge of our fertile bodies in our actual experiences and this led in many instances to more positive feelings towards our bodies and increased our sense of well-being.

This chapter begins with an analysis of why we did not observe the signs of our fertility before we learnt the OM utilising feminist theories on the body. It is followed by an analysis of the barriers we experienced to receiving fertility-awareness knowledge, and it is concluded by an analysis of women's utilisation of fertility-awareness for "fertility-manage". Where additional stories have been incorporated to illustrate certain points they have been attributed to pseudonyms.

### **Feminist Theories on the Body and Fertility-Awareness Knowledge**

Rebecca and Roberta asserted that women in the past *must* have known and talked about mucus and its relation to fertility. Indeed, Billings and Westmore (1992) and *The Fertility Consciousness Group* (1980) document that knowledge of mucus and its relation to fertility was passed to adolescent girls in rite of passage ceremonies in indigenous cultures in Australia, North America and Africa.

"Power-knowledge" theory provides a useful theoretical framework for analysing how medical discourse and practices can on the one hand, negate our ability to identify the signs of our fertility, but on the other, enable our recognition of them in all phases of female reproductive physiology. Essentially, feminist theorists on the body argue that cultural discourse and practices in the form of "power-knowledge" profoundly shape our knowledge and our expression of our body by determining what we can see and how we experience it. This situation is a vivid illustration that western science is a value laden enterprise which can function in inconsistent and ambiguous ways, as argued by Holmes (1980) and Bell (1995).

of them believes the root cause of most complaints of women attending them is psychological. Whether this assertion is true, or not, Jenny's story illustrates her claim. Jenny had attended a number of Vulval Clinics before she was advised to chart her "discharge" after an exhaustive range of tests had failed to find a pathological cause for it. A friend had had surgery to "get rid of hers" and she wanted a medical resolution too. Jenny could not/would not be persuaded that the mucus she was observing was an expression of her fertility.

Mosse and Heaton (1990) argue that it is precisely because the medical model of the menstrual cycle -- the academic outsider's knowledge -- dominates our knowing that we do not have a personal knowing of our fertility. The medical model constructs the menstrual cycle as a linear event with the interrelatedness of hormones, ovulation and menstruation as the total picture. Indeed, this was the sum of our sex education at school. Not one of us received information about the mucus symptom of fertility, and certainly we did not receive information about "vaginal discharge": its taboo ensured its denial by everyone. Nor did *we* discuss "vaginal discharge" until Kerry described the relief she felt when she was able to discard this term for cervical mucus after she had learnt the OM.

In addition to cervical mucus being omitted from the medical model of the menstrual cycle and overlaid with the concept of "vaginal discharge", our ability to perceive it at the vulva where it is best identified is inhibited. It is not uncommon for women not to be able to identify the vulva, but apply the term vagina, instead, to describe genital anatomy generally. Representation of the vulva is also minimal or absent in diagrams where it is generally bypassed -- swept aside -- to expose the vagina that lies beyond it, or not labelled at all (see, for example, Macquarie, 1994; Naish, 1994). Succinctly, the medical model of the menstrual cycle represents the female body in incomplete, disfigured, fragmented and incoherent ways, and this is

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reinforced because the dominant form of knowing militates against integrating our embodied subjectivity. *Don't Let Your Hormones Ruin Your Life* (Cabot, 1991) is a classic representation of this perspective. Complete with pictures of female hormones caricatured as demons, this text characterises the menstrual cycle as an anarchic, problematic and pathological condition; for which we need constant medical surveillance and from which we need rescuing, for example, as Cabot suggests by hormonal regulation. Sandra Cabot is a well known Australian specialist medical practitioner in women's health who promotes her texts extensively.

Feminist theorists on the body place emphasis on the lived experience of the body to reformulate a unity of being by disrupting the binary oppositions of western discourse and practices. Braidotti (1994) argues that the 'starting ground for revisioning our subjectivity is in a new form of materialism that places emphasis on the embodied and therefore sexually differentiated structure of the speaking subject' (1994, 199). Gatens (1996), also writes that grounding our knowledge of our bodies in our actual experience enables us to resist the binary oppositions of western science which encourage and attach untrue generalisations to the category of 'woman'. The fertility-awareness aspect of the OM enabled us to begin the process of grounding our knowledge of our fertility in our actual experience, and hence, has made a significant contribution to the feminist project of reclaiming our bodies for ourselves. With fertility-awareness knowledge we were liberated from the false notions of twenty-eight day cycles, "vaginal discharge", erratic cycles, medical and pharmaceutical dependence for "birth-control", medical dependence to establish birthing dates, and more.

