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Unsettling the (presumed) settled: Contents and Discontents of Contraception in Aotearoa New Zealand

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In January 2017, New Zealand's medicines and medical devices safety authority, Medsafe, announced in a press release that its Medicines Classification Committee (MCC) had recommended a reclassification of certain oral contraceptives in order for them to be made available over the counter in pharmacies (Medsafe 2017b). This decision effectively approved a 2015 proposal by Green Cross Healthcare Limited to the Medicines Classification Committee. Green Cross Healthcare Limited is a "leading primary healthcare provider" in Aotearoa/New Zealand (A/NZ) with three key divisions: pharmacy, medical and community health. The pharmacy division, which will be most impacted by this reclassification, includes "around 350 community Pharmacies throughout New Zealand under the Unichem and Life Pharmacy brands and hold equity interests in more than 80 of these pharmacies" (Green Cross Health n.d.).

Once oral contraceptives are reclassified as over the counter, the pharmacy division of Green Cross will be at the forefront of providing women access to oral contraceptive without prescriptions. However, this reclassification has not been an easy or quick process, but is the result of a sustained campaign to which Green Cross has been heavily committed since early 2015. Between Medsafe's 53rd meeting in 2015 and its 57th meeting in 2016, numerous objections from the Royal New Zealand College of General Practitioners (RNZCGP) led to reconfigured recommendations from Green Cross. Medsafe's ultimate decision is an outcome based on various negotiations between the public, private, and medical worlds of A/NZ. The news that some oral contraceptives will be reclassified as over-the-counter pills was received with great appreciation within the pharmacy community (Cameron 2017a). However, the same news was received with greater apprehension by women writers and journalists who critiqued the decision because of high costs and limiting access to certain lower socio-economic status communities (Duff 2017) and the health implications of the contraceptive pill (Cameron 2017a). A three-month supply of the pill will cost NZ$45 at the pharmacy for all women, while access-funded doctor visits which cost NZ$18 per visit allow women to consult with a physician and get contraceptives at a lower cost if they meet their physician twice a year. On the one hand, this move allows women direct access to their medicine and circumvent physician 'gatekeepers'. On the other, it does not give due consideration to the wide range of contraceptive experiences for women across different life circumstances. While this episode only hints at the range of complicated issues around contraception in A/NZ, it was an interesting window into the complexities of contraception in the contemporary: access, use, availability, need, and desire.

At the time of writing this article, June 2017, oral contraceptives are not yet available without prescription in A/NZ as pharmacists have yet to go through appropriate mandatory training (as stipulated by Medsafe). However, this moment has allowed me an opportunity to unsettle and examine contraceptive realities in/of A/NZ in a liminal space – after regulation, but before implementation. My previous work looks at the media advertising campaigns (Sheoran 2011) and 'stratified contraception' (Sheoran 2015) in India, as the morning-after-pill was made over the counter in similar ways, with the attempt to make available through ethnographic details how the assumed 'settled' conversation about contraception needs to be interrogated. The presumed 'liberal progressive' trajectory of making contraception available to all women easily need to be analyzed with a careful eye on not aligning the critical thinking project with the religious conservative project of denying women access to their needs.

In A/NZ, a progressive temporal narrative has been established around contraception that begins with the heroic struggle of women at the turn of the 20th Century to get access to contraception and abortion as a way to manage their reproductive lives and progresses to the guaranteed access of contraceptives to women (Smyth 2000).

Having met Dame Margaret Sparrow, an early champion making contraception accessible to women in A/NZ, and hearing her recounting of the battles women in A/NZ have undertaken to get some basic rights over their contraceptive lives, it is paramount to my work and thinking to allow for nuance in understanding the social lives of contraceptives here in A/NZ. My intention then to interrogate the contemporary contraceptive reality is not a project to undermine the historically important moves women like Dame Sparrow and others have made here; but, rather, to include new places of analysis including how indigenous communities experienced the same contraceptives moments differently under the gaze of a eugenics project (Smyth 2000:114–123). As contraceptives become over the counter, at a certain cost and profit motive, we also must move beyond that simplistic financialized analysis.

