Emergency Contraceptive Pills as a Social Problem in an Era of Safe Sex

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Abstract

The Emergency Contraceptive Pill (ECP) is a safe and effective post-coital contraceptive. As its name suggests, though, UK policy purposively suggests it ought only be used in 'emergencies'. Meanwhile, popular discourses frame the contraceptive as an ambiguous social problem. This thesis addresses the social problem process of the ECP on two levels. For the first level, it opens with a review of the social problem construct running throughout policy and research around the contraceptive. Early chapters demonstrate that this construct produces a dual meaning, in which use of ECPs is simultaneously framed as responsible and irresponsible. Using the framework of the pharmakon, this work then employs a microsociological approach to better understand the second level: how this construct impacts the lived experience of those who come into contact with the social problem of the ECP. A qualitative approach is used to investigate this lived experience. Semi-structured face-to-face interviews are conducted with sexual health nurses who distribute the ECP. Telephone and face-to-face interviews are conducted with women who use the ECP. Finally, focus groups are conducted with women of reproductive age who could access the ECP. Drawing on the findings from these interactions, the framework of the Pharmakon Tightrope is developed and utilised to outline the 'meaning making' processes of those who navigate the wider claims made around the ECP. The findings indicate that various actors that come into contact with the ECP are each impacted by its dual meanings, as they all come to make sense of social roles and identities that emerge in their contact with a social problem.

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Contents

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List of Abbreviations

Abbreviation	Meaning
Bpas	British Pregnancy Advisory Service
CSP	Constructing Social Problems
DoH	Department of Health
HoC	House of Commons
HoL	House of Lords
EC	Emergency Contraceptive
ECP	Emergency Contraception Pill
FPA	Family Planning Association
LARC	Long Acting Reversible Contraception
OCP	Oral Contraceptive Pill
OTC	Over The Counter
WHO	World Health Organisation

Introduction

In 2012, when I was an undergraduate student at the University of Kent, I distinctly remember a conversation that occurred during a seminar discussion about the contraceptive pill. Female students were unable to differentiate between the pill, the morning after pill or the Emergency Contraceptive Pill (ECP), and Early Medical Abortion. This experience made me curious about what it was that led a group of women who ostensibly needed to know about the various fertility control methods available to them to be apparently so confused. So, I decided to pursue the topic further. I took the opportunity offered by my undergraduate research dissertation to organise that research around focus groups discussions with female students about their experiences of and opinions on the ECP.

What emerged from this study continued to surprise me because of participant comments that featured repeatedly. These included remarks such as, "It has 100,000 more hormones than the everyday pill," and "I heard if you take it more than three times in a lifetime you will die!". The conclusions I drew from this research were around shared misunderstandings about the ECP's contraceptive properties, which the students associated with how the product was accessed. For them, the fact they had been advised that the product couldn't be used very often, or that in order to use it one would have to talk to a health professional, seemed to lead them to assume that ECP is *bad* for you. What surprised me even more was the comments made by some students about other women's behaviour when they had used the ECP. Terms such as 'slut' and 'slag' were used to describe such women; students saw such women's use of the ECP as not necessary. A consensus emerged from these discussions that ECP use was the result of the action of someone who had been 'stupid'. One student felt so strongly about ECP use that she told me she would escort her friends to the doctors if they wanted to get this pill, since she wanted to make sure the doctor would "tell her off". I found in this small, simple focus group study that these young women were unable to make sense of the ECP as a contraceptive, and held strong moral views on how it should be used. These conclusions led me to want to understand more about public discussion of the ECP, something that might be influencing and shaping what these women had told me. Subsequently, I opted to focus my work as an MA student on the question of the use of the ECP as a contraceptive.

For my MA research dissertation, I conducted a qualitative media analysis to consider how the general public discussion has developed around the ECP as a contraceptive. The project focused on the media discourse around 'advanced access' to the ECP, analysing media newspaper reporting between 2001 to 2014. The analysis brings to light a divide in the public discussion. One the one side are those who support increased access to the ECP as a contraceptive product, and on the other side are those who do not. It became apparent that not only did some simply oppose the ECP altogether, but there was also an ambiguity in the way that support for access to the drug was framed. There were significant variations in how newspapers concentrated their discussions on who would need ECP, including the person's age and the extent of acceptance of the 'need for responsible' contraceptive behaviour. This brought to light differences of opinion in how far and in what ways access to ECP should be made easy for women. The question of women being able to access ECP 'in advance' has been the subject of particular controversy. These findings underpin the development of my initial proposal for the research that is written up here. I have been fortunate to receive Economic Social Research Council (ESRC) funding to pursue this research further. I would like to thank the ESRC for their support, which has allowed me to dedicate four years to investigating more thoroughly those issues surrounding the ECP.

In this thesis, I have sought to look much further into public constructions of the ECP. I review existing literature, legal debates and the development of policy frameworks in an attempt to better understand ECP's position as a problematic contraceptive. As such, this thesis draws on a long and important tradition of sociological enquiry that considers the construction of phenomena as social problems. My work for this reason is situated firmly in the field of the sociology of social problems. My effort, however, has been to develop this sociology by investigating what I have called *people who live within the problem*. By this, I mean the relation between wider public constructions of the ECP and the experience of those who in some way come into contact with the ECP as part of their everyday lives. This thesis is therefore broadly situated as an investigation into a social problem, but seeks to make a particular contribution in a specific way. The bridge I have chosen to use to bring together an investigation of the construction of a public problem and the people who live within the problem is the *pharmakon*. As I explain in Chapter 2, this concept centres around the question of ambiguity – and, while the concept is a challenging one, my aim has

been to make use of it as part of my effort to take forward the study of the social problem in an innovative way.

As a student funded by the ESRC policy pathway, my intention from the outset was to make a contribution as a sociologist to ongoing and current discussion about an important policy area and its future. I have therefore sought to address the implications of my research of policy approaches that regulate women's use of, and access to, the ECP. In the conclusion, I return to consider this area and further. I discuss the issues my research has brought to light and specifically those concerning the barriers that continue to affect the recognition of the significance of women's autonomy as a principle influencing health policy. I now turn to discuss the contents and structure of the thesis as a whole.

Chapter 1 sets the scene for the social problem of the ECP. In review of current research and literature on the ECP, the opening chapter addresses the wider claims that appear to surface around the ECP as a contraceptive. It starts with a semiotic review of the purpose of the term *emergency* as a feature of the contraceptive's name: *Emergency* Contraceptive Pill. In conjunction with the findings from interdisciplinary fields of research in the natural sciences, and using qualitative research, Chapter 1 highlights a set of public opinions that frame the ECP as a contraceptive option. Part 1 contextualises the claims that appear to emerge around the construct of the 'emergency' contraceptive. Part 2 of the opening chapter offers a legislative overview of the 2001 change in the license for access to the product from Prescription Only Medicine status to Pharmacy Medicine. In an assessment of the arguments made both for and against the change in access, I review how further claims appear to surface around concerns about women's use and access to the ECP. The chapter summarises the wider public frame of the ECP as a problematic contraceptive and what impact this has so far had on its role as a contraceptive but also as a developing social problem.

Chapter 2 outlines the *pharmakon* framework. The pharmakon concept is discussed in detail, beginning from its heritage as a descriptive term that can be used to identify the existence of a dual meaning given to social problems, such as reading. The chapter offers an overview of the pharmakon concept and its ability to highlight ambiguous meaning. The medicalised nature of the concept can be recognised in our acknowledgement that drugs can exist as both a poison and a cure. The purpose and usefulness of the concept in its ability to bring clarity to ambiguity is addressed in this chapter. I explain that although social problems exist in various forms, not all

can be viewed as pharmakon. For that reason, I have developed a framework that uses the pharmakon as a tool to support the investigation into social identities and meaning making that support the existence of the dual meanings of a pharmakon.

The tightrope framework I discuss suggests that for a problem to exist with dual meaning, it must emerge in a suitable environment that supports its ambiguity. I use the example of the introduction of the 1967 National Health Service (Family Planning) Act to identify the historical legacy that supports the ECP's existence in modern health policy as a problematic contraceptive. In an effort to contribute to the field of sociology of the social problem, I have developed the pharmakon tightrope as a new and innovative framework to support further investigations into development of ambiguous social problems.

Chapter 3 addresses the methodological approach developed in this work as a study of social problem. The chapter recognises the various theoretical and sociological influences that have shaped this investigation. Influenced prominently by the study of meaning at the individual level, I highlight how I have used the study of social constructionism as a support for my microsociological investigation into 'meaning making'. Guided by the work of symbolic interactionists such as Goffman (1959, 1963, 1974), I have been able to address the actors and identities that emerge and work within the pharmakon framework to support the development of an ambiguous social problem.

The approach used to study the social problem process is described as 'contextual social constructionism.' In chapter 3 I briefly review the importance of the history of subjective approach developed by the work of Specture and Kituse (1977) Constructing Social Problems and their influence on the theoretical framework used here. This approach has centred numerous debates outside of the breadth of the thesis; however, I discuss in chapter 3 the division of "strict" vs "contextual" constructionists has shaped the study of social problems. My approach to the social problem investigation is contextual as I adopt and develop previously explored approaches to the study of the "constructed" social problem through the study of "meaningful" claims and claim making activities. Thus, choosing to adopt a contextual approach has allowed for the testing of the new framework without the taught boundaries of strict constructionism.

The theoretical approach is guided by the contextual social problem theorists Joel Best (2013) and Donileen Loseke (2011), whose work on the social problem process

has aided both my development of the tightrope framework and the identification of individuals who work within the social problem process as social problem workers. I review how other scholars also address the relevance of individual meaning making within a social problem process, and I have been able to identify the actors to support the tightrope framework.

Using qualitative methods in the form of semi-structured interviews and focus groups, I have studied individuals who exist within the social problem pharmakon of the ECP. Sampled for their connection with the current social problem under investigation, I recruit three participant groups. Using face-to-face interviews with 15 Sexual Health nurses, I study the role and meaning making of the social problem worker of the nurse. Using telephone and face- to-face methods, I conduct 20 interviews with women who have used the ECP in the last five years. I also explore the identity work of the social problem individual. Finally, through nine focus groups conducted with 33 women of reproductive age between 18- to 55-years-old, I investigate the role of the social problem worker, the audience and the meaning-making experienced by those who are the target audience of social problem claimsmaking.

Overall adopting a social constructionist approach, as well as testing the pharmakon tightrope, I have studied the meaning-making of individuals who exist within a social problem. The aim is to address the impact of ambiguous social policy problems on the lived experiences of individuals.

Chapter 4 is the first of three results chapters that set out my findings. Starting with the 15 face-to-face interviews with sexual health nurses as distributors of the ECP, the chapter addresses the role and impact of the social problem worker. I recognise that the institutional environment and health promotional role of the ECP distributor shapes and influences the meaning that nurses give to their role as gatekeepers to the ECP. In my analysis, I address four key themes that highlight the nurse's role as an institutionalised social problem worker professional. In their role as social problem worker, I assess how the nurses give meaning to the pharmakon the ECP in the clinic setting, as well as how they understand 'supervised access'. This is explored further in the nurses' discussion and reflective accounts of the meaning they give to their role. Finally, Chapter 4 addresses how the social problem work of the distributor of the ECP is shaped by institutionalised values and goal orientation. This is evident in the nurses' support of the social problem work in action that facilitates

in stabilising the ambiguous meaning given to the ECP as a contraceptive but also the identity work of the ECP user as a pharmakon in need of management.

Chapter 5 explores the identity work of the social problem individual. Influenced by the work of Goffman (1963), the chapter examines the social processes the women undergo when giving meaning to their behaviour as a stigmatised problem identity. I recount the EC users' 'ECP Stories' to share the narratives they have used to shape their identities, given by their experience as an EC user. The chapter splits the stories into three sections.

The opening section addresses women's 'Pre-EC' identities. In the women's previous experiences of using and choosing contraceptive methods, I find the cohort experiences a number of problems with hormonal contraception that leads to their use of the ECP. Following this, the chapter addresses the ECP user's experience of access via a consultation and explores the meaning the women give to these interactions. This addresses meaning-making through a reflective discussion of how women felt before, during and after the ECP consultation. The data collected here suggests that women appear to make sense of their problem identity by navigating their own meaning given to the ambiguous social problem. Finally, the chapter addresses the ECP identity post-use. The chapter examines how the women make sense and give meaning to their previous experiences, in light of wider claims made about ECP users to address the women's awareness and acceptance of the ECP user identity frame and what impact this has on their contractive identities.

Chapter 6, the last results chapter, assesses the data collected from nine focus groups with 33 women aged between 18- to 55-years-old. The purpose and design of the focus groups is to explore and assess the impact wider claimsmaking activities have on the meaning-making of the target social problem audiences. As women of reproductive age, the focus groups are sampled as women who could potentially access and use the ECP. The focus group discussions explore women's contraceptive identity formation, and what they perceive to be 'good' and 'bad' contraceptive behaviour. I recognise that as audience members, the women take on a unique and powerful position in social problem work. Through a process of analysis, I establish the meaning the women give to the construct of the ECP as a contraceptive product but also the constructed the identity of the ECP user.

The women in the focus groups are sampled simply as audience members and not because of their previous contraceptive histories. However, it appeared after

sampling that each group contained EC users, and this added an additional dimension to the investigation. In some focus groups, I observed real-life claimsmaking around the ECP as a problem. This meant I was able to assess the strength of the pharmakon tightrope as a framework used to bring clarity to the meaning-making process that makes sense of an ambiguous social problem.

By investigating the social problem of the ECP, I have explored the roles and meaning that individuals take on in the social problem. Through an assessment of meaningful interactions and the internalisation of wider claims, I have found that the microsociological approach to studying a social problem offers an insight into the experience of individuals. The introduction of the pharmakon framework offers as a useful tool to further investigate the lived experience of ambiguous social problems. Overall, the research makes a contribution to recognising how the wider problem claims that surface around women's use and access of the ECP impact on and are experienced by those who exist within the social problem.

Chapter 1

Part 1 Emergency contraception: *What is in a name?*

1.1 Introduction

Asked to picture a state of 'emergency', we might imagine riot vans, fires, people in danger, bloodied victims and crying families: a scene where harm is imminent, sadness evident and risk impending. The English Dictionary defines 'emergency':

> …something dangerous or serious, such as an accident, that happens suddenly or unexpectedly and needs fast action in order to avoid harmful results. (Cambridge Dictionary, 2016)

Indeed, often the term *emergency* is linked to natural disasters, the need for emergency services or events that lead to harm. Thus, using the word suggests making a social inference of an event, action, or situation in hand.

The term also functions as an adjective to emphasise the exceptionality of a situation in hand, insofar as declaring a thing an *emergency* thing indicates the severity of the issue or circumstance. A meeting is a meeting until it becomes an *emergency* meeting, resulting in a different and more serious attitude from those parties involved. The word itself is striking and effective in its purpose: from a young age, we are taught how to perceive and handle an emergency with folk tales such as 'The Boy Who Cried Wolf' guaranteeing an emergency is not something to be taken lightly. In sum, using the word *emergency* can change the framework of an event or highlight a subject's seriousness.

Hence, in emergency situations, we are expected to react swiftly or preferably to prevent the event from occurring in the first place. Subsequently, the medical use of the term often indicates a risk of harm to a person or to a person's health (Lupton, 1995). If you google *what to do in emergency*, you will be told to call 999, stay calm, to start CPR, to shout for help, or if you are a child, to find a responsible adult. Additionally, the google search provides solutions to various scenarios, such as how to handle an asthma attack, what to do in case of a heart attack, and how to notice the first signs of a stroke. For the adjective 'emergency', health proves an exceptional case, and indicates a potential life or death situation. This poses a question: why do we use the term *emergency* to refer to the one-off administration of a specific set of hormones, that used on a daily basis are considered 'merely' as contraception?

The study of linguistics indicates that the message received is constructed by the rhetoric of the language used to convey it. The current analysis allows for a subjective review of the language, exploring the persuasive nature of the terms we use and their effect on society (Frawley, 2015). Understood simply, the term *emergency* describes 'something dangerous or serious […] that happens unexpectedly […] and needs fast action' (Cambridge Dictionary, 2016); however, we can similarly identify its use as a tool for amplifying or uniquely positioning an issue, topic of discussion or situation in hand. Therefore, in order to further understand the role the term *emergency* plays in the context of a product or in health, we must deconstruct its purpose: what does the term set out to identify and describe? Furthermore, how has this term found its way into the contraceptive syntax?

The following section attempts to explore the term through a research review conducted on products labelled 'emergency' contraception (EC), and what significance this term has in constructing the product's position as a method of contraception.

In the UK, there are two Emergency Contraceptive Pill (ECP) products available over the counter (OTC) and from a clinic; they are known as Levonelle and ellaOne (FSRH, 2017). Health professionals claim it is the immediacy of the timeframe required for product utilisation that leads to the 'emergency' designation, resolving any questions about the name (Glaiser, 1993). Both pills are used post-coitally to prevent pregnancy; the window of use is any time within the first 24 to 120 hours after intercourse (Brand, 2016; Schwarts & Westley, 2012). The later Levonelle is used, the less effective it becomes (48-72hours = 58%); however, ellaOne is proven to be 95% effective at preventing pregnancy up to 48-120 hours after unprotected sex (FSRH, 2017). Therefore, the timing here would not be strictly considered as fitting what we think of as an emergency, since the five-day period of use suggests that, despite this short window, taking the pills requires less urgency than their designation implies. Moreover, if the 'emergency' here does not refer to the window of use, what precisely is the purpose of the ECP designation?

The Emergency Contraceptive Pill (ECP) is unique, not only according to its nature as a post-sex contraceptive method but also due to its numerous designated names. Initially, the ECP was manufactured under the title of 'postcoital contraception' due to the character of its mode of operation (Ellerston, 1996; Prasad, 1984). Nowadays, it is widely known as 'the Emergency Contraceptive Pill', a name approved by government and health officials alongside pharmaceutical companies, particularly in the UK (Bastinaellie, et al., 2008; Furedi, 2012; Haggi, 2003; Schiappacasse & Diaz, 2006). 'The

morning after pill', as it is known by many, also appears to describe the product, but officials consider this name to be misleading and likely to affect use because the time frame for product effectiveness lasts longer than 24 hours (Ziebland, 1999; Bastinaellie, et al., 2008). Unlike the various methods of hormonal oral contraception, the ECP is not considered a 'regular' method of choice (Ziebland, 1999). Marketed and advised as a 'back up only' method of contraception, the ECP is not recommended for use unless required (Moreau, et al., 2005; Trussell, et al., 1992). In review of the literature on the ECP we find that the deployment of the term surpasses a definition or explanation of the situation presented. Through an analysis of recent research into the product and its development from a post-coital contraceptive to an 'emergency' contraceptive pill, the following section attempts to identify apparent themes from deconstructing the meaning of the term 'emergency' and its relationship to contraception. It begins with a review of the pharmaceutical development of the post-coital article and the product categorisation of the pill known as 'emergency contraception'.

1.2. Emergency: The post-coital pill

Apart from barrier methods and hormonal pill products, the only other options for pregnancy prevention require administration after sex. The available methods for preventing pregnancy convey an image of a market of potions and practices informed by old wives' tales. Farrar, et al. (2003) describe post-coital methods used to prevent pregnancy such as 'sneezing, hopping, coughing and jumping is reported as far back to 1500 BC' (p. 284). Concoctions and various ingredients said to prevent pregnancy after sex include 'the use of herbs and plants, injections, urination after intercourse or an overdose of vitamin C, aspirin and chloroquine' (Haggi, 2003, p. 340). Prior to the introduction of progressive reproductive technology it was acceptable for people to practice contraceptive methods after the act had transpired, since, during this historical period, no other contraceptive options existed (Haste, 1992; Condit, 2000; Djerassi, 1992). Even after the introduction of methods of hormonal contraception, people would attempt to prevent pregnancy after the act of sex using 'mixtures of contraceptive pills and other substances, tequila, Coca-Cola, marijuana with alcohol, vinegar or baking soda vaginal douches and sucking on lemons' (Haggi, 2003, p. 340). The expansion of medicine and pharmaceuticals in the early nineteenth century, coupled with the ineffectual use of peculiar ingredients, led doctors to begin testing

various hormones to determine their potential as effective methods for post-coital contraception.

Earlier work in this area illustrates how the pharmaceutical development of methods of post-coital contraception, particularly ECP, were to give women having infrequent sex the option of taking one product rather than a cycle of OCP. Prasad (1984) explains that the primary objective of post-coital pill development was to 'limit drug exposure, particularly for women who do not have intercourse daily or have a limited number of coital exposures in a month' (p. 108). With continuing fears of thrombosis caused by the OCP, medical practitioners sought a safer option for women considered to engage in infrequent sex (Prasad, 1984).

1.2.1 Oestrogen

The first hormone trialled on women was oestrogen. Research suggested its introduction in the 1960s: a high dose of oestrogen was provided to women to prevent pregnancy after an incident of sexual assault. Gupa and Hewitt (2002) explain that women were given five oestrogen tablets for use over a five-day period, each tablet containing 1mg of ethinylestradiol. The products reported side effects were not well received by women, with 30 per cent reported vomiting (Gupa & Hewitt, 2002). However, because of the high dose of hormones delivered over the five-day period, Haggi (2003) indicates that the 'five-by-five' regimen of oestrogen produced an increased risk of suffering from thromboembolism for the recipient. Thus, trials continued for producing a product with fewer side effects, which led to the introduction of the combined method Yupze Regimen.

1.2.2 Yupze

The Yupze regimen is recognised as the first successful hormonal post-coital method used by women and the first of its kind to be offered through prescription (Mansour, 2006). Introduced in 1974, it consisted of 0.1mg ethinylestradiol and 0.5mg of levonorgestrel (LNG) to be taken within 72 hours of unprotected intercourse and then repeated after a further 12 hours (Berger, et al., 2013; Mansour, 2006). Also referred to as the 'combined method', Yupze was the first made available through a doctor's prescription (Ellerston, 1996). Nausea and vomiting were recorded as potential side effects of the Yupze regime:

> For the combined regimen (PC4) licensed in the UK in 1984 as of July 1996, there were 115 reports of 159 different reactions; 61 pregnancies, three cases of venous thrombolic embolism and three cases of cerebrovascular disorder (Gupa & Hewitt, 2002, p. 6).

With failure rates significantly lower than the 'five-by-five' regimen, in the 1970s Yupze became the first pill product to be offered via prescription from a general practitioner (GP) (Berger, et al., 2013). However, research indicates that issues with its side effects induced medical companies to maintain development into a product less harmful to women, resulting in the introduction of the Levonorgestrel method.

1.2.3 Levonorgestrel (LNG)

Originally developed as a two tablet dose taken 12 hours apart, the LNG product – also known as Levonelle or the progestin-only regimen – currently contains 0.75mg of levonorgestrel in a single tablet to be taken up to 72 hours after (Farrar, et al., 2003; Haggi, 2003; Westhoff, 2003). Approved as an effective post-coital product, its single pill dose and its low prospect for side effects has caused LNG to become the most used ECP product to date (Berger, et al., 2013).

> Not only does the [levonorgestrel] regimen offer improved efficacy and fewer side effects than the Yupze method, it is also very safe with pregnancy (Gupta & Hewitt, 2002, p. 6).

Many researchers into the mechanisms of post-coital pill products find that the hormones used in the prescribed dose have no effect on pregnancy and therefore do not cause abortion (Glaiser, 1993; Trussell, et al., 1992). Research into LNG indicates no effect after implantation, which proves a safe and effective method of birth control (Berger, et al., 2013). In 2001, it was this product that was deregulated in the UK as an over-the-counter (OTC) method of contraception due to its decreased prospect for side effects and the accumulative evidence supporting its efficacy and safety (Gupta & Hewitt, 2002).

EllaOne is the most recently developed Emergency Contraceptive Pill (ECP) available on prescription in the UK. Containing 30mg of Ulipristal Acetate, the product is considered the most effective method available to date that can be taken up to five days after unprotected intercourse (Brand, 2016). In 2015, the product transitioned to a non-prescription status after the European Medicines Agency authorized it as safe for sale without a prescription (Brand, 2016).

This review demonstrates that the purpose for manufacturing and developing these hormones is pregnancy prevention, in common with any other hormonal oral contraceptive pills (OCP) (Cleland, et al., 2014; Glasier & Westley, 2010). However, the unique nature of post-coital pill development has allowed women to choose to prevent pregnancy after sex. This expansion in contraceptive methods increased women's freedom of choice and provided broader options for preventing pregnancy and having sex (Jackson, 2001; Watkins, 1998). The development of the post-coital product changed the framework applied to contraceptive options. Until the introduction of barrier methods and hormonal pills, all available contraceptive options were post-coital; during this time, the framing of contraception made no impact on our understanding of preventative methods or the person using them, being merely the status quo. However, in review of the recent literature surrounding the ECP, it appears the messaging attached to its use significantly changes from the ECP being another contraceptive option to being one for emergency use only (Barrett & Harper, 2000; Hrokbak & Wilson, 2014; Ziebland, 1999). Exploring the original product marketing by the manufacturer and the introduction of the prescribed method of use further explains the problems arising with the introduction of the ECP.

1.3 'Emergency' contraception

The evidence indicates that the ECP's positioning outside the remit of other methods of contraception is the end result of a journey that takes it far from its origins. The product's classification as 'emergency contraceptive' was adopted after its original development (Bastinaellie, et al., 2008). Therefore, it is important to recognise the role claimsmakers have played in the categorisation of the ECP, and within a discourse featuring pharmaceutical companies and health officials and their decisions regarding the marketing and production of the post-coital product. Van Gorp (2007) explains that a crucial part of frame analysis is evaluating the presented package: 'the frame package suggests a definition, an explanation, a problematizing, and an evaluation of the event and ultimately results in a number of logical conclusions' (p. 65). Thus, in order to deconstruct the journey of the ECP, we must consider how these factors impact the manufacturing, marketing, and prescribing of the product and its migration from post-coital contraception to emergency contraception.

Sociologists studying risk and health argue that western culture is subjected to an increasingly anxious awareness of risk. (Furedi, 2002; Herdt, 2009; Lupton, 1999; Lupton & Peterson, 1996; Lupton & Tulloch, 2003) Furedi (2002) contends that the

traditional morals that formerly directed societal value systems have adapted to conform to a new moral etiquette, one dominated by risk awareness, since 'we live in a world that finds it hard to deal with uncertainty' (p. 10). This transformation from traditional value system to moral etiquette generates a new frame dominating health and medicine: prevention.

Modern medicine remains at the forefront of a movement of prevention, it focuses on technologies for reducing risk and concentrates concern on those perceived to encourage or take risks (Furedi, 2002; Furedi, 2008; Lupton, 1995; Lupton & Tulloch, 2003). We find pharmaceuticals, doctors, and health officials taking greater caution when introducing new medicines or therapies as the field becomes more precarious due to risk avoidance featuring higher on the agenda (Conrad, 2007; Furedi, 2002). This is evident in the original marketing of the ECP in the UK, first introduced by its pharmaceutical company.

In 1982, the British pharmaceutical corporation Schering Limited became the first company to create and brand a post-coital contraception method available for use via prescription (Furedi, 2012). Ann Furedi, then CEO of bpas (the British Pregnancy Advisory Service) and a lobbyist for EC, recounts the policy and the pharmaceutical development of the ECP:

> The marketing of a dedicated licensed product, for which a single pharmaceutical company was commercially liable, could be seen as a means to control and regularize the practice of post coital OCP use and render it subject to scrutiny and monitoring. (Furedi, 2012, p. 123)

As a consequence of Schering officials' tangible fears about the new product's liability, the product received only limited marketing (Furedi, 2012). Coinciding with the successful release and consistent uptake of OCP since the 1960s and the timing of the ECP's introduction, post-coital contraceptive options were considered irregular and less efficient when compared to OCP (Ellerston, 1996; Furedi, 2012; Westoff, 2003). Resultantly, its development became the 'embarrassing cuckoo' in their pharmaceutical repertoire, lacking any effort to market or develop the product in line with other 'regular methods' of OCP (Furedi, 2012, p. 124).

Compared with other contraceptive methods, the nature of the product's introduction and the timing of its technological development significantly impacted how health officials chose its initial framing. Their concern centred on rising teenage pregnancy rates and female sexuality, and so greater focus was drawn to the OCP, at that time

considered the gold standard in contraception (Barrett & Harper, 2000; Farrar, et al., 2003, Foster & Wynn, 2012; Latham, 2001; Moreau, et al., 2005). In order to reduce rates of teenage pregnancy and unplanned pregnancy, health professionals stressed that OCP should be considered the best option in terms of reliable and accessible methods of contraception (Glaiser, 1993; Trussell, 2012).

The OCP's position as a preferred preventative contraceptive method produced greater pressure for clarifying the ECP's purpose and role as a post-coital method of contraception. Amid this environment of official anxiety and pressure, the ECP's prescribed use became for emergencies only, and in 1974, the first combined method of ECP named 'Schering-PC4' became available via prescription from a doctor (Latham, 2002). However, the product was not a replacement for 'regular methods of contraception' and only for use in the case of 'emergencies' according to the message advised by Schering and reinforced by health professionals (Furedi, A, 2012).

Schering's concerns with the product and its reputation evidently changed ECP's framing from a method of contraception to an emergency-only product. Consequently, the anxieties apparent in the ECP's pharmaceutical development led to its construction as a 'back up' only method (Latham, 2002). Furedi (2012) signifies the lost opportunity for normalising this method as a possible form of contraceptive, creating a taboo product for use 'only when all else fails'(p.136). The meaning behind this change in categorisation can be viewed as an attempt at product segregation, with research indicating how pharmaceutical company decisions shaped its claims regarding the irregularity of its use and stressing an 'emergency only' message. Furthermore, the rhetoric of this message was perpetuated through distinguishing the product as abnormal, repeated later in the 1990s in statements rejecting it as a replacement for other methods of contraception. Various health professionals and organisations have echoed this claim:

> The WHO [World Health Organisation] also recommends utilizing HEC [Hormonal EC] only as emergency measures because failure rates - if the method is used for regular ongoing contraception – are too high compared with other hormonal contraceptive methods. (Bastianelli, et al., 2008, p. 12)

Similarly, the 'emergency-only' construct provides the support required for emphasising the product's unreliability, peripheral to a routine and therefore creating the concept of a disruptive product. By definition, the ECP is a product used after an incident of sex but before implantation (Glaiser & Westley, 2010). Resultantly, the term

'emergency' has been utilised by claimsmakers to enable the definition of this method of contraception as unusual.

Enabled by compatible rhetoric from health officials that designates the product as solely for 'emergency' situations, other pharmaceutical companies followed suit, as reported by the production changes made by the Hungarian company Gedeon Richter to underscore its status for use only in the case of an emergency. Hence,

> The Hungarian company Gedeon Richter once marketed a strip of 10 pills. Now the company markets a four pill strip, to emphasize that pills are intended for sporadic or emergency contraception. (Ellerston, 1996, p. 45)

This evidence suggests a precise influence of the term *emergency contraception*. A proclivity to react to the assertions of claimsmakers has resulted in isolating the method and its inevitable rebranding and conformation to the *emergency* category. To support this finding, it is important to review how women and health professionals receive the rhetoric of such a message. The following section addresses the qualitative ECP research indicating that women and health professionals are unable to accept the product as a viable contraceptive option, formerly established by the product's seclusion under its designation as 'emergency contraception'.

1.3.1 Emergency: a new construct

Through the review of more recent research, it appears that the category of 'post-coital contraception' has been removed and replaced by a newer one of 'emergency' contraception, with all products used post-sex now termed 'emergency contraception' (Ellerston, et al., 2000; Croxatto, et al. , 2001; Glaiser, 1993; Ziebland, 1999). This is evident not only in research but in general medicine, as in the case of the intrauterine device (IUD), often promoted as a Long Acting Reversible Contraceptive (LARC) but considered EC as it too can prevent pregnancy up to 120 hours after an act of unprotected sex (FPA, 2015). This change in categorisation only occurs once the product is inserted following a record of unprotected sex, yet if inserted under different circumstances is considered contraception (FPA, 2015). The significance of this in regard to the term 'emergency' is that it defines as irregular any particular situation requiring EC use, in comparison to those where other methods of contraception are utilised.

The situations accepted applicable for ECP use are described as:

> … a variety of situations where EC use is indicated [...] among them, condom rupture, unplanned unprotected intercourse (particularly in case of young adults engaging in sexual experience), incidental misuse of regular contraceptive methods and sexual assault. (Croxatto, et al., 2001, p. 112)

The construction of the types of sex leading to ECP use are described and portrayed as irregular events. The discourse identifies these occurrences as abnormal by connecting them with undesirable behaviour outside of prescribed accepted contraceptive behaviour, often considered as 'preplanning' (Croxatto, et al. , 2001; Latham, 2001; Shoveller, et al., 2007). As found by Hawkes (1995) in addressing the issue of responsibility and young women's family planning practices:

> 'Family Planning' in its accepted twentieth century form is about planned contraceptive practices, where arguably not just procreative but erotic practices require the containment which the notion of 'planning' suggests. (Hawkes, 1995, p. 264)

Already discussed in the previous sections, we can identify the tension resulting from positioning ECP as a method of contraception when competing with preferred preventative methods. Hawkes (1995) identifies this concern for using the correct prevention methods resides within the construction of preferred ways to practice 'safe sex', with 'planned sex' being the extant contemporary model.

This claim regarding unacceptable unprotected sex appears in the research stereotyped as occurring 'after single, unplanned events; when sex was with a casual partner, as a result of getting carried away and/or they were drunk' (Williamson, et al., 2009, p. 312). In Williams et al.'s (2009) study, this type of sex is described by health professionals as 'having sex without thinking of or forgetting about, contraception' (p. 312). Here, the issue is revealed as the unplanned nature of the sex leading up to ECP use, rather than the product itself (Barrett & Harper, 2000; Hrokbak & Wilson, 2014). Therefore, in response to these claims, it is arguable that the term *emergency* does not refer to the timing of use, but instead communicates the 'irregularity' of the manner of unplanned sex that requires this product.

The persuasive nature of the term *emergency* and its present meaning features prominently in research on ECP, and it is evident when reviewing the constructs attached to the individual using the product. Free et al. (2002) find in their interviews with women a lack of desire to admit to using ECP, as if doing so confessed to the behaviour associated with its use:

> Women who linked the EC to undesirable behaviour wanted to dissociate themselves from any negative connotations about themselves or their relationship if they sought EC. (p. 3)

A consequence of this discourse may be that associating the term *emergency* with a method of contraception constructs a barrier to the product, confirming its position as an unusual occurrence, i.e. only to be used after an accident, happening suddenly, and needing rapid action (Cambridge Dictionary, 2016). Significantly, the subsequent product categorisation ensuing from the name has resulted in the segregation of post-coital products from other 'regular' methods of contraception, despite a review of ECP products suggesting little difference to the oral contraceptive pill used daily by women.

When reviewing research addressing and testing the impact of increased access to the ECP, results demonstrate that health professionals are reluctant to engage in its promotion, and likewise, women are inclined to distance themselves from the product (Aiken, et al., 2005; Barrett & Harper, 2000; Free, et al., 2002; Gold, et al., 2011; Gold, et al., 2004; Williamson, et al., 2009). It appears that an as yet unaddressed theme in the extant literature is the origin of the apprehension surrounding the ECP and its connection to its 'emergency' construct beginnings. Although Grimes (2002) details that a cause of this anxiety may be linked to access to the product, there likewise exists a concern as to the potential impact it might bear on women's behaviour:

> They propose that a supply of emergency contraception in a medicine cabinet will undermine ongoing hormonal or barrier contraception. This is analogous to suggesting that having a fire extinguisher in the kitchen leads to hazardous cooking practices. (Grimes, 2002, p. 1537)

What Grimes reflects here is that, for many, the idea of providing women with *emergency* contraception appears to defeat the purpose of the product. However, it can be argued that if the product's main aim is pregnancy prevention then surely the time in which it is given to a woman would not affect or 'undermine' any other methods of contraception. Therefore, it is suggested that the issue here may not concern its impact on other methods, as suggested by other research.

Schiappacasse and Diaz (2006) describe that the reluctance of officials to increase ECP access stems from fears that ECP use will encourage 'risky' sexual behaviour. Consistent with the *emergency* framing, they indicate that health providers are troubled by 'fears of potential misuse and the widely held misconception that EC promotes promiscuity' (Schiappacasse & Diaz, 2006, p. 302). Accompanying this claim is the concept that women using the product are believed to have:

> Little or no concern for the long-term consequences, and that increasing access through deregulation would merely exacerbate this irresponsibility amongst users. (Barret and Harper, 2000, p. 204)

Consistent with the preferred construct of contraceptive preplanning, women's behaviour is evidently questioned. Within the literature, we find evidence supporting a collective pressure towards responsible action, consistent with the modern construct of planned sex as corresponding to safe sex.

Gold et al. (2004) find in their interviews with health professionals and patients that the latter could not accept EC as regular contraception because of its use following sex. The authors report that many felt that 'EC is not real contraception, and that the idea of a post coital method of birth control is morally problematic' (Gold, et al., 2004, p. 347). To question the morals of a person based on their contraceptive choices might be considered a little much; however, 'morals' feature significantly within the discourse as a measure of a person's ability to make contraceptive decisions.

Shoveller et al. (2007) find when interviewing women that there exist shared social values often internalised by women and observable in their discussion of ECP users:

> Women who had never used it identified users as irresponsible or careless with respect to their reproductive health or sexual behaviour […] never users asserted, for example that women resort to using EC because their 'poor judgement' or 'low character' leads them to have sex while drunk or high or to be promiscuous. (Shoveller, et al., 2007, p. 15)

This construct's impact on women results in those who have never used the product inclining to prejudge its use based on stereotypes or assumptions of needing to use EC. As Gold et al. discover in their interviews with women, 'Planning to use EC meant failing to plan for sex' and 'EC should not be for people who just want pleasure and don't think about consequences' (Gold et al., 2004, p. 347). This message materialising in ECP discourse can be suggested as a result of risk aversive culture in the twenty-first century, additionally impeding the progression of increasing ECP access (Furedi, 2002). Yet to be addressed is its association with the modern construct of safe sex and women's use of ECP. Furthermore, research on the ECP has previously focused mainly on young women aged 16-25, a gap in the current research lies in women outside of this age bracket (Aiken, et al., 2005; Blanchard, et al., 2000). In review, an indirect link is suggested between the segregation of the product as a method of contraception, and women's opinions and understanding of the method as a potential contraceptive option. This has yet to be explored in research but an in-depth study into women's

experiences of using the contraceptive would allow for further investigation into the causation of this construct.

1.4 Conclusion

In reviewing the term *emergency* and its role relating to the ECP contraceptive method, we can perceive that the label manipulates the product's social construction in ways otherwise unidentified by prior research. As a term, *emergency* is awkwardly positioned within the list of names given to contraception, and through reviewing the research we discover the product itself falling under various frames. Under a medical frame, it is viewed as a method of contraception, a safe and effective method for preventing pregnancy using the same hormones as other OCP. Pharmaceutical and health official framing produced its current construction as a 'backup' or 'emergency use only' method, creating a new category of contraception in response to competing factors such as the OCP and pressure to limit risky sexual behaviour. Consequently, this new construct for 'emergency contraception' is one wherein women's behaviour is questioned. These frames have led to its current position as an unacceptable contraceptive method of choice, only for use in 'emergency' situations.

As a result of the current ambiguous positioning of the ECP as a method of contraceptive choice, research efforts have aimed to highlight how enabling greater access to the product may influence issues in society. The review uncovers the frame possessed by ECP in a wider discourse, and as a factor in impacting those concerns considered 'social problems'. The moral undertone scrutinised in this section can be further explored by analysing what part played by ECP in developing the 'social problem'. The next section will investigate and review the concept of the social problem, whereby ECP is framed as a catalyst for both problem-causing and problem-solving behaviour, through an examination of the binary debate for and against the ECP.

Part 2 Access: the power of the claim

1.5 Introduction

Spector and Kituse (2001) argue against evaluating social problems through a manufactured understanding of the 'societal' concerns surrounding a given topic or situation: doing so requires broad assumptions insofar as every social problem functions for a specific audience and a particular set of claimsmakers. Similarly, we cannot assume that everyone within 'society' agrees with such claims, therefore suggesting that how an issue, topic or situation is received constructs our own understanding.

For example, if our consideration of an issue comes through taking it to court or debating it in the House of Lords or defining it in a dictionary, the issue exists. By existing in the realm of policy and policy decision-makers, a problem is given momentum and an audience – and importantly, these two factors prove crucial when considering the development and recognition of a social problem. From a social constructionist view, Spector and Kituse state that 'social problems are what we think they are' (2001, p. 73). Further developed in this section, this idea builds on the previous section's inquiry into the meaning of terms, alongside reviewing definitions of 'access' corresponding to the ECP and how the presented claims can be considered coherent with the social construction theory of claimsmaking activities.

Access is defined as:

> …the right or opportunity to use or look at something. (Cambridge Dictionary, 2017)

Socially, we can view acquiring access as a privilege or reward, often considering access as acquiring greater responsibility. In policy terms, access is often expressed in the form of a right. In the past, women fought for their rights to vote, to be given political access, and to have their views heard. In legislative terms, access is reviewed and approved by government and policy-makers who possess the power to grant access when deemed appropriate. For example, in the UK it is against the law for those under the age of 18 to drink or buy alcohol. This law exists to protect children from its harmful effects, therefore only those over 18 are permitted to access and consume alcohol. However, in policy and legislative terms, there are numerous ways to consider

this access. With regard to medicine, it is often the case that courts and policy-makers necessitate formulating evidence-based judgments as to whether access may be granted or denied (Conrad, 2007). Therefore, various claimsmakers play a part in either fighting for or against access, as is evident in the case for ECP access.

In the UK, access to medicine is regulated under various acts produced by parliament. The Human Medicines Regulations Act 2012, the Prescription only Medicine Act (for human use) 1997, the Medicines Act 1968, and many others determine the regulations for products available nationally. Unlike the US, the UK maintains strict rules regarding the prescription of medicine and access to products. Government guidelines outline the three ways in which medicines can be supplied in the UK:

- on a prescription (referred to as prescription-only medicines (POM)
- in a pharmacy without a prescription, under the supervision of a pharmacist (P)
- as a general sale list (GSL) medicine and sold in general retail outlets without the supervision of a pharmacist.

(Medicines and Healthcare products Regulatory Agency, 2014)

Currently, the ECP resides under P status, whereby women can access the product over the counter (OTC) under pharmacist supervision. This level of access has been disputed by different groups with some believing this provides too much access, advocating for the product's removal from sales and prescription, to be instead regulated under Abortion laws (Cook, et al., 2006; Fallon, 2009). Others consider this access insufficient, and that the ECP should progress to GSL status so that women be given a 'barrier-free' option to acquire the product (Grimes, 2002). Access to the ECP remained a consistent topic for discussion, as is observable through reviewing ECP discourse.

Continuing the previous section's discoveries on the construct of the term *emergency*, this section will evaluate the language used in discussions regarding ECP access. Furthermore, in consideration of the sociological study of social problems, this section reviews the construct of claims generated concerning access to the ECP and their subsequent consequences on the ECP's position as a method of contraception.

In ECP discourse, access features under two separate meanings. To some it appears a problem, producing arguments for highly regulated access to the ECP according to such claims as its function as an abortifacient, the potential for abuse of the product, and general concern as to its impact on teenagers (Aiken, et al., 2005; Hrokbak &

Wilson, 2014; Foster & Wynn, 2012). By comparison, competing claims argue for access to the ECP to be perceived as an opportunity, the main assertions being that: granting access will help reduce the number of unwanted pregnancies, likewise, it may decrease teenage pregnancy numbers, and finally, because women should be permitted access to contraception (Trussell, 2012; Glaiser & Lakha, 2006; Edouard, 2002). With two opposing positions as to what access to the ECP entails, this section reviews the evidence for a set of claims formulated around ECP access and their consequent impact on its presentation as a contraceptive method.

This section considers the sociological content for ECP discourse to be guided by ideas proposed by the study of 'the social problem', stressing the importance of a set of claims and their resultant outcomes. Beginning with the suggestion that the ECP is an abortifacient, this section evaluates the 2002 judicial review produced by Society for Protection against the Unborn Child (SPUC), exploring its relevant background motivations and the potential significance for women's access to contraceptive products. The second section evaluates the claims generated during its move from POM to P status, through a review of the 2000/1 House of Commons and House of Lords parliamentary debates. In an attempt to comprehend the purpose of the dominant claims within the OTC debate, the section reviews how claims regarding the ECP triggered the reorganisation of the legislative agreement from POM to P. Finally, it reviews the arguments for increased and advanced access to the ECP. Through reviewing claims from those advocating for the product and their arguments refuting its risk potential, this section considers how ECP access can be affirmatively championed in a modern world of 'safe sex'. Overall, the section considers what access embodies for the ECP.

1.6 Access: Denied

In 2002, SPUC requested a Judicial Review in response to the previous year's deregulation of the ECP, on the grounds of preventing its sale OTC because it procured a miscarriage and therefore should fall under the 1861 Offences Against the Person Act (Cook, et al., 2006; Fallon, 2009). The review brought together various groups, including SPUC, the State, health professionals, doctors, researchers, and charities (Cook, et al., 2006; Latham, 2002). The influential claimsmakers all contributed evidence to the case, and all maintained a personal stake in the outcome. Here, the significance occurs in the claims made both for and against ECP access and its meaning for women's access to contraception. This section reviews and outlines the 2002

conclusions of Justice Sir James Munby alongside revaluating the claims of both SPUC and the judge, for the purpose of grasping precisely the case's meaning in terms of 'access' to contraceptive products, and the matters considered important when approving or removing its access.

1.6.1 The meaning of the unrealised outcome of the case

When considering this case, it is necessary to understand what was being argued. Founded upon a technical argument, SPUC claimed that distributing the ECP was a criminal offence under sections 58 and 59 of the 1861 Offences against the Person Act:

> **58 Administering drugs or using instruments to procure abortion.**
>
> Every woman, being with child, who, with intent to procure her own miscarriage, shall unlawfully administer to herself any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, and whosoever, with intent to procure the miscarriage of any woman, whether she be or be not with child, shall unlawfully administer to her or cause to be taken by her any poison or other noxious thing, or shall unlawfully use any instrument or other means whatsoever with the like intent, shall be guilty of felony, and being convicted thereof shall be liable […] to be kept in penal servitude for life […].
>
> **59 Procuring drugs, [etc.] to cause abortion.**
>
> Whosoever shall unlawfully supply or procure any poison or other noxious thing, or any instrument or thing whatsoever, knowing that the same is intended to be unlawfully used or employed with intent to procure the miscarriage of any woman, whether she be or be not with child, shall be guilty of a misdemeanour, and being convicted thereof shall be liable […] to be kept in penal servitude.
>
> (Offences Against the Person Act 1861, S.58.59)

Focusing on the term 'miscarriage', SPUC argued the technical mechanisms of the hormones contained within ECP products procured a miscarriage, their main claim contending,

> …that *any* interference with a fertilised egg, if it leads to the loss of the egg, involves the procuring of a 'miscarriage' within the meaning of the 1861 Act, even – and this is the important point – if the interference takes place before the egg has implanted in the wall of the womb. (Munby, 2002, p. 151)

The SPUC case proposed that *any* hormonal product 'interfering' with a 'fertilised egg' would, therefore, fall under ss 58-59 of the 1861 Act, thus making it a criminal offence.

The significance of this claim meant that should this case be approved, all women, doctors, or nurses merely using or distributing *any* hormonal contraceptive product, such as the pill, the mini-pill, the IUD, the implant, the injection, and ECP would be breaking the law, and consequently, countless people could face imprisonment. While this case appeared to be dealing with one issue – specifically, access to the ECP - in turn, it uncovered major moral issues with the construct of the meaning of contraception. Equally, it disputed the understanding of terms such as 'miscarriage' and 'abortion', as was subsequently recognised in Justice Munby's review.

1.6.2 What does it mean for abortion?

Justice Munby carefully chose to outline his position not to provide answers to questions such as 'when does life begin?' but for making a judgment on the case of whether the ECP contravened ss 58/59 of the 1861 Act. He reiterated throughout 'that days are past when the business of the judges was the enforcement of morals or religious beliefs' (Munby, 2002, p. 157). That being said, Munby provided an extensive response to the review, using evidence from doctors clarifying their own interpretations of the word 'miscarriage', alongside the concept of 'abortion', and the characteristic mechanisms of hormonal products. Equally, the judge attempted reflection when responding to the law itself, including the apparent 'values' underpinning the law at its inception:

> …the world of 1803 or even of 1861 was very different from our own. A society which could believe that the pillory and the gallows were appropriate punishments for abortion is so utterly alien to our own as to make it almost impossible to bridge the gulf of incomprehension. (Munby, 2002, p. 227)

Conscious of the stark differences between perceptions of right and wrong in 1861 verses 2001, Munby led his judgement based on contemporary definitions of abortion and medical conclusions of miscarriage, opening the law to modern interpretation. Thus, Munby proposed to review the case according to the 'parliamentary intention' of the time of writing the 1861 Act (p219). From medical definitions to doctors' opinions, abundant claims were made differentiating the product from abortion, pragmatically forwarding evidence defending the ECP in both delivery and argument:

> …'miscarriage' means the loss of a clinically recognised pregnancy. Since a pregnancy cannot be recognised until HCG [human chorionic gonadotrophin] can be detected, and HCG is not produced until implantation has been initiated, a miscarriage will not occur prior to implantation. (p176)

Evoking emotion and producing value-laden statements, claimsmakers attempt to sway audiences according to their ability to touch upon the social constructs we perceive as right and wrong (Best & Loseke, 2003). In the presented case, the judge rejected the courts as a place for making judgements on 'values', particularly acknowledging the complexity of applying it to contemporary secular life:

> It can hardly be disputed that the last few years have marked the disappearance in an increasingly secular and pluralistic society of what until comparatively recently was in large measured a commonly accepted package of moral and ethical and religious values. This means that on many of the medical, religious and ethical issues which the courts increasingly have to grapple with there is simply no longer any generally accepted common view. (Munby 2002, p. 158)

However, in this case, the apparent 'common view' endorsed claims as to the dissimilarity of abortion and contraception, as can be seen in the arguments presented both for and against ECP access. Making the 'social' argument for the ECP, experts such as the CEO of the FPA stated, 'Emergency contraception is safe, simple and effective. Abortion is both medically and psychologically invasive' (Munby, 2002, p. 161). The defence case rested on the notion that the ECP could not procure abortion, corroborated by both medical evidence and the support and backing of doctors, but equally, that the terms 'abortion' and 'miscarriage' could be considered 'value sensitive' and therefore, requiring the court to produce a judgment without 'moral' consideration. Significantly, this conclusion founded on morally driven counterclaims contributed to the overall movement of the court's final decision.