Kerry described how knowledge of cervical mucus enabled her to re-frame what she had learnt was "vaginal discharge" into a positive and empowering aspect of her female identity which she used as a profound marker of her fertility, and which contributed to saving her life by enabling her to detect the early signs of a life threatening cancer. For Kerry, Cheree, Thalia and

Rebecca fertility-awareness restored a feeling of wholeness about the menstrual cycle by facilitating an understanding of the relatedness of menstrual cycle events. Thalia describes this when she said:

*Having fertility-awareness gives me an understanding of what it is to be a woman. I know much more about myself and I understand myself more too (...) My body seems to make much more sense (..). In the past I would feel PMT but I wouldn't know exactly what was going on. I'm more aware now and I'm more accepting.*

Rebecca related a similar experience. She said:

*Having this knowledge gives you so much more power over who you are (...) Fertility-awareness probably didn't give me any more body awareness than I already had but it enables me to put the changes into place and give it some sort of logic and meaning.*

Roberta said, "I agree with Rebecca, it is knowledge that is empowering. It makes you appreciate your body and the way it works. You come to know it as an amazing thing really. It gives you a sense of being positive."

Reflecting on the medical model, Roberta also said:

*I think we are expected to behave just like men in the sense that you have to be able to do exactly the same thing at the same level all of the time and not to take into account the whole cyclical way females are and appreciating it for what it is.*

Thalia said, "With this information I feel like my body is me. It makes me feel like a whole being and that's empowering." Cheree agreed with this comment and added, "tolerance isn't quite the word I'm looking for. It's more a freedom to accept who I am at a certain time."

Wolff (1990) and Harding (1990) caution the effectiveness of writing from the body as a strategy to avoid the influences of patriarchal language and symbolism and argue that the closest we might get to women-centred

knowledge is the exposing of the ideological limitations of male thought. Hence we can begin, but not complete the construction of feminine writing. This caution was illustrated most vividly with the use of such language as PMT.

## **Institutionalised Barriers to Acquiring Fertility-Awareness Knowledge**

### ***Fertility-Awareness Knowledge and the School Curricula***

Each of us spent at least twelve years in the education system preparing for adult life without learning a significant aspect of it -- our fertility. We found this situation astounding given that we had all received sex education at school, and particularly when fertility “management” is made *our* responsibility in adult life.

Reflecting on the sex education programs we attended, Heather concluded, “I basically didn’t have a sex education (...) You have a twenty-eight day cycle and this [ovulation] happens in the middle, and that’s that.” Rebecca related a similar story, “Basically all I learned at school was that the lining of the uterus built up over the cycle and then came away at the end of it.” Roberta identified, and we agreed that, “there was nothing about mucus, and nothing about PMT or the emotional side of how we relate to our cycle.” Accounts such as these of menstrual cycle education illustrate the assertion made by O’Brien (1986), Belenky et al. (1989), Martin (1989) and Mosse and Heaton (1990) that on the one hand there has been a general institutionalisation of the medical model of the menstrual cycle, and on the other, a general neglect of our phenomenological experience of the menstrual cycle.

### ***Fertility-Awareness Knowledge and Mothers and Daughters***

Feelings of shame, fear and isolation dominated the experience of menarche for most of us. Some of us still carry the hurt we felt at that time because of our mother's reactions. Reflecting on that time, Heather said:

*At school I didn't have many friends at all, and girls don't really talk about fertility, or your bodily experiences while on the Pill. So when your hormones play havoc who do you talk to? It's really wrong! You seem to plod along with everyone else, but deep down feelings are more of segregation. You almost feel an alien while menstruation is taking place. But, I now know this [menstruation] is normal. It's a shame no-one tells you this when you're younger.*

O'Brien (1986), Mosse and Heaton (1990) *The Fertility Consciousness Group* (1980) and Valins (1993) argue that our reproductive knowledge in patriarchal societies has been erased, as have rite of passage ceremonies in which women's knowledge was traditionally passed. The power western science exercises over "knowledge" and "truth" claims is also revealed by the fact that several of us received texts from our mothers to explain how *our* bodies work, rather than sharing *their* knowledge with us. Spender (1987) writes that women are silenced in patriarchal societies because they have been excluded from the production of knowledge on the one hand, and on the other, the validated knowledge is not theirs to pass on -- a situation that was exacerbated by the printing press. Spender asserts that women's talk in women's gatherings often plays a role in conveying information and for this reason it can be revolutionary.