New scholarship needs to engage with and unpack the impact of these 'progressive' moves on communities that can and cannot afford these pills, but also to ask nuanced questions about how the health and wellbeing of women living fulfilling and economically viable lives is a better option than allowing the market to offer a particular mode of pharmaceutical 'empowerment.' Within reproductive health care, the proponents of neoliberal reform insist that such changes improve quality of services, efficiency, and accountability to the people being served; however, critics argue this individualization of health, cost recovery/user pays plans, and the consumerist approach to health undermine and are an impediment to good reproductive health care for women (Petchesky 2003). In this context, contraception combined with neo-Malthusian logics becomes an interesting field for intervention. As Rachel Simon-Kumar points out when talking about India:

> The role of private companies, both international and domestic, in producing and marketing contraceptives is increasing. Feminist activists have been concerned about the private sector's role and the creation of a "contraceptive market" – and not without reason. (Simon-Kumar 2010:146)

This idea that only the market can provide women with "options" for contraception, while the state has proved ineffective at doing so, allows for two key issues to emerge. In the first instance, women are asked to believe that the state cannot (or should not) provide for them. In the second, they are disciplined into behaviors that start at the very personal level of their bodies and contraceptive pharmaceutical interventions and extend into their larger everyday practices. They develop practices that encourage them to be consumer-citizens, and withdraw further from making demands on the state but rather depend on the private market. With this new recommendation, Medsafe, a state-funded agency, allows Green Cross, a private health care provider, to be the place women are encouraged to turn for their contraceptive lives.

Contraceptive histories and science

As a technology, contraception has a rich, complex, and contradictory history, in which collusions and collisions between diverse groups have led to their development in the North (the United States in particular) and dissemination globally (Tone 2001). Historical accounts of the development of the contraceptive pill alone tell a story of how it was developed to address population problems, and re-assess the simplistic claim that the pill alone fueled the sexual revolution (Marks 2001). The absence of mass marketed male contraceptive options (Oudshoorn 2003), while making women the burden bearers of reproductive control, also hold them responsible for failed contraception. The contraceptive pill, in its various avatars, is in essence a non-innovative hormonal contraceptive option that can be detrimental to women's long-term health. In talking about the newer and novel methods of contraception (starting at the pill and developing into vaginal rings and hormonal patches), Watkins argues that there is nothing "new" or innovative about these methods of contraception, since they still rely on similar modes of sex hormone modification as that of the previous generations (Watkins 2012:1464).

As new research emerges about the links between mental health disorders and the hormonal contraceptive (Ross and Kaiser 2017; Skovlund et al. 2016), a popular backlash against the pill amongst certain women in the global north has been documented well in Holly Grigg-Spall's work (Grigg-Spall 2017; Grigg-Spall 2016). Once the news of the Medsafe recommendation was released in A/NZ, the nuanced critique in popular media reflected critiques similar to Grigg-Spall's - i.e. with women and physicians troubled by the practice of prescribing the pill for issues like acne and period regulation for young women as early as 15 (Cameron 2017b). These spaces of critical refusal of the pill have thus far been articulated amongst a limited number of radical and educated women. As a medical anthropologist, I situate this refusal and the ability to not participate not only amongst women that have the language to articulate this refusal, but also amongst women who are encouraged to participate in the contraceptive project as part of the larger global push to make contraceptive available to all women – particularly those in marginalized communities. These spaces then become a crucial site of analysis, because a contraceptive operates variously as oppressive, repressive, or an emancipatory technology.