1.6.3 In this case, what does access mean for the ECP?

Forceful counterclaims to SPUC's arguments highlighted other cases in defence of the product, emphasising the changing cultural significance of socially accepted terms used over 100 years ago, which, therefore, should not be relied on to inform the proceedings of twentieth century life. This case can be regarded as one wherein women's rights overcame claims targeting their reproductive choices, with its conclusions considered a progressive shift contributing to the ongoing widening of access to contraceptive methods (Cook, et al., 2006; Fallon, 2009; Furedi, A, 2012). However, through reviewing the claims we discover there remains a level of ambiguity in the law as to what is perceived as 'socially acceptable'.

While the judge's motion was careful not to define or to rewrite laws potentially criminalising women's contraceptive options, he equally allowed them to continue to

be questioned. Despite the claims emanating from SPUC demonstrating the flaw of relying on Victorian legal ambiguity and the resulting inevitabilities of interpreting women's autonomy through outdated legislation, the defence chose to ground their counterclaims to the court by legitimising the ECP as a product, and reaffirming the social exclusion of abortion from contraception. Thus, by legitimizing acceptable access to the ECP, the court highlighted the fixed division between abortion and contraception.

Claims perceived as solutions are argued as being for the benefit of those who the social problem concerns (Loseke, 2011; Henley, 1986; Rappaport & Seidman, 1986; Benney & Hughes, 1984). Here, we uncover that while 'access' is considered a remedy to the ongoing issue of women's contraceptive options, the claims provided supporting this move challenge the motivations of its original purpose. As a result, we find the claims addressed in this case are left up to debate, with many offering a potential progression towards allowing for greater discussion regarding women's rights but likewise, leaving the law open to facilitate its continuous interrogation. Without a firm stance in policy or law aimed at contesting the ambiguity surrounding women's access to reproductive technology, this policy area continues to be open to regulated access according to what others perceive acceptable and unacceptable. The solution supported by many for providing greater access to contraceptive options has correspondingly produced further barriers for the ongoing issue of access and the acceptance of reproductive technology.

This potential solution is constructed in response to social problems and is evident in the discourse surrounding the 2000/1 OTC debate.

1.7 Access: over the counter (OTC)

As highlighted in the previous section, since the 1984 amendment making the ECP product available as a POM, the product became another method of contraception for use 'in emergencies'. For many lobbying for women's reproductive rights, this was a step towards providing better control of their reproductive options (Furedi, A, 2012). From the early '90s, the product began to be considered as one that women should be able to access over the counter.

Accordingly, the House of Commons amended the 1997 Prescription Only Medicines (Human Use) Order to include the sale of Levonorgestrel in 0.75mg doses to women

aged over 16 without a prescription. In 2000, the order was reviewed in the House of Lords and Commons for the further amendment (no.3) as of the 1st January 2001:

> In Schedule 1 to the principal Order (which specifies substances which, if included in medicinal products, make those products prescription only medicines, and exemptions from the restrictions on the sale and supply of prescription only medicines), in relation to the substance Levonorgestrel, there are inserted the following entries—
>
> in column 2—
>
> '0.75mg'; and
>
> in column 3—
>
> 'for use as an emergency contraceptive in women aged 16 years and over'.
>
> (Prescription Only Medicine (Human Use) Order 1997)

With this change in legislation, it became legal for women aged over 16 to access the ECP OTC. However, prior to the January 2001 legislative reorganisation, both Houses debated the matter on a number of occasions. Social problem theory indicates that policy and legislation outcomes are often indirectly influenced by public discourse, and resultantly, the construction of social problems feature as the dominant reasoning behind policy and legislation (Armstrong, 2003; Barclay & Lupton, 1997; Best & Bogel, 2014; Gomez, 1997; Luker, 1996; Neiterman, 2012). These debates raised many questions regarding the claims made both for and against access to the ECP, highlighting considered to be the 'important issues' relating to its access.

Research demonstrates the product inhibits the same hormones produced by similar mechanisms in other available hormonal contraceptive products, with the single difference being in the taking of the product after the act rather than before (Hrokbak & Wilson, 2014). In this chapter, we have previously discussed the product's original design for women having infrequent sex, with the aim of limiting their unnecessary exposure to monthly hormones (Prasad, 1984; Ellerston, 1996). Allowing for the ECP to become a product option for women to use acknowledges that on the odd occasion they may have sex. Therefore, it may be assumed that arguments made for legislative change could be made on the basis that: 1. women should have better access to their contraception; 2. parliament should aim to encourage the free and open discussion of contraceptive options best suited to each women's lifestyle; or even 3. women should be afforded the right to full autonomy over their contraceptive options. It would be reasonable to assume these could-be arguments; however, that would be wrong. Even

though these claims were presented by a few, they did not receive the same recognition as those providing the momentum for deregulation.

The first claim receiving recognition concerned the ECP's potential for reducing the number of unwanted pregnancies, in turn reducing UK abortion levels (Cook, et al., 2006). The second claim regarded its prospective impact on the country's rising rates of teenage pregnancy; this received the attention of New Labour officials contributing to the 1999 Teenage Pregnancy Strategy (Fallon, 2009). In addition to these, the claims of the opposition received equal recognition, with many concerned as to the consequences of OTC access to the ECP to impact on women's behaviour, resulting in a third claim regarding its possible promotion of promiscuity. Thus, with a rising number of claims, the ECP soon became a pawn in the debate as to how to combat unwanted problems in society. With these claims receiving recognition, the deregulation was taken to parliament, progressing to the in both the House of Commons and the House of Lords debates wherein we may further observe these claims, and what the resulting access to the ECP means to many.

1.7.1 The claims in the debate

Best (2008) explains that 'all human knowledge is socially constructed through our language, which means that all social problems are socially constructed' (p. 16). The language we use supports our moral framework, allowing us to define a problem as good or bad, and so, in turn, we can describe our worries regarding a problem through the further use of language (Ibarra & Kitsuse, 1993). Through reviewing the debate in the Parliamentary houses, we begin to see how these claims develop and how they feature in the real-life discourse of the parliamentarians. With the strongest claims proffered against the sexual behaviour of teenagers and women, the following section revaluates how the arguments were made both for and against deregulation in both of the houses and what the claims meant for access to the ECP.

3.1.1 Teenagers

As predicted by social problem theory, teenagers became a focal point in the access discourse, presenting a problem requiring support as a group considered vulnerable (Best & Bogel, 2014; Kellerher, 2001). Thus, with teenagers considered vulnerable and often 'at risk', and amid growing concerns about rising rates of teenage pregnancy, a variety of claims ensued. With prominent claims as to the ECP's effect on teenagers, it

was argued that not only their health but, their 'morals' and behaviour were under threat (Latham, 2002).

Despite the proposed deregulation, specifying women aged under 16 would be unable to access the product OTC, for many, even this access appeared too accessible. It was suggested in the debate that teenagers would discover ways of gaining access, whether by their own accord, through the use of older women, or even being pressured into accessing it by their overbearing male counterparts (Callaghan, 2001). Claiming that young teenage girls may go to the extreme length of obtaining a fake ID, Baroness Young described how 'teenage magazines are full of advertisements showing how to obtain [ID cards]' (HL Deb 29 Jan 2001, C514).

Aside from the claims of fraudulent teenagers, the proposal to permit ECP availability in chemists shocked many due to the absence of a medical record review and the potential for a teenager to obtain a contraceptive product without parental consent (Callaghan, 2001). The claim framed around 'the potential health risk' posed by the product to young women appears after evaluation to possess a greater moral undertone. As Baroness Young continues, 'I understand, it is 50 times more powerful than the previous contraceptive pill. What adults choose to do is a matter for them but, as I have said before, we have a responsibility to the young' (HL Deb 29 Jan 2001, C515).

Equally, with concerns about teenage pregnancy used for supporting access to the product, it appears this argument is founded in response to the supposed resulting moral burden endured by a teenage pregnancy:

> My view is that the social and psychological impact of an unwanted pregnancy far outweighs concerns about the morality of prescribing emergency contraception. (HL Deb 29 Jan 2001, C517)

What appears to be suggested is that access to the ECP comes alongside 'moral concerns'. In evaluating the claims made regarding ECP access for teenagers, we can begin to understand what construct is considered with P access to the product. Morality is overtly questioned, with some ministers believing their position to be for arguing for those unable to argue, or expressing the fears of those unable to speak out. The Lord Bishop of Southwark stated his support for ECP access, thusly:

> There is no question that we must strengthen long-term methods of teaching morality, developing good sex education for boys and girls and increasing hope and choices for girls in areas of deprivation. (HL Deb 29 Jan, 2001. C522)

With claims not only for protecting the young but for continuing their moral education, combined with the suggestion that the deprived present as those most in need of the ECP, we can gather insights into the claims that its increased access could prove a solution to the ongoing issues of young deprived teenagers vulnerable to pregnancy. This debate provided a platform for addressing the ongoing 'moral' issues in society, particularly regarding the young. Numerous references drew on youth over-sexualisation, including magazines, sex education, and the modern acceptance of sex before marriage. While the debate is portrayed as specifically concerning access, its review also allowed for the questioning of acceptable and unacceptable behaviour by young people and its bearing on their innocence.

Here, the issue is evident in the research as well as policy, whereby it is perceived that ECP access comes a set of values requiring support. Indicated in the first section, the term 'emergency' enforces a construct of irregularity to its use so as not to encourage promiscuity or unacceptable unplanned sexual behaviour. Regarding access and teenagers, we find that their vulnerability overrides the potential for ECP to provide women with contraceptive options applicable to their respective lifestyles.

3.1.2 Women

With the original purpose of the debate determining whether OTC access would benefit women, the claims made in support of women's access centred on differing purposes. Even with more progressive claimsmakers highlighting the importance of giving women the autonomy to make their own contraceptive decisions, those questioning how greater access might impact women's behaviour invariably supersede and feature within the same claims (Callaghan, 2001). Within this debate, it was suggested that women could be 'reckless' in their decisions. Dr Jenny Tonge's statement referenced her concerns regarding rising rates of abortion and teenage pregnancy, maintaining that OTC access to the ECP was good as older women proved more 'cavalier' with their contraception:

> At first, they are careful. They have responsible parents and if they are lucky enough, that have had all their sex education and they know what to do, but when they reach their mid-20s they assume that because they have not become pregnant so far, precautions are not necessary […] it is important to remember older women and the freedom they should have in deciding what to do with their lives. (HC Deb 24 Jan, 2001)

This claim, otherwise supporting women's options to contraception, similarly emphasises that the ECP is used by women who are considered unsafe or unplanned,

even reckless in their judgments regarding contraception. The suggestion that women may be inclined towards promiscuity should the product be made available OTC features prominently within the opposition claims. For example, The Earl of Longford:

> If we had to choose between reducing the number teenage pregnancies and reducing the occurrences of fornication and adultery, I know which I should choose […] I cannot imagine how a Christian could think that adultery and fornication were the lesser evil. (HL Deb 31 Jan 2001. C515)

Claims appearing to support women's right to access contraception arrived hand in hand with references to responsible behaviour and action, underlining that supporting the move from POM to P was not an encouragement of an 'anything can go' attitude. Evidently, 'morals' dominated this debate, as regardless as to whether the lords or ladies supported women's rights they believed it important to state their positions on morality:

> We have had a useful debate. I reiterate that the debate is not about whether EHC should be available, nor about its moral legitimacy. Those are not considerations to be taken into account in this order. We are debating the practicality of it being available over the counter, in the way proposed by the government. (HC Deb 24 Jan 2001)

Significantly, while appearing to prohibit 'moral legitimacy' to influence their decisions, the final judgements were made by morally-laden claimsmakers given control over women's access to this product. It was agreed 'the morning-after pill is the lesser of two evils' (HL Deb 31 Jan 2001.C531), and while the debate for access presented a canvas for discussion it ultimately reinforced an understanding of the underlying moral issues.

1.7.2 What is meant by access OTC

While this review has chosen to focus on a dominant set of claims, arguably, many pragmatic claims were made both for and against access. A number of Members of the House of Lords and Commons, made evidence-based arguments grounded in research, some claiming that 70 per cent of women obtaining an abortion might have taken ECP if they had held prior knowledge (Callaghan, 2001). Furthermore, they quoted research highlighting that women possessing the product in advance to be more inclined to use it within the given period of efficacy (Callaghan, 2001). Some went further, suggesting that rather than the use of the product suggesting a personal recklessness, women using the ECP were highly responsible by taking measures to

protect themselves from unwanted pregnancy (Callaghan, 2001). Similarly, there were logical concerns raised regarding the rising rate of STIs, and if it were available over the counter, an admittance that the ECP would not protect against this.

However, the aim of this review is to identify and highlight the dominant moral claims featured in this debate, one that should have only featured a pragmatic discussion of reasons for and against access. In turn, we find that like the Judicial Review, ECP access is an area where morals and values are anticipated as grounds for consideration, thus allowing for a continuous open discussion on perceptions of right or wrong. The conclusion of this review is not a proposal for moral change, but an identification of how they feature in the landscape surrounding the ECP discourse, similarly appearing in research and policy, in addition to producing the components commonly found for constructing a 'social problem'. This discovery suggests that this backdrop centres as a foundation for claims that may influence how women understand the ECP as a method of contraception, prompting further research as to its identification in women's real-life experiences.

In conclusion, the debate led to the reorganisation of the legislation around the ECP, with the no.3 amendment to the 2000 Prescription Only Medicines (Human Use) Order allowing for women over the age of 16 to access the ECP OTC. Since 2001, research has developed further on the potential ECP access has for women, particularly in advance. However, even 16 years on from the change in legislation, we find similarities in the discourse.

1.8 Access: In advance

In social problem theory, we find that once a problem is considered solved, it is often difficult to bring the problem back into discussion without a motive (Best, 2008). With the two previous topics on access and the ECP, we discovered that because of its themes being considered public interest, it involved influential claimsmakers and a wide audience. Since the 2001 deregulation, there have been no further amendments to the current level of access although some have continued the discourse on ECP access, featuring claims made for its increase in advance or off the shelf. This section will review this discourse and the claims made for advance access in an attempt to further reflect on how access is constructed in relation to the ECP.

1.8.1 Claims for and against in advance provision: teenagers' and women's behaviour

Those advocating for expanded access to the ECP featured in this discourse may have been unable to change the legislation but have been pragmatic in their claimsmaking, including charities such as bpas in the UK, and academics researching the area, such as Trussell, Foster, and Glazier. The content of the claims made by these claimsmakers is interesting when compared to those previous as for many it is logical to possess the ECP in advance. Similar to having a 'fire extinguisher in the home', having the ECP in the bathroom cabinet is argued to be pragmatic, as with the short window for ECP time efficacy it makes sense that women should have a 'barrier' free access to the product, and therefore, removing unnecessary gatekeepers such as pharmacists and doctors (Furedi, A, 2012; Foster & Wynn, 2012; Trussell, 2012). Despite the rationality of this claim, it is not yet one making an impact on the current state of legislation.

Further to this, we find claimsmakers have further argued that increased access to the ECP is a right, suggested by:

> …denying or placing barriers to access to EC violates basic human rights, including the right to decide whether and when to bear children, the right to non-discrimination based on gender and/or age, and the right to have access to essential medicines and benefit from scientific progress. (Furedi, A, 2012, p. 235)

While the claims can be considered constructed as value-driven in their motive it appears that they are not recognised in policy. Social problem theory suggests that often claimsmakers should adapt their claims to fit the audience, as can be seen by advocating lobbyists for the ECP (Benford & Hunt, 2003; Best & Bogel, 2014; Ibarra & Kitsuse, 1993).

While it is understood that acquiring the ECP in advance or off the shelf is a logical addition to women's ongoing methods of contraception, or in case of 'emergency', it appears the claims feature ideals recognised and impacting the discourse. Thus, reverting to ideas of teenagers' and women's contraceptive behaviour, the 'in advance' discourse faces the challenge of highlighting the policy benefits of such a move in access (Aiken, et al., 2005; Anderson & Bissell, 2003; Farrar, et al., 2003; Free, et al., 2002; Hawkes, 1995).

Believing their argument a logical progression for women's rights, those advocating for 'in advance' access have similarly had to legitimise the product by highlighting women's intentions (Lo, et al., 2004; Gold, et al., 2011; Polis, et al., 2007). With research since deregulation looking at advanced access and its potential effect on women's

behaviour, we see how in order to support women's rights we require evidence similarly supporting women's ability to be 'sensible'. As recognised by Latham:

> Unfortunately, the issue of contraceptives such as emergency contraception becoming more easily available to women invariably gets erroneously associated with issues of single mothers, and underage sex. (2001 p. 240)

When we consider the reasons for the limited support for advance access, it is apparent that similar themes to those found in the Judicial review and House of Lords and Commons debate lie prominently in the discourse, with the underlining issue with ECP access being its presumed relationship to social problems. Research has shown that doctors and health professionals have taken a tough stance on the ECP and its resultant meaning for women having better access to the product (Anderson & Bissell, 2003; Bissell, et al., 2008; Bajos, et al., 2003; Grimes, 2002; Hawkes, 1995). Anderson et al. find after the 2006 deregulation, health professionals, particularly pharmacists, used their new role to regulate young women's ECP use, expressing concerns that women did not take their contraception seriously,

> I think we have to hammer home the message with some of them. I've felt that those who come in giggling about it, it's important to underline that this isn't a joke (Anderson, et al., 2006, p. 268)

The previous review of 'emergency' indicated the risks concerning the ECP as not being with the product *per se* but with the behaviour leading to needing the product (Blanchard, et al., 2003). Comparable to the move to isolate the product in the realm of regular contraceptive options, the research suggests that there is an undesirable construct associated with ECP access, one questioning a women's character. This is evident in the counterclaims made against increased access to the ECP.

Counterclaims made against increased ECP access regress to the concerns with teenagers. Claims contest that teenagers and their sexuality become a problem in need of combating, meaning the idea of increased access appears too much for some in case vulnerable teenagers may be affected, as is found by Williamson et al. (2009):

> The effort to make Emergency contraception (EC) more available has been challenged by concerns that prescribing EC may tempt adolescents to have unprotected intercourse, resulting in higher rates of pregnancy and sexually transmitted infections (STIs). (Williamson et al. 2009)

This demonstrates that for some, access to the ECP means encouraging undesirable behaviour, it is this construct that proves difficult for many to accept further access. As

seen in the first two extracts in this section, the idea of access and the ECP is not considered as presenting women with more 'responsibility', but a term in need of regulation. This regulation appears necessary to many as access presents risk, as highlighted by Bjos et al.'s research:

> [Access] may also have negative effects, such as the possibility of risk displacement, which in this case refers to a potential rise in the incidence of undiagnosed sexually transmitted infections since women who get the EC directly from a pharmacy do not visit a doctor. (Bajos, et al., 2003, p. 39)

It appears in reviewing the claims made on advanced access to the ECP that access is perceived as something *needing* regulation according to assumptions about the behaviour of teenagers and women. Thus, research has attempted to contest these claims, with those lobbying for off the shelf access to the ECP conducting and supporting studies showing its lack of impact on women's regular method of contraceptive or sexual behaviour. Trials have found that women with advance access to the ECP did not change their regular methods of contraception, nor did it lead to repeated use, or encourage risky behaviour (Gold, et al., 2011; Walsh & Frezieres, 2006). Furthermore, research conducted discovered that women with access at home were three times more likely to take it when needed (Lo, et al., 2004; Gold, et al., 2011).

Although the research and lobbyists have attempted to indicate the logical benefits of increased ECP access, they have needed to characterise their claims to suit the concerns made by those opposing its access. In line with the claims made around the ECP access, this evidence presents it as still being considered in need of regulation. While lobbyists have attempted to support women's rights, equally, they have needed to yield to the pressure of claimsmaking activities. Social problem theory would consider the lobbyists' claims to be weak in their delivery, since not being considered 'prognostic' they add little fervour to the cause (Best & Loseke, 2003). What these conclusions consider is the current state of policy requires that in order for broadening women's contraception options there needs to be a problem to be combated. These claims made for increased access have come attached with excuses shaped in attempt to legitimatise the product and women's behaviour. Therefore, we find the claims presenting access to the ECP to be considered on a 'need to have basis', and so if women do not need to have it in advance then, ultimately, they should not have it. Similarly, unless the situation is considered an 'emergency', women should not need to use it. What this means for the social construction of the ECP and its access is that product 'access' remains regulated based on perceptions about women and teenagers. In order

to explore this further, women's experiences using and choosing the ECP will need evaluation to present a full picture of what regulated access means for their contraceptive options.

1.9 Conclusion

This review has highlighted a set of dominant claims featured in the decision-making around women's contraceptive options, as well as a construct of what access means with regard to the ECP. In examining the Judicial Review, it became apparent that although the SPUC produced claims based on an interpretation of the term 'miscarriage' from 1861, it also allowed for the moral questioning of the position of contraception, and women's access to hormonal contraception in particular. Should the case have received an opposing judgement, all women's hormonal contraception would have been criminalised. Therefore, the case on access brought into question women's rights and framed women's access to the ECP morally, as right and wrong. Furthermore, the construction of the claims highlight that despite the legislation being outdated and illogical in defence of women's contraceptive options, this did not produce an incentive for changing the legislation to ensure women did not become targets in further value-laden disputes.

Equally, we found in the 2001 move to deregulate the ECP that the claims appearing in the House of Lords debate also consisted of morally driven intentions. Although some made a pragmatic case for the ECP and women's rights, the predominant components of the debate featured claims against women's sexual behaviour, and equally, concerns about teenagers, despite the awareness that the legislation specified that girls under 16 would not be granted access. Once again, the debate highlights that ECP access is not a simple consideration of research and facts in policy, as there is room for opening discussion on women's ability to have relationships, besides the use safe methods of contraception.

Finally, in the discourse on increased access almost 17 years after deregulation, we discover no move for continuing to increase ECP access despite research showing advanced access as beneficial to women possessing the option. This is evident in the position the advocating claimsmakers were forced into taking regarding the legitimisation of women's behaviour and making excuses for teenagers. To many, access is perceived as being given a greater level of responsibility, but not in the case of the ECP. This review suggests that access produces copious claims regarding women's behaviour and teenage innocence.

The section has identified the impact of these claims. However, research has yet to assess how intended recipients of the claims receive them. An in-depth study of women's experience using and choosing the ECP could explore how these claims are received by women, and the meaning they associate to the ECP in an era of safe sex. Further study of people within the problem and an investigation of this aspect of the social problem constitutes the main focus of empirical study as I go onto discuss in Chapter Three. However, I now first take further my account of the public construction of the ECP drawing on the concept pharmakon.

Chapter Two

ECPs as Pharmakon

2.1 Introduction

> *Pharmakon* can mean remedy and poison, good and evil, cure and its exact opposite; can mean either inside or outside, speech or writing.
>
> (Tampoia, 2017, p. 10)

Tampoia (2017) explains a *pharmakon* as a concept with a dual meaning: it allows an object, action or situation to be recognised as both good and bad, right and wrong. The term refines the meaning of a given subject, enabling the acceptance of an issue as both a blessing and a curse. The concept has been used to evaluate the meanings given to social problems (Furedi, 2015). In the investigation into social problems, others have considered the impact the social problem via the meaning it is given (Arai, 2009; Armstrong, 2003; Elliot, 2010; Ezeonu, 2008; Loseke, 1992; Rappaport & Seidman, 1986). The pharmakon framework supports the investigation into ideas, objects, people and problems that come to exist with dual meanings.

It is worth noting that not all social problems come to exist in the public domain with dual meanings. For instance, human trafficking, knife crime and homophobia are all considered social problems. However, none are publicly considered both good and bad. By contrast, a social problem that is recognised as a pharmakon is distinctly ambiguous with its dual meanings (Furedi, 2015). We can explore a pharmakon problem's dual meanings as it features in policy, in public discourse and is understood by individuals as both a: 'remedy and poison, good and evil, cure and it's exact opposite' (Tampoia, 2017 p. 10). This chapter continues to evaluate the social construction of 'emergency contraception' as I continue my investigation into how the ECP is viewed as a problematic contraceptive.

The previous chapter found, through deconstructing the term 'emergency' contraception, that the product is perceived as a contraceptive that women need but should not choose. This frame has defined the ECP as a problematic contraceptive, with dual meanings. This chapter will continue to explore the social construct of the ECP using the concept of the pharmakon as a framework for understanding ambiguity around a social problem.

The chapter begins by reviewing the concept of the pharmakon. Initially using ideas that originate from ancient Greece, the chapter then contextualises the concept through a selective review of the history of hormonal contraception, identifying how, at various points in history, hormonal contraception has been framed as both a blessing and a curse. Demonstrating how cultural values impact the framing of contraception and the ECP, we find how historically ambiguous the social problems are in public discourse. Finally, reviewing the emergence of sexual health as a field of policy, the chapter explores the values and institutions that determine access and frame ECP and its users as problematic.

The following chapter will outline the paradigm in which the ECP is recognised as a social problem with dual meaning, and investigate the ECP using the pharmakon framework. The chapter begins by outlining the pharmakon tightrope framework developed to aid the investigation of ambiguous social problems. It then explores the historical lineage of morality that forbears the ECP as a problematic contraceptive and other contraceptives throughout history. Finally, the chapter sociologically contextualises how the ECP exists as a pharmakon. Overall, the chapter explores how this social problem forms and is sustained in a state of ambiguity. The pharmakon framework offers a new and unique way to break down the features of the ambiguity at hand. We begin by reviewing the heritage of the pharmakon.

2.2 Pharmakon tightrope

This section highlights how the pharmakon can be used to further explore the social construct of the ECP as a problematic contraceptive. The background of the concept will be considered from its origins in ancient Greece, in terms of its ability to define a social problem through the example of the unknown risk of the written word. The concept of the pharmakon is explored using a tightrope analogy, developed for the purpose of the conceptual framework; the pharmakon is broken down to explain how it works in practice. The section also addresses the medicalised elements of the concept that strengthen its ability to clarify what is perceived as ambiguous and gain acceptance for the problem in hand. Finally, the section places the concept into context using a contemporary example of social media response to video on access to ECP via a consultation. Overall, the concept of the pharmakon will be explored to illuminate the framework used to understand the dual meaning attached to the ECP.

Historically, the pharmakon was used to identify social problems as both a blessing and a curse (Furedi, 2015). The concept originated in ancient Greece. It was introduced

by Plato, who used it to define the ambiguous consequences attached to the written word (Persson, 2004; McCarthy-Nielsen, 2016). The pharmakon was used to identify and clarify the risks attached to the social problem of reading; indeed, it was Plato who claimed that reading as an activity posed a potential threat to the social order (Furedi, 2015). Plato suggested that reading could have an unmeasurable impact on those who were perceived as unable to manage the benefits of knowledge (Furedi, 2015). Despite the powerful elites in ancient Greece being acutely aware of the benefits of the written word, they set out to control the reading of the masses in an effort to control this unknown risk.

The concept was developed to highlight the duality of meaning attached to the written word. On the one side, it was viewed and accepted as a blessing to the elites, who used the written word to educate themselves and reinforce their positions of power (Furedi, 2015). However, the written word was also viewed as a curse due to a perceived unmeasurable risk; it was regulated within the groups thought unable to cope with the consequences (Furedi, 2008). The risk attached to reading as an activity was abstract, with the greatest concern being the possible impact of the social mobility of underclasses; we find the reasoning behind the pharmakon stems from motives of control (Derrida, 1981). Plato's concerns captured the apprehension of the unknown risk that ultimately led to the mass regulation of culture. The reasoning for this regulation is described by Furedi (2003), as enforcement of a 'normative cultural narrative' (p. 9), further indicating that the pharmakon as an idea may be ambivalent but its purpose is distinct.

The origins of the concept in ancient Greece highlight the development of risk management through a process of the recognition of ambiguity. The social problem was constructed out of an acceptance that, although the written word was beneficial, it equally could cause unknown harm. Therefore, the philosophers clarified the position of the written word as a pharmakon: if used by certain groups, reading could be beneficial, but equally it could be harmful if used by other groups.

Derrida explains the concept as *ambivalent* because the subject does not remain on either side of the boundary line of good or bad, right or wrong, and therefore can cross over to each side interchangeably:

> If the pharmakon is 'ambivalent,' it is because it constitutes the medium in which opposites are opposed, the movement and the play that links them among themselves, reverses them or make one side cross over into the other (soul/body, good/evil, inside/outside, memory/forgetfulness, speech/writing, etc. (Derrida, 1981, p. 443)

Derrida explains that the purpose of the pharmakon is to capture ambiguity where one thing, action or social problem can share two (opposing) meanings. This chapter develops the idea that the pharmakon is understood by its ability to 'link' two opposing sides and 'make one side cross over into the other'. This aspect of the pharmakon will be explored further to understand the duality, flexibility and interchangeability of the concept.

I develop the idea further by discussing the 'cross over' as a symbolic line. We can visualise the pharmakon as a tightrope. The tightrope enables the problem to exist in the middle but can dip onto either side based on the subjective understanding of the problem in hand. The concept has the ability to address ambiguity when classifying the unexpected harms or concerns of a perceived problem. As a framework, it will be used here to understand the construct of the ECP as both a necessity but equally problematic.

Figure 1 is designed to aid the visualisation of the concept of the pharmakon as a tightrope and the activity that occurs when dual meanings are apparent. Derrida describes the action of the pharmakon as being like a 'pivot' (p. 444). He describes it as enacting see-saw motion whereby a meaning can lean either side to adjust to the context in which the pharmakon is understood (1981). I have chosen instead to describe the pharmakon as like a *tightrope*. Unlike a pivot, the tightrope line, although straight, is unsteady. It is strong but rarely tips entirely one way or another; rather, it vacillates continually.

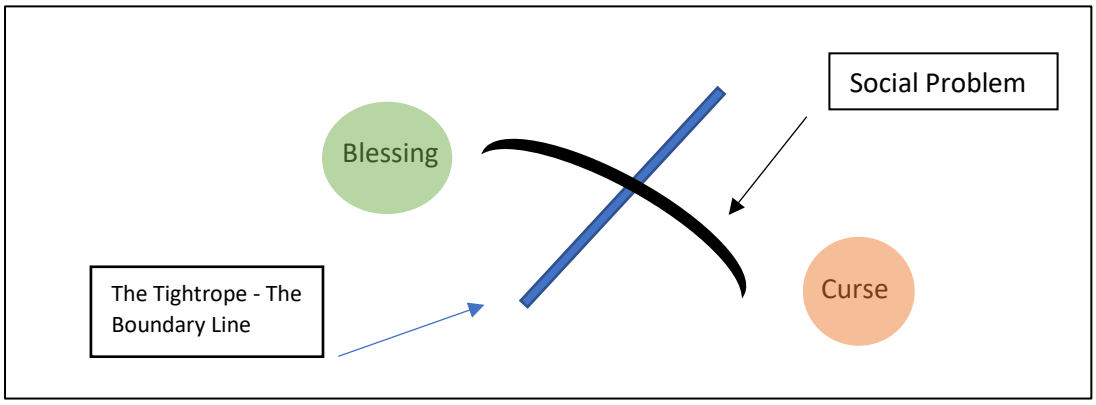


Figure 1: Applying the concept of the pharmakon tightrope

As well as using the term *pivot*, the tightrope line is described by Derrida as the *boundary line*. In these terms, we know the line that separates the two sides fundamentally regulates how the problem, event or object is observed in public construction. The line in Figure 1, labelled the Boundary Line, can be used to measure

the public construct of the problem and is the definitive regulator between opposing meanings. Additionally, unlike a pivot where the see-saw action amplifies the meaning on one side, we understand that the tightrope concept implies a greater degree of fluidity and the co-existence of competing meanings. Underneath the tightrope, but split either side, are nets that catch the meanings that fall either side of the boundary line/tightrope to facilitate the dual meanings existence.

The act of walking on a tightrope cannot be complete without someone or something taking part in the walk. The walker here is understood as the social problem, which essentially becomes the determiner of the balance of the meaning. The walker (or problem) can live neatly on the line (under the specific public construct); however, the balance is impacted when the meaning on either side is modified. When instability occurs, the social problem dips into opposing meanings, not changing its form but altering the meanings. Instability occurs because of outside influences impacting the balance of the problem on the boundary line. As a result, we find a social problem, event or object, can be publicly constructed under one form but can experience alternative meanings at various times. The tightrope in Figure 1 can be further explored through discussion of McCarthy-Nielsen (2016) in his understanding of the pharmakon as poison or cure.

McCarthy-Nielsen (2016) suggests that the pharmakon in its origins was distinctly ambiguous (and thus not necessarily 'ambivalent' as described by Derrida). McCarthy-Nielsen (2016) explains that the Greek word pharmakon 'can aptly translate as drug', because, although the concept stemmed from a means of regulation of behaviour, it was ultimately defined as a discussion of health (p. 182). He suggests the duality of the concept is transcended by the individual that defines either side pharmakon as problematic or beneficial. In the tightrope analogy, we would find this definition to impact or influence the balance of the walker on the tightrope. In ancient Greece, the pharmakon was considered a 'tonic' through a process of recognition of it as both a remedy or a poison. As McCarthy-Nielsen (2016) explains further, the origins of the dialectical understanding of the concept the pharmakon stem from the philosophical understanding of the process of the navigation of risk:

> The pharma words connote a sort of alchemy in which the cure for a poison is not a different substance, but the same substance transmuted. This transmutation can only be achieved under special conditions. Otherwise, the *pharmakon* remains inherently ambivalent – that is, potent both ways, positively and negatively. (McCarthy-Nielsen, 2016, p. 153)

Here, McCarthy-Nielsen further expands on the process whereby each side of the pharmakon is legitimised 'under special condition' by powerful influencers. He explains that although the problem may change in its understanding from cure to poison, it does not take a new form or definition, it simply alters appearance (McCarthy-Nielsen, 2016). This suggests that the duality of the meaning of action, problem or event, will remain ambivalent if not accepted as a pharmakon with a shared meaning. Through a process of 'transmutation' the problem can and will take on another meaning, however that is to be defined by a specific condition (McCarthy-Nielsen, 2016). In its origins, we can appreciate the pharmakon as a social sequence like 'alchemy', where the process of moralising events or problems could be reinforced by those with power and influence. The chapter will address the forces that dictate and influence the meaning surrounding the ECP through a review of historical events that led to its development and the cultural environment in which it exists.

If we return to the tightrope analogy in Figure 1, the boundary line that is metaphorically drawn as the measurement of the public construct of the social problem, ultimately legitimatising the problem's existence. In its ambiguous state, a problem is fortified by the reasoning presented by the governing body. The process continues to draw the line that defines and separates either side as good or bad, blessing or curse. The concept's validity is reinforced in its medicalised form of a poison and a cure. As Persson (2004) recognises, the medical construct of the pharmakon has the ability to address the ambiguity in medicine:

> Contemporary words like pharmacology and pharmacy, for example, carry little of the ambiguity of their etymological ancestor, but evoke the metaphysical principles that underpin biomedicine: truth, logic, reason. (Persson, 2004, p. 49)

Like a drug, we accept that the pharmakon is in a medicalised state. In some situations it is viewed as a cure and in others like a poison. We understand certain pills, such as paracetamol, if taken in small doses, can cure pain, yet if indulged can cause death:

> [J]ust as synthetic drugs have many properties, yielding a complex blend of beneficial and harmful effects, so the concept of pharmakon signifies a complex interweaving of benefit and harm through a power that is not quite understood. (McCarthy-Nielsen, 2016, p. 152)

McCarthy-Nielsen (2016), like others who have studied the historical relevance of the concept of *pharmakon*, has linked its ability to define dual meanings to social problems, and its relation to pharmacology. Viewed as something 'not quite understood' is the

pharmakon's power to define ambiguity. The strength and validity of the concept is certified through its ability to clarify the unknown. The power that McCarthy-Nielsen (2016) alludes to is the authoritative and regulative power that permits the measurement of the line that defines the problem in hand, and warrants the pharmakon as a definer of ambiguity.

In a medicalised state, we find the pharmakon emerges in situations where risk is measured as a health problem that can be prevented. The two sides of the pharmakon appear, where the cure is viewed as ideal, but only when the poison can be regulated by a higher power (McCarthy-Nielsen, 2016). As we see in modern society, drugs considered poisonous take on different forms based on the distinction of the risk. Class A drugs are regulated because of the potential harm they have on the body and society; however, the benefits perceived by the drug user are equally considered as strong. On the tightrope, we find the medicalised pharmakon as something to be regulated for the greater good and that the prevention of risk perceived meaningful to the masses outweighs the benefits of the individual. Lupton (1999) argues the risk features as a part of health policy discourse because 'risk is a pivotal discourse in strategies of normalization, used to glass the potential deviance from the norm' (p. 61). Here the power that defines the tightrope reinforces the line in which the problem is measured as a risk and strengthens that case for its position as a pharmakon.

As a concept, the pharmakon is complex. It can initially be considered 'ambivalent'. However, on the tightrope then the pharmakon should be understood as 'indifferent' (Derrida, 1981). As an idea, it enables the exploration of the developmental process of the formation of social problems, such as reading. What is more, the pharmakon can explain the recognition, acceptance and need for regulation of a problem such as the classification of drugs. Therefore, if we use the tightrope analogy to address the development of the problematic contraceptive, the ECP, we can further understand how the dual meaning is apparent as a contraceptive pharmakon.

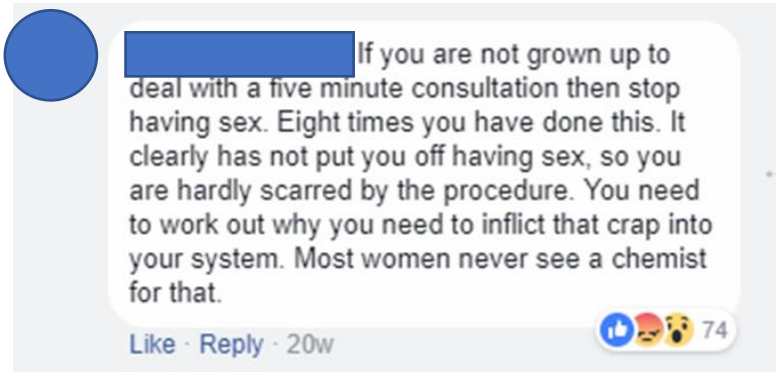
2. 2.1 ECP as pharmakon

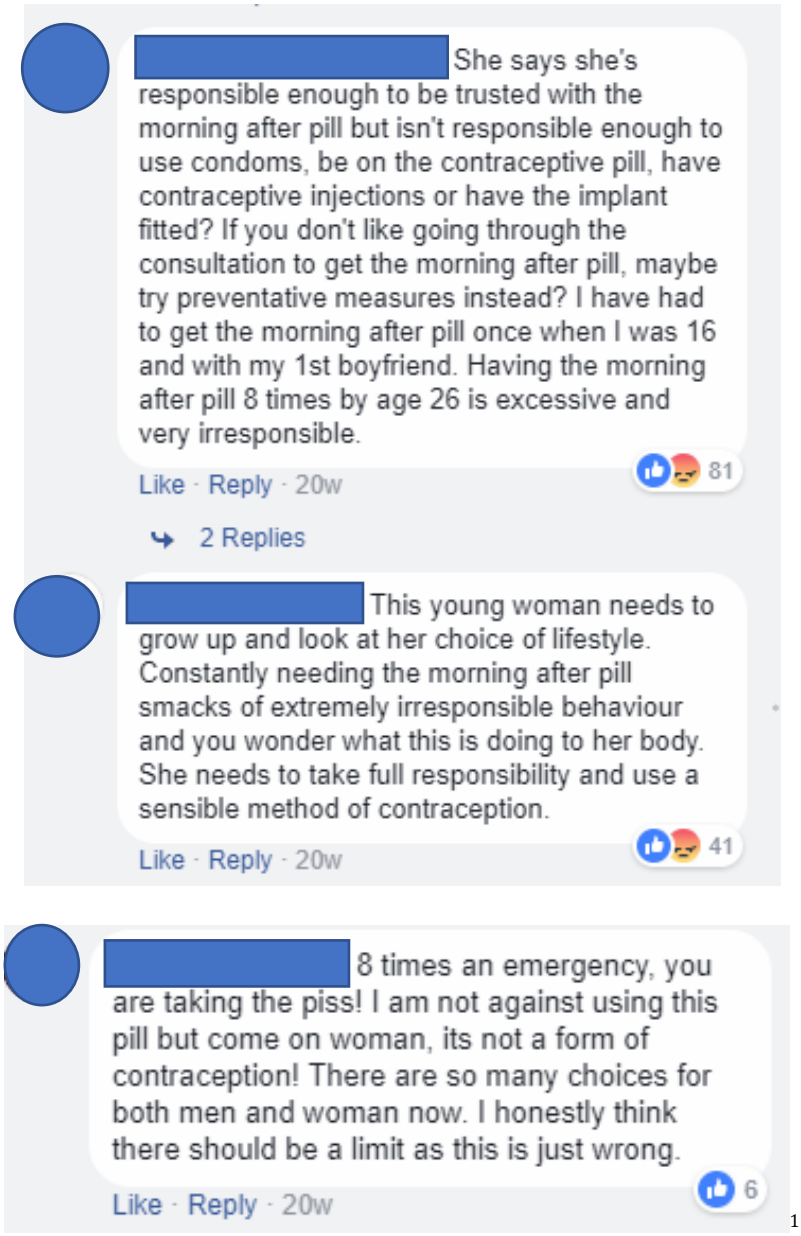
We know from the opening chapter that the ECP is constructed as 'emergency' contraception. As a pharmakon, we can think of the ECP as existing on a tightrope that is continually vacillating under the influence of competing claims about its risks and benefits. On one side, the ECP can be viewed through science as a method of hormonal contraception. On the other, claims indicate the ECP should not be publicised as a contraceptive of choice. Each side defines the same problem in very different ways.

The problem exists in the middle but adapts meaning based on the relative strength of the claims that influence the tightrope walker's stability. It is using this analogy that the concept of the pharmakon will now be developed further to understand the ambiguity that influences its social construction.

To put the idea into context with a contemporary example, the public discussion of the ECP and access to the product often leads to a controversial division of opinion. However, we know from the previous chapter that the ECP in its basic form is a hormonal drug. It contains the same hormones that are used daily in the oral contraceptive pill, yet it has become central to controversy about how and why women may need to use it. Although the product could be regulated and accessed like other methods of contraception, due to the ambiguity surrounding the ECP, it is regulated to be used only as a necessity and not as a choice – in other words, a pharmakon. The following example of the public response to a video on the ECP is used to further support this idea.

In 2017, BBC Radio 5 Live posted a video of a woman expressing her frustration of having to undergo a consultation each time she wanted to access ECP over the counter. The video explained that in her eight times of needing the ECP she felt the consultation was unnecessarily invasive (BBC Radio 5 Live, 2017). The video was popular, with over 100,000 views and over 250 comments. Furthermore, we find in the comment section evidence to highlight how the public view access and use of ECP. The below images are screenshots of a handful of comments left in the comment section of the Facebook post:





[1]

Figure 2: Facebook comments on BBC Radio 5 Live video posted in 2017

These comments indicate that although people do not have an issue with the product being available to women (with some cases having used it themselves), they appear to be concerned with the number of times a woman may need to use it, and this has many questioning her level of responsibility. The comments indicate the consultation process has 'not put [her] off sex', implying the consultations should be used as a deterrent for overuse. These comments suggest that if a woman is not willing to think about contraception she should refrain from sex. Additionally, it appears people do not expect women to repeatedly need to use the ECP because women have a variety of

[1] The use of facebook comments may be cause for ethical concern with the potential for identification through text search, however, on the notion that the comments were posted on a public forum it is assumed the authors deem their comments acceptable for public display.

contraceptive methods available to them and the ECP is 'not a form of contraception'. Finally, it seems that with the use of the 'morning after pill' comes a level of responsibility, and one sign of responsibility is using 'regular contraceptive methods'.

If we return to the elements that form the pharmakon tightrope, the ECP is viewed as a method of contraception to be used in 'emergencies'. That is its public construct and how it remains stable on the boundary line as a contraceptive, dipping to one side as responsible. However, if used more than once, it becomes viewed as 'irresponsible'. This impacts the balance of the construct in the middle and the meanings attached to it, so it can dip to either side of the line as both responsible and irresponsible. Following a similar pattern of concerns that manifested around the written word and its formation as a pharmakon, the ECP takes on a similar role in that people find it difficult to accept when not used in its preferred manner. This construct of the ECP sheds light on an area of discourse that links contraception and morality. It uncovers ideas that connect contraceptive decision making with constructs of responsibility and provides claims to normative behaviour expectations with women and sex.

The formation of ECP as a social problem is unique because of its dual meanings. Not all social problems come to take this form of ambiguity. Climate change is not considered both good and bad. Neither are issues like child obesity, the gender pay gap or racism. A social problem construct that takes on the pharmakon form comes to exist with dual meanings because of the environment in which it exists. The following sections outlines the elements that contribute to the ECP formation as a social problem that support the features of the tightrope.

2.3. Contraception: a pharmakon history

Throughout history, regulating family size and women's fertility have featured as topics of controversy in public discourse. This discourse has documented contraception as a solution to issues such as family size and women's fertility. At the same time, contraception has been viewed as a catalyst to debate moral behaviour and traditional values. The historical journey of contraception as a feature in public discourse suggests that contraceptives have long been viewed as pharmakon.

Events that have occurred over time in Britain and across the globe sustain the changing discourse that supports either side of the pharmakon. Negative concerns were raised in the 1870s when Charles Bradlaugh and Annie Besant were prosecuted for producing pamphlets and literature on contraceptive methods and practice (Hall,

1994; Pollock, 1985). In 1921, Britain saw the opening of its first Birth Control Clinics in London, with Marie Stopes being recognised as a pioneer for women's health (Cook, 2004; Haste, 1992; Marks, 2010). Moving into the 1950s, the pill became a medical marvel of the twentieth century (Djerassi, 1992). In the 1960s, the Catholic Church suggested that traditional values were undermined by the changing relationships in gender roles and sex because of contraception (Cook, 2004; Leathard, 1980). At various points in history, evidence suggests contraception and access to contraception have been viewed under different meanings. If we accept that meanings have long supported the construct of the tightrope, we can begin to explore how these historical foundations impact the current environment surrounding the ECP.

I will focus now specifically on the 1967 National Health Services (Family Planning) Act and the reorganisation of the Bill in the period 1972-1974 as significant events in the changing relationships between public and policy discourse on contraception. The discourse that appeared around the 1967 Act functions as evidence to support the heritage of meanings that support the current social problem the ECP. In review of this policy development we find a legacy of claims that feature around the legislation on access to contraception for women that are also recognisable in claims that appear almost 30 years later around the ECP.

2.3.1 1967 National Health Services (Family Planning) Act

In 1967, the National Health Services (Family Planning) Act gave local health authorities the duty of providing women with prescription for the pill for a small cost (45p for six months) (Leathard, 1980). What did the 1967 Act entail? It was decided by ministers that the government would work together with local authorities to provide family planning services. Some services were already available via Family Planning Association (FPA) clinics; however, the 1967 Act indicated the government would play a larger role in supporting these services financially (Watkins, 1998). This also meant the government would have a say on how they were governed.

The biggest change to come from the 1967 Act was prescription of the contraceptive pill. This was debated as a part of the legislation in the House of Lords. Questions were raised such as who would provide? who would access it? how much it would cost? In 1967, the Act was approved and finalised, with the addition of a small cost to women for access to contraception (Leathard, 1980). The cost was perceived by Labour Party officials as creating inequalities for those most in need (Leathard, 1980). Therefore the reorganisation of the bill occurred following the successful election campaign of the

Labour government. In 1974, the price for contraception was dropped and women were able to access the pill for free from NHS services across the country (Cook, 2004; Haste, 1992). The removal of cost was believed to support women from backgrounds particularly believed most vulnerable (Marks, 2010). However, it is important to our current pharmakon to investigate how the 1967 Act was received by public, and to explore the Act's lasting impact on policy on contraception since then.

In 1967, for the first time in British policy history, the British government became responsible for the delivery of contraceptive health services to women. This significant event changed the public discourse from a previously contested argument about the private relationship of women and their fertility, to a public policy field of health. The transition to a policy discourse is an important development for the tightrope environment. The Act generated claims that featured on either side of the tightrope. As the discourse around contraception became a matter of public policy, the pharmakon that is contraception appeared more meaningful to claimsmakers with greater power and a wider audience.

The introduction of the 1967 Act was received differently by different groups. For some, it was viewed as a response to the problem of population growth in the 1970s. For others, it was viewed as morally problematic for traditional values that bounded sex and relationships. In review of each side of the discourse that surfaced at the time of the introduction of the Act, we find evidence that suggests historically the environment that supported either side of the current ECP tightrope was previously established around contraception.

3.1.1 Population control

Population control was high on the agenda in 1960s following the Second World War and the 'baby boom' (Cook, 2004; Djerassi, 1992). The impending threat of overpopulation was a concern for many and featured as an argument for supporting women with ways to manage their fertility (Thomas, 1985; Weeks, 1995). As Samuels (1967) explains, the population concern was viewed as more than simply a social issue. It was considered a 'personal evil' and contraception was viewed as a solution. The support for contraception came from the idea that officials would give more 'responsibility' to individuals to manage family size, reducing the strain on welfare and health services (Cook, 2004; Marks, 2010; McLaren, 1994; Watkins, 1998). It appears that the 1967 Act set goals to introduce public education on contraceptive behaviour, which transferred responsibility to the individual but was framed as benefiting wider

society. Health professionals warned the population boom meant 'shortage of space and, possibly of food and water will become an enormous problem and increasing pollution of every kind will be an inevitable sequel' (Law, 1974, p.3). Recognised as a risk for all if not managed, the focus on specific groups meant targets were set on problem areas.

Dr Morgan, a physician and member of the eugenics society, recounted her meetings with 'problem families' in Southampton in late 1960s. Morgan defines the families in her study as 'problem families known to the local authorities for having need of services and welfare' (Morgan, 1965, p.199). She describes the families as malnourished and suffering from diseases like tuberculosis, and in need of rehabilitation. She claimed that 'the rapport between doctor and patient must be such that you give the patients a confidence in their capabilities' (1965, p.201). In her efforts to work with such 'problem families' and educate them on fertility control, her eugenic values emerged as a driving force for her goal to supply certain households with 'confidence in their capabilities'. She suggested:

> My dream is that this could be used as a boost to improve the living conditions of themselves and of their children and the services we give be a cornerstone in the rehabilitation of these families. (Morgan, 1965 p. 201)

The conclusions she makes from meeting such families are that they need more help than others because of their 'feckless' attitude towards having children (Morgan, 1965). The solution to this problem is ensuring they do not reproduce. Dr Morgan's views were shared by many, thus improving access to the contraceptive pill gained support (Cook, 2004; Haste, 1992). Arguments made in support for access to the pill indicate that the pill was considered by some as a blessing for society. Perceived as a solution to the growing problem groups and impending threat of population growth, we find meaning given to the pill as a positive solution.