We felt compassion for our mothers because they found our first menstruation a difficult time too, and also because they could not pass knowledge to us that they did not have. There was unanimity that mothers should also be included in fertility-awareness education programs for girls. Martin (1989, p. 107) found that girls who were supported when they got their first menstruation 'are moved by the experience: they feel close to the person, indebted to them, and dedicated to teaching others'.

### ***Fertility-Awareness Knowledge and the Medical Establishment***

When we consulted medical practitioners for contraceptive advice we assumed that the advice we would be given would be on our identity and in our best interests. With hindsight however, we realise that the medical practitioners we consulted simply perpetuated and reinforced the dominant view of what was/still is considered appropriate contraception for women. Our experiences concurred with Gordon's (1978), Albury's (1985) and Owen's (1988) thesis that "choice" of contraceptive method is basically a foregone conclusion that perpetuates and reinforces prescribed notions of sexuality and gendered stereotypes. Our experiences are summarised by Cheree who said, "(...) when they [we] went to the doctor to get contraception they [we] weren't given choices. It was presumed that if you want contraception then you want the Pill".

Without an adequate understanding of our fertility our ability to comprehend and resist pharmaceutical contraceptives was compromised, as was our ability to give informed consent to their use. Klein, Raymond and Dumble (1991), Rowland (1992), Raymond (1993), Richter (1996) question the ethics and validity of "informed consent" in relation to reproductive technologies in such circumstances and their argument concurs with our view. There was unanimity in group that medical practitioners *should* educate women about their fertility when they are consulted for contraceptive advice.

In summarising, we identified that we did not receive fertility-awareness knowledge from any of the sources we believed we *should* have because they themselves did not have the knowledge. As such, we identified three

critical sites for political intervention in the form of fertility-awareness education.

## **Fertility-Awareness and “Fertility Management”**

### ***Introduction***

Findings by the *Victorian Ministerial Women’s Health Working Party* (1987), Stanford et al. (1994) and the *Australian Catholic Social Welfare Commission* (Annual Report, 1995-96) indicate that more women would utilise fertility-awareness knowledge to “manage” their fertility, if it was made more accessible and made available. This concurs with our experiences and belief.

### ***Fertility-Awareness and Contraception***

Gordon (1978), Greer (1984) Albury (1985), Shapiro (1987), Owen (1988), Bell (1995), Richter (1996) Akhter (1996) argue that “choice” of contraceptive method is pre-determined to a large extent by dominant patriarchal values entrenched in cultural discourses and practices. While the notion of individual ‘rights’ and the ‘right’ to exercise choice freely is valued in democratic societies the review of the literature and our stories reveal that our right to make our choice of contraceptive method freely is denied us. Wide community acceptance of the Pill together with the belief that it is *our* responsibility to practice contraception obscures the reality that contraception, and choice of method, is political. O’Brien (1986) and Reinharz (1992) describe this situation as ‘false consciousness’ which accurately describes our situation before we learned about our fertility. Thalia described her situation experienced by many of us, when she said:

*Having the Pill as the answer to contraception, you grow up thinking that everything will be dandy. Then you realise that things*

*aren't the way you think they were. When I grew up and started doing research I began to realise just exactly what it [the Pill] was!.*

Cheree identified the combined effect of the inaccessibility and the general non-acceptance of fertility-awareness knowledge together with the mass dominance and vested interests of the pharmaceutical and medical establishments as contributing to the formation of peer pressure among adolescents to take the Pill. She said that, “*doing something different like watching your mucus patterns (...) would separate you from everyone else*” at a time when peer acceptance is very important. Cheree asserts, that not having an advocate for fertility-awareness knowledge, as pharmaceutical contraceptives do, exacerbates this situation.