The imperative to unsettle what is settled

Anthropologists of science and medicine, like our colleagues in Science and Technology Studies (STS), have looked at scientific knowledge/breakthroughs at moments when the debate is most intense about the future of that particular scientific "discovery." Langdon Winner articulates this in his article "Do artifacts have politics?" (Winner 1980), where he posits that the shape of scientific and technological "progress" is not inevitable; rather, it is a result of political decisions. He proposes that the moment of introduction of a particular technology is also a moment of contemplation and debate about the eventual benefits of that technological innovation. At the moment of introduction into wider markets, the politics and cultures that lead to scientific knowledge and technological innovations should be examined. Yet, this examination has to be multi-layered and nuanced because, as Thomas Hughes (1989) suggests, science and technology have allocated labels to innovation, development, technology, and science that are "imprecise" and do not make visible the multiplicities of each entity. For Winner, these technological artifacts contained within them politic directly for two reasons; first, to settle within communities debates about what technology to adopt; and secondly, to align man-made technologies with particular political projects. Other anthropologists of science, medicine, and reproduction have successfully argued that social factors do play a crucial role in how scientific and technological knowledge is developed, constructed, articulated, and stabilized, while at the same time understanding that this knowledge inherently contains a politics (Martin 2001; Rapp 2000; Franklin 2013).

When it comes to contraception, the temptation to imagine this 'old' technology as debated and thus settled is understandable. However, in extending Winner's argument, I assert a feminist need to continually unsettle what is presumed settled. In each unsettling lies the potential to ask for better for women, and in this particular case, better contraception options for women. However, this asking for better contraception places an emphasis on improved research programmes, not more innovative marketing campaigns to sell fancier patches and vaginal rings based on the same old hormonal technology. It also needs to be couched in the importance to recognize and respect refusal. Feminists, both academic and activist, ask simultaneously for four things: first, better contraception; second, access for women who want or need it at affordable prices; third, getting men involved in sharing the contraceptive burden; and finally to have structures in place where women who want to refuse contraception are not cast as deviant radical others who will not participate in this particular 'progressive' project. We need to acknowledge that different women, across time, bodies, and communities, will have different contraceptive needs.

So what?

As I start my research into unsettling the presumed settled debates around contraception in New Zealand, I realize I face an uphill battle. I will have to utilize the nuanced language and research skills I've developed through my various projects as a medical anthropologist and cultural studies scholar. Yes, I have to be careful, not to unsettle for the pure sake of unsettling; but rather in order to offer up spaces for new assemblages and trajectories. I would like to make the urgent case for 'unsettling' discourse, practice, and public policy around contraception for two important reasons. First, the physiological and emotional implications of contraception need further exploration. The unsettling

project allows us to ask for more research on the long-term health implications for contraception before they are ‘dumped’ on women – particularly women in lower socio-economic and marginalized communities. The unsettling makes evident that contraception as understood and used today is not a fait-accompli for all women but rather a contemporary, living project that requires vigorous debate for the next generation of women.

The second reason for this urgent unsettling is to build alliances with women and men in the environmental protection movement. There remains a temptation to blame environmental degradation on the ‘population bomb’ (Ehrlich 1968) and encourage ‘population control’ globally, particularly in developing countries and marginalized communities in developed countries. From the 18th Century onwards, this connection between scarcity of food and other resources and the “teeming” masses has found resonance in despotic orthodoxies ranging from racism to sexism, and eugenics (Hartman 2010; Hartman 2010; Rao 2005; Rao 2004).The elite do not want to change their consumption patterns (eat less meat, invest in public expenditure for mass transportation, etc.) and if the consuming class wants to continue to deny the impact of their actions, it seems morally and ethically problematic to pass the burden of the world’s problem onto poor black and brown bodies. This is doubly the case when these burdens are couched in promoting contraceptive consumption through the market, i.e. ‘choice,’ and ‘empowerment’, but do little to truly improve the conditions of women’s daily lives.

In conclusion, as feminists and medical anthropologists interested in women’s health and wellbeing, it is vital to unsettle the presumed ‘progressive’ narrative around contraception. Not only because of the implications to women’s health and wellbeing, but also because we, collectively, now live in a precarious time for the poor, marginalized, and environmentally dependent. Thus, when legislation is passed making contraception available over the counter to young women and to women in vulnerable communities, we should be careful not to champion this as another progressive move but rather to feel unsettled and unsettle the narrative to imagine the many burdens these ‘small’ decisions place on women’s lives and bodies.

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