The arguments that surfaced in support for the pill and the 1967 Act are similar to the arguments we see in 1990s around the deregulation of the ECP. In response to the growing teenage pregnancy problem in the 1990s, the ECP was praised as a solution to an ongoing problem of a specific group of women having children. In review, the discourse that features today mirrors the claims made in the 1960s. These findings indicate that meanings developed in public discourse around public problems have previously supported the construction of contraception as a problem-solver. As a historical backdrop to the current tightrope environment, we find that there is a legacy

of meanings that have developed throughout history that support contraception being viewed on one side of the pharmakon.

As a solution to an overarching social problem, the 1967 Act attempted to change traditional values and the public's outlook on sex outside marriage. As we continue to observe the two sides of the discourse, we find the discourse around the 'unmarried' indicates further support for the pill also being considered a pharmakon.

3.1.2 The Unmarried

'The [1967] Act speaks of 'any persons' so that the unmarried are eligible as a matter of law,' to access the contraceptive pill via prescription (Samuels, 1967, p. 178). The 1967 Act meant all women were given access to the pill despite their relationship status. For the first time in policy, the unmarried woman was approved as a person who may have a sexual relationship and have reproductive needs (Hall, 2004; Hawkes, 1996; Weeks, 1989). In the 1960s, the Catholic Church defined the use of artificial contraception as 'taking a life' because sex was not meant for pleasure but for the purpose of procreation (Leathard, 1980). Overtly traditional Catholic views remained a key feature of public influence until the late 1960s (Cook, 2004; Marks, 2010). Christian groups opposing contraception and abortion such as the Society for Protection of the Unborn Child (SPUC) were founded following the introduction of the 1967 Abortion Act and continue to lobby against contraception such as the ECP today (Leathard, 1980).

However, due to the growing interest in public discourse around the pill, the Catholic Church 'took a major step in acknowledging that sex was important as an expression of love between spouses as it was in furthering procreation' (Mark, 2010, p. 226). Supported by key figures such as the American Roman Catholic scientist John Rock, the pill challenged the previously promoted rhythm methods (Djerassi, 1992). However, this view was attacked by Pope Paul VI, 'who made it clear the proliferation of contraceptives might lead to abuse' (Marks, 2010, p. 227)

Despite the changing social developments that appeared to align with introduction the 1967 Act, the Act did not fully support the changing pace of relationships and sex. The FPA were the first to distribute the pill in the UK and they were the first to set the criteria of access to women who were married (Cook, 2004; Leathard, 1980). This key and significant development occurred because the officials at the FPA wanted to appease the policy concerns in the late 1950s. The FPA sought to limit concern around

what impact the pill might have on the traditional values in society by ensuring the pill would not get in the 'wrong hands' (Leathard, 1980). An idea we find prominent in the discourse around the ECP is the concern that greater access to a contraceptive pill would encourage the use of those groups considered problematic. This response, although supportive, continued to bring ambiguity to what it meant to access and use the pill. The claimsmakers at the FPA supported the claim that only certain woman could use the pill, while those who were unmarried were viewed as problematic. These claims can be recognised as stabilising the pill's position as pharmakon, on the opposing side of the tightrope.

Equally, I find that further support for the opposing side of the pharmakon appears in the debate for the 1967 Act in the House of Lords. Although the Act made 'no reference to marital status' ministers assured traditional values would not be affected as the decision on access 'would be left to the discretion of the individual local authorities' (Leathered, 1980, p. 143). This meant although the Act appeared to support women, it ultimately gave responsibility and authority to the health professional to decide whether or not a married or unmarried woman could or should have access. Samuels (1967) explains the 1967 Act laid no 'compulsion' on doctors to provide contraception, so many Catholic doctors who refused to offer contraception were not held by law to do so.

I find the introduction of the 1967 Act led to an opposing public discourse development. While the Act appeared to support women's ability to make autonomous decisions, it also continued to discriminate against women based on implicitly moral and traditional values associated with sex and relationships. The 1967 Act is a good example of how historically we find evidence to suggest there has been a divide in public discourse around contraception that leaves the topic ambiguous and existing with dual meanings. It suggests that the ECP's position as a contraceptive, in British contraceptive policy, is susceptible to differing meanings. With the policy inherently ambiguous, we find it sets out to both support and regulate women; its meaning therefore supports the sustainability of the pharmakon. As a backdrop and indicator of the environment, we find the policy developments around contraception in the UK are an ideal environment to support the existence of a tightrope and the dual meanings given to a social problem.

The discourse that emerged following the 1967 Act can be recognised as a good indicator of the environment that supports a tightrope. The medicalisation of contraception in policy further contributed to the foundations that support the

tightrope's dual sides. We can continue to explore this further, by considering the impact of the medicalisation of contraception as offering support to 'family planning'.

2.4 Medicalising contraception and the planned family

Medicalisation is understood here as the process whereby women's reproductive autonomy is defined by the acceptability of contraception (Condit, 2000; Cook, 2004; Hall, 2004; Lupton, 1997,1999; McLaren, 1994; Thomas, 1985). A medical framing given to contraception validates the medical relationship between doctor and a woman, giving the doctor the power of decision-making over how and what contraception the woman has access to (McLaren, 1994; Watkins, 1998). This overlap of 'medical' and 'social' appears as a concern for many feminists, who have argued that although the pill allows women control of their fertility, the medicalised prescription status means women's autonomy is still ruled over by the health profession (Jackson, 2001; Hawkes, 1996; McLaren, 1994).

There is as an extensive sociological literature on 'medicalisation', exploring issues from the power of pharmaceutical companies to the pathologizing of everyday life (Conrad, 2007;Fitzpatrick, 2001; Lupton, 1996/1997/1998/1999;Wainwright, 2008). Sociologists have considered the varying dimensions of the medicalisation thesis that influence the ways we view the medical profession and understand the motives of medicine (Calnan, 2015; Conrad, 2007; Evetts, 2003; Friedson, 1984; Lupton & Peterson, 1996; Burrows, et al., 1995; O'Brien, 1995). The approach and understanding of medicalisation used here concerns the ideas that feature as the observation of a social process being 'bound together by modern preoccupations with risk and surveillance' (Wainwright, 2008, p. 9). Using the pharmakon framework, I have begun to decipher how moral regulation via a process of claimsmaking tips the pharmakon to either side. The ECP sits on the line of the tightrope in a field of health policy and therefore it is important to consider the environment that claims come to exist within as health problems.

O'Brien (1995) explains the study of medicalisation allows for exploration of the 'widening meaning of health from an absence of disease or physical functioning to include social issues, such as transport, work, housing, sexuality and the politics of risk and choice as well as behavioural and attitudinal factors.' (p. 191). The process of medicalising social interaction and the introduction of the gatekeeper role in contraception access is explored further here to understand how the ECP is considered

a pharmakon. This will be addressed in review of the meaning we give to planned contraception.

In review of the arguments associated with the 1967-1974 legislation that determined access to the contraceptive pill, we find the final arguments legitimise the pill as a solution to problems. Highlighted in this review of the 1967 legislation is evidence to suggest that the discourse around the pill's introduction can be split into two sides. We find some support access to contraception for women based on population arguments and women's rights (Marks, 2010), while others oppose it due to moral concerns about the impact access might have on the stability of traditional values around sex and relationships (Cook, 2004). Ultimately, the arguments made for the Act were achieved and supported since access was framed as a medical solution to the issue of population growth and illegitimate children (Leathard, 1980). The 1967 Act was argued to support women to make 'responsible' decisions about planning a family. This approach to determine contraception as a medical solution is considered a form of medicalisation.

Despite concerns about the 1967-74 Act, it is heralded as a significant policy development that supports women. Indeed, part and parcel of the 1967 legislation was the cooperation of the medical profession. By allocating a gatekeeper role, access to contraception was legitimised as a medical service (McLaren, 1994; Thomas, 1985). Creating a medicalised framing of the pill purposely detached contraception from ideas of pleasure and women's sexuality, replacing it as a tool for planned family sizes (Beasley, 2008; Eastham & Hanbury, 2016; Lowe, 2005). We find this has had a long-term impact on legislation that determines access to contraception, such as the ECP. Although research has shown access in advance would be a suitable and practical option for a contraceptive, for which efficacy is higher the sooner it is taken, the concern around access in advance (as we saw in Chapter 1) centred on the issue of not having medical supervision (Anderson, et al., 2006; Farrar, et al., 2003; Grimes, 2002; Lo, et al., 2004; Meyer, et al., 2011). Therefore, we find the previous acceptance of the pill being accessible via a prescription is now considered to be the only way hormonal contraception can be accessed.

The relationship the medical profession had with contraception before 1960 was contentious. In the era of Marie Stopes it was perceived as 'professional suicide' to work within a clinical setting, since the clinics were considered 'unorthodox practices and quackery' (Marks, 2010, p. 118). The lack of support from medical bodies for contraception meant that during the 1960s-1970s medical students were not trained

in contraception. However, following the 1967 Act, increased access to the pill bridged the gap in the field of medicine. Access to the pill legitimised medical involvement and ultimately changed the frame we give to contraception:

> Oral contraception required professional advice. This decisive factor brought the medical profession into family planning [...] the medical profession now had a legitimate interest in birth control. (Leathard, 1980, p. 180)

The role of and need for the health professions' interaction was initially to ensure women were monitored medically for any potential life-threatening side effects such as thrombosis (Jackson, 2001; Marks, 2010). The medical 'check-up' soon became an important part of access to the contraceptive pill.

The check-up was justified because of practical fears surrounding thrombosis and the consequences of the thalidomide scandal (Leathard, 1980). The *British Medical Journal* warned that 'doctors were concerned about being required to make medical decisions on social grounds' (Marks, 2010, p. 193). The need for contraception was not a medical one, and the concern shown by some doctors was to the professional relationship they were perceived to have with women's reproductive choice (Hall, 2004; Haste, 1992; McLaren, 1994). However, the wider policy anxieties validated the reasoning that women undergo regular medical assessments in order to access contraception. Assessments that also gave the prescriber the power to refuse.

Argued by feminist groups as a cause for concern around women's autonomy, the prescription of the pill in a medical setting fortified the position of the doctor-patient relationship and access to contraception (Jackson, 2001; Marks, 2010; McLaren, 1994). Despite the safer options and minimal side effects of the contraceptives we have available today, women still undergo a multitude of medical barriers in order to access contraception (Hawkes, 1995; Latham, 2002). This suggests that although the Act set out to support women, it medicalised women's access to contraception barriers and medical supervision, which as a part of in turn, impacted the frame we give to access to contraceptives such as the ECP.

The 1967 Nation Health Services (Family Planning) Act brought to light a number of arguments both for and against access to contraception. What is significant about these developments is the similarities in arguments that feature over 30 years later about access to the ECP, where we find similar discussions around who should access the ECP and what should be the criteria. The pill and the ECP both remain in a position of being highly safe and effective methods of contraception, but where women's access is

supervised by a gatekeeper. In review we find that the history of policy legislation around the contraceptive pill laid the foundations for the legislative action to the ECP. Equally we find the ambiguity in the arguments around the pill can be observed as dual meanings which suggest the pill can be considered a pharmakon. These conclusions provide evidence to support the need for further investigation into how and why the ECP is also associated with similar ambiguity and what impact this may have on women's use and access to the ECP.

In addition to the policy made around the pill, we find the whole movement of 'family planning' services in the 1960s impacted the services offered to women today. Therefore, in order to understand how claims can tip a pharmakon onto either side of the tightrope, we must consider the environment within which the claims exist. The following section will examine what function the gatekeeper role plays in relation to the creation and maintenance of institutional goals and claims.

2.4.1 Family planning values and the professional

Further support for the suitable environment that aids the dual meanings given to the ECP can be found in the policy culture of managing behaviour and risk. At the time of the introduction of the 1967 Act, British policy experienced a transition in health policy. The timing of the shift in attitudes towards managing health also contributes to the support of the pharmakon tightrope.

The *Family Planning in the Sixties* (1961) report produced by Professor Lafitte (chairman of the Working Party set up to investigate the need for family planning services in Britain), found in 1961 that, '118 birth control clinics provided by 37 local health authorities' were providing married women with contraceptive services in Britain (Leathard, 1980 p. 118). It also found that 340 clinics were run by the Family Planning Association (FPA). Following a transformation of the FPA and the growing demand and need for services, the government stepped in to share the weight of offering and supplying family planning services to couples in Britain (Leathard, 1980). The FPA soon became 'legally incorporated' by the government and this meant that by 1967 the FPA had 51 branches which ran a total of 736 clinics in Britain that provided women with contraception and advice on family planning. The transition of the privately funded institution to a government-supported organisation is a significant development in the pharmakon tightrope. The FPA continued as a charity and became the front-line providers for contraception in the 1960s and it was this transition that

brought about the public discourse on the cost of contraception to women (Leathard, 1980). We know previously that the traditional values held by the FPA around the status of married women supported the claims on the opposing side of the tightrope. Here we see how an institution was given greater responsibility and a wider audience with government backing meant the values held by the FPA were reinforced by wider powers.

The opening of a variety of clinics including FPA and Brook (young people clinics) meant staffing of such services fell to the role of volunteers and nurses. Following the family planning developments of the 1960s, medical professionals' involvement varied in the delivery of contraceptive services. With the growing emphasis on family planning in policy, meeting the demands became essential and nurses were used as front-line staff to family planning service and advice (Boydell, et al., 2006). The family planning professional contributed to the legitimation of family planning services.

Trust in the medical profession and their power are topics explored under various sociological lenses that examine the relationship between the health professional, the patient and the wider medical institution (Calnan, 2015; Evetts, 2003; Friedson, 1984). Evetts (2003), indicates that professional authority stems from, 'acceptance of the authority of the professional expert […] as a part of the normalisation process of the citizen-subject' (p. 28). Through the transition to 'family planning services,' we find government gave authority to the FPA to staff and train the 'professionals' and offer women (the citizen-subject) contraceptive services. By allocating responsibility to professionals, we find additional support given to the tightrope stabilisation in the form of the family planning professional. Leathard (1980) notes that the staffing of services fell to predominantly nurses as the contraceptive services appeared to border holistic/medical care.

The professional identity of the nurse is recognised as being 'subject to powerful pressures to conform to organisational and institutional norms' (Fleming & May, 1997, p. 1097). Directed by the 'norms' of the family planning culture, it is important to consider how the tightrope is shaped by the presence of a professional gatekeeper to contraception and contraceptive services. An example of what was expected from a 1970s family planning professional can be given from a review of Barbara Law's book *Family Planning for Nurses 1973, a guide on contraception for nurses* (1973). In Law's book , we find similar concerns in her guidance to other nurses that featured in 1967 policy debates on access to the pill. Law acknowledges that the role of the family planning nurse differs from that of the doctor: 'a nurse is herself unable to give much

assistance over these problems other than to lend a sympathetic ear' (Law, 1973, p. 2). Thus, with minimal medical input the role of the nurse was recognised as a holistic role. From the arrival of the family planning services, it was considered the role of the professional within these settings to work with young couples to overcome issues such as 'subfertility' or 'marital problems' (Law, 1973).

The role of the family planning nurse was expected to 'read between the lines' as many who attended clinics to talk about family planning might be embarrassed or timid (Law, 1973). Law suggests this apprehension may mean the nurses are expected to make sense of patients concerns as she suggests, 'it is always useful to remember the term 'You know' can apply to almost anything and the nurse has to be very good at guessing meaning' (1973, p.7). Law explains that the family planning professional role is diverse; a number of problems can appear within a clinic setting and some problems should be given more attention.

Law's book adheres to the policy discourse around the need for family planning. Law offers advice on how the nurse should adapt their approach arguing that for example 'the young require maximum protection because they are seldom in a financial position to raise a family.' (p. 67). Additionally, she embraces the policy discourse that featured around 'problem families' and overpopulation. Law warns that problem families are a concern and identifies them as:

> …the tired, overworked and harassed mother, the irritable, irresponsible, drunkard father, the underfed and grubby children who may have chronic medical conditions or be potential delinquents, all these might have been avoided had the families been planned. (1973, p. 6)

Apparent in the advice to the new family planning nurse is the policy rhetoric for acceptance of the contraceptive pill and the ideal 'planned family'. With great attention to combating the issue of 'problem groups', Law's book suggests that the role of the family planning professional is perceived as one of carrying out the policy work on the ground.

The 'planned family' appeared as an important policy construction in 1960s that gathered support for access to contraception and equally met support from the lobbyists for women's rights (Leathard, 1980). Slogans such as 'babies by choice and not by chance' and 'every child a wanted child' appeared as rhetoric for access to contraception and supported the need for family planning services (Law, 1973). Such slogans also appear as frames for goals for nurses working in a clinic's setting. The

nurses' goal-orientation within the family planning setting suggests the role of the nurse from the onset was institutionalised to meet growing policy needs. Similar rhetoric features in modern health policy aimed at reducing rates of unwanted pregnancy (Lupton, 1995). The claims that warrant teenage pregnancy as concern are around 'children having children' (Macvarish, 2010). Modern sexual health services and the promotion of contraception centres on targeting such problem groups in order to combat social problems (DoH, 2001; Arai, 2009). The frame that good family planning is the planned contraceptive, however, segregated the post-coital contraceptive – the ECP – as a contraceptive option for women.

The responsibility given to the health professional in the 1970s has not changed much 40 years on, as we find new public health relies on services running towards goals and targets in a similar fashion (Fagermoen, 1997; Friedson, 1984; Finn, 2001; Sotiriadou & Tzenalis, 2010; Kang, et al., 2011). Modern health professionals are expected to deliver "health promotion" identifying a specific purpose and goal for the health professional. Lupton and Peterson indicate, 'contemporary health promoters have been at the forefront in the call for efforts to reorganise social institutions, and to implement different[…]levels of intervention[…] in the goal of 'health for all'' (1996, p.20). We find the training of the 'family planning professional' adheres to the medicalised value set of wider policy 'managing health' (Condit, 2000). Reaching targets and tackling problems makes the health professional an active participant in the tightrope. In their unique position as nurses, the professional is given the responsibility as a 'medical' professional to educate women on how to practice 'family planning'. This value-laden culture shapes the claims on either side of the pharmakon and supports the professional training of those who facilitate and manage the ambiguity around contraception.

2.4.2 From 'family planning' to 'sexual health'

Since the 1970s, health care has taken on a new domain. Described as the *new public health*, the aim of health sector is to encourage the individual to take repsonsibility for better health (Burrows, et al., 1995; Lupton & Peterson, 1996). The Canadian Lalonde report (1974) was the first of its kind to introduce 'a more collaborative less medicalised vision for public health' (Green, 2005, p. 286). As a result, we have seen a change in the professional health care dynamics. Patients are viewed as consumers of health and the 'patient-centred care' has created a new healthcare strategy for professionals (Borthwick & Nancarrow, 2005). 'Family planning' services have been

replaced with 'sexual health' clinics and sexual health as a field of health appears more broadly across fields of health as a part of everyday health in a patient centre care setting.

Lupton argues New Public Health is driven by 'risk aversion' (Lupton, 1995). Interventions developed by policy makers set targets to manage 'health', in the process raising awareness of 'health risks' (Lupton, 1998). This new approach is argued as by health officials as beneficial to patient centred care but also, the wider collective (Green, 2005). Lupton and Peterson suggest:

> the calculation of risks allows interventions to be legitimised not simply on the basis of the existence of actual concrete dangers, but rather on the because of the expert assessment that an undesirable event may occur and that intervention can prevent this. (Lupton & Peterson, 1996, p. 19)

Raising awareness on risk is central to contemporary health policy. Introducing interventions and medicalising the problems that feature in society as a risk in need of management supports the process of identifying "good" and "bad" health behaviour. The new public health approach to 'health promotion' is noted as central to the emergence of 'sexual health' as a field of health policy. Ehrhardt and Sandfort (2004) argue that combining sex and health is a problematic move for policymakers. They suggest, 'because health is first of all understood as a biomedical category, adopting the concept of sexual health runs the danger of medicalization of sexuality and reinforcing an underset of sexuality in term of normal and abnormal' (p. 184). The new public health's approach to sex and relationships as 'sexual health' is criticized as a negative approach of managing risk.

In the framework of sexual health, we find an approach to tackling the management of certain groups through health promotion. This approach to managing the risk impacts the frame given to the ECP as a contraceptive. In 2013, the UK government published the *National Framework for Sexual Health*. The framework set targets for the UK government in sexual health, including rates of unwanted pregnancy and teenage pregnancy. Concerns that features as determiners of 'sexual health outcomes' are identified as 'personal understanding and perceptions of risk associated certain sexual behaviour' (DoH, 2013, p. 13). The aim of reducing risk and preventing problems is described in the document as successful by 'ensure[ing] that people are motivated to practise safer sex, including using contraception and condoms' (DoH, 2013, p.22). The

approach taken by the DoH to tackle these issues is to increase the effective promotion of contraceptive options and access to services.

Although policy appears to have moved away from the term 'family planning' and favours the discourse of 'sexual health', sexual health as a field of health has been criticised for moralising behaviour management (Epstein & Mamo, 2017; Evans, 2006). The Department of Health (DoH) followed the WHO and recognised in the National Strategy document that 'sexual health is an important part of physical and mental health' (DoH, 2001). The 2001 document set how government must encourage better sexual health by defining the keys aspects:

> Essential elements of good sexual health are equitable relationships and sexual fulfilment with access to information and services to avoid the risk of unintended pregnancy, illness or disease. (DoH, 2001, 1.2)

Epstein and Mamo's (2017) analysis of emergence of sexual health as a policy field, found the goal of 'good sexual health' brought with it legitimising management health via 'sexual health'. Beasley (2008) suggests sexual health emerges as a part of the paternalist control of moral values and through a process of behaviour regulation under the construct of 'sexual health'. These findings suggest the policy environment of the ECP aims to use promotional strategies to encourage good sexual health via the prevention of risk. With planned contraception being considered an aspect of 'good sexual health', this indicates that the ECP may not fit in, since it is a post-coital contraceptive.

Health promotion initiatives dominate prevention campaigns on health problems that feature in sexual health, such as teenage pregnancy and STIs (sexually transmitted infections) (Eastham & Hanbury, 2016; Ehrhardt & Sandfort, 2004). New public health aims to 'make healthier choices easier ones' and I find the role of the sexual health nurse takes shapes as a health promoter (Baum, 2008; Burrows, et al., 1995; Parish, 2005). More recently, claims have been made that sexual health is not addressed enough with patients (Crouch, 1999; Fernandez, 2006). Sexual health is not only institutionalised as a separate field of policy, but also features as everyday health. This new field of health places a greater emphasis on the role of the professional to aid, manage and educate patients on sexual health management (Fernandez, 2006).

The use of health promotion in harm-reduction campaigns has been criticised as 'framing the individual as an autonomous decision-maker, whilst the state's role is to inform the public about the 'right decisions', urge them to assess risks, and advise on how to regulate behaviour' (Moore and Burgess, 2012, p. 2). The idea that health campaigns 'encourage [individuals] to voluntarily change their behaviour, retain[s]the paternalism that was a dominant feature in public health' (Lupton, 1998, p. 4). Sexual health as a field of health policy has also been criticised as paternalist.

We find official preventive strategies have set out terms and conditions regarding what is perceived as 'good' and 'bad' sexual behaviour. Beasley (2008) raises concerns about the 'counter product [ivity]' of the 'unsafe sex' rhetoric against wider normative standards (p.158). She discusses the problems that emerge from the 'preventive health' approach to sexual health as 'sex-as–danger', which overlooks the pleasure of sex. It is argued that terming behaviour as 'good' or 'bad', 'preventative' and 'risky', the concept of 'safer sex' brings to fruition the previously established family planning attitudes (Borthwick & Nancarrow, 2005). Today we find pill use being linked to 'good' sexual behaviour and the ECP falls into a place of ambiguity.

The process whereby the medicalisation of the pill legitimizes contraception as a medical practice has been discussed already. Here, we find further that, as a biproduct of the introduction of new regulative framework of sexual health, the medicalisation of behaviour continues (Evans, 2006). Achieving goals within this field of health requires the promotion of risk aversion (Coleman & Edwards, 2004). We can accept that the environment that regulates the ECP will continue to frame its position of ambiguity, being accepted as either 'normal' or 'abnormal' contraception.

The 1960s argument for access to the pill was to give women the opportunity to plan and control fertility. It legitimised the pill as a solution to a problem of population and granted access to the product. Contraception today features in the same frame of use; however, in modern sexual health promotion we find a greater focus on planned contraceptive use as a responsible decision. The 2013 framework aims to:

> Reduce unwanted pregnancies by ensuring the people have access to full range of contraception, can obtain their chosen method quickly and easily and can take control to plan the number of and spacing between their children. (DoH, 2013, p. 4)

With the focus on the *planned* family, we see the rhetoric that features in the 1967 debate reappears in 2013 as a goal of achieving *good* sexual health. However, with the standards set for what is expected of 'good sexual health', we find decisions around contraception are already defined as good or bad on the tightrope of the pharmakon. As Evans (2006) explains in regard to contraception options, we find 'women's choice and consistent use of particular methods are related primarily to access, effectiveness, ease of use and the women's desire to limit birth […] not to enhance or detract from sexual experience […] despite being designed specifically for use during sex' (p. 154). The sexual health environment that regulates access to the ECP retains the paternalized motivation found in early family planning movements (Ehrhardt & Sandfort, 2004; Beasley, 2008). Under the new public health, 'sexual health' and the 'sexual health professional' becomes a new form of risk management, through preventive health promotion (Crouch, 1999; Kang, et al., 2011; Sotiriadou & Tzenalis, 2010). The health professional adopts the appropriate professional boundaries as given by their professional role (Evetts, 2003). By complying with 'performance indicators or quality standard' that are 'used as 'public proofs' of a quality of their services under conditions of tighter control and regulation', we find the new public health sexual health nurse take on an active role in the tightrope the pharmakon (Calnan, 2015, p. 9).

2.5 Conclusion

The pharmakon tightrope is a framework adapted from the concept *pharmakon*. The framework was developed for the purpose of exploring social problems that exist in a state of ambiguity, such as the ECP. The tightrope framework draws attention to features that support the idea of a social problems existing with dual meanings. However, not all social problems can take form as pharmakon. The pharmakon construct is reinforced by values and cultural trends, which facilitate claims and claimsmaking activities that support acceptance of the problem in public discourse. The features of the pharmakon work together to create a vacillation of claims on either side of the tightrope that sustain the problem's stability in a state of dual meaning. This chapter has addressed a number of components that support the ECP's existence with dual meanings.

Chapter 1 documented claims that feature in the public frame of the ECP as a problematic contraceptive. This chapter has established how the frame of the ECP as a

problem contraceptive has emerged through a paradigm of claims and values that support the ECP's ambiguity. The ECP problem frame is shaped by its presence in public discourse with two meanings: as both a contraceptive option and not a contraceptive choice. We find through a historical review and by investigating current health policy approaches to health, risk and behaviour management, evidence to suggest the ECP is intentionally constructed as an ambiguous contraceptive by health policy.

British policy has a plethora of components that centre on contraception and access to contraceptive services. For this reason, I chose to focus on the 1967 National Health Services (Family Planning) Act as an example of how policy has reinforced pharmakon framework to contraception. In discourse that appeared around the introduction of the 1967 Act, we found officials actively chose *not* to clarify meanings in legislation on access to the pill. In review we find the legislators chose to leave the Act in an ambiguous position, open to interpretation, as a way of appeasing wider concerns around who may access the pill. This ambiguity in legislation meant the public were left to interpret the meaning behind the legislation.

On one side, we found the Act was perceived by supporters as a solution to the population problem in the 1960s. However, on the other, we found concerns and claims grew around the impact the Act had on the traditional values about sex and marriage. The response to the 1967 Act offers evidence to support dual meanings associated to contraception in the 1960s. With this as the ECPs heritage, we find the concept of the pharmakon describes the ambiguous policy approach used by legislators to regulate access to the pill. This approach is mirrored in policy and legislation about the ECP, and supports the ECP position as a pharmakon with dual meanings. However, these events alone cannot create the frame of the pharmakon. The tightrope must be reinforced by attitudes and values that support and continue the problems vacillation on the tightrope to sustain dual meanings.

In review of the medicalisation of family planning attitudes, we find claims that feature on either side of the tightrope are generated by a normalisation of family planning as a matter of 'health'. Prior to the introduction of the 1967 Act, tensions were high between the public and the private in relation to the access and use of contraception. By introducing the 1967 Act, as a 'health' policy, we find how attitudes towards planned contraceptive behaviour were developed. The new public health and the health promotion agenda from the 1970s brought into focus new health behaviour

management attitudes that surfaced and institutionalised the idea of the individual as responsible for their own health.

In the pharmakon tightrope we find values that surface as medicalised norms and create a net that catches claims on either side of tightrope. The values continue to vacillate the social problem in its position of ambiguity. The family planning values are further reinforced by the institutionalisation of the family planning professional.

In the pharmakon tightrope, the health professional becomes the stabilising force of the wider views in public health, since they facilitate the social problem existing with dual meanings. The problem comes to exists with two meanings because the professional person is normalising the values of the ambiguity on either side of the pharmakon. The health professional becomes active in the pharmakon tightrope by managing the ambiguity of the problem. Their role ensures the ECP does not fall too far either side of the tightrope. This is further supported by the transition of new public health from 'family planning' to 'sexual health' that legitimises the regulative environment of the tightrope.

In review of the current policy environment of 'safe sex' and 'sexual health', we find policy offers further support to the pharmakon allows it to exist in the public realm. The problem no longer sits behind closed doors of GP surgeries for people to only access if and when needed. The current state of *sex* as *health* has become a public matter and the ECP has become a feature of the wider public discourse of how to participate in 'safe sex'. The ECP tightrope environment can be described as an open discourse of behaviour management. Therefore, we find either side of the pharmakon continues to be refined by the government and global health officials.

The particular environment of the pharmakon is unique because for the vacillation of claims to occur, and in order to manage the ambiguity on either side, the various forces must work together in harmony. That is not to say this environment is exclusive to the ECP. This framework could be adapted to other social problems such as the policy issues around Prep and PEP. However, this framework allows for investigation into how health policy ambiguity surfaces and supports issues in the public realm to create a pharmakon. The following chapter describes how this framework was taken further though practical work and contextualises the social problem theory that supported the investigation.

Chapter 3

Methodology

Dear [BPAS]

Thank you for your email about the pricing of the progestogen-based emergency hormonal contraception (EHC) in our pharmacies.

I note your comments about the price of EHC being a barrier to women's access to this product. I have considered these comments very carefully and discussed them with relevant colleagues with the Company.

As you indicate in your email, supplies of EHC are available free of charge from a number of sources, including community pharmacies, and I can confirm that the majority of our pharmacies support a local fee NHS service for people who are eligible.

We consider that the customer having a conversation with the pharmacist is integral to the over the counter supply of emergency contraception as it helps to establish whether the medication can be taken within the required time frame for efficacy. The conversation also provides as an opportunity for the customer to consider her future contraceptive needs and how to minimise the risk of sexually-transmitted infections.

The consultation provides a means of identifying instances of abuse of young girls and vulnerable women, for example if a victim is being forced to buy the drug or even having it bought for her to try to conceal a crime. During the conversation, the pharmacist will enquire about medical history (to identify potential contraindications and drug interactions) or previous use of the drug. Therefore, the consultations with the pharmacist helps provide EHC being misused or overused. As you will be aware, EHC is not intended as a regular form of contraception as it is insufficiently reliable.

In our experience, the subject of EHC polarises public opinion and we receive frequent contact from individuals who voice their disapproval of the fact the Company chooses to provide the service. We would not want to be accused of incentivising inappropriate use, and provoking complaints, by significantly reducing the price of this produce

The price of our EHC offering over the counter is in line with that suggested by the manufacturers and we regularly review our pricing strategy. We do not propose to change the price at this current time.

Thank you for taking the time to get in touch and for giving me the opportunity to comment

Yours sincerely

[Dr X][2]

Chief Pharmacist '

(19th April 2017, Boots UK Limited)

[2] For the purpose of this work I have anonymised the Boots Chief Pharmacist.

3.1 Introduction

In 2017, the British Pregnancy Advisory Service (BPAS) launched the 'Just Say Non!' campaign, asking high street pharmacies to lower the cost of the ECP. The campaign set out to reduce the cost of the ECP after it was discovered that the UK pharmacy chains were charging almost five times more for the ECP than other European countries (bpas, 2017). A number of high street pharmacies responded well to the campaign and pledged to halve the cost of Emergency Hormonal Contraception (EHC). Boots, a well-established pharmacy with a long history of supporting women's campaigns, chose *not* to support the campaign. The above letter from Boots' Chief Pharmacist outlined the companies reasoning for choosing *not* to lower the cost. Boots' refusal to reduce the cost caused a media storm and members public responded by boycotting the stores. The campaign brought to light the issue of the excessive cost attached to contraception and using Dr X's letter I will consider in more depth issues attached to the ECP, that enable its frame as a social problem.

Dr X explains in his letter that Boots' refusal to reduce the cost of EC came from concerns that the lower cost might lead to 'misuse', 'inappropriate use' or even 'overuse' of the product. The concerns raised by Dr X appear to have little to do with health or risk attached to the product. Instead, Dr X acknowledged that 'the subject of EHC polarises public opinion and we receive frequent contact from individuals who voice their disapproval of the fact that the Company chooses to provide this services'. Dr X appeared sensitive to the complaints and concerns held by some around access to the product, at the cost of women's autonomy. This tension identified around access and use indicates there is a wider public frame given to the ECP that impacts its position as a contraceptive option for women. This tension will be addressed further in this chapter as we begin our investigation into the various approaches used to study a social problem.

The work has so far explored the social construction of the ECP and emphasised how it has been both legitimised and presented as a health and social risk. Despite the ECP being recognised as a safe and effective contraceptive, we note so far the risk frame associated to the product is disproportionate to the reality of the risk posed by the product itself. The pharmakon framework outlined in Chapter 2 can be used as a tool to offer clarity to an ambiguous social problem. The pharmakon framework enables the exploration of the social problem existence with competing meanings. The 'tightrope' metaphor outlined how, via a process of identifying the meaningful frames

given to the ECP, we can see how the product exists as both a blessing and a curse. Here we consider further how it is I have come to understand this process of meaning allocation and the theory that has influenced this research.

The components of this chapter are as follows: first, an account of the sociology of social problems. Implied in the discussion so far has been the proposition that the particular assembly of hormones could potentially be named, understood and provided and regulated in a variety of ways. That is to say, what has come to be known as the ECP, with all the associated presumptions, constitutes a particular social construction of the ECP and those women who use it. To take our discussion further, the subfield of contextual social constructionism will be outlined to make explicit the approach that has informed the analysis so far. Second, the chapter will set out how the approach taken through the empirical parts of the research aims to develop this subfield of sociology. Specifically, I consider the question of how social constructionism has, and may further, consider the question of how people internalise and relate to social problems they directly encounter and live with. To do so, I review relevant prior research informed by premises of social constructionism and also that which make use of the concept of identity work.

3.2 Social problems

Social problems can be differentiated in the public domain on two levels. Some problems such as global warming, poverty and crime might be noted as problems that affect society on a public level, to be investigated through macrosociology (Best, 2013). Issues such as teenage pregnancy, the gender pay gap and transphobia may also be viewed as public problems yet are characterised as having an impact on specific groups of people (Loseke, 2007). These issues are studied using a microsociological approach (Best, 2013). On one level we can agree that all these problems are identifiable in society in a public format with the potential to impact a number of people. However, we find some issues that affect one group may not have the same impact on a different group. For example, men may not feel the pinch of the gender pay gap and mothers over 18 years old are not looked upon in the same way as teenage mothers. Social problems are explored in various formats, and social theory has influenced the way problems are investigated. Influenced by authors such as Best and Loseke and the social constructionist approach, this work will develop an approach to the

investigating ECP as a social problem. My aim is to assess the ECP as a macro level social problem whilst also exploring its micro level features.

The opening chapters have therefore put into context the social problem the ECP in its public frame, in policy and in research. We now move onto the next stage of social problem investigation, by looking at the people within the problem. The following section will review how research has investigated individuals constructed within a social problem, starting with a review social constructionist approach taken to study the development of a social problem and the ontological position of myself as the researcher.

3.2.1 Strict and contextual social constructionism

The social constructionist approach to the study of social problems stems from the symbolic interactionist work of investigating meaningful social interactions[3]. Case studies such as Gusfield (1975) "drink driving", Pfohl (1977) "child abuse", Loseke (1992) "battered wives", have utilised social constructionism to better understand how social problems come to exist through a process of meaningful claims. These approaches compete with the objective conventions, also termed 'common-sense conceptions' by Holstein and Miller (2003). Unlike the objective researchers, social constructionists consider 'social problems not [as] objective conditions to be studied and corrected; rather they are interpretive processes' (Holstein & Miller, 2003 p2/3). However, debates amongst social constructionists have created a tension between what is described as 'strict' and 'contextual' constructionism. Spectre and Kitsuse (1978) work *Constructing Social Problems* (CSP) is understood to have given roots to the ontological development of social construction of social problems, and as a result, CSP is seen to have influenced both side of the constructionist debate.

Strict or 'strong' readings of the CSP work are understood as 'radically phenomenological' (Best 1993). This approach attempts to 'call into question all the commonsensical assumptions about deviant labels, official statistics, social problems and the alike' (Best, 1993 p129). The strict interpretation of CSP chooses to adopt an approach that 'asserts the unknowability of "reality" – any "reality" – in an objective sense' (Pawluch, 2019 p.211). It brings into question the objective world and recommends that the social problem investigator should pertain a neutral role in

[3] The theoretical infleunce of symbolic interactionism is discussed in more detail in the following section on *identity*.

interpreting the claims and claimsmaking activities by assuming all claims are socially constructed.

Pawluch (2019), a strict constructionist, explains that the 'subjectivist position suggests that we cannot know what, if anything exists outside of our interpretive lenses' (p211). Described as strict in nature, the approach has been criticised for not supporting the 'sociological imagination' (Best, 1993. Pg 139). Best (1993), a contextual constructionist, responded to Pawluch arguments suggesting, the strict approach creates taught boundaries that impact the progression and development of social problems investigation. With no room for movement, Best suggests 'strict constructionist researchers must ask the same questions about each claims-making campaign, rather than focusing on the interesting aspects of a particular case' (1993. pg137).

Offering a 'weaker' reading of the CSP work, social problem researchers such as Best and Loseke indicate that social constructionism can continue to investigate the emergence of social problems, without discounting the socio-cultural influences shaping and impacting the social problem development. The *contextual* reading of the CSP does not take for granted the original theoretical approach of the strict constructionists, however, seeks to continue to contribute to the quest of knowledge and social problem investigation in manner that is accessible for researchers. Best (2018), argues that it is impossible for researchers to remove all researcher infleunce in the interpretation, analysis and investigation of a social problem.

> [A]nalysts with strong roots in phenomenology sociology conceded the impossibility of conducting social problems construction that were not grounded in assumption (Best, 2018. p. 60).

Therefore, in line with the contextual approach, the work has so far worked towards identifying the wider frames placed on the ECP through a review in the policy claims and socio-cultural developments. This is evident in the opening chapters. Yet, taking this further the next stage of the research seeks to identify how and in what way claims and claims making activities impact the lived experiences. In this aim, I must take some caution on my part as a researcher to seek to interpret the analysis without offering researcher 'assumptions'. As the contextual constructionist approach is argued to be moving discipline to move 'firmly in a normative direction' it is argued it is susceptible to 'ontological gerrymandering' (Pawluch & Woolgar 1985. p, 214).

3.2.2 Ontological gerrymandering

Ontological Gerrymandering describes the process where researcher's interpretation of claims may lead to further claims making activities, that impact the way in which the problem is framed (Pawluch, 2019). For instance, my interpretation of DR X letter indicates Boots response to the ECP cost implies that ECP as a social problem. However, it may also be argued that I have chosen to interpret the claims made by Dr X as this and my actions in doing so are adding to the claims making activities. It is the suggestive nature of researcher interpretations that is criticised by strict constructions who believe:

> The successful social problems explanation depends on making problematic the truth status of certain states of affairs selected for analysis and explanation, while backgrounding or minimising the possibility that the same problems apply to assumptions upon which the analysis depends. (Pawluch & Woolgar, 1985, p. 216)

Therefore, ontological gerrymandering occurs when:

> Proponents of the definitional explanation place boundary between assumptions which are to be understood (ostensibly) problematic and those which are not. (Pawluch & Woolgar, 1985, p. 216)

Aware of the concerns raised by ontological gerrymandering, it is important to state here that I have chosen to adopt a contextual stance. Unlike the strict constructionist who claim that ontological gerrymandering causes the work to be invalid and unreliable, this work has adopted a weaker reading of CSP.

I have chosen to engage with the wider claims made around the ECP to support an investigation into how a social problem frame is experienced at the micro level. On some level the claims that I have reviewed so far, appear as part of an interpretation process undertaken by myself as a researcher. However, to remain as true as possible to the context of the claims making, I have allowed the claims that appear in wider discourse to guide the process of investigating the impact of these claims at the individual level. Thus, in the opening chapters I reviewed the science of the ECP that supports its frame as a contraceptive. In a review of the legislation I have explored a particular frame given to the ECP that appears to suggest it is risky and problematic, with dual meanings it forms in wider public discourse as a pharmakon. This investigation so far could be seen as problematic to a strict constructionist. However, Best (1996), suggests that it is impossible to pursue sociological investigation without some level of researcher interpretation engaging with wider social environment.

Therefore, in an effort to trial a new framework I am choosing to adopt a weaker reading of CSP that does not problematise the researcher involvement in the identification of claims. That is not to say I do not appreciate the concerns raised by the issue of ontological gerrymandering, however, it is understood that researchers can overcome this issue if they show awareness of this positionality in research. For instance, other constructionist suggests that as a researcher it is important to not blur the lines between being a researcher and an influencer. For instance, Gusfield (1976) suggests that researcher use the term 'we' as a rhetorical tool to gain the readers support. However, he also states that if a researcher is 'self-understanding and aware' off the attentive use of language being used then this can be overcome (Gusfield,1976). In line with Best (2019), I accept 'contextual constructionism is not a warrant that allows an analyst to do whatever they please, but an injunction to proceed with care' (pg.224). This I why I have chosen to adopt similar language used by other contextual constructionists, using the term 'we' but recognise to 'proceed with care' to ensure my interpretations seeks to offer an analysis of 'meaning making' of the social in context with the data collection, not led by assumptions made by myself.

In summary, the ontological approach used here supports an investigation where; 'we assume that we will understand the empirical world better if we pay attention to the manner in which social problems emerge and, at a more basic level they also assume that understandings the empirical world is desired' (Best, 1993 p.139). Sharing the same motivations as social constructionists such as Best and Loseke, I have chosen to adopt a contextual constructionist approach to studying the social problem formation of the ECP. The opening chapters have outlined how the frame shapes the ECP as a problematic contraceptive. Moving forward the work addresses how and in what ways the problem frame impacts those who come into contact with the problem. This begins by identifying what aspects of the social problem process can be investigated further as I explore further the process of claims and claims making activities.

3.2.3 Claims and claimsmaking

I have already referred to comments made in Dr X's letter as claims. Here, I explore further how claims are investigated. Claims are found in various formats: in the media, in policy, in lobbyists' protests. When claims reach a certain level of coverage, they then become recognized as influencing the construct of a social problem (Schneider, 1985):

> Claims are in constant play. They evolve, and they can both inspire both other claims and opposition, so new claims are almost always shaped by those that preceded. (Schneider 1985 p. 52)

The study of the claim provides an insight into how the social problem unfolds. If the claim is considered persuasive and is communicated by an influential source or is well received by its audience, then the claim can develop and cause awareness of a new social problem. Best (2008) explains how influential social actors play their part as 'claimsmakers' to bring the claim about the issue to the attention of an audience. Spector and Kitsuse (1997) explain that claimsmaking can take form in various activities:

> …demanding services, filling out forms, lodging complaints, filling lawsuits, calling press conferences, writing letters of protest, passing resolutions, publishing exposes, placing ads in newspapers, supporting or opposing some governmental practice or policy, setting up picket lines or boycotts. (p. 79)

The 'Just Say Non!' campaign led by BPASs can be recognised as claimsmaking activity. The organization believed the price of the EC should be reduced in order to remove barriers to access, therefore in order to gain support for their cause they created the campaign. It is in observation of these public claimsmaking activities that we can trace the social interaction to the public recognition of a social problem.

Best (2013) suggests that 'influential' claimsmakers appear to have greater success in their claimsmaking activities that those who do not hold social status. For example, actors that take on roles such as 'experts' may receive more support from audience members in gaining acceptance for a claim and in the construct of the problem. As we find with Dr X, as chief pharmacist for Boots, in his powerful position as an 'expert' he has the power to direct the company's decision to remove barriers such as price and review the need for the consultation process. As an 'expert', if he advises the reason for high price is to prevent 'inappropriate use', then the claim is likely to receive support and as will the idea that the product can be taken 'inappropriately' (Dr X, 2017). We find individuals who have authority or power can control the direction of the problem construct which determines the success of problem acceptance. In addition to this we find the tools explored earlier used to investigate meaning also impact the success of the claimsmaking activities.

Claims that appear persuasive to audiences are used to further gain support for ideas or claims that appear to aid the construction of a social problem, through the use of

cultural resources (Benford & Hunt, 2003; Spector & Kitsuse, 2001). Cultural resources can vary based on who is the audience of the claim (Loseke, 2012). Therefore, claimsmakers will strategically choose cultural resources that will have the greatest impact on particular group or a specific issue (Loseke, 2003). For example, in Dr X's letter he identifies possible EC users as young teenage girls, who are viewed as vulnerable or as victims. This description of the EC user can also be recognised as a claim that draws on cultural resources of the public attitude towards young people and access to contraception. This claim draws on what is described as moral incentives that allow people to give meaning to a person, event or idea, on an emotional level (Best, 2013; Loseke, 2003). Recognising use of cultural resources in the rhetoric of the claims and the public acceptance of the claimsmaking activities allows for the study of the impact of claimsmaking activities (Frawley, 2015). The influence of cultural resources has been addressed by some at the 'public problems marketplace' where claimsmakers compete for the attention of various audiences to gain recognition of the problem:

> Claims or frames are not merely preferred and the accepted or rejected. Rather, opponents and allies respond to public claims and identity attributions made by claimants, giving need meaning to or even subverting old symbols. These responses, which may be conflictual or amicable, are in turn often reframed by claimsmakers. (Benford & Hunt, 2003, p. 160)

This suggests that when a problem arises, the claimsmakers' activities in particular of those of two separate or conflicting groups, may use tactics to influence the audience acceptance of a problem. This often results in a variety of contrasting claims that mean the public construct of the problem is down to interpretation (Rappaport & Seidman, 1986; Spector & Kitsuse, 2001). Counterclaims are considered to feature within the social problem process as an alternative approach to gain support for opposing sides of one problem (Benford & Hunt, 2003).

With the identification of claims and claimsmaking activities, we consider how the social problem process begins to form the of public construction of a social problem. However, to understand whether social problem claims are internalized by those who the problem is tailored to, we must explore the actors and audiences of the social problem process. The following section will explore how one might investigate the problematic identity formation to consider how those who live within the problem also become the social problem. I start by outlining the role and construction of 'social problem workers and 'social problem identities'. In review of the historical

contribution of the concept identity work in social constructionism, I look at Goffman's (1963) work on stigma and the '*spoiled identity'*.

3.3 Social problem identities

The opening chapters offer a macro exploration of the social problem the ECP and highlight the ways in which social problems come to feature in social life. Here we consider the study of the social problem at the micro-level of the individual. The work is influenced by the social constructionist approach to understanding social experience. We make sense of our social world through a process of internalising meaningful social interactions with people, values, ideas and experiences (Berger & Luckmann, 1966; Best & Loseke, 2003; Gubrium & Holstein, 2003). We can further understand how the wider social problems impact the individual on a micro-level if we focus our investigation onto the individuals and the processes they go through to make sense of meaningful interactions.

The study of meaningful interactions originates with symbolic interactionism and has since developed as part of social constructionism (Gusfield, 1963). A long history of ethnographic studies focusing on meaningful social interactions are an important feature of the investigation of the social (Handberg, et al., 2014; Gordon, 1993). Berger and Luckman explain:

> Subjective appropriation of identity and subjective appropriation of the social world are merely different aspects of the same process of internalisation. (Berger & Luckman, 1966, p. 152)

Berger and Luckman (1966) indicate that we make sense of who we are and the social world around us, not because of our acceptance of the objective reality we are exposed to but rather because we subjectively internalise the interactions we experience in our everyday lives. Unlike the objective stance, the subjective approach to studying the social considers how we internalise our interactions and how we give meaning to our social learning (Best, 2013; Loseke, 2011). The following section will evaluate the various tools that enable us to explore meaning in the lived experience of identity work. We begin by considering how our language helps navigate our social meaning and the development of persuasive frames.

Dr X explains in his letter, 'the consultation with the pharmacist help prevent the EHC being misused or overused [...] EHC is not intended as a regular form of contraception as it is insufficiently reliable'. The claim the ECP is not a 'regular contraceptive method'

can be traced back to the problem frame we explored in Chapter 1. By framing the ECP to be used in 'emergencies only' we find its social meaning is impacted by the name given to the product. Although, this frame does not match the product's biological description, it is a good example of how the wider ideas and meaning given to ECP impact how it is viewed or framed as a contraceptive option. From this example we see how meaningful frames can impact the construction of a person or problem. Social constructionism indicates that '*meaning making*' can be a taken-for-granted process, which allows it to fit neatly into social interactions.

Sociologists observe the ways meaning comes to exist in the social world and it was George Herbert Mead who wrote:

> Meaning is implicit – if not always explicit – in the relationship among the various phases of the social act to which it refers, and out of which it develops. And its development takes places in terms of symbolization at the human evolutionary level. (Mead, 1934, p. 76)

Mead (1934) explains that meaningful interactions become a taken for granted part of our social world. However, by breaking down the 'symbolizes' and 'social acts', we can study the processes that allow individuals to navigate the social world (Mead, 1934; Blumer, 1980; Gusfield, 1963). Here we will take this idea further to explore how the frame given to the ECP as an irregular problematic contraceptive impacts the experience of those who distribute, use and access the product. The sociological approach to investigating 'meaning making' will be used to further explore the formation of meaningful identity constructions by adapting the social interactionist approach to further understanding identity work.

3.3.1 Identity work and the problem identity

Social problems rarely occur without characters/actors/persons involved in the problem itself (Best, 2013; Holstein & Miller, 2003 ; Michael, 1996). Problem identity formations give life to a problem and the lived experience of the problem, as they identify particular individuals or behaviour types to be associated with certain issues (Loseke, 2003). So far, we have established through a review of literature that particular behaviour types are given meaning through social construction of right or wrong, good or bad. In Chapter 2, the pharmakon tightrope created a framework for measuring such behaviour and here we will consider the theory that allows us to understand the problem identity further.