The power of companies to influence “choice” through the world bank is exposed by Akhter (1996) who writes that in Bangladesh, where a population control program has been operating for more than twenty years the government has prohibited publicity of the OM because it interferes with the government’s funding arrangements through the World Bank, which involve importing and distributing pharmaceutical contraceptives.

To reduce the discriminating burden we “shoulder” for contraception it was strongly argued by Roberta, Rebecca and Heather that boys should also be educated about their fertility and to take responsibility for it. This view is also advocated by Mosse and Heaton (1990), Akhter (1996) and Richter (1996).

Theorists such as Oakley (1976), Daly (1978), O’Brien (1986), Martin (1989) and Grosz (1990) have written extensively on the role western science, particularly nineteenth-century medical science, has played in constructing the female body and reproduction primarily in terms of fear.

This association is evident in the comments made by Cheree, Thalia and Rebecca who revealed that a number people had said that they were doing something “dangerous” because they were practising fertility-awareness. This perspective is in fact promoted in family planning pamphlets and texts. For example, in *Choosing Your Contraceptive* (Upjohn Pty Limited) the fertile days of the cycle are described as “dangerous”. Similarly, language such as “safe” and “unsafe” days of the menstrual cycle in relation to fertility promotes this perspective (see, for example, NFP pamphlet FPV Inc.; Macquarie, 1994).

For Owen (1988) a critical aspect of feminist health politics is the provision of knowledge that breaks down our isolation and enables us to assert self-determination in the private and public realms of our lives. Fertility-awareness knowledge enabled most of us to be able to resist pharmaceutical contraceptives. It also enabled Cheree to resist the medicalisation of her irregular cycles.

### ***Fertility-Awareness and Conception***

Even though fertility-awareness knowledge is more widely accepted to aid conception than it is for contraception, it is not routinely taught in women’s health services to women wishing to conceive. This is an issue that appears to be unaddressed, thus far, in feminist literature even though it is a significant issue for many women.

Marie’s, Josie’s and Roberta’s stories illustrate this assertion. Marie said: “No-one actually tells you when you are trying to get pregnant the days when that can happen in your cycle.” Marie came across fertility-awareness knowledge when she consulted the researcher for bereavement counselling following a miscarriage. Josie and her partner “tried” to achieve pregnancy

for twelve months before her partner was diagnosed infertile, without receiving fertility-awareness advice. And Roberta was actively dissuaded from utilising fertility-awareness knowledge by a specialist in reproductive biology even though he had prescribed her a drug to induced ovulation to assist her to become pregnant. Several times Roberta questioned the specialist about the mucus symptom that accompanied ovulation, and each time he told her not to worry about it. Roberta concluded, “they [health professionals] can’t tell us what they don’t know.”

The Melbourne Assisted Conception Centre (MACC) estimate that ‘one in six couples seek treatment for infertility’ (MACC, 1997). Smith et al. (1997) found that seventy-four per cent of women attending a New Zealand fertility clinic for assisted conception after more than two years of “infertility” did not know the days when they were fertile in their cycle, even though they had consulted medical practitioners prior to being referred. For this reason, Smith et al. (1997) suggest that many women referred for assisted conception treatment may not be infertile in a medical sense, but receive medical treatment as if they are. Merrin’s and John’s story illustrates Smith et al.’s hypothesis. After a year of “infertility” during which numerous medical and surgical examinations were carried out by a specialist in reproductive biology Merrin and John were diagnosed with idiopathic (unexplained) infertility for which they were given advice on assisted conception options and techniques. Before seriously considering this option Merrin requested fertility-awareness education. In consultation with Merrin it emerged she had been aware of the mucus symptom of fertility for many years but was unaware of its significance, and therefore did not utilise it in her attempts to become pregnant. Merrin was surprised she had not learnt more about her fertility in the numerous women’s health texts she had read or from the medical specialists she had consulted.

When women and their partners consult health services for advice when they are “trying” to become pregnant it is common for them to be told to go home and not to become concerned about their fertility until they have been “trying” for at least twelve months. In most cases this advice is given without fertility-awareness education. Michelle and Donald received this advice from their medical practitioner after they had been “trying” for ten months and describe it as “totally unsatisfactory”. This advice is given on two tenuous assumptions: first, that sex occurs often enough to include the fertile days of the cycle; and secondly, that women know more about their fertility than they actually do. Following fertility-awareness education Michelle and Donald “conceived” in the first cycle they timed sex with the mucus symptom of fertility, as did Cherly, following five years of apparent “infertility”.

### ***Fertility-Awareness Knowledge and Unplanned Pregnancy***

Whilst we did not discuss unplanned pregnancy in the group interviews, fear of unplanned pregnancies occurring is commonly cited by health practitioners for not teaching girls, and women, fertility-awareness for fertility “management” purposes. This is illustrated in the state and federally funded women’s health service discussed in chapter two. Many unplanned pregnancies occur, however, because of a lack of fertility-awareness. As Susan said, “I’ve only taken two “chances” in my life and both times resulted in an unplanned pregnancy. I couldn’t believe it!” Sarah (aged fifteen years) and Georgia (aged thirty-six years) also had unplanned pregnancies because they also took “chances”. Both said they were advised by their medical practitioners that they were probably infertile because they had endometriosis.

Seventy thousand abortions are performed annually in Australia (Siedlecky and Wybdham, 1990). In addition to those, innumerable emergency

(morning after sex) contraceptive Pills taken, “just in case”, when it is highly probable that most are unnecessary.

### ***Summary***

In summarising, the provision of fertility-awareness knowledge fulfils two feminist liberation ideals: firstly, it enables us to assert self-determination in the “management” of our fertility and to be able to resist reproductive technologies as advocated by the *Fertility Consciousness Group* (1980), Mosse and Heaton (1990), and Valins (1993); and secondly, because it facilitates basic social change in sexual and class relations because it disrupts the personal and broader social context in which we attempt to regulate our fertility, as discussed by Gordon (1978), Albury (1985), Greer (1984), Owen (1988) and Bell (1995).

## Chapter Five

### ***Critical Reflections***

#### **Introduction**

‘Praxis’ is emphasised as a critical aspect of feminist research and this project throughout its life was informed by this concept: firstly, the project identified three critical sites for political intervention to make fertility-awareness knowledge more widely available to women and girls; secondly, it identified critical aspects of what would constitute a feminist fertility consciousness program; and thirdly, it contributed to the development of our fertility consciousness.

This chapter begins by documenting the strategy for making fertility-awareness knowledge more widely available to women and girls, and the critical aspects of a feminist fertility consciousness program. It concludes with reflections on the research process.

#### **Towards a Feminist Philosophy of Fertility Consciousness**

This project identified nursing and medical, school and community education curricula as key sites for promoting fertility consciousness based on feminist principles. A feminist fertility consciousness program would:

- a) utilise a title such as ‘fertility consciousness’ to associate fertility knowledge more with *our* knowing than with science or NFP discourse, and also to indicate broadly the implications of such knowledge;

- b) emphasise the phenomenological experience of fertility knowledge and its relation to personal and social power, self-esteem, spirituality, well-being and “fertility management”
- c) emphasise the phenomenological experience of fertility knowledge and its relation to the whole of the menstrual cycle
- d) explicitly include such issues as, barrier contraception, sexually transmitted disease, unplanned pregnancy, abortion, non-penetrative sexual practices and “withdrawal”
- e) be inclusive of all sexualities
- d) provide a race, class, culture and gender analysis of contraception and how our “choice” of contraceptive method is influenced
- e) be based on feminist education principles, hence it would be experiential, interactive and based on the connected model of teaching

### **Reflections on the Research Process**

Very positive feedback by the women participating in this project on the value of having fertility-awareness knowledge engendered confidence to initiate discussions with a number of Victorian women’s health services to provide fertility education based on feminist principles. This resulted in the successful location of myself as a provider of fertility-awareness education

in a number of women's health services. Discussions leading to this outcome were successful primarily because they allowed for the opportunity of discriminating attitudes against fertility education to be aired and overcome. Comments such as, "NFP doesn't work", "adolescents can't be trusted with fertility-awareness knowledge", "NFP means you can't have spontaneous sex" and "women who breast-feed can't use NFP" were made on numerous occasions and reflect Gordon's (1978), Albury's (1985), Owen's (1995) analyses of biases that exist in women's health services. The research process enabled articulate responses to those comments which facilitated the recognition that they were discriminating. On numerous occasions this recognition stimulated intense interest in fertility-awareness education.