Goffman explains that 'spoiled identity' here considered as the problem identity, is constructed through social interaction:

> The normal and the stigmatised are not persons but rather perspectives. These are generated in social situations during mixed contact by virtue of the unrealized norms that are likely to play upon the encounter. (Goffman, 1963, p.164)

The 'problem identity' enables the distinction between behaviours perceived as normal and abnormal. The spoiled identity, understood by Goffman as the frame of the 'stigmatised person', is recognised not as a 'person but rather a perspective', suggesting the stigma associated with specific behaviour created identities that are putative and adaptable based on behaviour and experiences (Goffman, 1963). However, Loseke suggests there is room for 'constructionists [to] give more attention to examining this rhetorical practice of 'people production' by addressing the emotive language that create frames and support claimsmaking that 'produce' these problem identities' (Loseke, 2003, p. 120). We will consider further the tools that allow investigation of problem identities and the activities of those who facilitate the formation of the problem identity.

Loseke (2003) explains that the successful construction of problem identities that features in the 'folk universe' are successful based on the moral and emotive response they receive. She suggests that claimsmakers make use of 'cultural resources' or 'folk knowledge' to generate an emotive response to an identity construction and to gain acceptance for the categorisation of problem behaviour, and subsequently the problem individual (Loseke, 2003). For instance, Dr X describes the EC users in his letter as young, vulnerable and possible victims of a crime. The formation of the EC user in the description of Dr X is someone who would greatly benefit from the high regulation of the product and the need for consultation. Without reference to how Dr X supports his claims of this young child victim is the most common individual to access the ECP, Dr X uses this constructed identity to support the high price and consultation needed to access the ECP. The significance of this observation is that if we can explore how claims construct identities, then it would be necessary to further investigate what impact this identity work has on those who fulfil problem identity in order to further understand the lived experience of a social problem. As Berger and Luckman suggest:

> Identity is formed by social process. Once crystallised, it is maintained, modified, or even reshaped by social relations. The social processes informed in both the formation and maintenance of identity are determined by the special structure. (Berger & Luckman, 1966, p. 194)

The social constructionist approach to the study of the individual explores the relationships and encounters that aid an individual's construction of their own reality. Maticka-Tyndale (1992) explains that as 'authors' of our lives, we rely on 'common stock of knowledge rooted within existing institutions, everyday language, shared meaning and understanding' to create a reality we live within (p.239). The social constructionist approach appreciates how these social extensions of our existence come to aid our personal navigation of social reality.

Goffman (1959) explains that the identity of an individual is not stagnant; the identity we associate ourselves with can change and adapt as a result of meaningful interactions. This makes our identities changeable through our social experience, meaning we may take on more than one single identity at any given time (Goffman, 1959). As we continue to socially interact, we may take on a variety of roles and formulate different identities based on who we are with or what we are doing. Loseke (2011) suggests that as a result of claimsmaking strategies often used in policy, the 'problem identity' that features in the public discourse becomes relatable to events, ideas or experiences.

For example, there are two identities in a crime story. One individual becomes a victim of a crime, the other the villain who causes the crime; this one experience creates two separate meaningful identities (Loseke, 2011). Through social experiences, we give meaning to events that aid the identity given to individuals. We also know, using the pharmakon framework to investigate meaning, that we accept in some instances behaviours are constructed as right or wrong, good or bad and simultaneously both at the same time. The pharmakon therefore, becomes one person, event, or problem existing with dual meanings.

If we break down the frames that shape the meaning given to the identity, we can begin to piece together how problem identities form and their impact on those who come into contact with them (Goffman, 1963). Loseke suggested that 'constructing moral or immoral types of persons simultaneously constructs preferred *emotional* orientations', meaning we socially accept the right or preferred behaviour as it is constructed to produce an emotive response (Loseke, 2003, p. 123). Best (2013) explains social problem constructs receive an emotive response from an audience if cultural resources allow the audience to relate to the problem and fortify the problem identity. Therefore, the success of a spoiled identity can be supported by activities of claimsmakers and claimsmaking strategies that use effective cultural recourses. This has been previously explored by Goffman in his work on stigma.

Goffman (1963) suggests the 'spoiled identity' is exuded from a moral career of a person where the person in question 'becomes aware of the stigmatised identity', since it forms from morally constructed meaning given to behaviour or the experience of the person. He explains the various influences of the spoiled identity construct come from community-based interactions within the family or familiar social groups, or institutions (Goffman, 1963). We know public policy indicates the 'good contraceptive user' identity is one where contraception is pre-planned, 'long-acting' and used prior to sex. This identity construct featuring in policy creates an ideal type or 'norm', which equally creates the opposing, 'bad contraceptive user'. This identity is accepted as someone who has not pre-planned or used contraception before sex. With these identity constructs featuring prominently in folk knowledge, we can see how the 'EC user' identity becomes a 'spoiled identity'.

The identity work evident in Dr X's letter suggests the EC user is considered problematic and therefore, in order to see what impact this construct may have on the lived experience of the EC user, we must speak to the women constructed through the problem identity. This social construction of identity will be considered further through a review of research that has used qualitative interviews to investigate the study of the constructed social problem identity. The section reviews research that has focused on 'social problem groups' such as teenage pregnancy, to explore the methods of investigation that have been used to analyse the lived experience of social problems. Spoiled identities and problem identities have been investigated using a social constructionist approach and the problematisation of teenage pregnancy is a particularly good example how social problem identities have been explored on a micro level.

3.3.2 Spoiled identity: Teenage pregnancy

The identity work of an individual can be understood as a story (Best & Bogel, 2014; Benford & Hunt, 2003; Holstein & Miller, 2003 ; Loseke, 2007). Those who come to take on identity frames tend to be unaware of the sociological categorisation of their behaviour and view their life events as meaningful stories (Goffman, 1959). Through a sociological lens, we would define the story of an identity as a 'narrative' and as individuals tell their 'stories' we can begin to perceive the process of how meaning is made (Fagermoen, 1997):

> Stories or narratives are considered meaning making devices; that is to make sense of experience, individuals put together singular actions and events into a narrative form. (Fagermoen, 1997, p. 437)

The identity work of individuals can only be understood through an investigation into their life experience. When spoiled identities and problem identities come to feature in the public eye, on the micro-level, a life experience has occurred. In order to address the process of lived experiences of spoiled identity, it is important to investigate the identity work of the individual and the narratives that are told. Teenage pregnancy is an example how social problem identities have been explored on a micro-level.

Teenage pregnancy was recognised as an issue under the New Labour government in the early 1990s through the *Teenage Pregnancy Strategy* (Arai, 2009). Lisa Aria (2009) studied the lived experience of social problem construct through interviews with teens and qualitative media analysis. Arai explores the 'frame' of the social problem that was formulated from the policy discourse around young mothers:

> Teenage mothers are depicted, whether as moral deviants to be treated punitively or as vulnerable dependents to be helped through monitoring and surveillance, if necessary, to make the right choices, it is their cost to the taxpayer that matters. (Arai, 2009, p. 123)

The Teenage Pregnancy Strategy brought into focus the growing concern with young women engaging in sexual behaviour in the UK. The problem identity formed for teenage parents solidified in policy, as the media aided the growing concern with claims about 'children having children' (Elliot, 2010; Macvarish, 2010; Fields, 2005). The construction of the problem of youth creating more problem youths backed up the policymakers' move to regulate the growing problem impacting this vulnerable group (Arai, 2009; Harrison, et al., 2016; Luker, 1996; Rains, 1971). Arai addresses in her interviews with young mothers in 2009, the 'stigma' they experienced by being constructed as problematic individuals.

In semi-structured interviews, Arai (2009) finds that while some of the young women initially experienced difficulties within the family context (telling their parents they were pregnant), many of the women expressed happiness and newfound love in their knowledge of the pregnancy. Some of the women had difficult upbringings as care leavers and for them especially this was an opportunity to have their own family (Arai, 2009). What Arai (2009) was able to achieve through the use of qualitative interviews

was an in-depth understanding of the young women's experiences of being a teenage mother and living with a stereotyped label.

Although the women appeared to be aware of the wider public frame, Arai's interviews suggest that the social problem identity formed of claimsmaking activities did not impact the teenagers' experiences. Using a thematic analysis, Arai (2009) explored the problem identity work created around teenage mothers and explored its presence in the lived experience of the mothers. Using this as stimulus for my own methods, I have chosen to also conduct semi-structured interviews, as this has been proven a successful method to use when exploring the lived experiences of women. Others who have conducted similar work to that of Arai (2009) on the problem construct of the teenage mother have found similar findings to that of the identity work of the problem mother.

Harrison et al. (2016) use focus groups to investigate how teen mothers relate to media constructions of the 'teen mom' in the US MTV show. They find that the mothers did not relate to the images of the teenage mother that featured in these shows and this left the parents feeling 'misunderstood and poorly represented' (2016, p. 688). With the parents feeling the shows created negative construction of realities and experiences of teenage parenting, Harrison et al. conclude that the wider public construct 'failed to resonate with them' (p.690). The findings suggested the public frame of the teen mother 'contribute[d] to their own sense of alienation and isolation, and in some cases, the fear of judgment and affected their social and health interactions' (2016, p.689).

The research exploring the construct of problem identities suggests that those who fit the role of the problem individual are impacted by the wider public construction of their experience. Both Arai (2009) and Harrison et al. (2016) find the teenage mothers felt the wider frame did not resonate with their real-life experience. The public constructs of the social problem individual, however, impact the lived experience of those considered this way, although the social problem may not speak to the lived realities of the individuals it appropriates (Arai, 2009; Macvarish, 2010; Harrison, et al., 2016). If we return to the Dr X letter and the constructed EC user, the young and vulnerable teen may not represent the image of the EC user and therefore the justification for access determined on this construct may not speak the truth to real-life experiences of the ECP user. In order to explore this further, I chose to speak to EC users through interviews to explore their identity as an ECP user.

In the case of the ECP, those who use, access and distribute the ECP become part of the social problem. So far, I have made reference to the wider claimsmaking activities that have constructed the social problem on the macro-level, in discussion of claims and claimsmaking activities. However, it is important to note 'people are not passive recipients' (Best, 2008, p. 61). Individuals do not simply accept the claims that feature in the public discourse because they are exposed to them. How consider the tools that have been used to explore the identities the individuals defined in research as the 'audience/actors/perpetrators' of the problem (Best, 2013).

3.4 Social problem workers: the actors and the audience

The sociology of social problems evaluates the process of applying meaning to a condition perceived as harmful or problematic and we have learnt how emotive claims are used in the process of gaining public support for a developing social problem (Benford & Hunt, 2003; Best, 2013; Loseke, 2017). For example, in Dr X's letter to BPAS we can acknowledge that Boots' concern for vulnerable teens and suspected crimes adheres to similar concerns for young people in a wider discourse in policy and practice. Therefore, we can begin to piece together in this public construct of the problem that is EC, and the features of the identity of those distributing the pill. 'Social problem work' allows for the study of those who act as the gatekeepers or messengers to claims made on a wider scale (Benford & Hunt, 2003; Holstein & Miller, 2003). It is necessary to evaluate the role of those who act as messengers of a problem, since they are important to sustaining and developing of the problem from the macro public level to the micro individual level.

For the purpose of this study I have sampled those who have direct contact with the social problem and so feature in this work as 'social problem workers'. These are health professionals who distribute the ECP, and women who could access the ECP. In order to understand their role as social problem workers, the following section explores the roles of 'actors' and 'audience' members. We begin by exploring the purpose and role of the social problem worker, the actor.

3.4.1 Actors as social problem workers

Individuals who are identifiable by their activities within the social problem process can be recognised as claimsmakers, and they feature in the process as 'actors' (Best, 2001). Those who become actors in the social problem process do not necessarily fall into one particular profession, culture, or even one group based on their relationship

with the problem. What they have in common is their interaction with the social problem (Jamrozik, et al., 1998). Gubrium and Holstein (2003), suggest a social constructionist approach to exploring individuals 'meaning' should not 'set out with a priori assumptions' (p.192). They indicated that 'the analyst must seek out empirical traces of what context amounts to in particular situation, *as that situation is known and understood by social actors within it*' (Gubrium & Holstein, 2003, p. 192). Constructionist sociology suggests that it is important to acknowledge that those who feature as actors in the social problem process can come from all walks of life (Ashford & Schinoff, 2016). They are researchers, politicians, nurses, and the woman who visits the chemist. However, what may separate these actors is their influence in the problem process (Loseke, 2011). For instance, the experience that Julie has in Boots may not have the same impact as an MP in the House of Lords; thus we recognise with status comes power, and in the investigation of the social problem at the micro-level, we recognises the individuals with power have more success in their role as the social problem worker (Best, 2008).

Gerth and Mills (1970) explain that institutions educate individuals in value systems, and our social learning is accomplished as roles are designed by overarching institutions that encourage individuals to achieve 'goals and gratifications'. Here we consider how the social problem worker is formed out of institutional values and, therefore, these shape the goal orientated work the social problem worker takes on. Gerth and Mills suggest that:

> Institutions imprint their stamps upon the individual, modifying his external conduct as well as his inner life. For one aspects of learning a role consists of acquiring motives which guarantees its performance. (p. 173)

Gerth and Mills (1970) suggest the impact of institutional values dictates and controls the performance of the role given to an individual. The meaning the individual gives to their role can be explored through a review of how individuals internalise the values projected from the institutions (Fagermoen, 1997; Finn, 2001; Loseke, 2003). In order to consider what impact the institutionally constructed role has on the delivery and transfer of social problem constructs, we will need to further understand how the individual who take on the role designed for the social problem worker, makes sense of their role and their identity.

At the micro-level, individuals take on roles that aid the success of the social problem process and the problem identity formation, and here we consider these actors as social problem workers (Best, 2013). For example, Dr X works for Boots and therefore,

must represent the values and ideals of the high street pharmacist. This is evident in Dr X's claim that the company did not want to reduce the cost of ECP because 'we would not want to be accused of incentivising inappropriate use, and provoking complaints'. The role Dr X takes on in his capacity and role as actor in the social problem is to manage the problem from his position as Chief Pharmacist. However, unintendedly, Dr X letter suggests he is also aiding the construct of the ECP as a problematic contraceptive by choosing not to 'significantly reduce the price of the product' and therefore, takes on another role as the 'social problem worker'.

Holstein and Miller (2003) explain 'social problem work' as the process of the face-to-face interactions between actors in a social problem and those they describe as 'subjects' of the social problem work. Best (2008) explains that doctors, teachers or social workers all contribute to social problem work, as their jobs involve carrying out social policies designed to prevent or control a defined problem. For example, pharmacists, nurses and GPs are gatekeepers to EC on prescription and over the counter. They also work as social problem workers in that they abide by policy and legislation on the prescription of the product and by carrying out a consultation with the women who is in need of EC. By identifying these gatekeeper's role as social problem workers, we can begin to understand how it is claims that feature in public policy are transferred through the one to one consultation between a woman and a health professional.

Best understands that an important aspect of the role of a social problem worker is to 'construct cases' or in other words, to decide whether or not the subject 'requires attention through the application of an appropriate policy' (2008, p.236). The social problem worker takes on a significant role in the narrative of the social problem and this role is constructed from institutional identity work (Clarke & Willetts, 2014; Fagermoen, 1997; Holstein & Miller, 2003). For example, the sexual health nurse, unlike other nursing roles, works in a field of health that is not predominantly health originated. In Chapter 2 we considered the development of the new public health and sexual health, bringing with it the new role of the sexual health nurse. This nursing role allocates the individual a level of responsibility for health promotion (Friedson, 1984). This formal role is institutionalised through targets such as reducing the rates of teenage pregnancy (Ashford & Schinoff, 2016; Crouch, 1999; Fleming & May, 1997; Friedson, 1984). The duties allocated to the social problem worker in the institutionalised setting aim to solve the given social problem. For this reason, I have

sampled Sexual Health Nurses that distribute the ECP to explore how the nurses contribute to the social problem through their role as social problem workers.

Research into sexual health provider attitudes in the US highlights how interviews have been used to explore the ways staff relate to patients and how attitudes impact their work, in particular in a population where teenage pregnancy is considered a social problem (Fields, 2005; Gomez, 1997). Mann (2013) conducts research into sexual health care providers' attitudes towards regulating Latina teen's sexual and reproductive behaviour. The qualitative research set out to 'locate their [health providers] views and actions in the institutional contexts that make their work both possible and circumscribed' through the means of interviews and observation (p.686). Mann interviewed fifteen health professionals, including twelve medical professionals (MD, RN and PA) and three medical assistants over the space of three years. Using a mixed method approach (in-depth interviews and ethnography observation) and critical discourse analysis, it was found that the service providers had constructed the teenage pregnancy of the Latino girls as a problem, and this meant it was imperative to create intervention (2013).

The research found by constructing Latino teens' sexual and reproductive experiences as 'nonnormative, problematic and in need of prevention', the health care providers produced regulative regimes that were constructed from their own ideas of class, race and normative standards of behaviour (Mann, 2013, p. 686). Mann found the staff created their own construct of the social problem figure:

> The construction of girls' 'good citizenship' in relation to carefully monitored sexuality, delayed motherhood, full-time paid work, and participation in consumer capitalism and, by contrast, the 'bad citizenship' of girls who do not assimilate to this ideal is apparent in the discourses and practices of the health care providers. (2013, p. 697)

These results suggest that as a product of the wider social construction of the social problem that is teen pregnancy in Latino communities, the health care providers negotiated around the wider claims made about these girls, and manifested their own construction that allowed them to categorize and approach the girls as either 'good' or 'bad' (Mann, 2015). These findings highlight the construction of a social problem identity impacts the work and interaction the individual has with the social problem worker. We can conclude from Mann's research that is as a method of investigation, semi-structured interviews allowed for the exploration of the interaction between social problem workers and the formation of the social problem identity. This will be explored further in the following section.

However, these semi-structured interviews take the investigation one step further in analysing how the provider relates to the social problem in hand, how they view the individuals considered within the social problem and what their role is in the claimsmaking activity. Another significant group of individuals who come into direct contact with the social problem process is the audience.

3.4.2 The audience as social problem workers

In Chapter 2 we reviewed how policy aimed at promoting good contraceptive behaviour via sexual health promotion. Richardson (2000) acknowledges that within social problem discourse surrounding sexuality identity, there is a framing of what is perceived as 'good' sexual behaviour:

> As good citizens, we are enjoined to take care and assume responsibility for our own health and especially in the case of women, that of any future children we may have, in a context in which we are provided with 'informed choices' that we are expected to experience. (p. 106)

Richardson explains that as a product of the responsibilisation of sexual identity, we categorise certain behaviours. Through this categorisation, we find dual meanings are given to sexual behaviour. Lowe (2005) suggests that contraception features as a unique aspect of health care services because, unlike other medicines, contraception is not accessed because of ill health. In the policy discourse around sexual health and access to contraceptives, although contraception is not for ill health, it has become medicalised in order to manage the behaviour considered problematic. If we recognise the medicalised construct of 'good' and 'bad' contraceptive behaviour as the claims that support either side of the pharmakon, then we can begin to consider how they are received and internalised by those who are perceived as the target audience of the claims. The role of the audience is important to the success and structure of the problem and the problem identity.

Goffman (1963) suggests that individuals adapt to their social roles and take on 'team' or 'collective identities' as audiences to participate in 'shared performances' as they socially interact and make sense of everyday life. Loseke suggests:

> Audience members are practical actors who use our practical experience, popular wisdom, and a general understanding of the ways the world *does* work and the ways the world *should* work to evaluate social problem claims. (2003, p. 29)

The audience's opinions are considered important to the success of social problem claims and claimsmaking. A claimsmaker will adapt and design social problems so to appease audiences. The 'success' of a frame can be measured by the response the audience gives to the framing of a social problem:

> Successful framing draws upon the cultural resources; it incorporates familiar values, beliefs, imagery and other cultural elements that perspective members find persuasive and convincing. (Best, 2008. p. 73)

Cultural resources are understood as tools used by claims makers to persuade audiences and frame the problem. Resources are used that build on concerns already present in the social environment and which appeal to the value system of the audience members (Best, 2008 Loseke, 2011). For example, Boots' decision to not lower the cost of the ECP is evidence of a successful problem frame. Dr X explained that Boots did not want to be 'accused of incentivising inappropriate use, and provoking complaints, by significantly reducing the price of this product'. These claims indicate the ECP as a product is accepted and successfully framed as a problematic contraceptive. Successful frames are further assisted by the use of emotive and persuasive language:

> The study of rhetoric in constructionism can draw attention to the role of language in constructing and even constituting our sense of the world around us. (Frawley, 2015, p. 45)

Similar to the concepts applied in symbolic interactionism, rhetoric analysis allows for an enquiry into how language is used to emphasise or persuade an audience of the situation or problem in hand. Thus, if the purpose of language is to evoke emotion then through an investigation into this construct that we can begin to consider how it may be interpreted by an audience (Ibarra & Kitsuse, 1993). In order to address the success of the problem we must speak to the audience themselves. For this reason, I sampled the audience of the social problem of the ECP as women of reproductive age.

In Dr X's letter we find the rhetoric of problem-solving policy, with the aim of 'minimising risk' appearing as a justification of the high price and consultation. He claims that 'the EHC is not intended as a regular form of contraception as it is insufficiently reliable', despite the products' high effectiveness at preventing a pregnancy up to five days after sex. What appears to be certain is the frame that the ECP should not replace 'regular forms of contraception'. With this claim featuring at the centre for the product problem frame we understand that Dr X appears to justify the regulated access with the aim of stop the 'EHC [from] being misused or overused'.

However, when we combine the various claims that feature in the letter and in the policy reviewed in the earlier chapters of the thesis, the problem in need of regulation is not related to the product's ability to successfully do its job as a contraceptive. We find the efforts to regulate access to the product are directed towards managing the behaviour of women considered risky. With this being the underlying aim shaping the problem construct of the ECP, we find the problem identity forms because of concerns with the sexual behaviour of women.

In the case of the ECP and its construction as a pharmakon, we know the pharmakon's success is determined by its construct as ambiguous. In order for the pharmakon's successful construction, the audience must internalise the claims in a manner that will allow for ambiguity to continue. However, as subjective beings, we cannot assume or accept that all audience members will share the same meanings given to the suggested social problem (Benford & Hunt, 2003; Ibarra & Kitsuse, 1993). Audience members work within the realms of their social problem and take on a specific role of disseminating problem claims and fortifying the problem construct in common knowledge (Benford & Hunt, 2003; Loseke, 2003; Loseke, 2017). Loseke explains that:

> Audiences are critical because a social problem is created only when audience members evaluate claims as believable and important. In the metaphor of the social problem game: Who wins and who loses depends on how audience members vote. (2017, p. 27)

In terms of what we consider to be the winners and the loser in this 'game', the pharmakon tightrope creates the opposing sides for which the audience members play a role in deciding the success of the social problem identity formation. Loseke (2011) explains that audiences participate in the development of a *folk knowledge.*

The folk knowledge is understand as the development of social norms, norms that form as symbolic codes that indicate social activities as right wrong good and bad (Loseke, 2011; Goffman, 1961). A product of claims making activities is the projection of social norms that shape the meaning development in a 'folk universe' (Loseke, 2011). Through participation in the folk knowledge development, it could be suggested that the role of the audience member goes beyond simply a bystander. In a process of internalising the claims, an audience contribution to a folk universe can be considered as facilitating in claims making activities. Outside of the institution of social problem workers previously recognised as actors, this research addresses how the audience members take part in claims making. This is investigated further as the audience are expected to make sense of the claims that feature in the social problem and, consequently have a say on how successful claims are in the process which ultimately

impacts the social problem formation (Rappaport & Seidman, 1986). Therefore, in order to understand the impact of the social problem at the micro level, we must consider the lived experience of audience to claims and their claimsmaking activities.

We have established the ECP exists in an ambiguous position as a contraceptive option for women. The tightrope framework in Chapter 2 indicated that the state of ambiguity that surrounds the ECP is determined by the dual meanings given to the ECP. Fischer (2000) suggests that 'ambiguity' is often used as a tool in policy; by framing certain issues with an ambiguous status it 'satisfies different interest groups at the same time', permitting acceptance of a problem's existence with competing meanings (p.64). I suggest that the role the interest group here recognised as 'the audience' takes on, is to facilitate the ambiguity that stabilises the ECP's position as a pharmakon.

The process of stabilising ambiguity in policy additionally aims to impact individuals that are considered within the problem. Fischer explains, 'because ambiguity allows participants to read themselves into collective programmes and actions individuals can reconcile their own ambivalence and inconstant attitudes' (2000, p. 64). The role of the audience is important to sustaining the pharmakon's ambiguous position. The claimsmakers in control of the problem construct have worked hard to ensure the problem is well received by the audience but also to manage the stability of the problem so it does not fall too far either side of the pharmakon. The part the audience plays in the social problem process is to sustain the place of the problem on the tightrope. We know audience's perceptions are increasingly important to claimsmakers in social problems, and in order to investigate the social problem process impact at the microsociological level of social enquiry, it is necessary to speak to those who may take on the role of the audience member.

In summary, this work assesses how claims that feature in the macro public sphere reach and are internalised by those who are the target audience. I have chosen to develop ideas from the social constructionist approach to develop this social problem investigation. Influenced by the work of Goffman (1963), Loseke (2017) and Best (2013), I have developed a framework that supports the investigation into the social roles individuals take on when interacting with a social problem. The pharmakon framework outlined in Chapter 2 further supports the enquiry into an ambiguous social problem. The framework developed can be recognised as contribution to the field of the sociology of social problems.

The following section outlines the design of the research, from the decision to use qualitative methods, to the extensive ethics applications. The section outlines the various issues that were overcome and the analysis that was conducted.

3.5 Research design

> Qualitative researchers use a lens not based on scores, instruments, or research designs but a lens established using the views of people. (Creswell & Miller, 2000, p. 125)

In my investigation into the social problem process, I utilise qualitative methods as an appropriate methodology to explore the 'meaning making' of individuals and identity work that emerges in social problems. Handberg et al. (2015) suggest that symbolic interactionism should not be used as a 'cookbook' as it 'violates' the principle of inductive inquire's (p. 2). However, I have allowed the previous work of others to guide the investigation into the meaning-making of individuals in the social problem. I balance my attempts to adopt an approach to social constructionism that seeks to acknowledge the acknowledging the influence from symbolic interactionism and contextual constructionism, but also test a new framework to studying the social problem process in the pharmakon tightrope.

Loseke (2017) suggests that 'social constructionist approaches to social problems are an application of a general social constructionist perspective on social life which has philosophical and methodological roots in phenomenology' (p. 189). I have adopted an interpretative phenomenological approach to the investigation of the lived experience of the social problem. Biggerstaff and Thompson, (2008) suggest that the interperative phenonmenological analysis allows research to 'explore how people ascribe *meaning* to their experiences in their interactions with the envrionemnt' (p215). From this approach I set the following research objectives:

1) How do ambiguous social policy problems impact the lived experience of a social problem:
    i) for women who use the emergency contraceptive pill (ECP);
    ii) for sexual health nurses that distribute the ECP;
    iii) for women who are the target audience of claims made on the ECP?

2) Can the pharmakon tightrope framework be used to better understand the process of navigating dual meanings given to an ambiguous social problem?
3) How do professionals adopt the role of social problem workers in the pharmakon tightrope and how do social problem workers facilitate the social problem's stability on the pharmakon tightrope?
4) What impact does identity work within the social problem process have on those who adopt social problem behaviour?
5) How do social problem audiences navigate and give meaning to a social problem that exists with dual meanings?

The following section outlines the various methodological decisions made and issues overcome during the design stages of the research. I begin by offering an overview of the research design decisions.

Sociologists who have studied social problems have utilised qualitative methods (Best, 2013; Holstein & Miller, 2003 ; Ibarra & Kitsuse, 1993; Jamrozik, et al., 1998; Loseke, 1992). For instance, the impact of claimsmaking activities has been addressed using qualitative media analysis (Frawley, 2015; Arai, 2009). Frawley (2015) uses qualitative media analysis to assess rhetorical claimsmaking activities around the concept of 'happiness', using qualitative methods to better understand the process and impact claimsmaking has on the public construction of this social problem. Others have opted to speak directly to those who feature within the social problem using qualitative methods (Loseke, 1992; Luker, 1975). For this research it was decided that interviews and focus groups would be used to assess the lived experience of a social problem.

The pharmakon framework described in Chapter 2 identifies significant characters in the social problem process that support the criteria for participants. The participant groups were decided following a literature review on previous studies on the ECP. Health professional are important actors due to their role as social problem workers managing the ambiguity of the ECP. In addition, women as EC users were recognised as obviously important and I wanted to explore the impact the wider macro construct had on the identity work of women.

3.5.1 Semi-structured interviews

In order to address the feasibility of the tightrope framework and the role of the different actors involved, semi-structured interviews were decided to be suitable to explore the experiences of both health professionals that distribute the ECP and women that have used the ECP.

Semi-structured interviews have been used elsewhere to explore the professional identity of nurses. Fagermoen (1997) uses semi-structured interviews to explore the professional identities of Norwegian nurses. Her aim is to address the meaning nurses gave to their professional identity and she adopted a symbolic interactionist approach to the study of meaning. She finds that 'the interview evolved as a dialogue in which the nurse and the researcher together focused and explored the meaning of the nurses' work' (1997, p. 437). I adopt a similar approach in my own design of the semi-structured interviews carried out with both the women and health professionals. An issue that appeared for Fagermon (1997) is the concern of 'how to get information about what values were in fact actaulised in the nurses' practice' (p. 437). She overcome the concern that the nurses may fabricate 'values' by asking the nurses to 'tell stories as about meaningful patient care situations' (p. 437). In order to overcome similar concerns, I design interview schedules for both the health professionals and the EC users that would allow them to be reflective in their storytelling, but also share real-life stories. The nurses were to be asked open-ended questions about their experiences and role in access to EC services to allow the participants to offer their own understanding of this experience (see: Appendices 1 and 2 for interview schedules). This is then addressed carefully during analysis to ensure the validity of the discussion remained intact.

In addition, semi-structured interviews have been used to explore the identity work of the individual. Kirsten Luker's (1975) work on abortion, and the decision to not use contraceptives, explores the contraceptive risk-taking behaviour of women who attended an abortion clinic in the US. Through the use of interviews, Luker (1975) explores the wider construct of the risk-taking behaviour of women and their decisions made on using contraception. Luker (1975) finds in her interviews that women are able to weigh up their risk-taking against a cost and benefits framework. The framework developed by Luker (1975) identifies the themes in the discourse of the interviews that showed the women weighed the risks of pregnancy versus the cost of contraception. Luker's (1975) work created a new frame for understanding how and

why women choose to use contraception, and the results indicated that through qualitative methods, the researcher can explore the thought processes of women and contraceptive decisions. This finding supported my own design of interview schedules with women who had used the ECP that explores the contraceptive decision of women and their use of the ECP.

Although Luker's (1975) findings find some patterns to the explanation for the risk-taking behaviour of women, she also finds that the women reflected on their behaviour in light of how it was viewed by others. Luker (1975) explains that although she was able to create a way to measure risk-taking behaviour as a cost-benefit analysis, the women themselves faced a 'hierarchy of credibility' that impacted their reflections of their identity construct. Luker (1975) further explains that the women experienced meaningful interaction with 'abortion counsellors, social workers to doctors and to well-meaning friends' which ultimately impacted the way the women reflected on their behaviour. Luker explains that the women 'reconstruct[ed]' their behaviour in line with the hierarchy expectations and assumption that 'she should have known better' (p. 178). She shows that women experienced some level of reflection during their process of accessing abortion services. Influenced by Luker's approach to 'measure' risk-taking, I adopt a similar approach in the analysis of the interviews and focus groups and recognition of the pharmakon tightrope (see: Analysis for more details).

The identity work of an individual cannot be generalised, as we appreciate the various social and environmental aspects that may impact on it. Semi-structured interviews support the exploration into specific identity constructs that are given meaning by individuals. Furthermore, they suitably support the opportunity for women to share experiences of accessing the ECP via a consultation. I chose to adopt a similar approach to both Fagermoen (1997) and Luker (1975), as I designed the semi structured interviews used to interview sexual health nurses as social problem workers (see: Appendix 1) and women as EC users and the problem identity (see: Appendix 2). In addition to the semi-structured interviews, I chose to conduct focus groups with my final participant group, the audience.

3.5.2 Focus groups

Focus groups have been used to explore the people's opinions of family planning services since the 1980s (Folch-Lyon, et al., 1981; Kline, et al., 1992; Piet, et al., 1981; Schearer, 1981). In my investigation into the tightrope formation, one-to-one interviews would not support the investigation into how claims are received by the

'audience' to the social problem. In order to test the validity of the tightrope, it is important to also explore the impact claims had on the target audience. Women of reproductive age who could access the ECP if needed were chosen as the final participant group to explore their role as audience members. Focus groups have proven reliable methods assess individuals' opinions towards family planning services, and the research of others influenced the approach I used when designing the focus groups (Kline, et al., 1992; Schearer, 1981).

Folch-Lyon et al. (1981) use focus groups to explore men's and women's attitudes towards family planning services in Mexico in the 1980s. They find a mixed response to the attitudes towards family planning services, with 'both positive and negative attitudes towards family planning' services identifiers (p.430). Folch-Lyon et al. find the positive attitudes held towards family planning methods supported the view that family planning 'directly benefits the family by making more money available and by enhancing the welfare of children'(p.428). Compared to the negative views that were described as morally problematic, Folch- Lyon et al explain:

> Many men express fears that their wives will become adulterous if they use contraceptives; and most women believe their husbands wish to keep them tied down with pregnancies so that their power and control [...] the subject of family decision making about contraceptive use is emotionally loaded. (1981. p. 429)

The findings suggest that the focus group study has the ability to address the personal meaning given to contraception and the moral reasons behind it (Folch-Lyon, et al., 1981). I adopt a similar approach in my design of the focus groups as I attempt to explore a problem that is pharmakon with dual meanings. I design the focus group schedule that supported the open conversation of women's opinion of contraceptive use and access (see: Appendix 3). The focus groups supported the opportunity for women to share the meaning they give to claims that appear in the discourse around the ECP.

Before I could begin the process of recruitment, a number of ethical boards were contacted for approval to access participants from a variety of settings. The following section outlines the complications that were faced when finalising ethical approval and the impact this had on the time frame given to sample and recruit participants.

3.6 Ethics

Aware of the ethical implications this research posed and sensitive to the aim of having an open discussion with women and nurses about contraceptive behaviour, I

addressed any potential ethical issues during the design stages of the research. Ethics applications were submitted to both the NHS Health Research Authority and the Faculty of Social Science and Ethics Committee at the University of Kent. In addition, I was asked to also to complete a Research Passport to access and conduct interviews in the local NHS clinics the local Community Health Foundation Trust.

The nature of the topic was considered sensitive for all three participant groups in the various capacities (Keenan & Teijlingen, 2004). Therefore, it was important to ensure the interviews and focus groups were designed with the participant response in mind, to ensure that no participant experienced any distress or harm (Keenan & Teijlingen, 2004). Exclusion criteria were defined early on, and anyone who was considered vulnerable i.e. currently in social care services or unable to offer informed consent, were automatically excluded from the research. Keenan & Teijlingen (2004) explained that researchers should be aware of two points of interest when designing and conducting research in 'family planning'. The first is 'gaining informed consent from participants' followed by 'maintaining promises of anonymity and confidentiality' (Keenan & Teijlingen, 2004, p. 258). Moving forward, the names of all participants were changed using pseudonyms to conceal identities. Participant information collected has been kept in password-protected electronic files and will be destroyed one year after final submission of this thesis.

To gain informed consent, all participants were given information sheets explaining the research and were asked signed consent forms agreeing to take part.[4]There were no issues with participants withdrawing from the research. One participant did cancel after agreeing to take part due to a bereavement in the family and their contact details were wiped from the research participant records. Personal information that was obtained from participants, such as name and contact information, was stored on a secured file on an external hard drive. This information will be kept for the sole purpose of contacting participants on the submission of the thesis and destroyed one month after submission.

The following section breaks down the ethical applications submitted and highlights the various issues overcome during this stage of the research.

[4] See Appendices 4,5,6 for information sheets and 7,8,9 for consent forms.

3.6.1 Health Research Authority (HRA)

I started the HRA application process in September 2015. The application itself is quite long (over 80 pages) and complicated, which meant I needed to seek advice from both the University of Kent Ethics Support team as well as several individuals from HRA. However, I was told that HRA approval was not needed to speak to NHS health professionals; only one extensive HRA ethics application would be needed to recruit the health professionals from the NHS setting and to recruit and speak to women from an NHS setting.

Influenced by the previous investigation into health professionals and the ECP, the HRA application was initially used to gain approval to speak to two groups of health professionals; Pharmacists and Sexual Health Nurses. I had planned to recruit pharmacists from the locally commissioned group of Independent Pharmacists that provided free ECP from the NHS. The research suggested that the pharmacists that rarely distributed the ECP would produce a comparative view to the sexual health nurses that are regularly exposed to reproductive health issues (Anderson & Bissell, 2003; Anderson, et al., 2006; Biggerstaff & Thompson, 2008; Bissell, et al., 2008). Both professional groups would have allowed me to explore the role of social problem workers.

The application was submitted on April 2016. After months of edits and development of all the necessary interview material and participant information, the HRA application received a partial review which meant no panel interview was necessary for August 2016. The HRA application process took altogether 12 months to obtain approval in September 2016 and I was given the green light to begin my recruitment of women and contact NHS staff to take part in semi-structured interviews.

However, after receiving approval it became clear another lot of applications would be needed to access pharmacists to take part in the interviews. Due to the extensive process has taken to complete the initial HRA application a further ethics application was deemed an added complication. It was decided by my research supervisors and myself that only one group of health professionals would be needed, since the Sexual Health Nurses were deemed the most appropriate participant group. This decision led to the findings discussed in the Chapter 2. However, pharmacists were still contacted via letter to participate in third-party recruitment of women. (See: sampling and recruitment for more details).

3.6.2 Research Passport

After receiving my HRA approval I was then asked to complete a Research Passport that would allow me to access and use the Sexual Health Services in Kent. The passport asked for details on the various research activities proposed to be conducted within the clinic setting, along with information such as a list of who I was working with and how long I would be using the facilities for recruitment and conducting interviews. The research passport was approved a month after the final confirmation from the HRA. I began working in the Kent Community Health Foundation Trust (KCHFT) clinics in October 2016 and continued to interview staff until November 2017.

3.6.3 Faculty of Social Science Research and Ethics committee (REC)

The sampling for women to take part in focus groups was designed using a snowball technique relying on word of mouth, advertisement using posters and social media advertisement (see: sampling and recruitment for more details). For this I applied for ethical approval to conduct the focus groups from the University of Kent Faculty of Social Sciences REC in September 2016. It took around four weeks to receive approval to begin recruitment of focus groups in October 2016.

An amendment was made to the REC application halfway through the recruitment phase in April 2017. I found the third-party recruiter scheme designed as a part of the HRA application proved ineffective (see: sampling and recruitment for more details). After seeking advice from my research supervisors, I chose to adapt the design of interview for EC users to make it, firstly, a broader recruitment process outside the confines of the NHS and, secondly, make it more convenient and approachable for those willing to take part. Amendments were made in May 2017 to recruitment women as EC users for telephone interviews via audio skype call and approval was received on June 2017.

The ethics phases of the research were extensive, with a number of application processes prior to conducting the research and issues that followed in the sampling and recruitment phases of the research. These issues are recognised as weaknesses to the design, but unfortunately unavoidable due to time constraints. The following section outlines the sampling and recruitment of each of the participant groups with overview.

3.7 Sampling and recruitment

The research consists of three participant groups with the aim of collecting data on those most likely to be impacted by the social problem claimsmaking activities. The first are semi-structured interviews with sexual health nurses, conducted face-to-face. The second is women who have used emergency contraception in the last five years, conducted both face-to-face and via the telephone. The last is focus groups conducted with women of reproductive age. Each participant group offers a different insight into the impact of social problem claims and claimsmaking activities.

Due to earlier delays in the recruitment as a consequence of the ethics application process and the unsuccessful nature of the third party recruiters, the participant groups were recruited using a 'purposeful sampling'. Purposeful sampling techniques described by Coyne (1997), indicate that researchers seek to utilise the early design stages to create the criteria that support the suitable samples that are available to the researcher. Unlike theoretical sampling where the researcher adopts the sampling criteria through early stages of testing and investigation, purposeful sampling sets out to find suitable participants based on previous research creating criteria early on in the design phase (Coyne, 1997). Unfortunately, I was not in a position to test or investigate sampling procedures due to previous setback. However, it is suggested that 'there is no perfect 'way' of sampling, as it is a process that continues to evolve with the methodology' (Coyne, 1997, p. 630). I experienced this in the research with attempts to manage the ongoing issues with ethics and recruitment, I did alter the sampling criteria for the women interviews as discussed in more detail below.

The first participant group that was sampled successfully with little delay was the sexual health nurses.

3.7.1 Sexual health nurses

The sexual health nurses were recruited from the Community Health Foundation Trust through a contact made with the local Sexual Health Services. The role of the sexual health nurses is important to the research because, unlike the doctors in the clinics or in GP surgeries, the nurses are bound tightly by policy and guidance with limited room for movement in prescription, making the nurses' role the ideal 'gatekeeper' for the investigation (Clarke & Willetts, 2014; Crouch, 1999; Finn, 2001; Kang, et al., 2011; Upton, et al., 2010). Not only are the nurses regulated by the restricted policy guidelines, they also have the highest exposure to women and sexual-health-related

issues on a daily basis, making the nurses the primary source for distribution of EC in a health service setting. The criteria for the nurses is simple: they had to have experience distributing the ECP to women and work in the NHS sexual health clinic setting. The NHS sexual health nurses' positions are at a variety of levels, from Senior Sexual Health nurses to Locality Managers, and there is a wide range of statuses amongst the nurses interviewed. However, it was decided that this would not feature as a measure of their identity in the research, as there was no mention of the level of seniority of the nursing role impacting their role distributors of EC, since all the staff interviewed were qualified to prescribe the product. Therefore, from this point on, all participants interviewed are recognised as nurses and not by their specific job title, to ensure the identities remain anonymous.

A small difference is noted between experiences of the nurses who work in a clinic setting and those who experience working in outreach. Therefore, moving forward this is noted in relation to comments on their position as an outreach nurse. However, there appears to be no disparity in constraints within the levels of nursing, some of the nurses recognised how their role was more restrictive than other EC distributors such as pharmacists, General Practitioners (GPs) and Doctors. It became apparent the sexual health nurses understood the limitations of the medical side of the role. This is evident in their expressed efforts towards undertaking responsibilities that feature on the 'holistic side' of the job role this is discussed in more detail in the results chapter. Table 1 outlines the characteristics of the nurses interviewed.

No.	*Name*	*Age*	*Gender*	*Previous job*	*No. years in sexual health*
1	Kate	50	Female	School Nurse	14 years
2	Lesley	55	Female	School Nurse	12 years
3	Heather	63	Female	Baby Unit Nurse	25 years
4	Jane	47	Female	School Nurse, Practice Nurse, Outreach Nurse	8 years
5	Karen	45	Female	A&E Nurse, Outreach Nurse	15 years
6	Richard	52	Male	HIV nurse	20 years
7	Michelle	53	Female	Ward Nurse, School Nurse, Police Officer.	12 years
8	Mary	51	Female	Orthopaedic Nurse, Practice Nurse, School Nurse	20 years
9	Helen	36	Female	Gynaecology Nurse	10 years
10	Julie	45	Female	Forensic Nurse, Practice Nurse	20 months
11	Elaine	57	Female	Gynaecology Nurse, Young People Clinic Nurse	15 years
12	Emma	45	Female	Practice Nurse, School nurse	9 years
13	Susan	50	Female	Midwife, Outreach Nurse	20 years
14	Carol	63	Female	Health visitor	30 years
15	Gemma	56	Female	School Nurse, Outreach Nurse	12 years

Figure 3: Sexual health nurses demographics

Fifteen nurses were interviewed, with 14 female and one male nurse taking part in the research. The sample appears to represent the gender disparities of nursing. Due to the nature of the occupation, it appears that more women work in sexual health nursing than men. Those interviewed come from a variety of nursing backgrounds: school nurses (7/15); midwifery (2/15); gynaecology (1/15); and other nursing roles such as, practice nurse, A&E health care assistant, and HIV nurse (5/15).

The age of the nurses varies. The youngest nurse is 36 and the eldest 63. This range of ages also offers a range of experience of working in the sexual health setting, especially as some of the nurses have experience working in sexual health for over 20 years. This means that they entered the profession at a time when the ECP transitioned to an over the counter (OTC) product. This made for interesting discussions since four of the nurses had to experience using and distributing the earliest ECP prescribed product PC4.

All of the nurses share similar stories and motives for working in the field of sexual health. As professionals in a medical setting, they are recognised as the social problem workers balancing the tightrope. Each interview took between 40-80 minutes. They were conducted in a private room in the clinic. The interviews were recorded on a dictaphone and transcribed. The transcription for all the participant groups was conducted by both the researcher and an outsourced transcription service. All external transcribers signed a confidentiality contract (see: Appendix 10). The next group of participants sampled and recruited were the EC users.

3.7.2 Women as EC users

In the early design phase, I aimed to recruit women who had used emergency contraception from NHS sexual health clinics. For this I designed a third-party recruitment scheme (see: Appendix 12) that allowed the sexual health nurses and pharmacists in the locality to recruit women on my behalf. I designed the recruitment scheme to support the third-party recruiter to approach a woman that attended the clinic or pharmacy for ECP and inform them about the research with an information sheet. Following a face-to-face discussion, the third-party recruiter would ask women that showed an interested in taking part, to sign a consent to contact form that gave me permission to contact them (see: Appendix 12). This scheme was decided as the most suitable approach to contact women who had recently in the last 12 months used the ECP. This sampling is described as selective sampling via recruitment process where the women would voluntarily pass on their contact details (Coyne, 1997).

Although this approach limited the sample to women who volunteered, it appeared at the early design phases the most practical recruitment for EC users.

Unfortunately, following the 12 months of the ethics application process and six months into recruitment of women, I found the third-party recruiter approach was ineffective. I contacted 70 pharmacists by telephone and letter and received no response or interest in aiding the recruitment of women. In addition, I found the nurses as third party recruiters in the clinic setting were also unsuccessful. Three women who had signed the consent to contact form gave incorrect information or could not be contacted. The feedback I received from the recruiters was that women did not want to spend any longer in the clinic after long waiting times and extensive consultation.

For this reason, I decided to readdress the criteria for the EC users and the process of recruitment. In June 2017 I adapted my design to include telephone interviews to fit around women's schedules, as well as offer a wider area of recruitment across the UK. The advertisement for recruitment was conducted via social media using Facebook and Twitter and in the space of four months seventeen women were recruited to take part via telephone. The change in design and recruitment can be recognised as a weakness to the sample. Participants who responded to advertisement were recognised as wanting to share an agenda and could be suggested as having a different experience to those sampled using alternative routes (Coyne, 1997; Noy, 2008). However, due to the earlier setbacks in ethics applications it was the only suitable way to increase recruitment. Figure 3 details the final sample:

	Name	***Age***	***Relationship at time of use***	***Occupation***	***No. times of use EC***	***Contraception at time of use***
1	Danielle	21	Single	Student	30	Condoms
2	Hayley	27	Single	Student	4	Condoms
3	Jessica	21	Relationship	Student	1	Condoms
4	Gemma	35	Relationship	PG Student	2	Condoms
5	Sophie	23	Relationship	Student	2	Condoms
6	Zoe	26	Relationship	Customer service	2	Condoms
7	Louise	33	Relationship	Researcher	3	Condoms
8	Nicola	22	Single	Customer service	3	Condoms

9	Laura	24	Relationship	Sales and marketing	4	Condoms
10	Amelia	26	Single	PG student	6	Condoms
11	Faye	30	Relationship	Lecturer	7	Condoms
12	Katie	24	Relationship	Student	7	Condoms
13	Jenna	25	Relationship	Journalist	12	Condoms
14	Lydia	20	Relationship	Student	5	No condom
15	Emily	34	Single	Lawyer	2	No condom
16	Hannah	23	Single	Career	5	Planned to use EC
17	Amy	25	Single	Student	3	Condom
18	Steph	27	Relationship	Unemployed	1	Condom
19	Lauren	27	Relationship	Designer	6	Condom
20	Fern	24	Relationship	Occupational Therapist	2	Condoms

Figure 4: EC Users Demographics

Overall, 21 women are interviewed. Five of the interviews are face-to-face, the remaining sixteen by telephone. One of the telephone interviews is excluded from the results because the participant accessed the ECP from a pharmacy in the USA. In review, I believed although it was an interesting addition to the data collection, her experience did not meet the research criteria.

The use of the snowball technique of sampling means there was no control over the demographics of women applying to take part in the research (Noy, 2008). This is recognised as a weakness to the research since it could be considered as creating a bias in the participants based on ethnicity and class (Creswell & Miller, 2000). However, there is no significant research in the ECP literature to suggest women in the UK experience a broad difference in access based on demographics, and the demographic questions were kept to the minimum of job role and age (Blanchard, et al., 2000). This may be considered a weakness to the validity of the research as noted by Johnston & Vanderstoep (2009), since it could be suggested that with ethnicity comes cultural values that may impact the participants' views. However, this did not appear as an issue in the analysis stage. Country of origin did occur as an aspect to be considered in the investigation with a number of the participants in the interviewees (3/4) identifying as not born British citizens. This added to the investigation since these women were able to offer a country comparison in their experience that added to the analysis stages and improved the data collected.

The criteria for women to take part was advertised as aged between 18-55-years-old and having used the ECP in the last five years. The age of the sample was chosen purposefully to address the gap in the current ECP literature in ECP users aged 25 and above. The majority of the women who took part in the interviews fell between the ages of 25-30 years old, with the eldest being 35-years-old and the youngest 19-years-old. I found the sample interviewed, differentiated from the previously established characterisation of the young EC user. The occupations of the women ranged with a mixture of occupation from lawyers, to journalists to sales assistants. However, almost half (9/20) of the women were students and this included a mixture of undergraduate and postgraduate students. It meant the sample, although varied, was weighted by one occupation offering a narrower viewpoint that impacted the generalisability of the sample.

ECP 'use in the last five years' was amended in the criteria in the telephone interview recruitment, since I found this extended the previously restrictive criteria of 'used in the last 12 months'. This opened the sampling opportunity to a wider group of women, and I found during the interviews women wanted to share their previous ECP stories. It became apparent in the interviewees that EC users find the experience memorable, which made them want to share their stories in the interview. I was aware that stories that were older than five years old could be viewed as unreliable as reported experiences of the participants (Keenan & Teijlingen, 2004). However, I found the women's previous experiences of using the ECP added value to the identity work of the EC user and were therefore considered during the analysis stage of the research.

Following the review of research conducted in Chapters One and Two, and with the objective of exploring the identity of the EC user, three key pieces of information were collected about the women as EC users. Second, the method of contraception used at the time of needing the ECP. Finally, the ECP user's relationship status at the time of use (Figure 6). This information was collected as a point identifying the characteristics identified in the literature as good and bad contraceptive users and behaviour associated with the ECP use.

Thirty is the highest number of times reported of ECP use in the interviews, while the lowest number of times is one. It is difficult to accurately calculate the average with the abnormally high number of 30, therefore, the mode number of times the EC users had used the ECP is two. The majority of women (17/20) have used condoms at the time of use (see: Figure 5). However, what is interesting is that 16 of the 20 (80%) women had previously tried alternative hormonal contraception but had stopped using these

methods due to problems with side effects. Four of the women who said they had never used hormonal contraceptives explained that their decision was due to stories of others' negative experiences. Although this opens an interesting line of enquiry into the reasons how and why women choose to use contraception, for the purpose of this research it is not something that can be developed.

Contraception used at time of ECP use	***Total women***
Condoms	17
No Condoms	2
Planned to use EC	1
Total	***20***

Figure 5: Contraception used at time of ECP use

In addition, the women sampled for the interview do not represent the previously established construct of the 'promiscuous', 'single' EC user, with 67 per cent of the women interviewed in a relationship at the time of needing the ECP (see: Figure 6). Policy claims around access to the ECP and the construct of the risky ECP user do not representation of the ECP users sampled here.

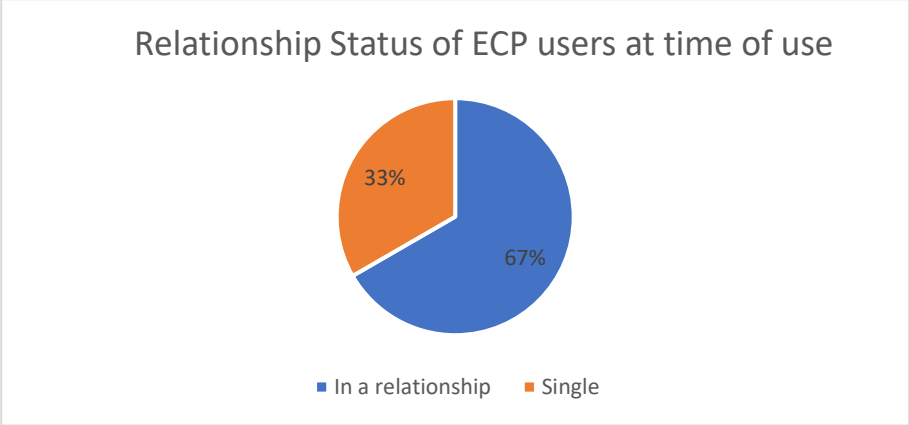


Figure 6: Relationship status of ECP users at the time of use

The sample of ECP users appeared to vary, it offers an interesting representation of the ECP user compared to the previously established 'young and risky user' in the opening chapters. Altogether, sixteen telephone interviews are conducted and five face-to-face interviews are conducted with women who had volunteered to take part in focus groups, but identified themselves as EC users and who agreed to take part in interviews instead. The women had experienced accessing the ECP from all possible routes of access, via a pharmacy, sexual health clinic and GP surgery settings.

Each interview lasted between 60-90 minutes. They were recorded using a dictaphone. The final group to be sampled and recruited were the focus groups.

3.7.3 Focus groups

During the design phase, focus groups were considered a useful tool to collect meaningful data on the public opinion of issues and social problems. Focus groups have been a popular method of choice for research into group opinions on social problems and health services (Johnston & Vanderstoep, 2009). Wilkson (1998), indicates that 'focus group interactions also encourage individuals to develop and elaborate their accounts in response to both agreed and disagreement for other group members' (p. 336). I found the focus groups offered a setting where women were asked to discuss their opinions around access to contraceptives but also offered a unique opportunity to witness first-hand claimsmaking activities. The women in the focus groups appeared to feel comfortable discussing their opinion in front of others, while equally feeling able to share disagreement. Wilkson describes this as 'collective sense-making, involved sharing information, pooling experience and comparing and contrasting them' (p. 338).

Additionally, the focus groups appear as another opportunity to see the claimsmaking activity in action. As an observer to the open group discussions, I was able to observe the dynamics of new information being discussed in the group and the way in which the participants responded to claims around the ECP (Marvasti, 2003). The focus group participants were women who are considered of reproductive age (18-55 years) and therefore could be potential ECP users. It is not a part of the criteria that these women had experience using the ECP, and it became important to have a variety of women (both users and not users), since this allowed for mixed opinions in the groups and refrained from creating a group bias.

In review, I recognise that in the sampling of the audiences, I could have included male opinions. However, it appeared in review of the literature, and in the objectives of the work, that male opinion on the ECP, while potentially interesting, may not be a product of the direct impact of claimsmaking activities, as males do not present as potential EC users. Thus, it was decided not to incorporate men into the research. This may be considered in future research options. Figure 8 summarises the characteristics of the participants in the focus groups.

Group	*Name*	*Age*	*Ethnicity*	*Occupation*	*Religion*	*Pregnancy*	*Used EC*	*Total*
1	Valerie Michelle Donna Abigail	25-55	X3White British X1White Italian	Lecturer Student Administrator PG Student	Christian x1	3/4	2/4	4
2	Emma Kayla Jennifer Heather Kirsty	25-36	4xWhite British X1White Icelandic	Lecturer Researcher Administrator X2 PG student	NA	1/5	3/5	5
3	Monica Erica Jenny Tina	20-45	3xWhite British 1xSouth East Asian	X4 Administration and student support	Catholic x1 Christian x1	3/4	1/4	4
4	Kelly Amber Harriet	18-28	3x White British	Student Health Carer Manager	NA	1/3	2/3	3
5	Sarah Elizabeth Samantha Grace	40-50	3xWhite Irish 1xWhite British	Health Care Assistant x3 Home maker	Catholic x3 Christian x1	4/4	2/4	4
6	Amy Jade Susan Claire	25-55	2xWhite Irish 2xWhite British	Learning Support Assistant Sales Administration Homemaker	Catholic x2	4/4	2/4	4
7	Charlotte Lizzie Sophie Katie	18-25	4xWhite British	Student Retail Assistant x2 Administration	NA	1/4	2/4	4
8	Jane Ella Hannah	30-50	3xWhite British	Lecturer Teaching Assistant Teacher	NA	1/3	2/3	3
9	Megan Holly Erin	18-25	3xWhite British	Student x3	Atheist x3	0/3	2/3	3
Total	33	33	33	33	33	18/33	18/33	33

Figure 5 Focus Group Demographics

Following the disruptions in ethics applications and the time allocated to recruitment, the focus group recruitment also fell to snowball techniques. This approach meant unfortunately the final sample of women did not offer as varied a representation of the current UK population of women as audience members as would have been ideal. For example, religion appeared to be a weighted variable in the focus groups.

During the design phase, religion was not anticipated as a dominant variable for women in 2017. However, with an unusually high number of women from White Irish backgrounds, Catholicism appeared to shape the women's earlier experiences of knowledge and understanding of contraception. This contributed to the various opinions of the women, but also indicated that the sample would not be representative of the wider population. Furthermore, during the focus groups recruitment phase, race appeared as an additional variable in need of including. However, the sample of women here did not represent a diverse range of cultures. With only one woman identifying as Asian and another as White Icelandic, the majority of women fell into White British category. If I were to repeat the study, I would ensure to sample a wider range of women as I believe the diversity in audience members would be a benefit to further investigation into the audience response to wider claimsmaking.

The focus groups were conducted in bookable meeting rooms on and off the university campus. The focus groups ranged from between 60 minutes to 120 minutes. The recordings were transcribed and analysed by the researcher. The following section outlines the analysis conducted on the data collection of all three participant groups.

3.8 Analysis

The analysis stage of the research proved difficult with three separate participant groups; I was surprised with the amount of data collected. For that reason, it was important that I was pragmatic with my analysis of the data collection, as well as, my reporting of the findings. In all three of the participant groups, I found themes that would support further investigations into the issues around women's contraceptive identities and the impact wider social problem claims have on the identity work of individuals. However, unable to explore all areas of interest, I chose to report on the main themes related to the problem frame of ECP.

Here, I indicate how I analysed of the social problem frame of the ECP at a micro level, from the interviews conducted with sexual health nurses, interviews with women who

used the ECP and focus groups with women of reproductive age. This analysis supports the identification of each participant group's role within the social problem process, and the following section details the predominantly inductive but partly deductive thematic analysis, and the development the pharmakon tightrope framework.

Fereday and Muir-Cochrane (2006), explains a "hybrid" approach to the thematic analysis is one that adopts aspects of both a deducted and inductive coding. "The primary purpose of the inductive approach [is] to allow research findings to emerge from the frequent, dominant, or significant themes inherent in raw data" (Thomas, 2006, p. 237). Unlike a solely deductive approach, I have allowed the raw data collected to guide the process of analysis and support the development of the framework the pharmakon tightrope. However, a deductive position would have maintained an investigation that tested previously established theoretical framework (Thomas, 2006). As the work addresses the concepts of the 'social problem process' and the 'pharmakon', the analysis is partly deductive as it also allows the theoretical framework to guide the research investigation. Therefore, the claims identified in the earlier chapters aided the distinction of particular themes around the problem frame of the ECP during the analysis. However, it was in assessing the transcripts from an inductive position that the emergence of 'meaning making' of the different participants became apparent.

In an effort to investigate if and how the social problem claimsmaking impacted the lived experience and meaning making of individuals, I used a coding process that supported the assessment of discourse for themes that indicate the framing of the ECP as a social problem. I initially began coding by hand to immerse myself in the transcripts and gauge the emerging themes. Then using the software Nvivo I progressed to categorise and code the transcripts from the interviews and focus groups. Each of the groups developed separate but similar codes that suggested ties between each of the group's experiences of the social problem claims making. Through exploring the reflective accounts of the participant experiences in, distributing, using and accessing the ECP, I was able to identify thematic examples of 'meaning' each group gave to the given problem frame of the ECP and their experience engaging with the social problem.

In assurance of the quality of the reporting of findings, as well as, to reduce the occurrence of ontological gerrymandering and over interpretation of the data collected, I coded with the intent to contextualise the meaning given to the ECP as described by the participants. Jones et al, (2016) suggest this approach:

> …enhances transparency and truthfulness, and facilitate transferability of findings to readers, [if] attention is given to data saturation, [via] description of the original context of data. (Jones, et al., 2016, p. 107)

I attempted to give saturation and transferability to the data by identifying codes that appeared to surface organically in the data and not influenced by my role as a researcher (Berg, 2004). However, I do accept there are some limitations to the data collection due to the sample of participants this is recognised previously in this chapter. However, it was not until I was halfway through the analysis process that it became clear I was developing a new framework. This meant it was important not only to the validity of the research but equally to the reliability of the framework, that I offered a contextual interpretation of data collection in the aim of assessing the 'meaning making' of individuals (Creswell & Miller, 2000). Therefore, despite some limitations in the potential bias based on the diversity of the sample, I have reported the information as true to the context of the discussions had with the participant groups.

Due to the three separate groups, one broad approach to the three data collections was not suitable. With three separate categories of people, social problem workers; actors and audience and the social problem identity, came three different experiences. Although numerous themes came to light in the analysis, in total, four main themes have been addressed per participant group in the results chapters. Within each of these themes were a number of 'child nodes' or sub themes, that grouped the discourse of the participants (Damschroder & Forman, 2008). By identifying sub themes and using child nodes, I was able to reduce the data collection. This was an important aspect of the quality control of the findings as Berg (2004) explains, "qualitative data needs to be reduced and transformed in order to make them more readily accessible, understandable and to draw out the carious themes" (pg39). By processing the codes through an iteration data reduction process, I was able to explore the 'meaning making' of each participant group and existence of the problem frame given to the ECP at a micro individual level. However, as a number of themes overlapped in the separate groups this led to the development of a tightrope framework.

3.8.1 The pharmakon framework development

As a result of the coding undertaken during the analysis, I developed a new and innovative framework that supports an investigation into how individuals interact with a social problem with dual meanings. The pharmakon tightrope framework

emerged following a process that 'involved several iterations before the analysis proceeded to an interpretative phase in which the units were connected into an explanatory framework consistent with the text' (Fereday & Muir-Cochrane, 2006, p. 8). Although, the pharmakon concept was applied initially to facilitate the investigation into the dual meanings, the tightrope design of the framework developed from engaging with the data collected from the individuals who experienced the reality of the pharmakon. Therefore, to 'establish clear links between the research objective and the summary findings' (Thomas, 2006, p. 238) the coding process supported the development of the new framework that investigations how separate individuals engage with the same social problem frame. Through the back and forth reviews of coding, I found the individuals appeared to engage similarly with the same problem frame, despite coming from different points of view and experiences. Consequently, it was important to design a framework that connected separate categories of people, yet, also allowed them to interact with one frame that had two existing meanings.

The tightrope design brought clarity to a complicated process of meaning making of a pharamkon. The design facilitated the relationship formed by of three separate categories of *people within the problem*. By identifying the social problem workers, social problem identities and the social problem audience, on the tightrope design, I was able to explore how they each engage with the same problem frame. The is addressed further in the results chapters.

The analysis was completed through a robust process of thematic coding and analysis, that constituted of repetitive reviews of the themes and consistency code checking (Thomas, 2006). In all, I found similarities emerging in the three participant groups data collections that suggested interaction with wider claims making appears at a micro level. The results chapters will explore in more detail how although the individual groups exist separate within the social problem, they share similar experiences of 'meaning making' that support the development of the pharmakon tightrope.

3.9 Limitations and reflections

The study of meaning as a topic is inherently subjective to individual experience (Ibarra & Kitsuse, 1993). This means any investigation into the process of 'meaning making' is susceptible to criticism. The social problem process under investigation here introduced a new framework of investigating the social problem identity work of individual using a microsociological approach. The research was designed in the aim

to contribute to the gap in the field of social problem investigation by addressing the impact the wider claimsmaking activities have on the lived experience of the individual. The social problem under investigation, the ECP, appeared unique in its form as a pharmakon.

By developing the framework of the pharmakon and adapting social constructionist approach to social problem process, the work had introduced a new method of assessing the social interaction of significant social problem workers and individuals in the form of the pharmakon tightrope. In all, the work offers a new approach to exploring the identity work of a social problem and the impact the wider claims have on the lived experience. Although the initial design and framework have a lot to offer as a contribution to the study of social problems, there are limitations to the research that lie with the sample accessed for the research and the time allocated to the different phases of the research.

The issues that came to light as limitations to the research centre on the time allocated to the ethics application phases and the impact this had on time left for recruitment. As unforeseeable problems the limitations are evident in lack of diversity in the sample recruited which impacts the overall representativeness of the research findings.

If I were to conduct the research again, I would readdress the necessity of having to receive clearance through specific ethics boards such as the HRA NHS ethics committee to gain ethical approval for recruitment. In hindsight I know now, the ethics evaluation of the University of Kent Research Ethics committee would have been an appropriate alone. I found I was able to recruit women who had used the ECP from a much less formal route following guidance from the University of Kent Research Ethics Committee after failing to do so through the NHS. I believe these complications could have been avoided if I had sought more guidance on which ethics boards I needed to contact and would have given me more time for both completion of the review alongside the recruitment of participants.

Furthermore, I would also design the research to give more time to recruited participants and ensure the greater diversity in the sample collected. However, with the challenging objective of testing a new framework for understanding the impact ambiguous social problems, the data collected here supports the work as a valid contribution to academic investigation.

The following chapters feature the findings from the data collection, starting with the interviews conducted with the sexual health nurses.

Chapter 4

Social Problem Workers: The Nurse

4.1 Introduction

This chapter begins an account of the role of the social problem worker. As explained in the previous chapter, it draws on a set of interviews with 15 nurses who work in sexual health clinics and who provide ECP as a part of their jobs. Through the interviews the nurses were asked questions about the product; how they make the ECP available to women; how they think about this part of their work; and how they think about the women they provide healthcare to. This chapter is structured around these four aspects of the interviews. It runs through an account of nurses' discussion of the product itself, considering how they see its place within or outside contraception. I then consider the question of access focusing on the theme of patient choice and the debate considered earlier in this thesis surrounding advance prescribing. Next, I discuss the place of providing ECP in the understanding of the professional role of the nurse. And finally, I discuss accounts of women as users of ECP. Throughout, I draw attention to the way in which the 'curse' aspect of the ECP as pharmakon is attached to the question of women's behaviour and how the nurse as social problem worker emerges as a manager of the risks associated with women's behaviour. I contend overall that the social problem of ECP in the clinic setting is constructed not so much around the pill as a medicine but rather around the attitudes and behaviours of those who use it. The ECP emerges as a problem subject to medicalisation less by merit of its existence as a drug than by the need for professional concern and intervention in the sex life of those who use it.

4.2. The ECP

In Chapter One, I explored the literature on the ECP that suggested it has been constructed as a problematic contraceptive. I discussed how, in different ways, claimsmakers including pharmaceutical companies, policymakers and health care professionals' organisations, categorise ECP as falling outside 'regular' contraception. Here I revisit this distancing of ECP from contraception as a whole by discussing how the nurses interviewed for this study framed their understanding of the product and their work in providing it to women.

In doing so, I make use of the pharmakon framework discussed previously that established how ambiguous claims enable the formation of dual meanings given to one social problem. I use this framework to show the ways in which nurses as social problem workers consider ECP to be both a blessing and a curse. I discuss the way they see the development of ECP as a product as at least unproblematic, and even as a gain, yet we show that at the same time they associate women's need for it as a problem associated centrally with the concept risk.

4.2.1 Before PC4

The opening chapter acknowledges the origins of the development the ECP, and explores the language used prior to the development of a dedicated post-coital contraceptive. The transition to a dedicated product is revisited here through discussion of nurses' accounts of the time they spent working as providers of contraception. The sexual health nursing experience varies across the interviewees. Some nurses had worked in a sexual health setting for under two years, compared to four nurses who had worked in a sexual health setting for over 30 years. This meant the older nurses had experience distributing the first prescribed ECP product made in the 1980s, PC4. The following discussion draws primarily on the accounts of those nurses and how they viewed the advent of EC as a particular contraceptive.

Chapter 2 indicated that the role of the nurse was an introduction to the institutionalised family planning service setting in the 1970s. Following the introduction of the 1974 The National Health Services (Family Planning) Act, nurses were given the responsibility of gatekeepers to contraceptive services. This included the earliest ECP product, the PC4. When speaking to the nurses who remembered the period when the PC4 product was introduced, they describe the introduction as a positive contribution to women's contraceptive options. This is understood here as on the pharmakon tightrope as a blessing:

> We didn't have emergency contraception as we know it now. We used to just give out huge doses of basically the combined pill. (Elaine)

The nurses who experienced life before the one-pill product describe the introduction of PC4 as a positive development. Carol suggested that women "would do what they could" to prevent pregnancy after sex, therefore, the introduction of a convenient two pill product was viewed as a positive contribution to women's contraceptive options. Unlike the rhetoric we see today around the ECP as a problematic contraceptive

product, the nurses' PC4 stories suggest that the PC4 was seen as a solution to the issue of preventing pregnancy after sex.

With the post-coital options being minimal prior to PC4, the nurses explained they would give women "about 30 progestogens only pills", making women "horrendously sick" (Elaine). PC4 was approved by the nurses since it reduced side effects and came in a two-pill option, so when speaking to the nurses it appeared they considered the PC4 product to meet the needs of women in many ways. I was surprised to find the nurses speak so highly of the PC4 product in their reflective accounts. It appeared the PC4 was introduced at a time when the post-coital alternative made women unwell, which meant that PC4 took on a frame as a solution to the problem. All four nurses shared this meaning given to the product. What appears to emerge as a negative discussion is the nurse's description of others' feelings towards the product. Although, the nurses felt the product's introduction was a good thing, they were aware others did not. However, I found in the conversation that they made a point of distancing themselves from the negative opinions they witnessed in the institutional setting.

Carol described how she and her colleagues, during the earlier years of distributing PC4, were expected to ask women to "sign disclaimer[s]". She told me "that if [a woman] took PC4 and become pregnant they would agree on having a termination, which of course had absolutely no legal validity whatsoever". When speaking to these few nurses who knew life before PC4, it was clear that the relationship between the doctor and the patient was more authoritarian than we see today. Carol explained that the reason the women would have to sign a disclaimer was that:

> It was drummed into these women that if they became pregnant we couldn't guarantee no foetal abnormalities so they would be expected to have a termination and I can remember the odd occasion when a woman did become pregnant and refused to have a termination, since it had no legal validity. But those were way back then. (Carol)

"Way back then" appears to describe a setting where risk aversion towards pharmaceuticals impacted health professionals' gatekeeper role. The use of disclaimers is presented as a worrying approach taken to women's autonomy. Despite there being no legal validity in the disclaimers, risk aversion towards the ECP or "new drugs" that meant the health professional felt they needed "legal support" (Carol). The nurses did not appear to support the use of disclaimers with them not considering the PC4 a 'risk'. They explained the use of the disclaimers fed into the institutional

anxieties of “doctors”, and did not mirror any risk-aversion they felt towards the product.

The existence of disclaimers used in the clinic setting acts as evidence of top-down anxiety transfer. The discussion with the PC4 nurses suggests they were exposed to anxieties shared by another health professional. The anxieties centred on the risk taken by distributing new pharmaceuticals, which exposed the medical profession as vulnerable to repercussions. However, the nurses did not show any support for this aversion to risk. They appeared to distance themselves from the anxieties and described that the concerns were shared by "others". The nurses continued to support the PC4 as a positive contribution to women’s contraceptive options, despite the ambiguity that appeared to emerge at the time of its introduction, and the possible risk of harmful side effects.

Elaine also indicated that doctors' disapproval of the PC4 product appeared to be for social reasons rather than health concerns. She described how doctors framed the use of ECP as ‘taboo’, not because of the mechanism of action or the product itself but rather because of the concern doctors had for women and sexual behaviour they considered inappropriate. Elaine said:

> Well I think it was almost like people were in denial that sex goes on and that sometimes things happen […] it was kind of like, why are we having to give this out. You should behave yourself. That was the impression I got. (Elaine)

In their reflective accounts, the PC4 nurses discussed how other health professionals viewed the product as something women "shouldn’t need" (Elaine). They described that the doctors’ use of disclaimers was a way to "cover their backs", despite the contracts having no legal validity (Carol).

The anxieties that appear in discussion of the heritage of the ECP are similar to those previously surfacing around the pill in the 1960s (Cook, 1997). The PC4 was recognised as a morally problematic topic for doctors in a family planning setting, as the nurses appeared aware of the wider macro-frame given to the PC4.

These PC4 stories indicate that, at the early stages of distributing the ECP, it was open to intense regulation due to ambiguities around the unknown side-effects and the moral frame associated with post-coital contraception. With this as an interesting account of the current ECP's history, I now turn to discuss nurses' responses to questions that focused on the description of ECP as an ‘emergency’ contraceptive.

4.2.2 It is for 'emergencies only' because the ECP 'is not a contraceptive method'

The term *emergency* was defined in Chapter 1 as describing something 'dangerous', in need of 'fast action' and/or something anticipated to cause 'harm' (Cambridge Dictionary, 2017). The previous chapters discussed how *emergency* as a term does not reflect the mechanism of action of the ECP, or any harm that may be inflicted from its use. However, during my discussions with the nurses on the role of the ECP as a contraceptive, the term *emergency* appeared to typify the contraceptive as something outside the 'regular' contraceptive methods available. I found that, as social problem workers, the nurses internalised the meaning given by the term *emergency* as a reason to segregate the product from other contraceptives.

During interviews, I asked the nurses about the role of the ECP. I found the nurses acknowledged that "there aren't that many risks involved. Its [a] progestogen-only method" (Gemma), which considered a "vital part of women's arsenal" (Lesley). However, despite the general acceptance that the product was a necessary contraceptive option for women, it was clear the nurses struggled to accept the ECP as a contraceptive option, for a number of reasons I explore below.

The nurses explained how they considered the ECP to be a good solution for preventing pregnancy after sex, but a number of the nurses did not feel comfortable describing the product as a contraceptive "method". The term *method* appeared to the nurses as a way to distinguish how contraceptives are used. "Methods" were noted by the nurses as something used "daily" or "regularly", so for this reason the ECP use was framed differently. For this reason, the nurses felt that describing the ECP as a *method* would inappropriately promote the "wrong type of use" for the product (Kate). Eight of the 14 (57%) nurses used different terms to define the ECP as a contraceptive; words such as: "failsafe", "rescue remedy", "backup" described the product. These terms appeared appropriate definitions for the product, since they separated the ECP from oral contraceptive pills or LARC, whilst further typifying its use as a "one-off". As the discussions continued, I found further explanation given for why the nurses were reluctant to categorise the ECP alongside the 'regular' contraceptive options for women.

Almost all (13/15 or 87%) explained they would not place ECP in the same category as the other contraceptive options available. Mary explained:

> I don't view it as an ongoing form of contraception because it's not, and it's not designed to be an ongoing method of contraception. It's designed just for emergency use. You expect maybe, once, twice a year or […] but you would certainly expect, not on a monthly basis. (Mary)

I found from speaking to the nurses that the ECP was legitimised as an irregular contraceptive because of its frame of 'emergency use'. The nurses referenced the term *emergency* as a way to justify its "one-off" use, not something that to be used on a "monthly basis" (Mary). Although the nurses considered the ECP as safe with 'no risks', they expressed some concern for women who used the product more than once or twice (Kate, Mary, Heather). Heather agreed:

> I would say that isn't a method of contraception. It's a rescue remedy if you, you know, make a mistake or something happens to prevent a pregnancy that's unwanted because you're not on contraception. (Heather)

The nurses differentiated types of contraceptive based on the nature of their use. With the ECP framed as for 'emergencies' in the nurses' discourse, as "failsafe" or used in "mistakes" we find the typifications used by the nurses (Susan, Michelle). The nurses believed that the name conveyed the product's "design" for "emergencies" (Mary), and therefore, its name justified how it was regulated and accessed by women. I found the nurses were able to rationalise the use of the ECP as limited to one-off or irregular events, through acknowledging its name and frame as 'emergency'. Lesley explained the role of the product this way:

> Well the role of emergency contraception is as *an emergency contraception*. [Stresses point] That's its licence and that is what we work towards as keeping it as a you know as an *emergency* backup […] our priority would be to give them emergency contraception and quick start them on to on to the pill or a LARC [Long Acting Reversible Contraception] you know a full proper method. (Lesley)

Chapter 1 reviewed how the original design of the ECP meant for it to be accessible in packs of 10, with the aim of offering women who have infrequent sex a contraceptive option. However, it appears the nurses were not aware of the historical aims of the product. They felt that the single pill design, attached to the name *emergency*, meant it was supposed to be separated from other methods as a way to differentiate its sporadic and irregular use.

In their role as social problem workers, the nurses' definition of the ECP use as *emergency* highlighted the meaning they gave to this ambiguous product. The tightrope of the pharmakon suggests that actors who exist within the construct of the

problem work towards stabilising the pharmakon's existence on the tightrope. In the case of the ECP categorisation as a contraceptive, the nurses felt unable to accept the ECP as a contraceptive "method" but recognised its value as a contraceptive option. Under this frame, it appeared the nurses did not feel the product should be viewed as another 'method of contraception' As Julie explained:

> If I'm not calling it a method I don't know what I would call it […] But I would discourage people from, you know, just coming back all the time for emergency contraception […] I don't mean like put them off it but just say, 'Look you know you really need to sort out a more reliable method'. (Julie)

The frame given to the ECP appears to impact not only the nurses' understanding of the ECP as a method but also their promotion of the product as a contraceptive option for women. In the nurses' discussions, the framing of the ECP appeared to centre on the ECP as an *emergency* contraceptive. Lesley explained, "it's not a method of contraception. It is an *emergency* measure". Alternative contraceptive methods were described by the nurses as "something that you have ongoing. Whereas emergency contraception is there if there's ever a failure in your method or you're at some sort of risk of pregnancy" (Julie). It is here we find the role of the nurse understood as a manager of risk and institutionalised by goals of the services to minimise risk, which impacts the nurses' ability to accept the ECP as a contraceptive method.

I went on to ask the nurses how they felt about the name of the product and what they would describe as an emergency. The nurses felt at ease describing their knowledge of 'medical emergencies'. They acknowledged these events as 'life and death' and recognised that the use of or need of ECP did not match the level of severity, "they're not going to die. Nothing is going to happen to them" (Mary). Although, the nurses concluded the situation a woman was in when using EC was not by Cambridge Dictionary standards an emergency, the majority (14/15), felt the term was an appropriate name for the post-coital pill.

The nurses suggested several reasons for why the ECP was defined as an *emergency* measure. Heather justified the use of the term not to describe a life or death event, but rather point out "it's contraception that can be given quickly to stop a pregnancy so in that sense it's an emergency for them the individual". It appears the nurses felt the term resonated with the situation an EC user would be in. The efficacy of the product meant its use was "time-related […] but you know, if you don't act in the time limit, the consequences of being pregnant" (Mary). Therefore, the term *emergency* highlighted

the severity and time frame of efficacy, so "it's very time focused hence the emergency" (Mary).

The nurses accepted their role as supporting patients by promoting "good contraceptive behaviour" (Richard). The nurses' reluctance to categorise the ECP as a 'method' was not due to any risk posed by the product. What appeared in the nurses' defence against the ECP as a 'method' of contraception was the idea that the ECP did not meet the standard constructed of 'good' contraceptive behaviour. The nurses' constructed "reliable contraception" as regular, used daily – and most importantly, used before sex. With Long Active Reversible Contraception (LARC) accepted by the nurses as the "gold standard" (Kate), the ECP appeared to fall short of the contraceptive method category because of its after-use (post-coital) mechanism. Carol supported this isolation of the product as she claimed contraception was meant to be "preventative". She argued that the ECP could not be viewed as a contraceptive method:

> Because it is not preventative. It is reactive. And *contra* meaning being *against*, is all about being *preventative*. (Carol)

The nurses considered contraception as something that is taken before sex, regularly or long term. By contrast, the term *emergency* "makes it clear that's what it should be used for, just for an emergency and not as a longstanding method of contraception ideally" (Karen). The nurses' recognition and definition of what they perceived to be reliable contraception appeared to mirror the institutional values of health promotion in new public health. In Carol's discussion of the 'contra' in contraception, we see how the embedding of policy aims of preventive sexual health care in the role of the nurse. As social problem workers we find the institutional setting enables the nurses to embody the values of the system, and to actively participate in the regulation of the social problems concerns on the ground.

In their role as social problem workers, the nurses thus attempted to stabilise both sides of the pharmakon. I found that none of the nurses denied the ECP as a contraceptive option for women, but simultaneously that none supported the ECP as a contraceptive method. In the nurses' description of the ECP as a contraceptive method, I found evidence to support the ECP as a pharmakon that comes to exist with dual meanings.

Centrally, we find the nurses understanding of the ECP as a contraceptive method distances this from the product's ability to prevent pregnancy, and focuses more on

how and when it is used. We find that although the nurses accept the ECP as a good solution to preventing pregnancy after sex, its emergency frame stops it from being an option of contraception the nurses would promote to women. The meaning given to the product and support for the stabilisation of the pharmakon on the tightrope comes from the underlying meaning the nurses give to managing the risky behaviour associated with the product. This in turn suggest that as social problem workers the nurses control the pharmakon on the tightrope by accepting it exists under two meanings of both a blessing and a curse. We explore this further in the nurses' discussion of access to the product.

4.3. Access

When access to the ECP was debated in the House of Lords in 2000, concerns centred on the problematic framing of the ECP as a contraceptive. I suggested in a review of the legislative debate in Chapter 2 that the two sides might have involved topics such as risk to health and safety concerns. Although these matters did appear in the debate, greater emphasis was given to moral concerns around what impact better access to the ECP might have on women's behaviour. The review found that the problematic framing of the ECP impacted the legislative approach taken to access the product.

In my investigation into the role of the social problem worker, I consider further the impact the values of the institution have on the individual who works within the problem. Best (2013) indicates that the role of social problem worker gives warrant to the management of problem 'individuals'. In the case of the pharmakon, this task is shaped as managing the problem's stability on the tightrope. For the nurses, this appears to take form in the management of the problem behaviour of women. I address here how nurses facilitate the identity work of the individual who exists within the claims. Against this background, I chose to speak to the nurses about the various ways in which access to the ECP has been suggested, in its current form through consultation and the proposed options of access in advance.

Following on from the ECP not being a seen as a 'method' of contraception, the discussion of 'patient choice' and women's autonomy are now considered in my account of the nurses' opinions about women's ability to choose contraception. Access to the ECP enabled the nurses to take on the role of gatekeeper, and this role will be explored in more detail in the following section. We consider how the nurses understood women's access to the ECP as a part of women's autonomous contraceptive decision-making and

what impact the problem frame already discussed had on the nurse's opinions on women's ability to choose the ECP.

4.3.1 Supervised access as an opportunity for health promotion

The nurses reflected on the supportive role they took on as distributors of the ECP; all 15 nurses agreed that it was important for women to have access to a post-coital contraceptive. Reasons given to support access were identifiable in the nurses' acknowledgement that "accidents happen" and not all contraception is "100% effective" (Mary and Gemma). With the ECP presenting minimal risks and no safety concerns, the nurses accepted that it could be accessed without the need for a consultation. Carol explained: "It is such low risk now, I don't see that there is much difference between women buying their emergency contraception off the shelf and self-medicating their headaches" (Carol). Overall, I found the nurses to be genuinely supportive of women's access to the ECP.

None of the nurses indicated they had ever refused a women access to the ECP. Support was shown by the nurses for the reduction of barriers to women's access, with four of the nurses criticising pharmacy schemes that regulated access to ECP based on age: "All women of all ages should have access to it" (Helen). Initially, I found that the nurses showed a high level of support for access to the ECP as an additional 'back up' to women's contraceptive options. However, I found as the conversations continued, some tensions emerged in relation to supervised access.

I found the nurses showed more support for the current state of access to the ECP via a pharmacy or through NHS services following a consultation. Almost all the nurses (11/15 or 73%) referred to the sexual health clinic setting being the most valuable service setting for women to access the ECP. It was suggested that because the nurses were trained medical staff, they could offer more support to women when accessing the ECP compared to the local pharmacist. This view was shared by Emma, who suggested that women should access their ECP from the "clinic rather than a pharmacy". I asked Emma to explain further why she believed women should choose to access from clinics. She explained, "it's because of the lost opportunity"(Emma). In her discussion, she indicated that pharmacy services did not offer the same health promotion or safeguarding services that the nurses in the sexual health services had to offer. In their role as regulators of access, the nurses felt that "the consultation is a good opportunity for health promotion" (Elaine).

In their roles as social problem workers, I found the nurses were aware of what access to the ECP also meant in terms of the possibility of health promotion. All 15 nurses recognised that supervised access had little to do with managing the health risks of the product, as Mary confirmed: "no, [it's] nothing to do with what you're going to give". With the product's minimal risks, the nurses such as Carol further supported the product's safety as less harmful than 'painkillers'. However, concerns were raised about unsupervised access and suggested 'overuse', an idea Dr X discussed previously. Coral said:

> If someone who is constantly buying paracetamol because they're constantly getting headaches chooses not to go to a doctor, that's their choice. But I do worry that by making it available to all, you are losing the chance for the health promotion aspect. (Carol)

I found that underlying the nurses' acceptance of access was risk management. The role of the nurse is balanced between medical and holistic care. The ECP poses minimal health risks, therefore the need for supervised access has "nothing to do with what you are going to give" (Mary). The 'supervised' access considered by the nurses as valuable to the women did not offer greater medical services. However, supervised access via clinics was championed by the nurses to ensure women "are [not] losing the chance for the health promotion" (Carol). This was supported by the nurses who suggested the consultation was a necessary part of access. Lesley explains; "I still think that a consultation is important rather than just buying the tablets. I think to buy the tablets you don't address all the other issues […] it is not just emergency contraception it's the start of the ongoing sexual health needs and care" (Lesley). In their role as social problem workers, I found the nurses actively facilitated the wider policy programme of health promotion. The nurses appeared to embrace the gatekeeper role that supported supervised access because unsupervised access appeared problematic.

Access as a theme addressed several issues around the ECP position as pharmakon. The House of Lords debate brought to light concerns about unsupervised access for the behaviour of women. The same concerns raised here supported the regulation of the ECP as an over the counter (OTC) contraceptive accessible via consultation. The nurses, in their role as social problem workers, appeared to carry out the work at the micro level of managing the problem behaviour that featured in wider claims. In their role as nurses, I found they shared the values of the public health institution by proactively managing the risks through preventive health promotion. However, in the case of the ECP (a product that offers no risks) we find access accompanied by health promotion seeks not

to medically support women. Instead supervised access facilitates the control of potentially 'risky' behaviour. This is further supported by the nurse's discussion of the 'quick start'.

4.3.2 'Quick start'

In the investigation into the meaning-making of the nurses, I recognise that meaningful claims that appear to be constructed via institutional settings were well received by the nurses. In the case of the ECP, it appeared that it competed against the wider policy meaning given to 'good' contraceptive behaviour. As social problem workers, I found the nurses attempted to manage the meaning given to the role of the ECP as a contraceptive and their task of *quick-starting*. Here I consider in more detail the meaning the nurses gave to the social problem work of *quick-starting*.

Supervised access to the ECP was viewed as an opportunity to *quick-start*. This term described the action where a woman who attends a clinic for EC is 'quick started' onto 'reliable' contraception. The purpose of quick-starting was understood by the nurses as purposively maintaining and managing targets set by the Community Health Foundation Trust. Key Performance Indicators (KPI) were recognized as goals and as targets the nurses worked towards. Chapter 2 discussed that nurses are expected to meet standards set in health service setting to maintain and reach targets of 'good health' (Calnan, 2015). Therefore, to quick-start and contribute to the management of KPIs was perceived by the nurses as success. Here these activities are recognised in the analysis as successful social problem work. KPIs were explained as this way:

> It's what the government target [...] our commissioners set out they want certain things [...] you'll be aware of this information and [...] it's also about, you know, uptake, long acting contraception so it's making people more aware of that and see if they can go onto more forms. (Richard)

What appeared in the description of KPIs were the overarching policy aims. Chapter 1 discussed that access to the ECP was first widened based on claims that the product could impact the rates of teenage pregnancy. Here we find that access is viewed by the nurses as an opportunity to aid the wider policy aim to combat social problems.

I found the aim of contributing to the management of social problems featured as rhetoric in discussion of nurses' interactions with women. EC users were perceived by the nurses as potential 'risk' takers, with their need of the ECP being the initial indefinable feature of this risk-taking behaviour. For this reason the nurses supported

supervised access as opportunity to actively engage with patients they felt could be a problem. As Karen explained, "one of our targets is, you know, to reduce the teenage pregnancy rate" (Karen), which supported the nurses' reasoning for "giving the younger ones more time" (Lesley). With specialised services aimed at targeting these specific groups, the nurses acknowledged that young people were a priority. The nurses considered access as a matter of problem-solving and supervised access was giving meaning because of the institutional setting. I found in the analysis that supervised access appeared important to the nurses as a matter of fulfilling their roles as social problem workers. The success of an interaction was also deemed by the nurses as product of *quick-start*.

To 'quick-start' was the vernacular used by the nurses to describe the events that support women onto alternative or reliable methods of contraception. This appeared to support the meaning the nurses gave to the activity of supervised access. As gatekeepers to the ECP, the interaction described by the nurses was a more of an exchange than a transfer of medicine. Kate explained:

> I think they think they can just walk in get the morning after pill and that's it just go [...] because you're not just giving them emergency contraception and letting them walk out the door, you want to start them on something else so they are covered moving forward. (Kate)

The process called *quick-starting* supports the health promotion conducted by the nurses, and was considered important to their role. As rhetoric for good health promotion, it appeared the nurses made sense of this task of the social problem work. Susan explained, "you want to try and quick start someone as quick as possible, because they're so risky you almost know, if you give them too long before they're protected, they're probably going to have unprotected sex again". (Carol). This view was shared by 9/15 nurses. ECP users were branded as 'risky' and their access to the ECP is considered a key opportunity for the nurses to work with the women to prevent further risks. Quick-starting appeared to mean more to the nurses than simply carrying out the work designed for their role. The frame of the EC user is a woman who is "probably going to have unprotected sex again", suggesting that the nurses considered the supervised access directly impacted women's contraceptive decision-making. I found the nurses truly believed in the process of quick-start and therefore gave meaning to the success of their interactions. I consider this to support the social problem work of the social

problem worker: the nurses appeared to give greater meaning to the tasks they undertake. I found what competed with this access was the concept of *patient choice*.

Aware of the patient-centred care approach, the nurses acknowledged 'patient choice' as a key element to the contraceptive services offered: "at the end of the day it's all about patients' choice" said Richard. The nurses explained that they could not "force them" to choose contraception as "it's their choice at the end of the day" (Helen, Julie). However, despite these claims, the role nurses took on in the sexual health setting shaped the contraceptive decisions:

> I think it is actually my job to work with them and say oh ok so that one didn't suit you but hang on I can change this hormone and this dose of hormone […] I feel it's my duty to work with them to find a method that does suit and encourage them to come back and say oh I don't like this this makes me feel whatever. (Michelle)

All fifteen nurses recognised that women have an array of options when choosing contraception and it was important for the nurses to "work with them" to find an option that best suits. This process was viewed as an extension of the quick-start; the nurses felt women "had lots to choose from" (Mary). Success of the nurses' interactions was measured by women leaving consultations with alternative contraceptive methods. Quick-starting is also considered here as the social problem work of the social problem worker. The nurses gave meaning to supervised access as a matter of fulfilling problem management. They became invested in their interactions with EC users, which I considered as a product of the internalised values of their institution and meanings they gave to their role. What complicated this frame of access and interactions with nurses further was the possibility that a woman might *choose* to use the ECP.

4.3.3 Choose to use or in advance

The contraceptive properties of the ECP and early manufacturing in packs of 10 might suggest the ECP may once have been considered a method of contraception a woman could *choose* to use. Access to the ECP was discussed further with the nurses as I offered two hypothetical scenarios. One suggested a scenario where a woman might choose to use the ECP as her primary method of contraception. The other suggested a scenario where women could access the product off-the-shelf or in advance to have at home. Both were presented to the nurses as way to observe the meaning the nurses gave to supervised access.

The first scenario was viewed by the nurses as alien, as Julie explained: "I have never met a woman that chooses to use it" (Julie). I proposed the women would not replace her everyday contraceptive products (as the ECP would not be as efficient), yet suggested a woman who might have sex irregularly chooses to use the ECP, as an after-sex contraceptive. All 15 nurses appeared concerned about a woman who might choose to use the product this way. It was considered problematic and abnormal for the nurses, as it conflicted with their goals to 'quick-start' and 'reduce risk'. Within the institutionalised setting, choosing to use the ECP appeared to go against the role and health promotion the nurses were comfortable with. As Carol explained:

> To use it as a choice of a method of contraception, you might as well throw health promotion out the window because you don't know how effective it is, and you will, one day get pregnant. So it is not something that I encourage in any way as a method of contraception. It's an emergency measure and if she's needing it more than two or three times, we need to be thinking about contraception for her. (Carol)

This scenario appeared to stir the nurses' institutional value sets, since the hypothetical woman challenged the responsibilities expected of the nursing role. On one side, the nurses found choice to mean supporting patient centre care service's delivery role. This competed with ECP use being an indicator of risky behaviour and the nurses' responsibilities to prevent prevention and promote health. The risks suggested as consequence of this type of use were suggested to be unwanted pregnancy and were described by the nurses as "traumatic" (Susan), while choosing to use the EC was viewed by some as "daring" (Heather). However, the nurses accepted that in their dual role of offering patient choice with health promotion, if a woman were to choose to use the EC then that was her "patient choice". The alternative scenario, in advance or off-the-shelf, also appeared to compete with the nurses' values.

The off-the-shelf or in advance scenario received a mixed response. I found a few nurses showed support for the increased access, with seven of the nurses suggesting that there was nothing wrong with increasing access in advance. Mary explains, "I don't see any problem, just like giving condoms, you say, this is your one pack of emergency contraception" (Mary). She went on to explain that women who suffer from thrush are often given prescriptions to access over the year, and therefore, she could see the benefits of the EPC being accessible in the same way. Others like Lesley felt the option in advance would be better than the risk of unwanted pregnancy:

> I think it's an option isn't it? I think it is another option that is available to women. We know that it is not quite as effective as you know as a LARC method or a standard pills

> but it is an option and its use, because it has relative very few side effects it's much better than women use emergency contraception rather than risk an unwanted pregnancy! (Lesley)

In the nurses' accounts I found support for in advance or increased access were indicators of the nurses' role of 'patient-centred care' and trusting women. These nurses appreciated the contraceptive qualities of the ECP and accepted that, with minimal risks, the ECP posed no harm in unsupervised access. Despite some of the nurses showing support for the scenario, a number felt very strongly against the prospect of in advance or off-the-shelf. In Kate's view, access in advance is:

> Just wrong. Well I don't think there is any need for them to use it that way, I would advocate them being on a contraception, but it's not that I have got any issues that it is a terrible thing but if they are planning that they might go and have unprotected sex then why not be on a contraception? (Kate)

The disagreement with the scenario came from the support that 'access in advance' would be, "encouraging maybe unprotected sex" (Jane). Access in advance, for some nurses, appeared to conflict with their role of health promoter discouraging 'unprotected sex'. Elaine felt that access in advance or 'off-the-shelf' would impact the work of the nurse: "that is something I feel quite strongly, about in that it shouldn't be [available in advance]". She continued, "why am I here, why are we promoting good contraception, why are we providing good health if all women need to do is buy a pack of pills of a shelf?" Other nurses shared the same view as Elaine: they believed access in advance or to-have-at-home appeared to conflict too much with the role and responsibilities of the nurses. In their position as social problem workers the nurses manage the stability of the problem on the line of the tightrope. It appeared the hypothetical scenario attempted to tip the pharmakon too far to one side of the tightrope.

The nurses' mixed response indicates how pharmakon comes to exist with dual meanings, as social problem workers facilitate the wider claimsmaking activities by managing the claims on the individual level. The role of the nurses is defined in the overarching policy aim to combat risk through prevention and health promotion. The nurses are then expected navigate the role they take on and make sense of the claims they are exposed to in their institutionalised setting. We find the policy rhetoric of 'health promotion' is key to the role suggesting that access to the ECP in advance for these nurses would be "encouraging poor health poor outcomes".

Overall, in my discussion of access with the nurses, I found the meaning the nurses gave to supervised access, the task of quick starting and potential change in access, defined the role of social problem worker. In this role, the nurses are expected navigate the claims that are made on the ECP in line with their position as gatekeeper, while upholding the values of the institution. Gerth and Mills (1970) explain that professionals who share the values of their institution are more successful in the goals expected in their professional roles. This is evident in the nurses' belief that supervised access is an opportunity to promote health. The theme of access appeared to highlight the motivation of the nurse but also the activities of the social problem worker. This navigation can be explored as the allocation of meaning to the role the nurses take on and can be further supported in the exploration of the nurse's construct of the role they take on as a part of the consultation process.

4.4. The role

Goffman (1959) suggests that our identities evolve and develop through a process of meaningful social interactions. Furthermore, we recognise that individuals may take on a number of identities, some formal (doctor/pharmacist/nurse) and informal (mother/sister/neighbour), they may overlap and may remain separate, they exist by our own definition and can be impacted on by wider institutions (the NHS or policy). Here we consider the dimensions of the identity of the nursing role to better understand how the nurses reflect their responsibilities as distributors of the ECP. All 15 nurses suggested the ECP consultation was the "longest of all the consultations" (Kate), making it significant in the eyes of the nurses and their roles as health promoters. I consider here the meaning the nurses give to their role and the consultation as a site for social problem work in action.

Using the pharmakon framework, I find that the role of the social problem worker is driven towards making sure the pharmakon does not fall too far on either side of the tightrope. This is explored further in the nurses' description of their role as distributors and the processes they undertake for regulating the product through a consultation. In review of the identity work the nurses carry out in their professional setting, I consider how wider institutional values impact the views and opinions of the nurses and explore the way they give purpose and value to their role. It is here that I address what is expected from the nurses in their professional role and what this means to their role as social problem worker. The section begins by exploring the

meaning given to the significance of the gatekeeper role of the nurse in the process of the consultation.

4.4.1 The consultation; social problem work in action

The nurses were asked how a consultation with a woman may go. All 15 nurses explained the two most important points were: first, to find out when the woman last had sex; and second, to determine whether or not the woman could be pregnant. Most of the nurses (10/15) considered the consultation for EC as the longest of sexual health consultations, since "the [EC] consultations are quite rigorous" (Susan) with the need to take a general sexual health assessment as well as an emergency contraception assessment (Carol). Michelle explained that, "I usually say to my clients, 'Right take your coat off, we're going to be here for the whole of your life!'' (Michelle). Kate expressed her dismay when a woman attends for an EC consultation. As she explained, "my heart sinks a little bit if I am really rushed [...] I do think emergency contraception is a more in-depth consultation there are more questions to be asked. It's more complex. There is more to think about" (Kate). The consultation appeared significant to the nurses, with their terms of phase such as, "heart sinking" and not wanting to "rush" the appointment (Susan), it appeared the nurses felt a sense of agency when beginning a consultation with an EC user.

The nurses suggested they would begin the consultation by obtaining the 'story' from the women on why they needed the ECP. These stories were elicited from the women via health assessment. All fifteen nurses indicated there were two to three possible assessments that were used in the consultation. The first two were the initial sexual health assessment and the second the ECP assessment. The third was a safeguarding assessment, this was often decided on the age of the user. Risk management and health promotion were accepted by the nurses as the driver for the number of health assessments. In the nurses' acknowledgement that the ECP poses no health risks, the risk management did not centre on health but rather behaviour.

The line of questions used during the consultation was understood by the nurses as invasive but necessary in order to achieve the goal of reducing risk and promoting healthy behaviour. Emma explained, "it sounds a bit odd, but we're not being nosey, but they are important for us to understand" (Emma). The nurses explained the depth of the questions that were asked during the interview had little to nothing to do with the safety of the ECP as it had minimal side effects and contradictions. However, they

explained the consultations were in-depth in order to identify the risk behaviour. Helen said:

> All the questions that we ask around their partners, the type of sex they engage in, whether they do drugs, whether their partners do drugs, whether they've had self-tattoos, piercings how they get those piercing, it's all about the risky behaviour and what puts them at risk in relation to their sexual health. (Helen)[5]

The nurses described the in-depth nature of the questions and topics featured as a part of the 'safe sex' agenda in sexual health. The nurses were asked what they considered 'safe sex', with all agreeing it featured as a core part of the consultation with the women. As explained by Richard:

> *Richard:* Safe sex to me is basically reducing your risks for pregnancies as well as sexually infections and making people aware of the risks and if they want to make unwise decisions they can do.
>
> *Researcher*: And what would an unwise decision be?
>
> *Richard:* An unwise decision? Well from a professional point of view it's putting yourself at risk. That's an unwise decision.