Finbar wondered if medical practitioners might be too embarrassed to talk about such things as vaginal fluids as a marker of fertility. It is possible that some doctors, and indeed some nurses, feel inhibited to teach fertility-awareness for this reason. I hope that the concept of cervical mucus (rather than "vaginal discharge") and its relation to fertility is a step in the direction towards dismantling this barrier.

A major barrier to progressing in the writing up phase occurred when I realised that I had not asked a crucial question in the group interviews, which was, "Why are we unable to identify our symptoms of fertility before we learn the OM? Whilst pondering this question I began to realise more fully the extent to which a taboo operates around *our* knowing of our fertility and the role western science has played in the construction of this taboo. It also raised my consciousness of the extent to which our knowing of our fertility is limited to "managing" or "controlling" it. Dr. Renate Klein (Director of the Australian Women's Research Centre (AWRC) raised in conversation two years ago the implications of using such words as

“management” and “control” in relation to our fertility. Where these words are used in this thesis they have been placed within quotation marks in recognition of this concern. The concept of fertility consciousness militates to some extent against the single emphasis of “management” and “control”, that is inherent in both NFP and fertility-awareness discourse, in relation to our fertility.

While the activity of diary writing is advocated by many feminists as a form of consciousness raising it is not always practical because of time constraints in the real lives of women. For this reason the research participants were asked to either diary their reflections between interviews or to amend and extend the interview transcripts. All the participants chose to amend and extend their interview transcripts.

The value of group work in facilitating consciousness raising and breaking down the isolation we experience in this aspect of our lives is illustrated in the interview transcripts and by the evaluation forms. Four out of six Evaluation Forms were returned and are included in Appendix Four. The major feature of the evaluations was the pleasure and the value the participants said they experienced discussing their fertility and related matters in a group situation with other women. They also said that the group experience normalised a number of experiences that they previously felt uncertain about. The group situation also facilitated greater consciousness in the group of the wider social context which influences our “choice” of contraceptive method.

Some of us chose to be published under a pseudonym of our choice and some of us chose to be published under our own names.

The concept of 'successor science' as advocated by Haraway (1988), Smith (1988) and Fox Keller (1990) provided a welcomed framework establishing a sophisticated concept of feminist fertility consciousness. 'Successor science' also enabling this project to come to fruition without taking an oppositional stance to the Roman-Catholic Church and its position on NFP. If it were not for the Roman-Catholic Church's interest in NFP it is highly probable that the OM would not have been developed.

## **Conclusion**

The hypotheses that fertility-awareness knowledge can liberate us from patriarchal “birth-control” practices and that most women learn fertility-awareness for this reason was proved correct. It was also proved correct that fertility-awareness can commence a process of redefining our bodies.

The hypotheses that more women would utilise fertility-awareness knowledge if it were more accessible and available was also proved correct.

## **Recommendations**

Findings in the review of the literature and research data lead to the following recommendation being made:

For feminist fertility consciousness programs be developed and placed in medical and nursing, school and community education curricula.

# Appendix One

## *Research Invitation*

Kerry Hampton  
PO Box 250  
Canterbury 3126  
Victoria

Dear.....

As part of the requirement to complete the Degree of Master of Arts (Research), at Victoria University of Technology, I am inviting you to take part in a small discussion group to discuss fertility-awareness knowledge and education with other women, who like yourself, have attended a fertility-awareness education program.

The data gathered at these meetings will form part of my final submission. It will also be used to extend and improve the current fertility-awareness education program I am teaching.

The group discussions will take place at The Clinic for Women on Richmond Hill, 366. Church Street, Richmond. They will be led by a series of open ended questions that will inquire about your level of knowledge of your fertility prior to entering the program, what it means to you to have this knowledge and any changes you would like to make to the program that would improve it from your perspective. You will also be asked to keep a diary between meetings to record any thoughts and feelings you have in relation to your participation.

If for any reason related issues arise that are of concern to you, you will be given support within the group and a referral for further support should this be necessary.

I would very much value your input into this project.

If you would like to participate, please contact me on 9830 5280.

Sincerely

Kerry Hampton

## Appendix Two

### ***Informed Consent***

We would like to invite you to be part of a study that has as its objective to write a collection of women's stories reflecting on their experience of fertility-awareness knowledge and education.