Safe sex was recognised as a scheme that bought together the health promotion values of preventing risk but also wellbeing. Karen described safe sex as, 'their vision of sex and what it entails' (Karen). As Richard discussed further, he interpreted his teaching of safe sex as a matter of supporting women in recognising where the risks have been taken:

> Making people aware of how [...] 'How would you reduce your risks?' 'How do you think you could reduce your risk?' they call it motivational interview techniques [...] when I completed a health promotion module they basically turned around the first thing they said is, if people don't want to change they're not going to change. (Richard)

Motivational techniques were suggested as used by the nurses during the consultation to address the risk-taking behaviour of the women; this was achieved by the nurses by working with the women to reflect on their behaviour. The pattern that emerged in the description of the consultation process indicates the nurses fulfil their social problem work of health promotion through various meaningful interaction techniques. In the aim of modifying women's behaviour, the consultation appeared to frame an

[5] It is important to note that an allocated amount of time was given during the consultation to discussion the risk of STIs and the exposure to further risk of disease. However, based on the scope of the thesis I am unable to address the concern around STI as another line of enquiry but acknowledge that in the conversation around risk in the consultation that STI were apparent.

opportunity to manage the risks taken. This process was explained as non-judgement to support Julie explained:

> You've got to be careful not to come across as being judgemental […] you've got to handle the situation a certain way […] I mean if they're putting themselves in harm's way, then it's a bit , you know like, 'this is dangerous what you're doing' […] then you've got to sort of take action.

Karen agreed that the "ambience" of consultation facilitates women "reassessing their behaviour" (Karen). Therefore, the nurses suggested consultation did not present as an opportunity for "being critical of them" (Jane). The purpose of the consultation was described as supporting women "practising safe sex and they know their risks of what type of sex they're having" (Helen). Mary explained that the consultation was significant to their role of the nurse. However, the distribution of the ECP was considered "as a very small part of my role as a sexual health nurse" (Mary). She suggested:

> It's part of it but if you are doing emergency contraception for somebody, it opens up everything else as well. So, it's not just a single act really. It's about future contraception and risk-taking behaviour and health education and normalising screening and all of that sort of thing. (Mary)

The management of "risk-taking behaviour" emerged as the goal for all the nurses to address in the consultation. The nurses accepted that there were many reasons why a woman would attend a clinic of EC and from their assessment if they deemed any behaviour as problematic they would use the health promotion techniques to reduce the possibility of the women coming back.

The consultation is suggested as both motivational and educational, shaped by the overarching policy agenda of 'safe sex' and risk prevention. The consultation appears to be weighted by the institutional values, meaning in their roles as social problem workers the nurses accept they are managing the problem behaviour displayed by women. However, in addition to their remit as holistic nurses providers, they also believed "it's not for us to judge them. It's not for us to say, that was a very stupid thing to do, but for us to encourage them and saying … how does that make you feel? It's about empowering people"(Mary). The consultation described as 'holistic' emerged as social problem work that sought to investigate and manage the problem that appeared before them. What was significant about these discussions was the problem did not appear to be a product with no health risk and no need for a consultation. The problem the nurses sought to manage became women. The meaning the nurses' gave to this role

featured in their belief they were working with the women to support them, not manage them or judge them.

The consultation is a good example of the place where medical meets moral. Portrayed as an important element to access the ECP, these findings unearth the real aim of the consultation is to address and eliminate risks. With this as its goal, the nurses pardon the invasive nature of the questions and excuse it as 'holistic'. It further confirms the reality of the social problem worker role in action. The nurses valued their position as health promotor and support their work to ensure the reduce risk moving. In the nurses' reflective account of their role I found further support for the role of the nurses as a facilitator of the pharmakon tightrope, was evident in meaning the nurses gave to their roles.

4.4.2 Meaning of social problem work

Gerth and Mills (1970) suggest that the identity formation of the professional is enhanced when the individual shares the wider values of the institution. I now consider the nurses' life stories to observe how they made sense of their experiences and gave meaning to their role as nurse in a sexual health setting.

In our conversations I found the nurses were given the opportunity to reflect on their role and the interactions they have with women. Lesley reflected on the importance of her role this way:

> I actually feel I am doing the most important job in the whole wide world. Every intervention that we do helps to control our population and that population impacts on every other single service so one baby born with need health care, social care, education. The impacts of that long term […] and you see we are all working together to the same aim and that really does give you, that what you do on a day to day basis to me has worth. (Lesley)

Lesley appeared enthused by the perceived opportunity she has to help change women's behaviours, and I recognised this as goal orientation to problem-solving. Gerth and Mills' (1970) understanding of the professional would indicate the role of the nurse is moulded by the institution, while the individual taking on the role must believe in the values of the institution. Here, this nurse values the interactions she has with a specific target groups to manage wider public problems.

This goal orientation of combating wider social issues that feature in social policy was apparent in the accounts of other nurses. Michelle explained her reasoning for working in sexual health is the power of the role:

> *Researcher*: And what made you interested in working in sexual health?
>
> *Michelle*: I wanted to prevent teenage pregnancy.
>
> *Researcher*: Okay and where did that come from?
>
> *Michelle*: Probably because I've always worked with young people on and off, and this sounds like a diatribe but, I believe that babies deserve to have parents that want them, and that are able to give them the best start in life and if you're very, very young. I'm afraid a 14 years old can be really, really good but, you've got to have masses and masses of support, and I haven't met one young person yet, who doesn't say that if they had their time over again they wouldn't do it.

Michelle went on to explain from her previous job roles she had built a skill set that enabled her to work closely with vulnerable young people and found herself in a role that could help them from making mistakes such as teenage pregnancy. In her role, Michelle considered her role as a problem solver and believes the contact she makes in her role could impact the wider set of issues indicating.

The meaning the nurses gave to their role as a distributor of the ECP emerged as they reflected on the impact of their interactions with women. As Gemma explained, "it's that consultation that's so important, because it about compliance, and if they have any concerns, they come back and talk to us about it, so we can get them on the right method". With quick-starting outlining the success of the interaction and the social problem work, the nurses appeared to give meaning to the ability to support women to make contraceptive decisions.

The nurses recognised that access to the ECP was meaningful. They suggested it was not a health care necessity that a woman speaks to a nurse; however, they believed the interaction could support women to take action in their behaviour and responsibility for their risk. Heather explained:

> I always say to the patient, 'Look after yourself. It's your body. You look after yourself. You're the only one that knows what you do. You don't know what anybody else does at all so you look after yourself'. (Heather)

Heather acknowledged that women must take responsibility for their actions as the women who present needing the EC are the only ones to face the consequences

(pregnancy). These consequences were understood by the nurses as a result of "not looking after yourself" and as a result of 'risky' contraceptive behaviour. Emerging from this discourse came the activity of the social problem worker and the allocation of responsibility. Here we find that the social problem work in action is achieved through consultation. The allocation of responsibility was recognised as important part of the interaction with the women. Julie suggested that "a lot of them seem to not want to take responsibility". She explained further:

> They come in and they think, oh sort me out. It's like well you've been doing this, this and this. And I say, 'You know you've got to take responsibility'. 'You're all going out and having sex, so actually you need to have a bit of responsibility for what you're doing and accept some of the risks you're taking.' (Julie)

The nurses expressed some frustration towards women and their behaviour. Eight of the 15 nurses indicated that women who repeatedly used EC were not 'learning' from their actions. The nurses explained that women were not "absorbing what you're saying about contraception" and this led to women returning for EC more than once (Karen). Mary said, "it's also pushing it back to patients and saying, 'you have a responsibility in this' and 'it's not about the hand holding'" (Mary). For this reason, the nurses felt that the contraception and the services they were offering were costly, and Jane said, "we have to draw the line somewhere and women have to take some responsibility" (Jane).

As discussed in Chapter 2, Dr Morgan aims to build a rapport with 'problem families'. The nurses similarly acknowledge the meaning they give to their role is to work with the 'problem' groups in order to successfully promote healthy lifestyle choices. The nurses were aware of the restrictions placed on them in their position. However, they felt they could do a lot to improve society through the health promotion they provided to women. As Lesley put it, "it is our job that we make sure that people understand what they are doing, the risks of what they are doing". In the discussion on the consultation with nurses, we begin to observe the meaning the nurses give to their roles and the underlying aims that appear to shape the role of the nurse that filter through the institutional values.

The role of the social problem worker explored in this discussion shows that nurses reflect on the role they take on as a distributor, and give meaning to the interactions that they have with women needing EC. We find through a process of internalising wider claims the nurses actively participate in the wider social problem work of maintaining the ECP frame as a pharmakon. The nurses accept that the ECP features

with two meanings. They accept its value as a contraceptive option, yet work hard towards maintaining its limited use. I found the nurses believed they take on a more holistic role as a result of institutional and professional boundaries. However, I found this aspect of their roles appeared to strengthen their activities as social problem workers. This increased the nurses' motivation to successfully manage the risk behaviour of women and fulfil their role of managing the problem that appeared before them – not the ECP, but the women.

I found from speaking to the nurses about their role that through their social problem work, the nurses actively contribute to the medicalisation of moral concerns, with the risk management aimed at women and their behaviour. I found the goal orientation of the work enables the nurses to achieve health promotion as a process of allocating to women their responsibility. In all, we find that the interviews suggest that although the problem appears on the surface to be the ECP, we find the social problem work undertaken by the nurses is to manage the underlying problem of women who take on the dual meaning as a pharmakon.

4.5. The user as pharmakon

The following section explores how the nurses construct the ECP user as a problem. So far, I have established how the nurses navigate and give meaning to the claims made around the ECP and their role as a distributor. I have acknowledged that the nurses do not consider the ECP as a method of contraception because of its 'emergency only' frame. Additionally, it is suggested that the role of distributor is goal orientated and works towards maintaining and achieving the health promotion goals that exist in the sexual health service setting. Here I conclude that by combining all elements the frame of the ECP as a problematic contraceptive and the meaning given to the role of the nurse, that the ECP user takes shape as a pharmakon identity.

Chapter 1 identified the claims that suggested the ECP user was constructed as women that have 'poor judgement' or 'low character', leading them to have sex while drunk or high, or to be promiscuous (Shoveller, et al., 2007, p. 15). In review of the ECP literature I addressed the identity of the ECP user that emerged in policy and the wider claimsmaking activities around the ECP. Here I consider how the nurses as social problem workers facilitate the identity work of the social problem individual.

The previous section indicated that the task and responsibilities of the nurse supported the concept and the work the nurses take on a social problem workers. It also indicated

that the problem managed by the nurses was not the ECP but in fact, the behaviour of women. Here I explore the nurses; discussions to support how the women take form as a pharmakon.

4.5.1 Age and the young user

In a review of the debate that occurred in the House of Lords and Commons we saw the woman that appeared as a concern was the 'young', 'risky' user. The same user's typifications support the need for regulation of access and the high price of the ECP in Dr X's letter. Here I explore the impact the construction of the problematic EC user has on those who distribute the ECP. The social problem worker role of the nurses supported their problem management at the micro level and I now consider how the nurses gave meaning to the ECP user.

All the nurses were asked from their experience what they considered to be the most common reasons a woman attends the clinic for EC. The nurses gave a variety of answers from, "no contraception used" to "they were on the drink" to "the throes of passion"(Richard, Susan, Kate). However, speaking to the nurses, a consensus appeared to align with the idea that:

> It used to be, oh the condoms split, all the time. But now I find it more common that people just say, we ask as a part of our sexual health assessment, was the sex protected or unprotected? And they all just say unprotected. (Lesley)

This behaviour, characterised as 'risky', appeared to surface in the nurses' discussion to explain the women's need for EC. Interestingly without prompting or indication, the nurses began to describe the EC users as young.

The young person frame of the ECP user appeared to fall naturally into the nurses' description, more so in discussions of risks being taken. I found this to be the case for Kate, who responded to the question 'what is the most common reason why a woman would attend the clinic for ECP?' with:

> Maybe the young girls that have had the sex you know that wasn't planned. So, you have those that aren't on contraception and have had an unplanned episode of unprotected sex or we have highlighted it in a consultation when they have come for something else. (Kate)

Like Kate, some of the nurses began describing the EC user with terms such as 'girls' 'teenagers' and 'young people'. I found this was due to the nature of the behaviour under discussion. Like Kate, many of the nurses defined the reason for use as the result

of ‘unplanned sex’ or the women taking risks. This construct appeared to describe the behaviour of ‘girls’ or ‘young people’. I found the nurses considered young women most likely to have unplanned or unprotected sex.

I found the nurses constructed the EC identity as a young woman in need of management. Part of the role of the social problem worker is to manage the claims on either side of the tightrope to support the ambiguity of the problem in the middle. I found the claims made around the age of the ECP user appeared to support the stability of the character framed in the middle. The EC user construct appeared significant to the social problem work of the nurses. I chose to investigate the nurses' opinions of the EC users further by asking the nurses to describe the age group of the most common user group.

With a mixture of responses, I found the majority of the nurses estimated most common age groups were 16-25, with the occasional reference to under 16 and a handful of references to ‘over the age of 25’. Karen explained, "I think under 25 covers probably the majority of what we see" (Karen). The reason young women are most likely to use EC was suggested as, "it’s the younger ones who are starting out who often have the unprotected sex because they’re not on any form of contraception" (Emma).

The young women frame of the EC user was further evident in the nurses' description of risky behaviour and lack of planning. Michelle explained: "especially young people, they live disorganised lives. Unless something is very, very easy for them they don’t really try, you know" (Michelle). The young ECP user emerged as a taken for granted construct in the nurses' discussions of the women "under 25s who take a risk" (Heather) and who aren’t always "proactive" (Mary). This construct featured prominently in the opinions of the nurses; however, the young women user became more real to the nurses when they began to explain the purpose of safeguarding and the EC.

Meaning has already been established in relation to the nurses' role in meeting targets and problem behaviour management. What I found from speaking to the nurses was support for the wider claimsmaking that gives meaning to the ECP as a social problem. As the nurses continued to define the ECP user as the young woman who take risks. This added support to the wider policy concerns around who has access to the ECP. This further became evident in the nurses' responsibility for health promotion and for holistic care. Richard explained further, "young people are more vulnerable, especially being more sexually active, grooming, trafficking and all that sort of stuff and it’s

actually a good way to actually get them in. We have young people's clinics" (Richard). With the wider policy aimed at managing the young and the Key Performance Indicators (KPI) indicating the young are a cause for concern, I began to understand how the discourse around young women impacts the nurses' own construct of the EC user.

I found because of the frame of the EC user being young and vulnerable, the nurses' health promotion role intensified in relation to the social problem work of managing young people and their sexual behaviour. As Karen reflected when asked, 'what would kind of discussion would you have with women about safe sex?':

> A lot of the youngsters under the age of 16, you know we're talking to them about relationship, the law, and sex, have they got respect in that relationship, they've never been forced, what consent means, all those kind of things really, it comes as a sort of whole package. (Karen)

Words used to describe this category of young people were "vulnerable", "extra care", "naïve", "risky" (Helen, Mary, Michelle). This rhetoric framed young people as a potentially problematic group, as a red flag in need of prioritising and risk management. This intensified the interaction the nurses had with young people and further intensified the goal orientation of the role. The characterisation of the EC user as young and vulnerable in need of care and greater attention, appeared to bring more value and purpose to the nurse's role. It supported the wider claims that feature in the debate around access and also, supported the need for the nurses to have interaction with EC users.

The problem with this age category was the range of ages the 'young person' label included. Some of the nurses referred to and showed concern for girls aged 13 years and below. Others discussed the young person as 16- to 17-years-old and ages 18+ were also identified. This meant the young person frame could be aged 11- to 25-years-old, including a mixture of women who are schoolgirls to adults. The construct, although prominent in the discussion, appeared to make the user an ambiguous character. However, as we know, the sole and only users of EC are not aged 11- to 25-years-old; as the nurses explained, many users are over 25.

In the process of the social problem formation, it is suggested that when a problem includes problem identities that draw on cultural resources such as 'victim' or 'vulnerable people', the problem receives greater acceptance. At the individual level, where nurses take on the role of the social problem worker, they support this process

by facilitating the social problem construct of the young vulnerable woman in need of great care. What I found was these typifications of the EC user became a part of the social problem worker role and the identity work of the nurse. However, the construction of uses as having 'needs' was not restricted to young women.

Gemma explained, "the 40-50s" are "an age group we are seeing more of"; "they're coming out of relationships into new ones and then it's just like a whole new game for these poor people" she said. Older EC users were considered women who had recently experienced a "break down" in a relationship, and had exposed themselves to risk because they were "new to the dating game" (Heather). Julie explained, because "they're going online and having relationships with new men and moving on from, you know long-term relationships, so really it's all about life really, but some of the older women don't really think that it's possible, you know, for them" (Julie). This frame of the older EC user as not knowing they needed the ECP further legitimated the role the nurses undertook as health promoter. Although the older woman was considered to have more knowledge about sex and relationships, they were considered to be naive to risks of STIs and contraceptive options. It was also suggested by the nurses that it would be harder for the older woman:

> In the older woman she can be quite embarrassed. She can feel that she's going to be judged because she needs emergency contraception therefore the implication may be that she is loose or careless or not have morals, you know she's had unprotected sex with someone. (Kate)

Further descriptive terms appeared to support the nurses' understanding of why older women might be 'embarrassed' to have to access the ECP.

In reflection on the nurse's descriptive accounts of the EC users, I found support for the idea that nurses take on the role of social problem worker by managing the construct of the social problem individual. The nurses construct a young vulnerable character that not only featured in wider policy claims, but also supported the meaning the nurses gave to their role. Part of the responsibility of the nurses came from the management of targets and health promotion. In my consideration of their discussion of the EC users, I found the construct of the young user appeared to strengthen the nurse's support for supervised access. The claims that appeared to be attached to this young EC user construct was "not anyone can access the EC" (Kate) because the EC user was deemed as needing the extra support of a consultation.

However, despite this not being a full representation of the EC users the nurses came into contact with, it featured prominently in their discourse. It signified an underlying meaning the nurses gave to the wider claims. This meaning appeared to support the nurse's management of the problem behaviour. However, I found further discussion around the risk behaviour of women indicated the nurses shared the ambiguity of the ECP as a pharmakon, as they struggled to navigate the competing meanings either side of the ECP contraceptive behaviour.

4.5.2 Women are the pharmakon

There are various elements to the role of the nurse that they are expected to manage day to day and this emerged in the interviews. I found from speaking to the nurses about their role that they valued and gave meaning to the interactions they have with women as an important part of the work that they do. The EC user in its frame as young and vulnerable supported the work carried out by the nurses. As the conversations progressed, however, it became apparent that the EC user, outside of the framework of age, was more difficult.

The nurses indicated that the behaviour of an EC user is not necessarily 'sensible' because they had taken a 'risk'. Risk behaviour was identified and discussed themes such as relationship status (being 'single 'or 'multiple partners'); not being "aware of contraception services"; and for the unique setting of the clinic the "not knowing they needed ECP"[6] (Gemma, Helen, Susan). These factors were framed by the nurses as risks, described generally as "not knowing how to protect themselves" (Richard). Nurses categorised the behaviour of women on each side of the pharmakon. Mary explained:

> Age is nothing to do with whether you're sensible or not. It's got nothing to do with it. Some people are just naturally, yes, I'm definitely clued up and they are less risk taking or more protective of themselves, they're more aware. (Mary)

In my analysis of the nurses' accounts, I found the nurses struggled to categorise the behaviour of the women. They appeared certain in their definition of behaviour perceived as 'risky' and were able to offer reasons why and how a woman would take risks. However, the nurses also accepted that a woman's use of the ECP was important, and ECP use could be a "responsible reaction" to preventing pregnancy (Helen). Under these meanings I found use of the ECP was viewed as risky but at the same time

[6] All fifteen nurses made reference to EC users that were not aware they needed to use the ECP. This categorisation represented a small group of the EC users they came into contact with and did not represent the general population of EC users therefore, I have been unable to address this in more detail in this thesis.

responsible. It is in these conversations that I found evidence to suggest that the EC user ultimately takes form as pharmakon. The following section breaks down either side of the pharmakon behaviour of women as described by the nurses to highlight how the women became the pharmakon in need of management.

5.3 The 'good contraceptive user'

The nurses, in their roles as gatekeepers, but also in their roles as social problem workers, are exposed to a variety of claims and claimsmaking. These claims appear to influence what is expected from sexual health services, as well as in definition of sexual health behaviour promoted as both 'good' and 'bad'. With good behaviour recognised as expressed in use of LARCs or as being 'clued up' and 'aware', I explored further the ways in which the nurses considered the behaviour of EC users as good contraceptive behaviour.

The nurses accepted that all women were 'different'. Kate suggested that, "I think people choose their contraception depending on their lifestyles, but it very much depends on how they feel about it and whether they agree with it or not". In their patient-centred care role, the nurses accepted women as contraceptive consumers. Michelle described their choice of contraception as the same as "choosing shampoo" and explained "we work with the women to help them find something that suits" (Michelle). In their role as nurses, they worked towards ensuring the women were 'quick-started' onto a contraceptive that suits the women's lifestyle. This line of discussion also indicated that the nurses believed the actions of a woman who has attended a clinic for ECP could be 'responsible', as we see in Gemma's comments:

> I think it's a very useful thing to use. And I think when somebody's gone through the service and used it and they've highlighted they've made that mistake I think the majority of people make sure that didn't happen again in the future you know they are sensible enough to protect themselves. (Gemma)

The nurses accepted that on the occasion where a woman attends the clinic for ECP, their actions are 'responsible'. This received more support from the nurses when the women have admitted to having 'made a mistake'. In their admission, and by seeking access to services the nurses praised women and viewed their interaction as an opportunity to quick-start.

In our discussion around access in advance, some of the nurses found that if a woman were to have the ECP at home, she would be proactively protecting herself from

pregnancy. Emma said: "I think people that would be accessing it prior, they would probably be the lower end of the risk group" (Emma). These women who were approved as a 'low risk' group since they were suggested to be planning their contraceptives, this is approved of as good contraceptive behaviour. Good contraceptive behaviour was recognised by the nurses as "preplanning" (Kate). In the scenario where a woman could access the ECP in advance, this was accepted by the nurses as actions they could support as responsible. Julie explained:

> Just because somebody has unprotected sex doesn't mean they're being promiscuous. It means in that instance they had unprotected sex and they're being quite sensible I think, accessing emergency contraception. (Julie)

These conversations highlighted that although women make "mistakes", the use of the ECP is viewed as "pretty sensible" and these women were accepted by the nurses as making proactive decisions (Mary, Michelle). The term 'sensible' appeared as supporting the behaviour of EC users as the EC user was understood by some of the nurses as the 'less risky' woman. When Heather was asked to describe the behaviour of the EC user she suggested:

> You can't say it's a woman who takes risks because they won't bother to take ECP. At least the ones that are taking EC are the ones who acknowledge that they have taken a risk and they want to do something about it. (Heather)

I found that where the nurses were able to accept the behaviour of the ECP user as 'good' 'sensible' and 'responsible', it was if the behaviour appeared to demonstrate the value set of the institutional setting, as 'planned'. Risk management appeared to impact the approach the nurses took when interacting with women but also shaped the identity formation of the EC user. Some suggested that the behaviour of the EC user, although initially risky, would be overlooked because accessing the ECP omitted the previously risky be behaviour. Richard put it this way:

> Sex is risky. My rationale for that is basically people come in for the morning after pill, okay, then basically they're not having a lot more unprotected so where they're more likely using condoms all the rest of the time. (Richard)

The rationale provided by Richard suggested that although EC users are categorised as risky, however, they are more likely to be using condoms. The behaviour he described as the most risk-conscious approach was defined this way because condom use protected against both pregnancy and STI. However, with the notion that "sex is risky", it still appeared difficult for all the nurses to side with the idea that an EC user is

practising ‘good contraceptive behaviour’. On the opposing side of the pharmakon it became apparent that although women may be seen as proactive, their use of the ECP can also indicate ‘unprotected sex’ with this behaviour viewed as risky. This impacted the meaning some of the nurses gave to EC users.

5.4 The ‘bad contraceptive user’

In the institutionalised setting, the nurses are expected to participate in the promotion of ‘good’ sexual health behaviours. Gerth and Mills (1970) explain that when the values of the institution are supported or shared the goal orientation of the professional is more likely to be successful. In the case of the nurse’s role in managing sexual health, all 15 nurses showed support for their health promotion efforts and the impact they have on the health of women. As Jane explained:

> Everything’s an opportunity for like health education really. It’s like an opportunity to, promote their health, promote safe sex, and promote using contraception. You know address risky behaviour, safeguarding issues and things like that. (Jane)

All fifteen nurses recognised the importance of interacting with EC users. The shared meaning given to these interactions was suggested as a good opportunity to offer ‘health education’ to women that appeared as sexual health risk-takers. Health promotion in the eyes of the nurse did not include promotion of the ECP, as Jane suggested:

> Obviously in sexual health we encourage people to use condoms whenever they have sex. It goes a little bit against the grain I think if you’re encouraging emergency contraception because then people are having unprotected sex. (Jane)

The use of the ECP was linked to the concept of ‘unprotected sex’ and to promote the use of the ECP was suggested by the nurses as encouraging women to have unprotected sex. Therefore, the use and promotion of the ECP appeared to ‘go against the grain’ of the institutionalised setting, and as professionals participating in the management of the social problem, women who appeared as EC users also emerged as a problem.

The women that were framed under the ‘bad contraceptive user’ construct were accepted as more likely to display risk behaviours. Not being on contraception was the main indicator of a ‘risky woman’. With contraception being accepted as ‘planned’, it was suggested that "a lot of the risky behaviour happens, as a spontaneous thing, it’s not something they’re planning to do" (Lesley). Some described as this as a "one-night stand", as Richard explained, "emergency contraception is more that they’ve been a one-night stand, normally they would use condoms, this time they’ve not used the condom"

(Richard). Susan suggested the women that fall into this category do not recognise the risks they are taking: "It's like a lot of them seem to sort of in denial to not want to take responsibility" (Susan). 'Lack of awareness' of risk closely linked to perceived absence of responsibility and displays of these behaviours, were open to more criticism from the nurses and perceived as more problematic.

ECP users' behaviour that surfaced in the discussion as problematic was recognised as "repeated EC use" with "multiple partners" and "taking no responsibility' (Michelle, Richard, Mary). Women who were repeatedly using the services were indicating that 'quick-starting' had been unsuccessful in their care, and therefore featured as problem in the discussions with the nurses. Elaine suggested the nurses targeted the "riskier women" defined as "the ones that keep coming back and back are the ones we want to talk to" (Elaine). The social problem work of the nurse appeared to highlight the "most risky" women as ones "that don't listen" (Heather). Already established is the meaning the nurse give to the consultation and the value the nurses give to the success of the consultation measured by 'quick-starting'. Here I found the women that are alleged as 'bad contraceptive users' are typified by the nurses as not likely to adhere to 'health education' or 'health promotion' offered by the nurses. These women are also described as the type that are "having lots of unprotected sex" (Carol). Carol explained that in the case where a women is having "lots of unprotected sex", she will "give them a choice" of contraception moving forward, but she would "want to try and quick start someone as quick as possible, because they're so risky you almost know, if you give them too long before they're protected, they're probably going to have unprotected sex again" (Carol).

The 'riskiest' woman appeared as a challenge to the institutionalised values of 'good contraceptive behaviour'; they were women that was suggested did not "learn" from the interactions made with clinic staff and continued to take "risks" with unprotected sex (Julie). Elaine indicated these were the type of women who are "not taking on the information" (Elaine). It was suggested that the unsuccessful health promotion was not a fault of the approach used, or advice given. It was reflected back onto the woman, for example as in Elaine's comments that, "[health promotion] will never affect the women who are actually prepared to take a risk and don't worry about the outcome" (Elaine). This characterisation of the women appeared to be in conflict with EC users who are perceived as 'good'. Unlike the good EC user, the "higher risk individuals would be the ones that would just go and buy it" (Helen). Established earlier in the chapter, was the nurses' confirmation that they believed the pharmacy setting was a missed opportunity for health promotion. Here it is seen to support the idea of the risky EC users who will

"just go and buy it" and is "prepared to take a risk". The characterisation of the 'bad contraceptive user' depicts women that appear to challenge the sexual health standards strived to be achieved in the institutionalised setting. I found this supported the values the nurse gave to their roles as social problem workers as a part of their 'mission' to quick-start women onto contraception was aimed at the 'bad contraceptive user'. This in turn supported the need for the social problem worker and their role.

The risky ECP user was established as a woman who 'takes that risk'. For Heather she considered this to be a sequence of events that eventually means the woman will experience untoward consequences:

> We all know you don't instantly become pregnant the first time you have unprotected sex – you do it for three or four months. And then suddenly it bites you in the backside because that's the time you become pregnant. (Heather)

Heather describes an EC user as a woman who engages in bad contraceptive behaviour and pays the price. On this side of the pharmakon, we find the nurses described the behaviour and attitude of the 'risky' woman as showing and accepting a lack of 'responsibility' evident in pregnancy. These women identified as risky appeared to fall to the 'bad contraceptive user' side of the pharmakon because they repeatedly challenged the goal orientation of the nurse.

The nurses valued and gave meaning to their efforts to encourage and promote 'good contraceptive behaviour'. With this motivating their interactions, it also supported the negative construct allocated to the 'bad contraceptive user'. These women were seen as not wanting the advice or education provided by the nurses and in turn this was viewed by the nurses as evidence of the irresponsibility of the women. The unsuccessful encounters supported the frame that some women are just 'risky', and it was perceived that no 'good contraceptive behaviour' or user would display such behaviour. As Richard explained:

> If somebody is going to take risk taking behaviour, they're going to take risk taking behaviour regardless. They're going to do that regardless and it's not about emergency contraception. That's about risk taking. It's not going to make any difference. (Richard)

The behaviour of the EC appeared to be identifiable by the meaning the nurses gave to the actions of the women. If the EC user was observed by the nurses as modifying or changing her behaviour following her use of the ECP, she was framed as displaying 'good contraceptive behaviour'. However, if the EC user displayed repeated use of the ECP or actively chose to 'take risks' by not accepting quick starting, this conflicted with the

health promotional aims of the nurse and framed the woman as demonstrates 'bad contraceptive behaviour.'

4.6 Conclusion

Overall, we find the nurses take on the role of the social problem worker that facilitates the maintenance of the ambiguity of the social problem, but that also constructs an identity of the social problem individual. The role of the social problem worker is to manage the claims on either side of the tightrope. This role is important to the success of the social problem formation as it needs to be stabilised to support the right level of ambiguity to sustain its current state as pharmakon.

This chapter began by investigating the frame the nurses gave to the ECP as a contraceptive. In a state of dual meanings, I found the nurses role as social problem workers was centred on managing this construct of the product, in particular through in the interactions they have with women as EC users.

The product's ambiguity was further supported by the meaning nurses they gave to 'access'. The discussion around access identified underlying idea of the responsibility of the social problem worker. The social problem worker was perceived as having responsibility of managing the EPC and access to it via supervised gatekeeping. However, the underlying meaning the nurses gave to the concept of access was an opportunity to prevent risk moving forward. With health promotion at the top of the goal oriented agenda of the nurses, I found supervised access was considered by the nurses to be a problem solving opportunity. This was supported further in the nurses' description of the meaning they gave to their roles.

In the nurses' reflective accounts of their work as nurses, and also in the discussion about the purpose of the consultation, ECP was considered a problem in need of regulation. However, as we established in the frames given to access, the underlying problem became the behaviour of women. Therefore the consultation was considered by the nurses as an opportunity. In their roles as social problem workers, the nurses facilitate the controlled state of the pharmakon on the line of the tight rope. This is achieved by giving women access to the ECP, but, by also not promoting it as a contraceptive option. The work of the social problem worker was deemed a success by the measure of quick starting. I found the nurses gave meaning to and became invested in their interactions as it appeared quick starting to highlight the success of their job roles. In this analogy,

the women are recognised as safely walking the tightrope if there is evidence of a successful quick start.

Interestingly, on the opposing side of the pharmakon, I found the success of the nurses consultation appeared to change. On one side, viewed as 'good contraceptive behaviour' women were praised as adhering to the values and goal orientation of the nurses if they modified their behaviour and quick started onto contraceptive. This behaviour was given the meaningful category on the good side of the pharmakon tightrope. What appeared to challenge the success of the nursing role and social problem work was women who appeared to deviate from this prescribed ideal behaviour pattern. I recognise this as social problem identity work, since the nurses appeared to measure the behaviour of the women against standards set as 'good' and 'bad' contraceptive behaviour. They ultimately facilitate the construction and management that use is either good or bad meaning ECP it remains in a state of ambiguity.

I found that in the role of the social problem worker, the nurses worked hard to manage the construct of the pharmakon by the sustaining ECP's position as ambiguous. The ECP was neither promoted as a contraceptive method nor denied as a contraceptive option by the nurses. However, in the process of managing the ambiguity around the ECP, it appeared that the women's behaviour was experienced as the application of the dual meanings of the pharmakon. These findings suggest that when ambiguity constructs problems, individuals who emerge within the problem are measured under the same framing.

I now explore the pharmakon framework and social problem process further, in the discussion and interviews conducted with women as EC users by exploring the identity work of the women.

Chapter 5

The Spoiled Identity of the EC user

5.1. Introduction

> The concept of social identity allowed us to consider stigmatization. The concept of personal identity allowed us to consider the role of information control in stigma management. The idea of ego identity allows us to consider what the individual may feel about stigma and its management, and leads us to give special attention to the advice he is given regarding these matters. (Goffman, 1963 p. 130)

Influenced by the work Goffman (1963) on identity and the spoiled identity, I now turn to investigate the EC stories of EC users. Goffman is recognised as the first sociologist to take seriously the question of the social construction of identity. His study of identity work introduced new ideas to sociology about the meaningful interactions we make in our day-to-day lives, and the study of them. In this investigation into *the spoiled identity*, I adapt Goffman's (1963) approach to investigating the identity work of an individual by evaluating the meaningful social interactions in EC users' experience. The chapter addresses the influence of the wider public claimsmaking activities discussed earlier on the individual, here recognised as EC users. More specifically, I outline the identity work of the individual who is constructed as a pharmakon. The EC users interviewed become unique characters in the social problem process since their identity construct is built on dual and opposing meanings. Chapter 4 identified how the EC users' behaviour has been typified on either side of the pharmakon tightrope as both responsible and irresponsible. This chapter will explore the ways the EC user navigates the wider claims made about her identity, and how she makes sense of the dual meanings given to her behaviour. I use the work of Goffman (1959 & 1963) to break down the identity work of the EC user as we consider the *moral careers* of women who use the ECP.

The EC stories are considered here as portrayals of the women's *moral careers*, a term used by Goffman to understand the process that constructs the problem identity of a stigmatised individual. Goffman (1968) suggests that we can explore the biography of an individual to better understand their life and transition to stigmatised identity formation. In the investigation into the EC users' *moral career*, the chapter examines how pre-ECP stories act as a guide to the identity work of an individual transitioning to a stigmatised identity. In the women's biographies, I explore the various experiences that lead the women to use the ECP, from contraceptive use to awareness of risk. The chapter

begins by breaking down these biographies and pre-EC lives to explore, firstly, the contraceptive identity of the users and, secondly, their understanding of contraceptive choice.

Goffman (1963) explains that the stigmatised individual develops different identities throughout their moral career. The meaningful interactions a person makes with values, situations and actors come to shape the individual's own understanding of their identity. Part 2 of this chapter assesses the meaningful interactions the women interviewed make in their reflective accounts of the consultation experience. These interactions contribute to the identity career of the individual, but also teach the individuals the ways in which their behaviour spoils normative identity formations. From these stories, I formulate a storyline about what it is like to be a woman needing EC, and what it is like to live out a stigmatised identity.

Goffman explains that part of our identity formation comes from the process of reflecting on our actions, as the stigmatised individual becomes, 'a critic of the social scene as an observer of human relations' (1963, p. 135). As part of our identity work, we measure our actions against the 'norm' behaviour and accept our own as 'abnormal'; we begin to believe in the deviant construct given to our experiences and our identity. Goffman (1963) describes this process as one where we are 'led into placing brackets around a spate of casual social interaction so as to examine what is contained therein for general themes' (p. 135). This is described as *situation consciousness*. Here, I assess the EC users' situation consciousness in the narratives of their 'EC stories' and the women's understanding of their own 'contraceptive identities'.

The contraceptive identity of a woman is one of many identities she may take on. In the case of this sample, the identities range from sister to journalist, graduate student to lawyer. What unites these women is their experience of needing the ECP. It is important to note that each of the women interviewed had their own unique ECP story; however, what I have been able to investigate is the commonalities in their stories that lead us to accept that there is a shared problem identity formation among them. I have here assessed the women's navigation of the wider meanings given to their behaviour through the vacillation of the problem identity along the tightrope. The navigation of meaning is addressed as the *pharmakon spectrum.* This element of the pharmakon framework supports the investigation into the meaning-making of the women and how they make sense of their experience of an ambiguous social problem identity. The chapter ends by examining the EC users' understanding of the wider claims of the ECP alongside their own stories, as I investigate how and whether the wider macro-level of

claimsmaking activities impact the lived experience of the individual on the micro-level. The users' stories are divided into three sections: (i) before; (ii) accessed; and (iii) after. By deconstructing the women's experiences, we consider what it is like to live within a problem and the self-identification of a problem identity.

5.2. Before ECP

My discussion begins with an account of the women's commentaries of their contraceptive use before requesting ECP. In the women's 'pre-EC' stories, I find that the accounts of the women I interviewed and their associated identity formations do not match those of the EC user that emerges and circulates in the public domain. As discussed previously, these descriptions have centred on the EC user being young, single and risky, but this construct does not characterise the sample of women I interviewed. With ages ranging from 20 to 35-years-old, and with 15 of the 20 women in relationships or with a regular partner at the time of needing the ECP, they do not match the 'young girl' construct that features in Dr X's letter in Chapter 3. In fact, their pre-ECP stories focus primarily on their difficulties and struggles living as the 'ideal contraceptive user'. The women who were quick-started onto hormonal contraception express their difficulties with using hormonal contraception routinely, this formed a central part of their contraceptive career and strongly influenced their pathway to ECP use. In discussing their difficulties with 'regular' contraceptive use, I therefore highlight how prior to attempting to manage identity as an EC user, women's identities were already shaped by the ambiguity and dilemmas associated with attainting stability as a woman who uses contraception in the 'right way'. My account of these women's contraceptive careers pre-ECP is necessarily brief, it focuses on difficulties associated with the regular contraceptive pill. It was genuinely surprising to find that these difficulties were so pronounced, and that women could not bring together their identity as a woman seeking to regulate her fertility and being a pill user. The most remarkable absence in the women's narratives was any association between the contraceptive pill and women's liberation. I come back to this question in the conclusion to my thesis where I discuss possibilities for future research, but for now I focus on three areas of identity conflicts and interactional difficulties which are interactions with medical professionals and responsibility in relationships, and next concerns about hormones and health.

5.2.1 Contraceptive identity

When asked about contraceptive choice, women referred back to their first consultations with either a General Practitioner (GP) or a sexual health nurse. Many felt they were, in their initial consultation in their teenage years, "steered towards the pill" as Zoe put it. Health professionals considered the pill to be the "standard" contraceptive (Lauren). Sophie said, "I feel like they kind of encourage you to take things like the pill". She compared this to other forms of contraception, noting, "Whereas the pill I feel, like, is a lot more known on where you can get it, and the convenience of it to be able to get" (Sophie). Women explained that often health professionals made them feel they were not in control of their decision. Steph described the choice she had as "the best of the worst" with her concerns focusing on hormones (a concern I detail further below). The women felt they did not have the final say in their contraceptive choice and this emerged as true for some when they discussed their experience with LARC. Danielle explained:

> They were more than happy to help me with it, but I didn't really have a say once it was in! I felt very much like they were in control of what happened then. I went back multiple times asking for them to take it out, and then once they put me on the pill, I didn't know what the different options were off the pill. (Danielle)

All 20 of the women indicated that health professionals played an important role as gatekeepers to contraception, and it appeared they felt they had handed their autonomy over to medical professionals. Many of the women considered their contraceptive decisions to have been already made for them based on what the health professional promoted.

The question of control also featured when women discussed the expectations placed on women. The respondents communicated they thought there were a lot of expectations placed on them as women, from boyfriends expecting women to take the pill (Hayley), to relationship status impacting contraceptive options (Laura). They indicated a sense of tension between social expectations for women as 'good contraceptive users' and their own experiences and feelings about their personal lives. Lauren put it this way:

> If you're in a long term relationship and not wanting children at the moment, it is just expected that the woman goes on the pill. That is just expected and if you say you're not on the pill, people are like, really? Why not? So, I think if you're not in a long term relationship and just having casual sex […] I think you are expected to use condoms which obviously is the correct thing to do if you're not with a constant partner. (Lauren)

Lauren's comments can be interpreted as an implicit response or disagreement with nurses' interpretation discussed in the previous chapter. This idea coincides with that previously discussed in Chapter 4, which emerged in the nurses' interpretation of 'responsible' contraceptive users, those considered to be having regular sex who should also be using regular contraceptives.

The women interviewed certainly considered, in this case, that the consequences of unplanned pregnancy fell mainly on women, and the allocation of responsibility to them emerged as a talking point. The sense that emerged from the discussion around responsibility was of taking responsibility as a burdensome necessity. The fact that the consequences of sex impact men and women differentially emerged as something associated with negativity. Danielle, for example, commented, 'Women have to take responsibility for not getting pregnant. If you choose to have sex and it happens, then it is your fault'. The need to contracept was recognised by some of the women as 'pressure' that the male partners do not experience. Sophie explained, "I do feel like there's a pressure for women to be on something more than there is for a man … I feel like it's more the woman's fault for not being on something if they were to hook up" (Sophie). The words "fault" and "guilt" featured in women's description of contraceptive failure indicating a gendered divide in contraceptive responsibility. All 20 interviewees understood that contraceptive "responsibility falls to women"(Faye).

Many expressed frustration about bearing this responsibility, explaining they had "arguments with my boyfriend" (Sophie) about having to bear the responsibility of contraceptive decisions. Others made reference to studies on the "male contraceptive pill" as "a much better option", as it would be "fairer" to share the responsibility (Fern, Steph). Male contraceptive options were considered minimal and women felt their contraceptive responsibility brought with it "guilt" and "blame" for making the wrong contraceptive decisions:

> I even felt bad when I told my boyfriend. We'd been together for three years and I was like look, I think I'm going to come off the pill and I had this inbuilt guilt inside me as though … I felt like oh gosh, I should be the one taking control of that. (Fern)

Feelings of guilt and "feeling bad" appeared to give meaning to the women's understanding of their responsibility to control their fertility options. Their contraceptive identities emerged as shaped by more than simply managing fertility. I found the contraceptive identity to centre on the ambiguities that appear to relate to the perceived social expectations set out for women as contraceptive users. These

expectations emerged as shaped by narratives of upholding an 'ideal contraceptive identity', they appeared to be influenced by the meaning they gave to being autonomous in decision-making. I recognise this as the women's moral career of the pharmakon identity, which emerged in relation to the stigmatised behaviour of the EC user (which I detail further below). First, however, I continue my discussion of identity before EC, through a consideration of 'hormones'. This was a striking area of discussion. It featured prominently in what women had to say, with concerns about the effect of regular hormonal contraception perhaps paradoxically forming the entry route for requesting ECP.

5.2.2 'Regular' contraception and the side effects

Eighteen of the 20 women interviewed had experience of using hormonal contraception; 15 of the women had experience of using the pill, while eight had used the implant. The options not used by the women were the injection, the nuva ring, IUD and IUS. Consistent in women's accounts of contraceptive history were comments about the convenience and efficacy of the 'regular', hormonal long term or daily contraceptive options (with some moving onto the daily pill or a LARC method following their last EC consultation). However, all expressed concerns about the side effects of hormonal contraceptives. Some had experienced issues that led them to not use the more 'regular' contraceptive options.

"For me, it's all about the side effects," said Lauren, continuing, "that's what I think about when using contraception". Emily said, "I ballooned and put on a stone in a month". Danielle discussed headaches: "I kept getting migraines so I stopped using the pill". These side effects (weight gain, headaches) were explained by the women as good reasons to discontinue use since they had a negative impact on their mood and emotion. The negative impact the hormonal contraception had on mood and emotional stability especially was referred to as a deterrent for use. For example, Jenna suggested that "lots of contraception either made my hair fall out or made me put on weight or had terrible mood swings. So, the side effects certainly, after my teenage years, was the main consideration of how it was going to make me feel rather than, how often I'd have to take it or how effective it was" (Jenna).

'Mood changes' and 'depression' appeared in all 20 conversations. Nine of the women experienced mood changes after using the hormonal contraceptives, with the pill and

the implant accounting for the main source of side effects. When speaking to Fern about her use of the pill. I asked her, "You said your mood changed?" she replied, "Yes, drastically,", continuing:

> I noticed I used to get really paranoid. I had really low self-confidence and even though I was with my fiancé I just always thought he was going to leave me all the time. I had really paranoid thoughts and pretty much I'd say about a month after stopping taking any form of contraception other than condoms, I felt completely different. Back to myself again, so much happier. (Fern)

Women explained that hormonal contraception made them feel 'different'. Faye said she "didn't like taking hormones … because of how they made me feel". Feeling 'low', 'bad' and 'depressed' were terms used by women and some indicated they women that others, including health professionals, would not take seriously (Hayley, Amelia, Lauren). Katie for example discussed how: "I had the implant when I was 18 and I didn't get on with that at all". She talked about 'feeling low' and 'putting on weight', but told me ''they said it doesn't happen but it did to me" (Katie). Katie was referring here to doctors' perceived dismissal of the mood changes and side effect of gaining weight, two of the most common side effects noted by the interviewees.

The effect hormonal contraception had on 'mood' appeared to have a great impact on the way women chose their contraception and shaped their contraceptive identities. Although Hayley and Steph did not have any personal experience using hormonal contraception, the discussion they had heard among friends, mothers and sisters, influenced their decision to not try the method. Seventeen women expressed some concern about the impact hormones had on their emotions and their bodies. Amy explained, "I just prefer not to have anything in my body", and related this preference against using the pill to the nature of her relationship. She said, "Me and my partner don't live together so I don't like the idea of taking a pill every day when me and my boyfriend only see each other maybe once a week or once every few weeks" (Amy).

Women who rejected hormonal contraception were quite aware that alternative options to hormonal contraception were viewed as risky. In other words, their contraceptive identity was organised around managing how to be a 'good contraceptive user' whilst wanting to eschew hormones. Katie, who used barrier methods, recognised her contraceptive choice could be considered 'risky' but rationalised this as follows:

> It [the diaphragm] is 96 or 97% effective, so not as effective as using a pill but then I think in terms of the overall well-being, if it's less effective but you're feeling better, then it's probably better. (Katie)

Emily rationalised her non-use of the pill through reference to what might make sense for an individual. She said:

> If you're a very forgetful person, the pill probably isn't the best thing to do then. It's [contraception] is an inconvenience on women right? You have to think about it constantly for 40 years of our life so it should definitely be the easiest possible for you. (Emily)

Danielle also commented on individuals' characteristics and what she termed 'lifestyle':

> I think it is really important to me that the method does suit my lifestyle. I think if it not going to fit in then I am not going to remember to take it or to want to …. If it doesn't fit in it is a bit pointless really. (Danielle)

In this sense, women did appear to draw on the cultural resource of individual choice in a certain form to attempt to resolve the ambiguity surrounding how to form a stable identity as a good contraceptive user. I found the women showed some awareness of what is expected from them and other women when it comes to participating in the normative identity construct of the "good" contraceptive user. I now move onto consider further how women make sense of their identity as contraceptive users who others may consider risky, whose strategies did not correspond with official construction of risk avoidance and responsibility. I explore the women's experience of the stigmatised identity from the point of entry at the risk behaviour. Throughout the chapters we have come to accept women's contraceptive behaviour is established under two constructs the contraceptive users, as "good" and "bad". Chapter 2 indicated that contraception has long been considered under two meanings and can be further recognised as pharmakon. Here I consider now how the pharmakon identity is then experienced by women. In their navigation of the wider meanings given to 'good' and 'bad' contraceptive behaviours, I consider the women's transition and experience of a new identity formation as the *spoiled identity.*

5.2.3 The pharmakon spectrum: experiencing the vacillation of the pharmakon identity

The social problem identity established in earlier chapters constructs the ECP user as reckless and risky. In Chapter 2, we concluded that new public health promotion techniques set out to encourage individuals to adopt preventative behaviour through careful use of regular contraception. In Chapter 4, we showed how the nurses' goal-orientation for consultation with women aimed to limit risk-taking behaviour moving forward. I now consider how women describe their own risk-taking behaviour and the relation between the wider frame of risk and experience their own identity formations.

Although risk identities are subjective to individual experience, I found similarities in the accounts. Women commonly discussed the risks of unprotected sex as becoming pregnant and contracting STIs, in the discourse, I found an awareness of these risks influenced contraceptive decision-making. In the investigation into the ambiguous social problem and the identity work of the social problem individual within this social problem, it was difficult to assess the variances in the meanings that appear as pharmakon. In Chapter 4 I was able to differentiate between the meanings the nurses gave to EC users' behaviour as both 'good' and 'bad', as this behaviour featured in the discourse as objective to the nurses. However, the women appear as individuals, each with different experiences, which meant I was unable to categorise all the behaviour as either, 'good' or 'bad'. I found it easier to establish two opposing starting points in the discourse of the women's experiences and plot the behaviour of the women as a spectrum between these two points. If we return to the pharmakon tightrope and consider the stigmatised pharmakon identity as a tightrope walking experience, this spectrum can be visible as the distance between the dual meanings (see Figure 9). This element of the pharmakon tightrope is described as the *pharmakon spectrum.*

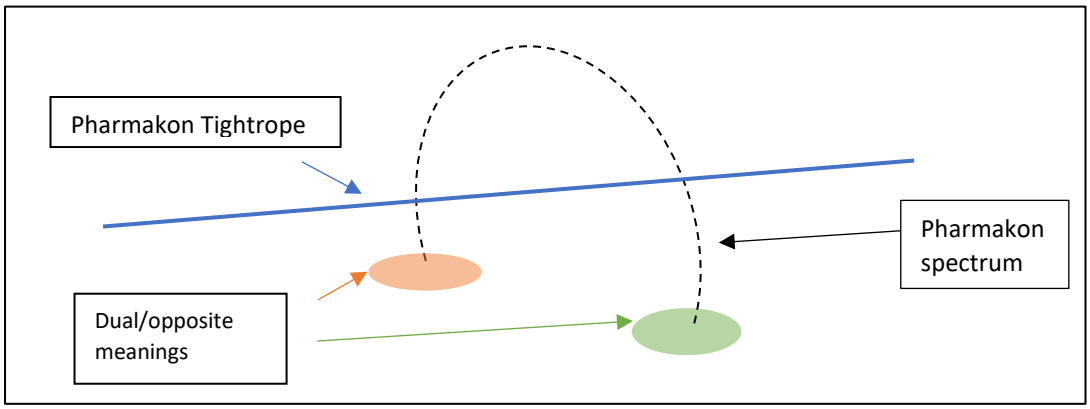


Figure 6: The Pharmakon Spectrum

The pharmakon is unique as it is in a constant state of ambiguity. With the 'ECP user' appearing as a meaningful identity formation, it is up to women to navigate through this ambiguity to make sense of their experiences against the wider claims – or to walk across the tightrope without falling too far either side. The pharmakon identity is thus forth an experience of dual meanings. Here I use the spectrum to better understand how women make sense of the dual meanings given to their behaviour and their experiences, to explore how the vacillation of meaning from wider claims impacts their walk across the tightrope line.

Using the pharmakon spectrum as an aid to addressing the behaviours and identity viewed as ambiguous, we can better understand how each of the women experience the stigmatised identity. Using this spectrum, I categorise the pre-EC contraceptive behaviour as discussed by the women as either 'high risk' or 'low risk'. I now discuss risk identity along the pharmakon spectrum.

One group of women considered themselves unlikely to be at risk of pregnancy but their accounts notably communicated the highest level of risk aversion of all the women I interviewed, and this formed the entry route into them seeking ECP. Their descriptions of themselves included 'hyper-paranoid' about the risk of pregnancy and as having 'overly cautious' behaviour patterns. Gemma was one of these women. When she accessed EC, she was on the mini-pill, using condoms and in a long term relationship. She said she used EC for "peace of mind" and although she knew she was not necessarily "at risk", she did not want to take any chances (Gemma). Her risk-averse use of EC appeared to be related to her family's experience of unplanned pregnancy. Gemma explained:

> I know my grandma got pregnant when she was on the pill. And I think as soon as my mum comes off the pill she got pregnant. So, for me the pill … I think, I just prefer having two methods rather than one. It makes me feel safer to have two. And then you've always got one as a fall back if the other one goes wrong. (Gemma)

Gemma considered that using more than one contraceptive was the "safest". Danielle explained that despite using condoms, she chose to use the EC on 30 separate occasions. She described herself as "far too paranoid" (Danielle) to only rely on condoms. Danielle explained her risk consciousness grew from her own anxieties around young parents in her hometown. This 'overcautious' awareness was apparent for around a third of the women interviewed. Katie explained that although she used condoms, her decision to use the ECP was considered 'better safe than sorry':

> Yeah, it was probably me being overcautious than an actual likelihood that I was going to be pregnant. But getting the pill [ECP] is a lot better in the long run than having a baby that you don't want to have. (Katie)

For these women, the risk of unplanned pregnancy was too high and their contraceptive decision- making centred on eliminating all risks. On the pharmakon spectrum, these women's tightrope walk would lean closer to one side as they appear to take minimal to no risk when making the contraceptive decisions that lead them to using the ECP.

To the other side of the risk spectrum are women who discussed taking risks in a different way. These women arguably would meet the criteria of the 'risky contraceptive users' that drives the health promotion strategies, although none of them are teenagers. The striking aspect of these women's accounts is that they tend more to see ECP as a method of contraception that could allow them to address the potential consequences of unplanned sex or irregular relationships. Emily for example explained:

> That was the whole problem. At the time, I wasn't actually using contraception because I was not sexually active. And then I met this man and we had sex and I didn't expect him to cum without letting me know or asking me or anything. He just came in me and I was like 'Uhh shit! Excuse me you were not supposed to do that!' (Emily)

In these women's accounts there is, however, some evidence of a struggle to reconcile ECP use with the identity of the 'good' contraceptive user: "I suppose in those moments, I made the choice to just do what I felt like doing, which wasn't particularly sensible," said Amelia. It appears from the accounts of these women that they are aware of how some of their contraceptive decisions were made 'in the moment', in comparison to the highly promoted 'planned' contraceptive behaviour preferred and promoted by the nurses in Chapter 4. These women's tightrope experience would see them leaning further to the opposing side, as they appear to be displaying the behaviour that would identify them as a 'risky' contraceptive user.

Other women interviewed fell somewhere in the middle of the risk spectrum, managing the meaning vacillation on both sides of the tightrope. They appear to be using methods such as the pill or condoms but had either "forgotten" as a result of "human error" or the contraceptive had "failed" (Hayley, Zoe, Lydia) . In these women's accounts, it is arguably the case that there is most evidence of finding a way to reconcile ECP use as a part of contraceptive identities. I found this is because the women seem to manage to find a way of accounting for the failure or non-use of routine contraception as outside their control. Hannah is in this group:

> I'm not personally a fan of condoms. I find them inconvenient when you're getting there. So I don't really like them. Also, the morning after pill, I had more control, I knew what was crackalacking and it was easy because I was sporadically having sex and I didn't want to take a long term hormonal contraception, because I wanted to stay as natural as possible. (Hannah)

However, even Hannah, who in some parts of her account appears to be most able to make sense of her identity as EC user in a positive way, still indicates difficulty with maintaining this identity:

> I personally regret not being safer. I think that's something life has taught me. That's how I feel about the decisions now. Having used it, I know it's vital when you've made those choices. I don't know if I went into … no, I did. I just went into the weekend thinking, I'll use the morning after pill if we had sex, because I didn't know if we would. (Hannah)

As the women continued to tell their EC stories, I found that prior to their needing to use ECP, they showed some awareness of the wider EC identity construct associated with the ECP. In the women's accounts of the 'pre-EC', stories it appears women are aware of the stigma attached to their contraceptive behaviours and decisions to either not use 'regular' contraception or not to pre-plan' contraception. This behaviour was recognised as associated with EC use; the women addressed how their behaviour mirrors that as 'not being safer'. I found the women experienced some issues with side effects that meant they were unable to use hormonal contraception. Also, I found the women appeared to accept that contraception should be tailored to meet the needs of women without impacting their lifestyle. Therefore, it could be suggested that for some of these women, the ECP would be an ideal method to have or use alongside barrier methods, since it would be used if needed. However, in these discussions, women indicated their awareness of a particular construct of a good contraceptive user which did not include using the ECP.

We have established, through our discussion of women's pre-EC use biographies, that EC use emerges against the background of pre-existing ambiguity in the women's identities as contraceptive users. This takes different forms, reflecting variations in family background relationship and the sort of regular contraception used. The difficulties associated with use of the pill as a routine form of contraception have emerged however as probably the most significant factor. I did identify variations in risk consciousness, which influence how the identity of an EC user forms; however, there were no women who came to the point of requesting EC outside a framework of

contraceptive ambiguity. I found evidence to support the women ability to navigate the vacillation of meaning along the pharmakon spectrum, as they make sense of their experience under dual meanings. I now move to discuss EC use, considering first women's experiences of accessing EC. Overall, the main theme I highlight is the way pre-existing ambiguities of identity are then further shaped, as women become users of a pharmakon product, characterised itself by its ambiguity.

5.3 'Accessed'

I now explore discussions about access to the ECP via the consultation, and consider how this interaction aids women's transition to an EC user identity. Other methods of contraception such as condoms that are also available in commercial settings do not need a consultation to access them. No other hormonal contraceptives are available in a commercial setting for purchase, and they can only be accessed through an appointment at a sexual health clinic or a GP surgery. This makes access to the ECP unique in comparison to all other contraceptive options. The argument put forward in the over the counter (OTC) debate reviewed in Chapter 2 was that the ECP has been made more readily available to women through an OTC. This move was praised by lobbyists, since it was perceived that increased access would mean women could use ECP as and when they need. However, I have found that this mode of access (with the added addition of another health professional body having control of access in the form of pharmacists) influences women's use and understanding of their experience. The consultation also features as an experience of the EC users that can be measured along the pharmakon spectrum as they make sense of their interaction with the nurses; they give meaning to their use of the ECP. This interaction is considered the facilitation of the women's walk along the tightrope and the management of the spoiled identity formation.

The following section breaks down the consultation to shed light on the experiences of an EC user. It examines how, although OTC access is meant to give women an additional form of access to contraception, the reality appears to suggest that access via a consultation has added another barrier. The consultation process further impacts women's recognition that the ECP is a problematic contraceptive and influences their identity as an EC user. In an attempt to explore the lived experience of a stigmatised identity of a social problem, I consider women's understanding of what it means to access the ECP. I begin by discussing the process of the consultation.

5.3.1 The consultation

What makes the ECP unique is the consultation. The need to speak to someone in a commercial setting separates access to the ECP from all other contraceptives able to be accessed. This consultation process creates a different kind of health professional/patient interaction whereby a health professional is not only given control over access, but the everyday pharmacist is given a say in how women access their contraception. I have broken down the women's EC stories and their experience of accessing the ECP through sexual health services and via pharmacies to get a better understanding of what it is like to be a woman and access the ECP and to investigate the experience of transition to a problem identity.

The majority (19/20) of the women interviewed accessed the ECP from pharmacies, with nine of them also having experienced access from a GP or a clinic setting. One woman accessed ECP from A&E. This meant the health professionals women met were not nurses as discussed in the previous chapter. Part of the limitation of the study, as discussed previously, is the inability to speak to pharmacists as part of the research.

I found there is a basic framework to the consultation at the GP, the clinic and at a pharmacy. Women appeared to be less apprehensive about attending a GP surgery or clinic when compared to their experience of the pharmacy. The pharmacy discussion made them feel "nervous" (Jessica). Women's opinions towards access in the pharmacy also varied, with some of the women suggesting they found asking for the ECP on the shop floor no less daunting than buying other items in a shop (Jenna, Lauren).

For other women, however, OTC access caused apprehension and set the tone for how they felt about their access to the ECP. Hannah indicated,"'I always hated asking for it at the counter. I thought that made me so uncomfortable". Fern shared these feelings: "I remember getting embarrassed to ask for it". Some of the women felt they needed to be accompanied to access the ECP from a pharmacy; Zoe explained, "I asked my boyfriend to come with me specifically and I felt very strongly about this at the time". Although an adult, Zoe felt concerned about how her access to the ECP as a lone female might look as she explained the reasons for her escort:

> I wanted him to come with me so that I didn't feel like judged and that I could show them that I was there with a boyfriend and that I wasn't just like, someone turning up from a night out. (Zoe)

Zoe's awareness of the EC user identity and tries not to engage with this identity by bringing her boyfriend supports the idea that women who use the ECP must navigate around the wider claims and stigmatisation associated with their use of the ECP. The EC user identity appears in the women's discourse in their acknowledgement of the need for ECP. It then strengthens in the women's apprehension of their access. This apprehension appears greater in the pharmacy setting. Women enter an environment in which they feel exposed to judgment, increasing the significance of the identity transition experience.

Women who accessed the ECP in the pharmacy setting shared similar stories. Amy said, "I went to the pharmacy and I told them that I wanted the pill. They took me into a little room and they asked me questions". For some women, no room was offered: the conversation was had either over the counter or to the side of the counter. This received a mixed response. Five women appeared to not have the option to go to a room to discuss their need for the ECP, which left them feeling uncertain and embarrassed about their interaction:

> He didn't take us off anywhere, he literally just did it over the counter. I can't remember if he asked any formal questions, he certainly didn't ask anything private, because I remember we were just stood in the queue in front of everybody. (Fern)

This was considered by some of the women as inappropriate, since they felt apprehensive about having to discuss intimate details in front of others in the queue. However, some women who attended a pharmacy did not want to go to the consultation room.

Lauren explained she did not have time to go into a separate room to have her consultation. She said she had waited in line for 20 minutes before the young girl at the counter had a 'hush-hush' conversation with another pharmacist. After waiting another 15 minutes for the senior pharmacist to come through to see her, Lauren explained, "I was like, I haven't got time to come into the consultation room. I've got to be at work in five minutes" (Lauren). The consultation appeared a long and drawn-out process for many. Louise explained:

> They asked me things like that ‘when did you last have sex?’ and ‘what happened?’ and ‘what contraception are you usually on, if any?’ They might have asked me whether I’d taken any emergency pills before. I didn’t feel like it was anything too interesting. (Lauren).

The women who attended the GP or clinic explained they considered their consultation similar to any other appointment. They either called ahead to book an appointment or attended the walk-in clinic, they then had the consultation in the doctor's/nursing room. The GP and clinic experiences appeared to vary. Some discussed that the GP experience felt "rushed". Nicole said: "That felt very rushed in and out, here you go. There’s a prescription for it, done. I didn’t really feel like I had any idea what was going on". Sophie felt that it was a "very quick consultation … but if anything, she made me feel comfortable and relieved I was getting it easy".

Across the various settings for consultation, there appears no general pattern in initial access. Some women preferred the quick 'one-stop-shop' approach to having access over the counter or from nurse in a timely manner. Others preferred to have the option to sit down, to discuss the experience and the product. None of the women were refused and all of the women left with the product. One woman used the ECP once, and one participant used the ECP over 30 occasions. In between these numbers, the experience varied but I found the average number of uses was three to five times. Despite there appearing to be no general pattern in the women’s initial experience of access and women having their own reasons for needing the ECP, I did find some commonalities in the stories of the feelings the women had towards their consultation experience.

5.3.2 The spectrum of experiences

Goffman (1959) suggests that social interactions that are meaningful help us to make sense of our social role. These women understood their consultation as a meaningful and memorable experience. However, although all women experienced the consultation, the consultations were not all the same. The consultations became a spectrum of experiences from negative to positive; therefore, we consider the different consultation experiences as meaningful to the women that can be measured along the pharmakon spectrum. Here I consider the women’s accounts of their consultation experience as a walk along the pharmakon tightrope, as they manage and make sense of their spoiled identity.

We begin with the consultations described by the women as negative. These interactions appear to centre on the women's experience of feeling 'judged' by the health professional they came into contact with (Emily). Various factors appear as a reason to impact their experience and I found the women were able to reflect and rationalise why they felt the interaction was negative.

Age appeared as a factor impacting the negative EC stories. Women suggested when they accessed the ECP as a teen, their younger selves were more susceptible to feeling "embarrassed" and "naïve" (Zoe, Nicola) and this made their experience more problematic. In Jenna's account, of when she accessed the ECP when she was 16 or 17, she described herself as in her school uniform, in her hometown local pharmacy, where she was concerned about her parents finding out. She explained, "It was really horrible because I probably didn't need it. I think I was just sort of panicked by the idea that I might get pregnant" (Jenna). Despite feeling proactive about her worries Jenna described her experience as negative because:

> I was *really* given a lecture about how it wasn't good to be having sex at my age. Did my parents know that I was getting this? You know, had I thought about the consequences of having unprotected sex? And, I said, 'It wasn't unprotected,' and but I really felt like I received a stern talking to. (Jenna)

Jenna commented she felt frustrated by the issues raised in her consultation, since in her eyes she had responded "responsibly". She felt judged for her behaviour. She explained that the whole process of consultation, in order to access the ECP, was not something she agreed with:

> I take umbrage with the fact that in order for me to gain medicine someone has to basically, whether or not they personally care, the system has to pass a judgement on you before you get it which I think is mad! And yeah, that was a very bad experience I had when I was young. (Jenna)

Jenna went onto explain she felt the need for a consultation attempted to 'infantilise' women and their behaviour and this impacted the way she believed people viewed access to the product and the women who used it. The 'judgement' described by Jenna appeared in others 'bad' EC stories as the women explained they felt that the consultation was used as an opportunity to "tell me off" (Lydia). Being given a "lecture"

(Lecture) about their behaviour resonated with many of the women's stories and it was not unique to young women either.

Emily, a 30-year-old lawyer, explained that her most recent EC experience was very different to one she had when she was younger and living in France. She explained her recent consultation she felt quite uncomfortable having a conversation about her intimate experience with a man. She did not think he was "rude" and she did not experience any "straight judgemental attacks" (Emily). However, she did express concern with his approach to questions such as, 'Why don't you use contraception?' Although she accepted his role as a 'professional' made him impartial to her experience, she found the line of questions intrusive and unnecessary:

> Like, I don't think you should be asking these sorts of questions. For instance, I was asked 'How often I have unprotected sex?' and I was reminded that 'it's not good enough', I should protect myself and make an appointment with my doctor to get contraception methods. (Emily)

Emily felt the questions should not probe her own personal reasons for "why I'm not taking contraception" and she came away feeling her behaviour was "not good enough". This discussion highlights similar themes to those reported in Chapter 4. The nurses' justification for the detailed consultation assessment as a matter of 'quick-starting' onto other options of contraception appears to surface in Emily's experience of accessing the ECP. The experiences of Jenna and Emily appear different because of their relative ages at the time, yet the similarity in the discussions is that the women felt susceptible to judgement. Although neither of the women, in their situations, felt they needed to 'reflect' on their behaviour, the line of questioning appeared to make the women feel unnecessarily uncomfortable with their actions. Emily said the questions made her feel uneasy about her decisions and her experience. She continued to explain that the pharmacist did not outright suggest "you're a slut" or "you're irresponsible". However, Emily indicated "that's how I took it", and as she continued to reflect on her experience, she stated:

> I'm a customer. I'm a 30-year-old woman. I'm coming to pay for my morning-after pill; why do you need to know? Why do you need to tell me that I need to be on the contraception? That I shouldn't be having unprotected sex? It's all judgmental things that aren't relevant to the fact that I'm buying the morning-after pill. I'm not here for a moral lesson, I am here to buy medicine if that makes sense? (Emily)

The ‘moral lesson’ discussed here is where women are expected to reflect on their actions. We can see how women are aware that the consultation does not appear to offer ‘medical’ consultation, but rather, constitutes an opportunity to make the women ‘morally’ aware of their behaviour. This is evident in the women’s accounts, as they believed part of being an EC user is they are expected to feel like they have done something wrong. This is confirmed in their understanding that the consultation is viewed as an opportunity for the women to learn from their mistakes. This ‘judgment’ continued to feature in the discussion, and it did emerge only as part of account of with those considered to be women who have taken risks. The consultations described as bad experiences appeared to impact the way the women view their behaviour. However, this was not the case for all. This could be because some of the women explained that although they had mixed feelings before the consultation, they had a positive experience with the health professionals.

Women who do not fall into the ‘bad’ experience category vary in their feelings towards the consultation. Some women felt ‘informed’ and that the health professional gave them time and they felt ‘relieved’ after accessing the product. Sophie explained:

> I felt really relieved because I think I was panicking because I’d never taken that before. (Sophie)

A shared experience for some of the women was "panic" as they realised they needed the ECP. For these women who did feel concerned, their contact with the health professional put them at ease. Nicole described her experience at a pharmacy as "amazing". She said, "they have always been really nice and give you lots of information" (Nicole). Louise also indicated she appreciate the approach taken by her who made her feel "comfortable". Louise explained the consultation "just felt very professional, like she cared and like she just wanted me to get the right treatment at the right time she took an interest and that it was very professional and easy" (Louise).

We can identify two distinct ends to the consultation experience spectrum, but most women fell somewhere in the middle. This indicates that the consultation experience itself is not the sole influence on the EC user identity: the varying experiences of the consultation indicate that the process of access is subjective to the individual. However, what becomes apparent from the EC stories is the impact the consultation has on the women's reflectivity of their own behaviour. The women explained that in various ways

their feelings towards the ECP were different from those towards other contraceptive methods. I found this the purpose of the consultation brought to light the meaning they gave to their experience and identities.

5.3.3 Purpose of the consultation

It was interesting that, speaking to the women about their experiences, they began to reflect on the necessity of the consultation. Laura explained:

> I'm healthy, I'm a non-smoker, I don't really drink and all the rest of it. I don't know what would affect it, but if I said the wrong answer, I wonder would they then not provide me with that pill that I definitely need? (Laura)

The consultation process was considered by Laura as a "faff", as she explained, "I just think to have to go through that process to get contraception that at the end of the day I decided for myself is what I require" (Laura). Aware of the intrusion on her autonomy, Laura and others explained the experience that did not heighten their resolve to change contraceptives, nor did the women feel it benefited from in terms of knowledge on the product. The main impact the consultation had was to exceptionalize their experiences as abnormal.

Although the women's feelings varied regarding the consultation, the impact of the consultation was evident in all the EC stories. Access to the ECP via a consultation was recognised as exceptional to all their contraceptive experiences. Through the process of access via a consultation, the women are expected to reflect and consider their actions which in turn, give a new meaning and identity contraceptive behaviour. Jenna suggested she felt the consultation "certainly made me think about why I had to do this to get medicine?" (Jenna).

We know from Chapter 1 that the ECP is a safe and effective contraceptive pill, yet the process of the consultation makes it seem like it is not. The consultation is unique to the ECP. It suggests that it is something that requires extra medical supervision. Amy suggested she thought the consultation "made it into a bigger deal than it should be". She explained her feeling towards the consultation: the questions are "irrelevant" (Amy) and the consultation puts people off. With the ECP also being recognised as "doing the same

thing as any other contraception method" (Amy), the consultation was perceived as a barrier creates an unnecessarily meaningful experience. Amy further suggested:

> I think the whole way of accessing it makes it into a big deal and I think it prevents a lot of people from going to the pharmacy and get it. If you bought some condoms, you can buy them from Asda and you're not asked anything. I think it's made into a bigger deal than it should be. (Amy)

This attitude was shared by others. Emily described the consultation as a 'moral lesson' that she didn't need:

> It already sucks when something like this happens and you have to go and rush and buy the morning after pill. So I didn't need the 15 minutes moral lesson in some male pharmacist's office. (Emily)

The findings suggest that the women are aware of the stigmatised identity associated with the EC. They may not have a direct experience of judgment, but women who use the ECP anticipate judgment for their behaviour since their need for ECP is considered outside of the norm. The EC user identity is, therefore, a construct that women are aware of; however, it may not fit the characteristics of the wider identity formation.

In the women's stories, it became evident how the consultation becomes a meaningful experience. Some find the process helpful and informative while others find the process negative and judgmental, but the interaction between the women and the process of access generated a significant change in identity formations. An experience unique to EC users becomes one where these women are exposed to questions and intrusion into their personal experience of contraceptive decision-making. In light of this experience, the women become aware of the shift in their contraceptive identity, to one that is stigmatised and open to question. This is further apparent in the women's reflection on the meaning given to their contraceptive behaviour, since their EC stories provide evidence to suggest the formation of spoiled identity.

5.4 EC User identity

Goffman (1963) explains that when an individual internalises a stigmatised identity, he or she gives meaning to the label or characterisation of their new stigma identity. Here I consider how the women recognised an EC user identity, and what it meant to

them as users of the EC. This section considers how problem identity is formed and internalised by those considered to live with stigma of the social problem. On the tightrope, the pharmakon identity formation is recognised as the tightrope walker participating in the walk along the tightrope, navigating the meaning that impacts their vacillation onto either side. The women give meaning to their identity as they interact with the wider claims made about EC use and the EC user.

Throughout the EC storytelling, I found the women were aware of the EC user identity. Almost all made reference to the "type of women" considered to use the ECP as negatively viewed by others (Lauren). Katie elaborated on this construct in her belief that others, "think that 'you're a bit of a slut'" or that maybe "you're sleeping around" (Katie). The negative EC user was considered by the interviewees to be a product of the "society voice" (Emily), that a woman who has used the ECP has not been "sensible" (Jessica) and this characterisation resonated with the users as they felt "judged" against this construct (Emily). Zoe explains:

> I feel like people assume why you're going in there and what it is you're doing they might have an opinion on it which I think, but I was definitely nervous and I'm not a nervous person. I'm not a shy person, I'm not someone that feels like that, but I definitely do feel awkward when I go in there. (Zoe)

This 'judgement' appeared to emerge not from the contact the users had with the health professionals, since we understand that some of the women stated they had a good or positive experience. The 'judgment' of the EC user appeared to feature as a product of wider public opinions. When I asked the women to explain where they felt this frame of the EC user came from, many were unable to give an answer:

> I don't know where it's come from, I do just think it is a social thing still. I guess that's where it's embedded into me. I just feel a bit ashamed about it, about discussing anything and it is obviously a private thing, and the thought of saying that in front of a bunch of strangers that you've either made a mistake or you haven't thought through well enough to get a condom or something like that, I feel people get a bit judgey. (Fern)

This construct of the EC user appears to also shape certain types of behaviour here described in the women's accounts as a "mistake". This identity work resonates with the users, as they expressed feelings of "shame" and "guilt" for making such "mistakes". However, what makes the identity work successful is the 'audience' the women are

aware of. Goffman (1963) explains that behaviour that becomes stigmatised is viewed by outsiders as against the norm. In the case of many who did not experience direct judgment, they explained that they still experienced some judgment but this is suggested as deriving from the wider public lens. Fern explains her apprehension of asking for the ECP was concern about "saying in front of a bunch of strangers" on the shop floor. Although Fern might not actually experience any other shoppers' direct judgment for what she was doing, she believed her need for the ECP left her open to the judging eyes of others. This was something shared by most of the women who too felt that the action of asking for or needing the ECP, particularly in the pharmacy setting, left them vulnerable to others' judgments.

The identity work was not necessarily influenced by the women's first-hand or direct experience. Wider and public 'judgment' appeared to exist in the women's understanding of what it meant to need the ECP. I found the meaning the women gave to their experience stemmed from the wider construct of the ECP stigma identity and perceptions of what it meant to access the product. Amy explained: "You feel like, 'Oh God', you've done something really naughty and you've had to go to the doctor and they've got to ask you these questions" (Amy). With access through a consultation exceptionalising the experience, the meaning given to the process was viewed by some as 'naughty'. With the frame given to given to access as sign of 'naughty' or 'wrong' behaviour, many women indicated they felt that needed to 'apologise' for this behaviour. Amy continued:

> You have to almost say sorry for what you've done and said, 'I'm really sorry, I've done this and come here and I need to take emergency contraception'. (Amy)

Amy's consultation experience and the image she formed about the EC user appear to show different experiences. Although the established exceptionalisation of the ECP access via consultation added to her awareness of the significance of her actions.

> I think I did feel, and all the times I've been to the pharmacy to get it, a bit unnerved and a bit embarrassed and a bit *silly* I think. I think because it's just what emergency contraception is perceived to be, you just feel a bit like you've done something bad. (Amy).

Amy appears to have emotionally internalised her need for access to the ECP as 'something bad' and something she should apologise for. As an indication of the transition in identity, it becomes evident in the stories of the women who became self-

aware that they were branded with the construct of wider claims that come attached to using the ECP. As the women become aware of their stigmatised identity, their awareness of the 'ideal' contraceptive behaviour appeared to become more apparent in their discussions.

What appeared to solidify the women's internalisation of the new EC identity construct was the acknowledgement of rhetoric of what it meant to have 'contraceptive identity'. We have seen this construct from the nurses as a 'responsible contraceptive user' and in policy as 'planned contraception' verses 'risky' contraceptive behaviour. The women were aware of what was constructed as the 'ideal' or 'right' contraceptive behaviour, and for this reason they felt they were not adhering to the wider 'norm'. This meant they accepted their new stigmatised identity and the emotional response of 'shame' and 'guilt':

> I felt, ashamed! I can't speak for all women, right? But I think generally when we end up having to take the morning-after pill, it's because something else not worked the way we planned. And that's really annoying and that's usually for a lot of women already pretty shaming. (Emily)

Although the women appeared to be aware that this construct of EC user may not fit their own experience or need for the ECP, I found the dominant EC identity did cast a shadow on the women's ability to rationalise their experience. I asked Lydia to explain further where she considered her construct came from:

> I guess just stuff like sort of like pervasive ideas that women who have a lot of sex are sluts or whatever. Which is hard to shake that even when I logically know it not to be true…I guess I get like worried they'll judge me for having been irresponsible. (Lydia)

The construct that appeared consistent in the women's discussions of EC user identity indicated that women who use the ECP expect to be questioned about their behaviour. Jessica indicated that the stigmatised image of the ECP user is that "you end up having to take the morning after pill because you've been careless" (Jessica). This image of the ECP user meant Jessica gave meaning to her own behaviour:

> Like I felt like 'how stupid are you to have sex with this guy not telling upfront that he needs to put on protection?' You know? I felt stupid, like, already because of the situation. (Jessica)

She described that, particularly for women who have used the EC more than once, the exceptionalisation of access and the process of letting others know become an experience that women feel is significant. The meaning they gave the experience was

agreed as overtly negative. The women used words such as ‘stupid’ or ‘silly’ to describe their behaviour as they showed awareness stigmatised behaviour, they too internalised the meaning given to their actions. Jessica explained further:

> I think there is a sense of shaming there that ‘you could end up being in trouble and it’s your own fault’ because I think there is a voice at the back of your head that tells you, you know ‘nowadays with all the protection that are available, how can women get pregnant when’ you know ‘they don’t want to?!’ (Jessica)

As I discussed the EC experience with the women, words such as guilt, shame, bad, silly and stupid were used to describe their experiences. In their emotive reflections it became apparent that the women acknowledged the spoiled identity given to them, which in turn made the experience meaningful. Goffman’s (1963) understanding of the spoiled identity suggests individuals measure their behaviour against social expectations when they do not meet social expectations a new identity forms around them and their behaviour. We know the contraceptive expectations placed on women mean the EC user is susceptible to stigma. In the women’s accounts it became clear the wider social problem claims of the ECP being a problem did impact their lived experience, as we explore further in the reality of stigmatised identity.

5.4.1 The reality of stigma

No two EC stories were identical, and the women interviewed had their own reasons as to why they needed EC. However, consistent in the conversations was the EC users' construct of what it meant to be an EC user was claims made around behaviour: names were mentioned such as "slut" and "slag". Although none of the women considered this to be a true representation of their own behaviour, they accepted that this was the identity they acquired through their need to use the ECP. I went on to ask them more specifically if they believed there was a stigma attached to the ECP. This allowed them to reflect on experience and the wider public frame of what it means to be an ECP user.

Eighteen of the 20 women said they did feel there was a stigma attached to using the ECP. Faye explained that, ‘if you are using emergency contraception, you’re not a responsible woman or girl’. The women accepted that in their stigmatised state they were open to ‘judgement’ from others about their behaviour as perceived as problematic. Faye compared her experiences of using EC services against her use of abortion services. She suggested that she "definitely felt like there was some judgement on the part of health professionals not being very supportive" (Faye) when she attended pharmacy for EC. She felt her use of abortion services "was completely different,

everybody was super supportive" (Faye). She suggested that having an abortion might be viewed as more problematic than using EC, but indicated she felt more judgement on her ability to be 'responsible' in the contraceptive service setting than she did in abortion services. She explained that judgement stemmed from preconceived ideas around contraceptive behaviour that were heightened in the EC service setting. Faye suggested:

> There's definitely stigma attached to using the emergency pill, related with this idea of like what it means to be responsible in relation to contraception. And just more generally, there's still that thing of if you're not responsible then, you know images of like, you being easy and you know not taking care of yourself and stuff like that. (Faye)

'Responsibility' appeared to relate to the women's inability or lack of contraceptive decision-making. The EC users were aware of the standards expected of them to make contraceptive decisions and these decisions of the EC user appeared to be open to questioning as their 'choice':

> It's just emergency contraception is unexpected, risky. I feel like people think you're irresponsible. Because coming back to the riskiness, unless it's something horrible like rape there's always the choice. So, you either choose to have sex without contraception or you don't. (Hannah)

Women appeared to internalise the message that comes with certain contraceptive behaviour. The EC users are aware that "people thank you're irresponsible" (Sophie). The EC users reflected on their behaviour as a 'choice' that they have made.

The EC user construct is here recognised as a *stigmatised identity* and it features as the identity associated with EC use. Although women did not necessarily participate in the stigmatised behaviour associated with the EC user construct, the women's awareness of this identity formation meant they experienced feelings of 'shame' and 'embarrassment', or reflected on their behaviour as having 'done something wrong'. I found that this identity formation developed against wider folk knowledge of contraceptive behaviour. Chapter 2 explored the ways public health promotion constructs responsible and irresponsible contraceptive behaviours; here we see how those wider typified behaviour constructs impact the women's experience. Awareness of contraceptive behaviour constructs strengthened the women's feelings towards the identity of the ECP user and impacted the meaning they gave to their experience. Although, some of the women explained that their consultation and health professionals were pleasant, others felt their experience was negative because of 'judgement'.

Here I found evidence to support the identity work of the stigmatised identity formation. This process can be broken down into steps that appear to emerge in the EC user stories when accessing the ECP. On the tightrope, this identity work is recognised as the tightrope walker participating in the walk along the boundary line between the two meanings, managing and navigating the claims the feature either side. I found the acknowledgement of the ECP user identity begins with a woman recognising her need and accessing the ECP. Through this recognition, the women suggest in their discussions that they then make sense of their own need of the ECP against the wider construction of responsible contraceptive behaviour. Through this social process of allocating meaning to interactions and identities, which is evident in the meaning the women appear to give to their access of the ECP, we find the women experience a transition into a spoiled identity. The ECP stories have supported this investigation into the process of women's experience of a stigmatised identity.

However, it is important to note that not all 20 EC stories were the same; therefore, we cannot assume that identity transition was experienced in the same way by all. What can be said from the women's accounts of their consultation is the stigmatised identity is multifaceted. We find the identity work of the individual appears as a process of navigating around the claims in wider setting. This navigation also supports the dual meanings given to the ECP and stabilises its place on the pharmakon tightrope. This identity work can be further understood in the women's reflective accounts of their understanding of the ECP as a contraceptive after they have used the product.

5.5 Post-EC

On working with the interview material, I was reminded by Goffman's work that spoiled identity is 'not persons, but rather perspectives' (1968, p. 164). We know individuals can take on a variety of identities at any given time, and the EC user identity can be added to the women's many repertoires of identity forms. However, the formation of a 'perspective' suggests that the identity exists as the individual becomes aware of it. The awareness stems from influences. Goffman (1968) suggests we don't simply accept who we are without the process of categorising the behaviour or experience against identifiable social norms. The women interviewed reflected on their behaviour in line with a wider construct of what it means to use the ECP. This final section reviews this reflection process.

This section evaluates women's understanding of the ECP as a contraceptive post-consultation. It considers how women reflect on the name of the product as an

'emergency' measure and what impact this has on their understanding of their own experience. I explore how the women interpret access to the ECP from their own experience and what they consider to be 'barriers' to access. Finally, the section addresses the EC users' understanding of the ECP post-consultation.

5.5.1 Characterising the ECP

The ECP is a pharmakon because it is neither accepted nor denied as a contraceptive. This dual meaning means nurses find it difficult to promote women's use of the contraceptive. Despite having used the ECP for various reasons, women also feel unsure about categorising the ECP as a 'method' of contraception alongside the other methods available because it does not fit the regular contraceptive criteria. For example, Katie commented:

> I'd categorize it as exactly that, as 'emergency' contraception. I do think that it's right that it's not used *all* the time, cause if it was something that you could use all the time, then it would just be called 'the pill' or a different type of pill. But it's obviously not. It obviously has something different in it to make sure that you don't have a baby within a particular time frame. Is it maybe. Maybe it's just a big *whack* of hormones but I'm not really sure. (Katie)

Katie, and four other women, made reference to the claims that the ECP could be an abortifacient and therefore could not be used regularly. The ambiguity surrounding the ECP's mechanism of action left women to assume the product has potential "safety" issues (Sophie). The concept that the ECP is a "big whack of hormones" (Katie) appeared to resonate with the women since they assumed that because it is used post-sex, it must sit somewhere between contraception and abortion. Katie explained she accepted the categorisation of the ECP as an 'emergency' pill product since it enabled the segregation of the product as a "different type of pill" (Katie). Jenna explained she was unsure of the nature of the mechanisms of the product.

> I'd say it's sort of contraception. I'd say it's … Even though it's… Tech … It's… It's not … I actually don't know. Is it preventative? I might be scientifically wrong on this. (Jenna)

Jenna and others expressed their concern with being unable to identify the 'science' behind the ECP, but concluded that ambiguity around its mechanisms was an indicator of its contraceptive status. Emily explained, "like abortion is not a method of contraception … obviously the morning-after pills are something completely different but its too much of a risk" (Emily). Despite not knowing what the ECP was or how it worked, the women accepted the ECP was 'riskier' than the oral contraceptive pill but

did not cause an abortion. Discussions suggested that the women felt the ECP's ambiguity created a spectrum of fertility regulative options. The contraceptive pill was presented as the ideal, and abortion a last resort. The ECP then became the turning point from contraception to abortion and gained its status as a pharmakon.

This spectrum of fertility regulation and placement of the ECP as 'something different' was supported by the women's awareness that the ECP is not 'promoted' as a contraceptive option. Fern explained:

> I would think of it as a last resort, maybe not alongside them as such. I'm just guessing from how you have to go about getting it, the hoops you have to jump to get it, I'm guessing it shouldn't be used on a regular basis for your own personal safety probably. Also just the cost of it, I wouldn't want to use it regularly. (Fern)

I found that women rationalised their need and use of the ECP, as not something you would "want to use … regularly", against the product's special regulation and lack of promotion. In Chapter 3, Dr X explained that Boots' decision to not lower the cost of the ECP came from the company not wanting to 'incentivise use'. Here we find the repercussions of such claimsmaking activities appear has led women to internalise the high price and 'hoops' as an indicator that, 'it shouldn't be used on a regular basis for your own personal safety'. Although some women saw the ECP as another "line of defence" (Hannah), the frame that ECP should not be taken 'regularly' and only if they 'need' to, appeared to resonate most with the women as they could make sense of what ECP is through its name. Amy suggested she would categorise the ECP as:

> The one out of all the methods that people don't really take unless they really have to. So, I think it's definitely seen as different from other forms otherwise it wouldn't be seen as such a big deal to take it. (Amy)

I found from speaking to women that the public health rhetoric around 'planned' contraception appeared to aid their segregation of the ECP. Women accepted that a 'method' of contraception is something that can be taken 'long term' and 'something you plan and you have already. To "make sure you don't get pregnant" (Emily). Nicole explained she "wouldn't plan to use it. I would just use it as a backup. If and when I needed it" (Nicole). The ECP appeared to be framed to the women as "different from other forms" as Amy explains above because 'otherwise it wouldn't be seen as such a big deal to take it'.

The women's identity development appeared to indicate that, through the process of needing and accessing the ECP, they accepted their use of a contraceptive 'different'

from other forms. This shaped their understanding of their experience and identity as it appeared to aid their acceptance that they have gone outside the norm. Goffman (1963) suggests that in the process of spoiled identity transformation, when an individual becomes aware of the behaviour as *abnormal*, they facilitate their identity work to a stigmatised identity formation. The ECP's ambiguity as a pharmakon ultimately facilitates the women's experiences of the social problem identity formation, since they accept their need of the ECP as contact with 'abnormal' contraception, going outside of the norm.

The women make sense of the ECP as a contraceptive option alongside the wider norms that shape contraceptive behaviour types. In Chapter 2 we understood that 'safe sex' in public health guidelines is perceived as preventative, with minimal risk. Goffman (1963) explains that behaviour perceived as outside the normative social standards impacts the stigmatised individual's moral career. The problematisation of the ECP featured as a moralised construct for some, as the ECP use was linked to behaviour perceived as rule-breaking and 'naughty':

> I think alongside the methods, it's seen as the naughty one, the one that promiscuous people take or careless people take, whereas I think all other forms are openly accepted. You can openly say, yes, I use condoms, I take the pill, but emergency contraception is the one that people don't really talk about. (Amy)

Viewed as 'the naughty one', the ECP is considered not something 'people really talk about'. With other contraceptives being highly promoted with an open discourse, women find it difficult to categorise the ECP. I found the inability to categorise the product means it is associated with problematic behaviour, allowing the product to adopt the frame as 'the one that promiscuous people' or 'careless people take'. With 'care' being associated with 'planned' and using 'regular' contraception being the norm, ECP use appears to designate women's behaviour lazy and 'careless'. Despite this not resembling many of the women's EC stories, women appear aware of the wider construct and the claims made about women and using the ECP.

As a pharmakon, is it understandable that the ECP is a difficult contraceptive for women to categorize. The ECP is not promoted as a contraceptive and appears to go against the norm of contraceptive behaviour that is planned and used before sex. In this frame, it is considered 'naughty', as the identity associated with the pharmakon is perceived as morally problematic. In addition, due to the product's highly regulated position, it sits outside of the contraceptive options for women but is accepted as an option in preference to an abortion. I find in the identity work of the individual within

the problem is that women who have direct contact with the ambiguous pharmakon are expected to make sense of their experiences against these social norms and claimsmaking activities. We find further evidence of this as we explore the impact of the term *emergency* in the women's understanding of the EC and their reflections on their behaviour.

5.5.2 'Emergency' contraception

I found that none of the women had particularly thought about the term *emergency*; many of them suggested the name *morning after pill* as a more familiar phrase. It took a few minutes of talking for the women to consider what *emergency* meant. Jenna suggested she preferred the name *morning after pill* because, "*emergency*, I suppose makes it sound like it's sort of a panicked thing" (Jenna). Although many felt the *morning after pill* was a less alarming name for the pill than the ECP, some made reference to the stigmatised behaviour associated with that name. Lauren suggested:

> I always call it the morning after pill, that's what everyone calls it. But I think that makes it seem a bit seedy. The morning after the irresponsible night before. (Lauren)

Like Amy's definition of the ECP as the 'naughty one', we find Lauren is aware of the wider frame of the behaviour associated with the term *morning after pill*. A product used post-sex is associated with 'seedy behaviour', giving meaning to the behaviour as "irresponsible'"(Lauren). We find women's awareness of the contraceptive expectations put on women meant they reflected on use of the ECP as against the norm. Lauren further explained her interpretation of 'seedy behaviour':

> It's seen that you're either irresponsible or like it's a one-night stand. You got too drunk and had sex without anything and then had to get it sorted out. (Lauren)

In Lauren's description, she is explicit in her construct of the morally problematic behaviour associated with the name *morning after pill*. As Lauren puts it, the ECP is viewed as the solution to "the irresponsible night before" (Lauren). Through this definition we see how stigmatised behaviour associated with the post-sex contraception forms a stigmatised identity. However, although this identity formation exits, Lauren, in her long-term relationship, does not fit the characterisation of someone involved in a 'seedy' one nightstand. Rather, her experience indicates as an EC user she is aware of how her need for the ECP appears to others.

Women felt the term, *emergency contraception*, led by medical professional bodies, also had intent. Hannah explained:

> I suppose it's indicative of a *risky emergency*. It's something that's alarming, risky, alarming. All those words. It's for an emergency rather than everyday use. The name means to me that it's not for use all the time, that it's only for use in last resorts. (Hannah)

Hannah rationalised the use of the term *emergency* for the purpose of being "alarming", as an indicator that the ECP is 'not for use all of the time' only for 'last resorts'. We find the term *emergency* appeared to resonate with the women to define use and need. Sixteen of the women considered the term *emergency* to identify the product's use as "not for every day". Steph described the term *emergency* as inciting "panic" into women, "maybe that's because of the word association I have with an emergency? Then it is panic contraception. I took it in a panic. I'm sure most people do" (Steph). Like Steph, the women began to consider their own need to use the ECP as "something gone wrong" (Lydia). An association was made by the women that meant they reflected on the dictionary definition of *emergency* and their own experiences.

The term *emergency* appeared to bring out the risk averse rhetoric featured in the earlier chapter on health promotion and ideal behaviour. Women suggested they believed the nature of the term used to describe a contraceptive had purpose to manage the way in which it should be used. Lydia explained she felt the name made her think "something [had] gone wrong", suggesting that the term does impact the experience of women. The pre-determined stigma associated with the name meant the women reflected on their need. Amelia considered how the term was purposefully used with the 'intention to separate it as something you can't rely on'. She reflected on her situation, accepting the *emergency* frame had an impact on how she viewed her experience. She explained:

> It makes it a little bit more stressful if that makes sense. Like you, it makes the taking of it somehow, more significant because it's somehow an emergency rather than, you know, a day where I forget to take my pill and I take two the next day wouldn't see that as an emergency but I guess it's an interesting choice of words, I guess the intention is to separate it. (Amelia)

Amelia's reflective process suggests she begins to make sense of her situation by disentangling the meaning she gave to her experiences of using other contraceptives compared to her use of the ECP. The morally explicit meaning given to the term *emergency* implicitly impacted the way women experience their need for postcoital contraception. Although as Amelia explained it might just be "a day where I forgot to take my pill", the term *emergency* made her experience its use as "significan[t]". This

is something I found true for many of the women. As I began to explore the formation of the EC identity, I found the women did consider their experiences of using the ECP to be more significant than their everyday use of contraceptive.

Katie, for example, commented on how the term *emergency* made her feel about the situation she was in:

> I suppose the implication there is that you've made a mistake, isn't it? Cause it's called *emergency* it's not like … It's not called like *accident pill* is it? It's got a very like … It's got a serious name. Essentially saying that this is like 'this is your *last* ... That's like your *last* choice' or like 'the *last* thing that you should be doing. You should be using it *in an emergency*'. (Katie)

Katie understood that the term *emergency* gave meaning to her situation as "serious", frame indicating that her use should be "the last choice". The women negatively associated the term *emergency* with a description of their own situations. The moralisation of behaviour associated with the term *emergency* and women's autonomy to choose or use the ECP is evident in the women's discussions. In the reflective part of the interview, I found some of the women began to reassess their decisions Hannah, who choose to use the ECP reflected:

> I personally regret not being safer. I think that's something life has taught me. That's how I feel about the decisions now. Having used it, I know it's vital when you've made those choices. I don't know if I went into … no, I did. I just went into the weekend thinking, I'll use the morning after pill if we had sex, because I didn't know if we would. (Hannah)

For Hannah, our conversation shed light on her decision-making. Despite not experiencing any consequences of pregnancy or STI, the meaning she gave to her situation was that she put herself "in danger" as she wished she had been "safer". This moralisation appeared to stem from the ECP and stigmatisation of behaviour influenced the way Hannah rationalised and make sense of her experience.

I found the women appear to rationalise the name and the frame given to the pharmakon with its ambiguous categorisation. This leaves women reflecting on their situation through the lens of the folk universe that encapsulates the meaning given to the after-sex pill. The women in the interview are aware of the meaning given to the product and so associate the meaning to their own behaviour. The identity work of an individual within a social problem is impacted by the wider claims and claimsmaking activities. With the wider frame of the problem pill accepted by the user, I wanted to

continue in our line of reflective enquiry and consider how the women viewed access to the pill following their own use.

5.5.3 Access

I posed the option of access 'off the shelf' and 'keep at home' to further understand women's view of EC as a contraceptive. I found the majority (15/20) thought having the ECP at home or in advance would be a ‘sensible’ idea. Louise said:

> I think women are more than capable. I wish I had it in my cabinet. I think I can judge for myself when to use it and how to use it. And I don’t think it would change my choices or behaviour. (Louise)

With increased access being viewed by many of the women as an opportunity to ‘judge’ for themselves, it appeared access was accepted as a question of autonomy. Nicole said, ‘I do think it would be good to have if it's just sort of there then. If you had one or two in the cupboard just for emergencies’. Access in advance was accepted by women when needed for ‘emergencies’ and suggested giving women ‘more responsibility’ to make decisions about their contraception (Katie). Katie explained:

> I do think it would be good to have it for an emergency contraception in advance, because it means that no matter what day it is, or what time of day it is, if something goes wrong with your usual contraceptive or if you’re just not using any, you’ve got that back up and you don’t have to wait and you don’t have to worry about how you’re going to get hold of it. You’ve got it there. So, I think that would actually be really good. (Katie)

The women indicated that access to the ECP in advance would have been a ‘good’ option for them. They would have been able to make a clearer decision about their contraception and it reduced risk of failure. The women considered increased access to the ECP as supporting their right to choose and use contraception.

However, there was a disparity in some of the women’s views, with a minority of women disagreeing with the option of access in advance despite having used the EC themselves. These concerns centred on the women's views that increased access might lead it being considered ‘a regular thing’. Sophie did not approve of access in this way, she felt that it would encourage women to have unprotected sex:

> I don’t like that. I know I’ve taken it but I still think it’s quite a bad thing and I don’t think it should be a regular thing. I think women should prepare. As much as this is

> contradicting me saying but if you can wake up in the morning and just take the morning after pill, I don't know, I just think that's wrong. (Sophie)

Sophie perceived her experience as something she should feel "guilty" about, and as a process of "learning from behaviours", that if accessed in advance women will not be given the opportunity to reflect on their behaviour. She continued:

> That might just be instilled in my mind, but I don't like the idea of that. When I went to the nurse, she didn't make me feel guilty or anything, but in a weird way, maybe she did make me feel guilty for taking it because I haven't done it since. Still, to me, it's like, if I ever needed it, I would be like oh no, I've got to go and get it, that's really bad. (Sophie)

Understood by Sophie as "really bad", she appears to accept that the contact she had with a health professional impacted the meaning she gave to her experience. As we know, nurses felt that access in advanced would be a "missed opportunity to offer health promotion" (Carol). Sophie's opinion appears to resonate with that view.

Faye discussed the consultation as important to offer women an 'informed choice'. She explained she felt that the access without consultation could be good for 'normalising' the product but this also could be a cause for concern:

> It could be a really good thing but then on the other hand, if it's sort of normalized it to the extent that people just kind of started relying on it too much, it sort of depends on what the long term health effects to have a relatively normalized use would be. But I'm not against it in principle, *if* sufficient information is provided to people about effects and stuff and so that people are able to, I guess, make a good choice or an *informed* choice rather about using it. (Faye)

Although the majority of the women felt themselves and other women 'capable' of making a contraceptive decision, a few felt this that access in advance presented problems to women's health and behaviour. Despite using the ECP themselves, it appeared the concern around 'other women' and their EC user identity impacted the women's views of women's ability to make 'sensible' contraceptive decisions.

5.6 Conclusion

Goffman's (1964) work on the spoiled identity suggests that individuals make sense of their experiences by giving meaning to their interactions. He also suggests individuals make sense of their behaviour against wider normative behaviour standards. In summary, the EC stories I have found show how women make sense of their

contraceptive identities against the wider claims made about EC use. These findings also highlight how women navigate and make sense of claims through their experience of the consultation.

I have explored the identity work of the social problem identity that forms as pharmakon. Here I have investigated the women's experience of a specific ambiguous social problem and the dual meanings given to their behaviour and identities. Using the pharmakon spectrum, I was able to identify two opposing meanings that supported the vacillation of the tightrope that sustains the problem's ambiguity. By doing so, I was then able to explore how women manage and navigate these meanings that form out of wider claims and structure their experiences. The framework used here allows for a better understanding of how women give meaning to an ambiguous social problem.