#### CERTIFICATION BY SUBJECT

I

.....of.....  
.....

certify that I am at least 17 years old and am giving voluntary consent to participate in this research entitled "Using Feminist Theories To Construct A Women-Centred Discourse on Fertility-awareness Knowledge and Education.

I agree to meet with 4-7 other women three times to discuss my experiences which will be tape-recorded and later placed within a feminist research project under a pseudonym of my choice.

I agree to accept a referral for support for appropriate counselling should related issues arise for any reason what so ever relating to my involvement in this project.

I certify that the objectives of this research have been explained to me and that I have clarified where necessary with the researcher any uncertainties before I made the decision whether or not to participate. My signature indicates that I have been informed and that I freely consent to participate. I acknowledge my right to refuse to participate in the research and to withdraw from it at any time without penalty.

Any queries about your participation in this project may be directed to the researcher Dr B. Brook. ph: 9365 2149. If you have any queries or complaints about the way you have been treated, you may contact the Secretary, University Human Research Ethics Committee, Victoria University of Technology, PO Box 14428 MCMC, Melbourne, 8001 (telephone no: 03 9688 4710)

Date .....  
Time .....  
Signature indicating consent .....  
Signature of researcher .....  
Witness other than researcher .....

## **Appendix Three**

### ***Interview Questions***

#### **Group Interview One**

What factors influenced your choice of contraceptive method in the past?

Can you describe how you came to the decision to learn fertility-awareness?

Can you describe your experiences in accessing fertility-awareness information?

#### **Group Interview Two**

Can you describe how much you knew about your fertility before attending a fertility-awareness program?

What do you see as the barriers that prevent women and girls from accessing fertility-awareness information.

Is fertility-awareness knowledge significant to you in any other way than for managing your fertility.

## Appendix Four

### Evaluation Form

Please rate your level of satisfaction being involved in this project?

Excellent

Very Good

Good

Fair

Poor

What did you gain from your involvement in this research project?

- The pleasure of hearing other women's stories
- Confidence that my experience has been similar in lots of ways, to that of others

What did you like most about being involved?

Sitting round talking with other women about things that aren't generally talked about. Mutual respect.  
I got a referral to a homeopath specializing in women's health - "networking"

What did you like least about being involved? Could anything have been done differently which would have improved it?

Found the 2nd session easier, once a bit of shyness had been overcome.

Any other comments you would like to make?

Kerry, I've skimmed over your chapter and it looks great - I'll read it more thoroughly soon + send it back if I've got any comments.

**Thank you for taking the time to complete this evaluation.**

I hope you aren't stressed out + that your writing is going okay.

ps Merry Christmas xx

## Appendix Four

### Evaluation Form

Please rate your level of satisfaction being involved in this project?

Excellent      Very Good      Good      Fair      Poor

What did you gain from your involvement in this research project?

That as an individual we are not isolated,  
if women talked more, a lot of problems or  
issues would easier be resolved.

What did you like most about being involved?

Being in a group it is easier to discuss issues  
as they arise that you would normally not  
thought about as being important or regard as  
being a problem.

What did you like least about being involved? Could anything have been done differently which would have improved it?

NO.

Any other comments you would like to make?

Please let me know if I can be of assistance in other  
discussion groups in the future.

**Thank you for taking the time to complete this evaluation.**

Many thanks.

## Appendix Four

### Evaluation Form

Please rate your level of satisfaction being involved in this project?

Excellent

Very Good

Good

Fair

Poor

What did you gain from your involvement in this research project?

Learning all about my body  
and getting aware of myself.

What did you like most about being involved?

Learning that I was not the  
only one looking for please  
at my time of need.

What did you like least about being involved? Could anything have been done differently which would have improved it?

I had no problems about the involved  
I find it very interesting.

Any other comments you would like to make?

We have covered everything.

**Thank you for taking the time to complete this evaluation.**

## Appendix Four

### Evaluation Form

Please rate your level of satisfaction being involved in this project?

Excellent

Very Good

Good

Fair

Poor

What did you gain from your involvement in this research project?

Confirmation of information already learnt about natural fertility management & the sense that I'm not alone in using this method of contraception.

What did you like most about being involved?

Meeting & discussing with the others involved.

What did you like least about being involved? Could anything have been done differently which would have improved it?

Missing the 1st session! (My fault!)

Any other comments you would like to make?

Thanks for the experience.

**Thank you for taking the time to complete this evaluation.**

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