In the women's pre-EC stories, we found the women were aware of the various risks taken in the lead up to their use of the product. On a spectrum from low to high risk, it became apparent the EC users' opinions towards managing risk differed, yet ultimately they were brought to the same aim of preventing pregnancy. In reflection of the contraceptive identities and previous experience of hormonal contraception, the EC users turned to the ECP as a solution to earlier issues with alternative contraceptive methods. However, not being recognised as a contraception women can choose, the women experienced their EC use typified as stigmatised behaviour.

This stigmatised behaviour is further explored in the women's experience of the consultation. Outside all other contraceptive options, the ECP consultation provides a unique and meaningful experience for women. This, in turn, constructs a new identity for the EC user. Aware of the wider construct of the EC user, the women reflected on the consultation and the meaning they gave to their interactions. We found the consultation, similar to the risk experience, could be reviewed on a spectrum of good to bad interactions. This spectrum indicated the consultation experience does not have the same shared meaning. However, what appeared in all 20 interviews was the impact the access via consultation experience had on the meaning the women gave to their identity as an EC user. Although recognized by many as unnecessary and intrusive, the consultation is a shared experience of all EC users. This suggest the access to the ECP through a consultation is exceptional to all other contraceptives. We found in consultation as viewed by the women as a process of segregating the access to the ECP. This, in turn, heightened the women's feelings towards the wider frame of behaviour

associated to the ECP user and made the women feel they had “done something wrong”(Amy).

The EC stories highlight a range of social interactions that supported the way women giving meaning to their experience and new formed identity of EC user. In light of this, the women reflected on their understanding of the product and its access through consultation. It appeared, despite the women sharing different experiences for their need and use of the EC, they came to similar conclusions on the product as a contraceptive. In its pharmakon state, with dual meanings as both responsible and irresponsible, the women found it difficult to categorise the ECP as a contraceptive method. As pharmakon inherently ambiguous, this leaves the ECP open as a contraceptive women could choose. However, this rubs against the grain of the pre-ECP contraceptive identities women are exposed to. It appeared the frame as an *emergency* supported the women's view of the ECP as outside contraceptive options, since the term gave meaning to their situation as ‘wrong’ and/or bad behaviour. We find, post-EC use, the women still associate the morally implicit construct of the EC user and use the product despite not showing or displaying similar behaviour themselves. This awareness of such a construct suggests that the identity formed in the social problem, although not true to real-life experiences. impacts the way women view and make sense of their experiences. Finally, in discussions around access we find the impact these wider contraceptive behaviour standards have on the women’s opinions of access to the ECP. Since the women found it difficult to categorise the ECP as a contraceptive, they too find it difficult to accept greater access. In its construct as a contraceptive pharmakon, one that can be used in need and not chosen as an option, the women reflect on their behaviour and experiences.

We find in women’s ECs stories evidence to support how wider claimsmaking activities and social interactions can impact the lived experience of meaning-making within a social problem. In the case of the pharmakon, we see how women are expected to navigate wider claims about behaviour and contraceptive expectations against their lived experience of needing and using contraception. I found that all EC users’ stories are subjective to the individual. However, patterns have emerged in the collective identity that suggests the social problem identity and construct impact the lived realities of those who interact with the problem on the micro-level. The findings suggest there is room for further research on how social problem claims-making and identity work impacts the lived experience of individuals. This can be further explored in the final chapter of the social problem worker group, the audience.

Chapter 6
The Audience and the Pharmakon Flux

6.1 Introduction

As discussed in Chapter 3, the audience play an important role in the social problem process. Claimsmaking activities are often designed for the purpose of eliciting an emotive response from audience members (Loseke, 2003). Here we consider the audience response to claims made about contraception and the ECP in order to explore the ways women, who are considered the target audience, respond to them. The investigation uses focus groups and aims to evaluate how a social problem audience interacts with, and gives meaning to, a social problem. The women sampled are selected not because of their previous experiences using contraception or the ECP, but as women of reproductive age who could or might need to access the ECP.

Cerulo's (2000) focus group study suggests that audiences as meaning-makers take on a more active role than simply 'receiving' messages that feature in the media. Her work indicates the audience takes the role of the storytelling team, as *elaborators* (Cerulo, 2000). In the social problem process, the audience plays a part in social problem storytelling by interacting with claimsmaking activities and supporting the existence of social problems. I examine these dimensions here by exploring the narratives and stories of audience members to evaluate whether and how the wider claims feature.

Loseke (2007) suggests there are three levels of storytelling with which humans interact to aid the identity work of individuals and social narratives. In the opening chapters, we examined the macro-level social construction of the EC as a social problem, and the cultural identity formation of the ECP user. We understood that the 'construct[ed] symbolic boundaries' around the 'social actors' within this social problem feature as the claims and claimsmaking activities on the ECP (Loseke, 2007, p. 665). Here we investigate the final line of enquiry: the impact this macro-level claimsmaking has on the micro-level reality. Loseke (2007) also acknowledges the 'personal identities' of actors within a social problem are built from 'symbolic codes':

> Symbolic codes surround cultural narratives of identities because they contain images of the rights, responsibility and normative expectations of people in the world, and of the expected effective response to these people. (Loseke, 2007, p. 666)

The symbolic codes of the audience will be explored here in relation to themselves as women, and their opinion of women as EC users.

Each of the nine focus groups opened with a discussion of the various contraceptive methods available to women. All 33 women discussed their various experiences using hormonal contraceptives, from different perspectives. All had experienced accessing and using hormonal contraceptive methods, such as the pill, implant, IUD and injections. This created a common ground in the discussion as the women proceeded to explore the similarities in their experiences, and the side effects that made them change or try alternative methods such as condoms and natural cycles[7].

However, I did not intend to explore each individual women's personal contraceptive identity. Rather, my aim was to consider what *influences* the women's storytelling of contraceptive identities. So, from these conversations, I focused on what the women discussed as influencing how they made contraceptive decisions. The following section breaks down the symbolic codes that appear to influence the folk knowledge of the audience's collective identity. These sociological tools are used to further the investigation into the contraceptive identities internalised by the audience, and that aid the identity work of the social problem and facilitate the ambiguity that supports the pharmakon on its tightrope.

The data collected from the focus groups generated a large number of themes and ideas that cannot all be addressed. I focus on the themes most directly connected to those discussed so far. The audience's opinions on these topics varied, with some women feeling strongly on either side of the tightrope meanings, while others shifted between the two. I describe this as a *flux*, that impacts the vacillation of the identity and problem on the tightrope spectrum as discussed in Chapter 5.

The chapter opens by exploring the audience's folk knowledge on sex and contraception that structures and influences their meaning-making. In the second part of the chapter, I address the ways women respond to messages of risk, and the problem identities constructed around the spread of STIs and unplanned pregnancy. Next, I explore the contraceptive identity work of the audience members by addressing the normative standards they construct around contraceptive behaviour on a the pharmakon spectrum on the tightrope. Finally, the chapter ends by breaking down how audience members' interaction with these wider social claims create a flux in the pharmakon tightrope for

[7] **Natural Cycles** is a mobile app designed to help women track their fertility. The app predicts the days on which a woman is fertile and may be used for planning pregnancy and contraception. FDA approved in 2016.

the ECP. I then consider further how this ambiguity is also evident in the identity work of the audience, as I discuss how they make sense of the EC user.

6.2 Contraceptive identities: knowledge about sex and contraception

As the point of entry for the nine focus groups discussions, I asked what contraceptives were available to women. All the women in the various groups named between 10-13 different contraceptive options. However, the nine groups came to the same conclusion that there was very little choice in the contraceptives they chose. Ella and Hannah's conversation went like this:

> *Ella*: I think when it boils down to it, there's a choice of the two methods and that's it, no matter how it's dressed up. That's what it boils down to.
>
> *Hannah*: Yes, and there are certain ones … everybody knows about the pill, everybody knows about condoms but sometimes the other ones are not necessarily presented as an immediate option unless you go to your doctor or clinic. The first one they're going to present to you is the contraceptive pill rather than anything else.

Mirroring the experience of EC users, I found the audience's discussion indicated a shared experience of being 'put on the pill', with limited options to choose from. This suggests that from their earliest biographies of being contraceptive users, women are steered to using the pill. I found this created a baseline for the contraceptive career of the women. What seems to follow is that, should a woman not be using what is considered the basic form of contraception, it could be viewed as problematic.

It appears that although medical professionals are gatekeepers to contraception, the women do not feel they can fully trust the advice they give. In Chapter 4, I discussed how the nurses gave the meaning to their role as a distributor of ECP because they valued the interaction and health education they could offer. The nurses validated their interaction as a part of 'holistic' care; this approach has also be interpreted in the medicalisation of relationships of the building of 'trust' (Clanan & Rowe, 2006).

However, I found women in the focus groups shared similar experiences to the EC users in Chapter 5. They appeared suspicious about the contact they had with health professionals. Valarie understood this as 'doctors have their own motivations'. Twenty-eight of the 33 women (85%) agreed that they had tried the pill as their first contraceptive option as a result of meeting with a doctor at a young age. As Kayla explained:

> I wasn't really given a choice when I first went. I was 16 and I went to the doctors and, you know they say, 'I want to go on the pill,' because that's what everybody else is doing and the doctor definitely didn't sit there and say, 'Well have you thought about other things?' And then it's not, 'Do you know what sort of pills are available?' 'These are a selection of mini pills. This is what they will do,' It was just, 'Yes, we have this at our pharmacy, off you go'. (Kayla)

Doctors and health professionals were accepted by the women as source of information however, this information appeared to be tailored to certain contraception. The women suggested this came with limited to no compassion. The focus groups brought to light that at a young age, women's first contact with a health professional was when they started to have sex, with this perceived to be a time when they needed more than medical advice. Although knowledge sourced from doctors was perceived by the audience as somewhat reliable, the women also approved of others 'experience' as a part of their folk knowledge.

Across the nine focus groups, women accepted they are the bearers of responsibility for contraception, in a way that seemed similar to the conversations with EC users reported in Chapter 5. This came to light in the discussion around 'men don't have to worry' (Donna).[8] With hormonal contraception targeting women's fertility, they accepted that men do not have to experience the side effects of contraception. Also supported the concept that women bear the responsibility for contraception and this created a certain expectations on them and their behaviour.

Also, and similarly reported in Chapter 5, women in the focus groups listed a variety of experiences of side effects from contraception. Amber noted "being spotty" and "putting on weight". Jennifer explained, "some of the pills have really nasty side effects as well as mood swings. Like, I had migraines really badly on the combined pill so I couldn't have that" (Jennifer). The women shared the same experiences as EC users in Chapter 5, with the most common side effects discussed as "mood swings", "depression", and changes to "emotions" (Emma, Kirsty, Ella). The focus group discussions became more intense when the topic was side effects and weariness of hormones, as many of the women expressed their discontent with contraception and 'extra hormones'. Kirsty explained:

> I just don't like the idea of getting extra hormones. I don't know. I think there is a lot more than what we know about, you know ... I don't know, maybe it has something to do with

[8] The focus groups discussed at length the gendered divide in contraceptive options, which indicated an interesting line of enquiry into how the women viewed fertility regulation and autonomy; however, this is not something I am able to address in detail in the thesis.

> breast cancer or, you know, something but I am scared of extra hormones so I don't want to take them. (Kirsty)

Concerns about hormones were more apparent in six of the nine focus groups. These groups had the highest proportion of participants under the age of 45, suggesting younger women were more influenced by hormone concern than the older women. Concerns about long-term hormone use for the body meant contraception appeared mystified. Conversations about side effects created a hum of engaged debate in all nine of the focus groups.

The 'anti-hormone' discussions ranged from uncertainty on what hormones might do to the body, to extreme views about the concerns that hormones might have on an 'ecosystem'. As Valerie explained:

> The issue is well that doesn't stay in the body, it gets reintroduced into the big ecosystem and that bothers me. Like fish grow breasts, or like two-headed sharks. I am just conscious of the fact that we are a part of an ecosystem that could also be affected by my choices in contraception. (Valerie)

Although Valerie was the only participant out of the 33 to show any concern of what the hormones in contraception might have on the "ecosystem", her view indicated that as far as 'folk knowledge' spreads, even the most extreme claims appear to impact the views of women.

Overall, the focus groups brought to light similar themes around contraceptive use to those discussed previously. The health professionals that women reported coming into contact with appeared to exist as gatekeepers, but also the women recognised the agenda of the health professional as a part of a wider public health setting. However, as sounding boards to each other in their discussions, I observed how the women shifted in their roles from audience to claimsmakers. As an observer, I began to see the ways in which claimsmaking within the group discussions created a flux in opinion amongst the women. As an audience, although they did not have the same experiences, they appeared to share the same processes of navigating wider claims around behaviour and accepted the previously established expectations of women.

6.2.1 Safe sex and risk messages

Cerulo (2000) argues that audience members use tools to facilitate meaning-making, explaining, 'these tools included the intensification of details, the applications of widely embraced cultural stereotypes, the integration of concurrent media stories and the use

of personal experience' (2000, p. 671). Here, I consider the 'tools' that appear in the focus groups discussions, as described by Cerulo (2000) that support navigation of meanings and become signifiers of behaviour types. These tools are noted as media campaigns that influence the women's understanding and meaning given to the spread of STIs. I also explore the women's experiences and stereotypes that appear to surface in the discourses around the consequences of sex in STIs and pregnancy. The following section assesses how women used these tools to create value sets to construct the meaning they give to the risks associated with sex.

When all nine focus groups were asked about the risks that come with sex, and about what they understand to be *safe sex*, they each identified sexually transmitted infections (STIs) and pregnancy to be the biggest concerns. These risks were recognized as the consequences of not using contraception and were the dominant topics they associated with 'safe sex'. Both topics featured in the policy discussion around the ECP in Chapter 1 and resurfaced as issues in Chapter 2. Here, they are readdressed to better understand how the audience members interact with the constructions of risk in the wider social environment.

6.2.2 STIs, risk and responsibility

In the 1980s, a high-profile campaign was launched in the UK to raise awareness of AIDS. The campaign received criticism for scaremongering, as the advert showing a tombstone engraved with *AIDS* suggested to viewers that the disease could cause death to anyone. The campaign also appeared as a tool for meaning-making for the older women in the groups. I found during our focus group discussions that the spread of STIs appeared as a serious concern. This concern appeared salient for women over the age of 40, who remembered this campaign and its portrayal of HIV. Susan and Claire recounted their memories of the campaign:

> *Susan*: Oh it was vicious. Yeah, it was a tombstone and it said people die of ignorance and then it went *AIDS*. It was like a volcano, wasn't it? Yeah. But AIDS had only sort of really come out and nobody knew what was causing it. They knew that men were dying from it, but they said it was a gay disease and then people ...
>
> *Claire*: But a lot of people back then, people would discuss it and say, 'Well they deserve it.' You know, it was awful. It was awful the way people ...

Susan: Because men shouldn't be sleeping with each other anyway, is what they would say.

Claire: How awful, but ignorance is an amazing killer. I don't recall having discussions about it in detail though. We just saw the adverts and that's how we knew.

Susan: Yeah, it was on the adverts.

The women aged 35- to 55-years-old referred to the campaign and the impact it had. They all agreed that the campaign was “scary” and the message was something they believed “sticks with you” (Samantha). The women explained that during the 1970s, 1980s and for some the 1990s, there was not an “open” and “accessible” discussion about sex and risk. The discussions suggested that what these women considered they learned about the spread of disease, and risks linked to sex, came from campaigns such as this. They described sex education today as an opportunity they “didn't' have” (Claire). Sarah described the differences this way:

> Well you see now you could almost discuss it sitting in a coffee shop, couldn't you, certain things. You couldn't back then. It was all behind closed doors and hush, hush, hush! (Sarah)

As a result of "hush, hush, hush!", these women indicated that what they learnt about women's health and the risk of STIs was overtly negative. The negative construct of STI appeared as 'folk knowledge' in all nine of the focus groups.

The idea that individuals can ‘catch an STI’ was used and framed the risk of spread of disease. The conversations suggested that the spread of STI was associated to unhygienic behaviour perceived as risky. A specific language emerged in the conversations that highlighted the frame of the risk of STI terms such as "dirty" (Lizzie). In all the groups, it was agreed that STIs were an avoidable risk. Influenced by sexual health campaigns, it was suggested that "everyone knows" STIs can be caught via sex (Kirsty). This information formed as a tool that supported the meaning given to the spread of STIs. Although some of the younger women in the focus groups did not have the same exposure to campaigns such as the 1980s AIDS campaign, they shared similar views towards to spread of disease as a negative consequence of sex. The women appear to give further meaning to their ideas about the risks of the STIs, as associated to certain behaviour and identity constructs.

In the conversations, it appeared the spread of STIs were considered directly linked to "promiscuous" behaviour, "one-night stands" and "casual sex" (Emma, Jenny, Jade). The woman who had an STI was described as someone who had taken risks from "sleeping around" and this was not an identity formation that the women wanted to be associated with. Harriet, in her discussion about her reason for not having casual sex, said:

> Hell no! No, you would not catch me having sex with no stranger ... well, not a stranger – I'm not a whore – but anyway I wouldn't because there's too much about ... I'd be absolutely adamant I'd catch HIV or AIDS. (Harriet)

Although she did not directly use the terminology 'Don't Die of Ignorance' from the 1980s public health campaign, Harriet brought together risk of catching disease, with moral condemnation of sex with 'a stranger'.

All nine of the focus groups indicated that risk of STI was a reality for any women having sex at any age. The terms *casual sex* or *one night stands* were used to discuss women who were both 'at risk' or not 'safe' because they might contract an STI, and that presented their sexual behaviour as morally dubious. Younger women, who explained they had more access to things such as 'testing' or 'clinics', having used them themselves, communicated even *greater* risk aversion. Compared to some of the older women, who felt they had limited knowledge on how services were accessed, some younger women who indicated they felt knowledgeable about the services seemed to show greater anxiety towards the reality of disease. Their discussion was less condemnatory of the sexual behaviour of other women, but they seemed highly vigilant around their own sexual health.

Harriet told others in the group, "Don't wind me up, I'm convinced I've got something!" (Harriet). She explained her anxieties about catching an STI, and despite knowing her previous partner's and current boyfriend's sexual history, she went "to get tested". Harriet described her feelings towards her use of sexual health services as for STI testing as "shameful": "Like it's shameful when you walk in there even though I've been there for my coil before and you walk in with your head down. Like it shouldn't be like that because actually, you're doing something about it" (Harriet). Valerie explained

people were shamed for attending the "clap clinic". Although the women appeared to be worried about the risks of sex, attending a clinic appeared to add to these anxieties.

It appeared that, as 'folk knowledge' that STIs were negative and associated behaviour such as accessing services from a clinic for STI considered 'shameful' or 'embarrassing'. Despite some women acknowledging what they were doing was "proactive" (Heather), the negative framing seemed to overshadow this 'positive' behaviour, since STIs were directly linked to risk-taking behaviour and being "dirty" (Lizzie). Heather explained there is still a "massive taboo with like discussion on STIs and stuff, it's not an open dialogue". Jennifer responded:

> Nobody talks about STIs whatsoever. I think it's really a bit strange. That thing about the 'shame' thing, I think it's really important to get tested and I make a point of saying that and the number of people who've told me they've never, ever make me like don't ever want to have sex again! (Jennifer)

Unlike women who witnessed the 'scaremongering' HIV campaign of the 1980s, the younger women in the focus groups also suggested it was appropriate to use fear, Sophie said, "I think sometimes scaremongering people into ... I think it's being realistic". She went on to explain:

> At the end of the day, you can get a really large threatening disease and this could be with you for life and *it could affect other people that you love you know*?! [stressed point] That is something that is *major* and you *should be worried about it!* And you should be questioning and, you know, making sure you make the right precautions to prevent that. (Sophie)

Sophie's choice of words stressing the point of "a really large threatening disease" suggests the portrayal of the large-scale threat of HIV in the 1980s is still evident in the discourse of younger women today. In Focus Group 7, whose age range was 18- to 21-years-old, I found from speaking to these younger women they considered the "scaremongering" tactic as a "realistic" approach to sex education (Charlotte). The meaning the Focus Group 7 gave to risks associated to sex meant that they suggested young people weren't "scared enough" about the risks (Katie).

Overall, in discussions on risk and STIs, I found there to be a morally negative framing to certain behaviour types. Explored here were the tools that support the meaning-making

of the women in the focus groups. Influenced by media campaigns and stereotyped behaviour that leads to the spread of disease, the women gave specific meaning to the risk of STIs and the responsible behaviour of individuals. Evidence to support this appeared in the emotions of 'shame' and 'embarrassment' being linked to the risks identified as consequences of sex. In Chapter 5, I found the EC users felt vulnerable to 'judgment' about their need for the ECP. Here, there appears to be a similar moralisation of the need for services for STI. This underlying moral tone appeared to impact how the women gave meaning to the risk consequences related to sex and supported the definition of problem behaviours. STIs were believed by all the women to be a very real and avoidable risk and sexual behaviour was the source of the problem.

6.2.3 Unplanned, unwanted and teenage pregnancy

In all of the focus groups, regardless of age, pregnancy was considered a risk of sex. However, pregnancy as a problem was differentiated as 'unplanned', 'unwanted' and as 'teenage'. However, a shared understanding around pregnancy was that attitudes towards pregnancy have changed and, as Grace put it of women who are young or not in a relationship, "having a baby it's not such a bad taboo anymore" (Grace). Experience of motherhood appeared to shape understandings of risk, and I found mothers approached the idea of risk from a different perspective from those who did not have children. However, unplanned pregnancy was perceived by all women as avoidable. Pregnancy was perceived as a choice, and the discussion around pregnancy as a consequence of sex further supported the audience's definition of risky behaviour types.

Grace, a parent of two children, explained, "see I think that's why I didn't use contraception because if it did happen to me I'd have my baby and I'd look after it". Grace's approach to contraception and the risk of pregnancy appeared to stem from her experience of two long term relationships, and being in her 40s. She did not perceive pregnancy as a risk to be avoided and an outcome to fear, since she could "look after" (Grace) a baby if she fell pregnant. I found women who were in similar situations to Grace, being older, in a long-term relationship or who had children already, appeared to share this view and it here recognised as a tool to guide the meaning they gave to the risk.

These women's narrative was shaped strongly by their parental identity and they shared similar feelings towards the risk of an 'unplanned' pregnancy. Fifteen of women in the

focus groups who had children explained that, in some way or another, not all of their children were conventionally 'planned', and this did not pose as a major issue. Acknowledged in the earlier chapters, 'planned' was also associated with 'good' contraceptive behaviour and perceived as the right approach to managing risk. Here we find similarities in the meaning given to 'planned' pregnancy being the ideal; however, also recognised as not being as problematic as an 'unwanted' pregnancy. If women have experienced an unplanned pregnancy and had a baby, this moderates the meaning they give to 'planning'. Tina explained:

> If you said pregnancy's a risk, it depends on how you see it, isn't it? So if you really want a baby and you're married and with a solid partner then it's not a risk at all, it's just what you want. (Tina)

In all of the groups, the shared idea emerged that relationship status appeared to impact the frame of the risk attached to the pregnancy. However, the women explained when pregnancy was 'unwanted', and not only 'unplanned', then it became a cause for concern. The women differentiated between unplanned and unwanted pregnancy as a matter of social situations.

Married women who were older were considered to potentially want a child from an accidental pregnancy, compared to women who were single and not in a stable relationship. The two constructed pregnancy risks were measured against social ideals of women's behaviour and expectations of ideal family types. This, in turn, created a frame of 'good' and 'bad' pregnancies as 'unplanned' and 'unwanted'. Interestingly, what strengthened these constructs was the women's understanding that pregnancy is considered a *choice*. It appeared in the discussions that women accepted pregnancy as a responsibility that only women can bear and, therefore, it was up to women to take the 'precautions'. This meant 'unwanted pregnancies' were constructed as riskier and to bring greater consequences than the 'unplanned pregnancies'. As audience members to the wider claims on pregnancies, women agreed that if a woman who did not 'want' a pregnancy she could choose to prevent one using contraception.

Although pregnancy was discussed in these different frames, presenting as a different problem for different women, we can see a shared view that with contraception available pregnancy was a choice, and something that could be avoided. This was viewed as folk knowledge, as Kelly indicated:

> It's because it's all we've ever known, what we're used to. We've known from a young age that other than a guy putting a condom on, which is safe sex STI-wise you don't want to get pregnant you control it yourself. (Kelly)

With the responsibility of pregnancy falling to women, the idea of unwanted pregnancy was viewed as a consequence of the women not taking 'control'. In the development of the 1974 Act, we found similar claims being made around the introduction of free accessible contraception. With the introduction of the pill available on prescription, the legislation was supported as allowing women to 'take control' of their pregnancies and to plan their family size. These claims have been used to support the uptake of contraception in health promotion since the 1970s and appear to be internalised by the women in the focus groups. This, in turn, has allowed women to accept a specific risk consciousness towards the prevention of pregnancy, that identifies pregnancy in different frames as a 'problem'. Control was further discussed around pregnancy as 'responsibility' was identified as a behaviour type for women who avoid risk and take precautions.

'Responsibility' appeared as a description of behaviour. Contraception was viewed as accessible since it was believed that women at all ages were given the tools to 'control' pregnancy risks and, therefore, teenagers who became pregnant must have chosen to take the risk. Despite teenage pregnancy being viewed as a problem pregnancy, this type of pregnancy was still seen as an avoidable consequence of risky behaviour. Emma responded to discussion of teenage pregnancy this way:

> *Emma*: But my friend was in her early 30s when she accidentally got pregnant so ...
> *Jennifer*: Oh yeah, people accidentally get pregnant at all ages but ...
> *Emma*: I think the assumption is if you're in a relationship then it's not really an accident, like ... You know, I don't think people even consider that it could be.

The 'relationship status' of a woman appeared to justify or reduce the riskiness of accidental pregnancies of single mothers and young mothers who were assumed to give children a bad start in life. Charlotte's understanding of a young person being unable to offer a particular ‘quality of life’ typified this view:

> *Charlotte*: Say if you had a child and then you become pregnant and you actually had it, like you didn't abort it or whatever, you'd be worried that they would have a bad quality of life and then you would think that that falls down on your head as well.
>
> *Katie*: Yeah, it's guilt.

Understood by Katie as "guilt", we see how risk and pregnancy are moralised. The risk of pregnancy appears to be measured based on cultural ideas of 'good' and 'bad' pregnancy types, and we see how the rhetoric of the 1970s introduction of contraception to combat 'problem families' still exists in folk knowledge today.

Although pregnancy in its different problem formations was measured through factors such as age and intent, the common theme appeared that pregnancy was viewed as a choice. With contraceptive options seen as widely accessible and from a young age, the women believed that it was an unnecessary and avoidable consequence:

> *Sarah*: Well the thing is I don't think there's any need to have an unwanted pregnancy anymore.
>
> *Elizabeth*: Because the knowledge base that they have.
>
> *Sarah*: There is so much out there to accidentally fall pregnant, you know?

With the acceptance that accidental pregnancies happen, the shared theme appeared to suggest that pregnancy was a choice and therefore, women must accept the consequences of their actions. This was understood through the use of the terms unexpected, unwanted or teenage pregnancies. In all of the focus groups, problem identities were formed around age, relationship status and sexual behaviour, that impacted the severity and frame of the risk of pregnancy. This suggested that risk-consciousness appeared to impact the way women give meaning to certain problems. The conversations appeared to identify symbolic codes of problem individuals that supported the construct of risky behaviour. By internalising the meaning given to certain codes the audience members were able to identify behaviours they perceived as risky. In turn, the audience members were able to categorise behaviours they perceived as risky and non-risky and this supported the navigation of meaning on either side of the pharmakon tightrope.

The focus group conversations on STIs and unplanned pregnancy suggest the audience are aware of social problem identity constructed around sex and contraception. The discussions highlighted how the audience participates in the formation of problem

identities. The women used a combination of symbolic codes and folk knowledge to facilitate the construction of problem identities and give meaning to people as personifications of social problems. In addition, it became apparent that these problem identities also enabled the audience members to typify behaviour linked to contraceptive identities. The following section addresses how the audience members make sense of normative behaviour they viewed as ideal and risky. In turn, we find contraceptive identities are formed out of folk knowledge and given a shared meaning that facilitates the construct of social problem identities with dual meanings and take shape as a pharmakon.

6.3 Safe sex and contraceptive behaviour: facilitating pharmakon identities

Goffman (1959) suggests that as individuals, our social interactions aid the creation and acceptance of collective identity formations. The focus groups sampled here are selected as audience members because they are women of reproductive age and are an audience to the social problem, the ECP. In addition, they take on the role of social problem workers in the social problem process. This role enlists the audience members as actors who facilitate stabilising the pharmakon's position on the tightrope. I found support for this aspect of their role in the discussions of 'safe sex' and contraceptive behaviour, and I have established the ways this audience constructed risk around STIs and contraceptive use. I now continue the investigation as I assess how the women shared opinions on behaviour they perceived as right or wrong.

As women of reproductive age, my focus group participants can be thought of not only as audience members, but also as performers. Their performances are not only for the others in the focus groups, but for themselves, as well. Goffman explains:

> The performer comes to be his own audience; he comes to be the performer and observer of the same show. Presumably, he intercepts or incorporates the standards he attempts to maintain in the presence of others so that his consciences requires him to act in a socially proper way. (Goffman 1967, p. 86)

As elaborators to the social problem story, the women interact with folk knowledge that typifies particular behaviour, as they give meaning to certain behaviours. I found in the discussions that the groups collectively identified behaviour they considered right or wrong. Loseke explains that, 'for the good and the bad, social actors can use their understanding of socially circulating formula stories as resources to make sense of their selves and unique others' (2007 p. 673). I found the earlier sections in this chapter create

a backdrop for formula stories about the ECP as a problem and I now consider the meaning women give to certain behaviours from preconceived ideas that are 'resourced' from their collective folk knowledge.

6.3.1 Safe sex and 'good' contraceptive behaviour

All agreed that it was 'good' and 'safe' to use contraception if you are a woman having sexual relationships. Contraception was discussed as the 'norm' and something women automatically do if they are contemplating having sex and do not want to get pregnant. Hannah suggested that she would adapt her contraceptive behaviour to her relationship status. She said, "I am always on the pill. But when I was single I would double up". By 'double up', she meant using both condoms and the pill to prevent all possible risks. These behaviour traits appeared to form the identity structure of the 'good contraceptive user'. Using the pill was viewed as the 'norm', but adapting contraceptives to relationship status or partner was praised by the women as 'good'. As the audience tell the story of the 'good contraceptive user' at the same time they create a standard or expectation of women's behaviour that others can be measured against.

Risk prevention was addressed as the key to good contraceptive behaviour and as something that women measured themselves by. As Amber explained:

> I think in Britain it's quite a good thing for women ... like women take pride in actually going on the pill and being safe about things so I think it's a good like label ... not a label but do you know what I mean? It's good to have ... Like I can say, 'Yeah, I'm on the pill,' because we see it as all right, we're being safe. (Amber)

It was accepted by all the women that women take care of themselves by taking responsibility for preventing pregnancy, and this was praised as something "women take pride in". Being on the pill was viewed as the 'good' and 'sensible' contraceptive decision made by women and essentially a sign of good contraceptive behaviour. The consensus in the focus groups was that in order to practice 'good contraceptive behaviours', women had to limit risks of pregnancy and STIs. Terms that have been previously highlighted to support the 'good' contraceptive behaviour construct by both the nurses and the EC users emerged in the focus group discussions.

'Planned', 'prepared' and 'proactive', were terms the women used to describe safe sex. For example:

> *Ella*: I guess making a decision at all is quite sensible because you are having that thought process about it, you are thinking about it.

Hannah: Being proactive with your sexual health, being prepared.

Ella: You're prepared. You're actively thinking about what you want to do, rather than just being like, oh, I've never thought about that.

Women appeared aware of the construct that 'good' or 'sensible' contraceptive behaviours were something you 'were thinking about':

Grace: Because girls go on the pill ... I was going to say girls go on the pill before they're with a regular boyfriend in case they have sex so they're putting drugs into their body that they don't need to put into their body ...

Sarah: But they're forward planning, aren't they.

Samantha: Yeah.

Sarah: They're thinking ahead, they're being responsible and thinking ahead. I think if you go out and you think *oh yeah, well whatever, I'll take the morning after pill tomorrow*, that to me is not a contraception, that's covering your bases really. And they're still leaving themselves open to all sorts of everything else.

It was suggested that sex that was unplanned was problematic as the women indicated that it is important to be "proactive with your sexual health". These conversations mirrored the concerns the nurses had about women's contraceptive behaviour and echoed the rhetoric we discussed in Chapter 2 on new public health promotion on risk. With good behaviour being shaped as planned, the problematic sexual behaviour was equally identifiable.

Rhetoric associated with public health campaigns appeared naturally in the discussions. Megan, Holly and Erin used turns of phrase could have easily been taken from the latest official safe sex campaign. With a strong sense of 'being prepared' and 'proactive', there seemed to be evidence of the performance shaped by expectations of behaviours.

The construct of the 'good contraceptive user' suggested a few things about women's role as audience members and social problem workers. I found the discussions indicated there are formula stories that facilitate the identity work of a social problem. As elaborators to the wider claimsmaking activities, the audience makes sense of claims and give meaning to behaviour. In turn the audience of the social problem facilitate the identity work of the problem individual by constructing behaviour they perceived as associated to the 'good contraceptive user'. On the tightrope of the pharmakon, we see this echo the 'blessing' side of the social problem. We continue this line of enquiry by

considering the behaviour the women associated to 'bad contraceptive user' and on the pharmakon tightrope with the curse.

6.3.2 Unsafe sex and 'bad' contraceptive behaviour

The audience accepted that safe sex was 'good practice' and something that was pre-planned using contraception. Women who were recognised as actively not using contraception were open to criticism and 'judgment'. Focus Group 4 indicated that 'bad contraceptive behaviour' was linked to women who have experienced casual sex, repeat abortions and unplanned pregnancies:

> *Harriet*: Actually, if one of my friends said to me, 'I'm having sex with god knows whoever,' and said to me they weren't on the pill I'd be horrified.
>
> *Kelly*: One of my friends isn't. She's never, ever been on the pill.
>
> *Amber*: Mine's been pregnant about ten times, my best friend, and she's had about five abortions, one actual baby and a couple of miscarriages and every time she'd be like, 'I was on the pill.' Like, mate, no-one falls pregnant that many times!

The identity formed of the 'bad contraceptive user' was around a woman who 'lied' but also actively participated in sex knowing that risks had been taking. This was considered unacceptable by the women in this group and Kelly grouped the pattern of consequences for these women as: "Miscarriage / abortion / morning after pill / things like that. I'd just think *why are you putting yourself through it*" (Kelly). This characterisation of the problematic behaviour is indicative of the wider problem identities associated with risky sexual behaviour. The consequences listed by Kelly were understood as avoidable through use of contraception. This identity formation is one we have previously touched upon in the earlier chapters. It mirrors the concerns raised in Chapters 4 and 5 that women have a 'choice' when it comes to contraception, and the 'good' choices are evident as those who coherent with the 'good contraceptive user' frame. The opposing behaviour has previously been explored as a part of the spoiled identity. Stigmatised behaviour that has been negatively constructed and related to the curse side of the pharmakon social problem appears here, in the focus groups discussions.

In the discussion, women however acknowledged 'stigma' as an avenue to 'judgement'. The women did not sympathise with the behaviour of 'bad contraceptive users' as they considered the behaviour as a matter of choices made. This indicated the role the audiences takes on within on the social problem is to proceed with the performance of

placing ‘judgment’ of another for their behaviour perceived outside the norm. For example:

> *Amber*: I think there’s a stigma for women that are not on the pill, having sex and not wanting to get pregnant so if someone said to me, ‘I’m having sex with somebody, not taking the pill or any contraception like that,’ I’d judge ...
>
> *Kelly*: I’d judge them.
>
> *Amber*: Yeah, I would. I’d be horrified; *what are you doing?!* I would automatically be like *are you trying to get pregnant then?* Even though I know it’s choice and it’s they don’t have to, I think *oh my god, what an idiot*. *Sort yourself out!*

Women who participated in "unsafe sex" and made "poor" contraceptive decisions were linked to behaviours such as "casual sex" when "drunk" on a "night out" or "with a random" (Amy, Michelle, Jennifer, Amber). This behaviour was identified as problematic:

> *Megan*: I’d also say, safe sex also includes not having sex when you’re completely intoxicated whether that be on alcohol of drugs. I know… have you heard of that new craze with the kids, the chem-sex, when you’re really high on drugs and then you have sex. It’s very dangerous because you can forget all the contraception and stuff like that. So, I class that as a new thing that people need to be wary of when talking about safe sex.
>
> *Erin*: I just associate that with night out sex.
>
> *Holly*: Casual Saturday night.

As the conversations continued, and the folk knowledge established, the women shared their feelings on what they perceived was 'unsafe sex'. Sophie suggested;

> *Sophie*: I think unsafe sex is something you can be accountable for. Like when you look back and you think *do you know what? I actually could have got a condom* or *I could have been on the pill that day* or whatever, that’ something that makes safe sex; when you are in control of the situation.

As Sophie explained, "unsafe sex" can be controlled and viewed as something women are "accountable" for. This approach to women’s autonomy highlights how the conversations on the negative side of the pharmakon brought to light the moral lessons the women developed for other women. As the women appeared to support the social problem framing of ‘unsafe sex’ by holding women accountable, it suggested the social

problem work is carried out through the judgement made. I asked Sophie to expand on what she meant by 'accountable for':

> *Sophie*: Like say if you said you were going to be raped, you're never accountable for that. It's never your fault so you can't decide at that minute *oh wait, like please put a condom on*. Like you can't decide that. Whereas if you choose to have sex with someone it's *you* that makes the decision whether it's going to be safe or not. If you are with someone that it's an equal kind of thing. Do you get what I mean? So you're with someone who's willing and not forcing you.
>
> *Lizzie*: Yeah, well even in that decision so if you then decide *oh I want to put a condom on* and the other person didn't then that's still in your control to then decide not to have sex with that person.

In Focus Group 9, the audience perceived women as accountable and in control of what happens with their contraception. Women's behaviour then becomes an indicator of their ability to comply with the expectations of 'safe sex'. This was shared by focus group 3 who were asked to give examples of the behaviour they were described as 'unsafe sex':

> *Erica*: I feel like if you went out on a night out and you went back and hooked up with someone and you were like okay, do you have a condom and they were like no, and you were like, oh well, we'll be alright anyway. Can you get pregnant six days in to your cycle? What's the chances? I feel like that's more reckless.
>
> *Jenny*: Not purchasing condoms beforehand if you know you're going on a night out and you thought, I might get lucky and then just don't purchase condoms.
>
> *Researcher*: And not doing so, would be considered?
>
> *Erica*: Reckless I think.
>
> *Jenny*: Unwise.

The conversations brought clarity to the typified behaviour traits as the audience set the bar for the expectations placed on women's contraceptive behaviour. I found the more the women accepted and agreed with the expectations placed on women outside of themselves, the more the behaviour went beyond simply being problematic to having moral meaning. Megan explained what she considered to be a consequence of such behaviour:

> Guilt. Guilt in a sense that I should have been more prepared. I should have been more ready. That was, if you've not taken the precautions and then afterwards, you think I

should have. So, then you feel a bit guilty and then you're a bit like self-condemning about it all, is what I meant.

Explicit morality appeared to shape the 'bad' contraceptive behaviour. Outside of the acknowledged risks of pregnancy and STI, moral lessons were accepted as a part of the consequences of 'unsafe sex'. Guilt was viewed as an emotional response that women experience of participating in sex recognised as unsafe.

The focus groups discussions highlighted how the women as audience member identified certain behaviours as good and bad. What differentiated the views in the groups was the concept of risk. Those older and possibly less inclined to worry about pregnancy were more concerned around STI than pregnancy. However, I was surprised to find the intensity of views held by the women that gave support for the meanings to exist on either side of the tightrope.

In the discussions, I found the women embraced their roles as story elaborators and audience members, particularly when opportunity rose to place judgment on others. It appeared in the focus groups setting the women felt comfortable giving morally explicit meaning to certain behaviour of other women. What I found surprising in the setting of the focus group they were able to distance themselves from the constructed women and identify her behaviour as both good and bad. In these groups, I found the women took on their role as social problem workers and facilitated in the identity work of the good and bad contraceptive users as constructed from folk knowledge. The focus groups suggest that audience members facilitate in the formula stories that develop the normative standards placed on women and their contraceptive behaviour, as women have control and therefore can make the 'right' choices.

6.4 The pharmakon flux: ECP and the EC user

Throughout this chapter we have established how messages of risk and contraception are received by women. The findings suggest that the audience members make sense of the risk claims related to sex and contraception to form *folk knowledge*. Social problem identities are formed and accepted as audience members become exposed to constructs of problem behaviour frames. I continue this line of investigation to examine how these various activities create a platform for audience members to carry out the problem worker activity of facilitating the rhetoric of good and bad behaviour and contraceptive identities, turning to consider how audience members interact with the social problem the ECP. I begin by establishing how the product is viewed as a contraceptive option. I then consider how the audience members believe the product should be accessed and

end with exploring how the women make sense of the pharmakon identity formation of the EC user.

6.4.1 Storytelling and the pharmakon flux

The focus groups agreed the base line of good contraceptive behaviour was pre-planning contraception. Across all focus groups, this was accepted as the norm for contraceptive options, with women supporting the expectations placed on women as, at a minimum, using the pill. With that in mind, I wanted to know how women categorise the ECP as a method of contraception. This question received a mixed response. I found women did not find it a simple task to categorise the ECP as a contraceptive. There were a few who shared strong views that the ECP either was or was not a contraceptive; however, most women fell somewhere in between. Using the pharmakon spectrum, the distance between the two opposing meanings, I have identified the opposing meanings but also addressed the impact of the dual meanings and claims that are used to support each side of the pharmakon.

On one side, we have women who categorised the ECP as a contraceptive. Kirsty was one of the few and she explained, "it's definitely a contraceptive. I literally think about it as taking a pill but you're taking it afterwards" (Kirsty). In its most basic form, Kirsty recognised the ECP contraceptive qualities as the same as that of the pill, except "you're taking it afterwards". These views, although in a minority, were recognised as supporting the blessing side of the pharmakon. On the opposing side we find the women who did not accept the ECP as a contraceptive method.

Erica was one of the women who claimed the ECP was used after sex and therefore could not be a contraceptive. Rather, she characterised it in the same category as abortion. She explained her opinions were formed because of her exposure to Catholic views at a Catholic school:

> I view it as a mini abortion because I was always taught that life begins at the combination of cells, it's not when the baby's born, so for me that was like a very kind of surreal experience to think there could be – it's going to sound slightly weird saying it but I could be aborting a baby in some sense. (Erica)

Erica was the only woman who explicitly claimed the ECP performed an abortion. However, the conversation did appear in all the nine focus groups. I found the ambiguity that surrounds the ECP's mechanisms of action left its contraceptive status open to

question. As an after-sex contraceptive, many of the women found it difficult to categorise the ECP as a contraceptive, as we see from Focus Group 2 conversation:

> *Kayla*: It's difficult, isn't it, because if contraception's meant to prevent you from getting pregnant but you could already be pregnant when you take it so...
>
> *Kirsty*: But you aren't pregnant at the time.
>
> *Heather*: Yeah, because isn't that why you have to take it within 48 hours or slightly less?
>
> *Jennifer*: It just stops the egg from settling in the cervix whatever it does.
>
> *Kirsty*: I mean it literally works the same way as the emergency contraception; it's just that the egg doesn't get stuck.
>
> *Jennifer*: It makes an inhospitable environment!

The women struggled to make sense of the product's ability to prevent pregnancy after sex. This uncertainty around the product appeared to mirror the women's lack of understanding of the fertilisation process. Although the other women did not agree the ECP was an abortifacient, their understanding was "if you have fallen pregnant it forces it out" (Sarah). With the two opposing sides clarified, I began to focus on the ways the women's claims facilitate the ambiguity in the middle. The flux was addressed as the women made sense of the ECP as a pharmakon against these two opposing sides and supporting the instability and dual meanings.

During the discussions, I witnessed how women supported others in the group by becoming a sounding boards for one another. The women appeared to clarify each other's confusions or ideas. Kelly, for instance, explained she was unsure of the ECP contraceptive properties, but after talking with the others, she felt she was able to make sense of the ECP against her own experience. As she indicated, "so it stops it before it gets that far?… when I took it I remember thinking 'oh my god have I just killed my baby?" but that seems ridiculous now.' The conversations about the ECP being an abortifacient indicated the ECP categorisation as a contraceptive was ambiguous and therefore the women struggled to place it on either side of the pharmakon. This in turn created a spectrum of uncertainty, but from the discussion we see how the flux operates in action.

Although Kelly previously accepted the product's ambiguity, following the conversation with other women she appeared to fall closer on one side of the tightrope than the other. In their role of social problem workers, the main task of the women was to facilitate the wider claimsmaking and storytelling of the social problem. I found evidence to support this as women became sounding boards for one other. The women became key to transferring wider claims to other audience members. I began to see how certain participants shifted between role as audience and as the social problem worker, embracing their task of storytelling elaborators. The difficulty the women then faced was navigating the ambiguity that emerged around the ECP. This is further evident as the women attempted to categorise the ECP as a contraceptive.

6.4.2 Dual meanings: the ECP as a contraceptive

The claims that surrounded the ECP varied and I found further support for the product's inherent ambiguity as a pharmakon in the women's attempts to categorise it as a contraceptive. They agreed the ECP "was not an everyday" contraceptive, and "you shouldn't use it that way" (Kelly) because as Amy understood it, it was not "normal" contraception because "it's like a ridiculous amount of hormones" (Donna). They framed the ECP "as a last resort" (Amber) and therefore could not be viewed as a "good contraceptive option" (Charlotte). The segregation of the ECP outside of contraception methods was rationalised by the focus groups, as Jane suggested that the ECP could not be a contraceptive because "it's not as successful as normal contraception". Sophie made sense of the ECP's contraceptive status through its "accessibility" as she acknowledged that the ECP "is accessible but not that accessible" because "you have to pay for it" (Jade). It appeared when the women were trying to categorise the ECP as a contraceptive option they struggled to place the ECP in amongst the already ambiguous categorisation of contraception and contraceptive behaviours. Therefore, the women simply accepted that the product could be categorised as outside of other contraceptives, this was further supported by the name *emergency* contraception.

Chapter 1 explored the meaning behind the term emergency, and the problem it posed when featuring in the name of contraceptive product. Throughout the results we have seen how nurses and EC users make sense of the name and here we continue to investigate the impact the term 'emergency' has on the audience members opinions. The term *emergency* was justified as the name for the product because it was believed that the product was to be "used in emergencies" (Michelle). Holly suggested the ECP was recognised as "the one you use when you weren't prepared". Amber suggested the

situation a woman is in when she needs the ECP is one she would "class as an emergency". In situations where contraception had either failed and/or had not been used. The term *emergency* typified the situation where a woman is at risk of pregnancy after sex and the audience accepted the term as an appropriate characterisation ECP use. I found the internalisation of the meaning given to the term emergency further supported the women's role as facilitating the ECP on the tightrope. In their position as social problem workers the women appear to accept the wider framing of the ECP as an *emergency* as a purposeful definition and this supports the segregation, whilst also maintaining its position in ambiguity.

The phrase that appeared to accompany *emergency* conversations was the characterisation that the ECP was a 'last resort'. The same phrase appeared in both Chapters 4 and 5 and it was suggested that the ECP was not viewed as a contraceptive because it was not accepted as a contraceptive a woman would 'choose'. This characterisation of the ECP has previously been noted as not supported by anything other than speculation on the product's ambiguous mechanism of action. This suggests that if a woman wanted to, she could choose to use the product. However, I found the more the women discussed the term *emergency*, the more they became aware of the implicit moralism surrounding the product's categorisation. Emma identified the underlying intent of the term *emergency* to describe the contraception:

> I think maybe because it's called 'emergency' so you kind of assume that something's gone wrong beforehand that that's why you needed to use it maybe. (Emma)

Women were unable to categorise the ECP as a contraceptive. The conversations suggest they make sense of the name as an indicator of how and when it should be used. These findings (in a way similar to those of the nurses and the women) represent how the audience interacts with the wider construct of the ECP as an ambiguous contraceptive option. However, this ambiguity, that facilitated the product's segregation, also clarified for some women how it should be used. Sophie explained:

> I think the whole point of it is it's the very last resort. You're not supposed to have sex and then be like *oh it's all right, I'll go and get the pill in the morning.* You're not supposed to do that. It's like literally under extreme circumstances. It's not something you can use all the time which is why they make you come in and make sure it's you that's taking it. (Sophie)

As an indicator of its use, the term *emergency* appeared to stabilise the ECP on the tightrope. The ECP was measured against the previously established good contraceptive

behaviour viewed as planned and risk-free; therefore, it could not be accepted as a contraceptive option. However, it was also recognised as an option used "in extreme circumstance" and, therefore, not denied to women either. While it continued to exist with two meanings, both a contraceptive option but only when needed, I found the women facilitated the meaning given to each side of the pharmakon as story elaborators. With the ECP construct understood as ambiguous, I found the women formulated an ECP user identity in tandem with the ambiguous contraceptive.

In the audience's discussions, I found evidence to support the idea that the ambiguity that features in policy around the ECP at the macro-level claims does impact the individual navigation of meaning on the micro-level. However, I also found that the roles of the audience member and social problem worker can overlap. In observations I made during the focus group discussions, I found evidence of the claimsmaking activities of the audience members in their roles as story elaborators. They also adopted the position of a trusted source of folk knowledge for others in the groups, as they became sounding boards for other claims and ideas. In this multitasking role, the audience appear to facilitate the ambiguity that stabilises the ECP on the tightrope. By sustaining the claims that support the dual meanings either side of the tightrope, the audience members experience their own process of meaning-making that supports the ECP in its position as pharmakon. These actions have been recognised as creating a flux on the tightrope to ensure the problem or individual does not fall too far either side. By vacillating the problem, the audience members maintain the ambiguity. This is further evident in the audience claims made around the identity of the ECP user.

6.5 The EC users in the group and other women

The problem identity of the EC user has been previously explored, from the institutionalised setting of the sexual health clinic, to the women who participate in the stigmatised behaviour in the EC users. Here we recognise the identity work of the social problem workers, the audience, as they navigate the wider folk knowledge. Goffman (1963) indicates that the problem identity formation develops out of social norms and awareness of typified behaviour types. Goffman (1963) further establishes in his work that problem identities are complicated and multifaceted; for that reason, we accept that identity formations are also ambiguous. Here we consider further the navigation of meaning that is experienced by the women in their audience groups as they discuss the EC user from both an outsider and insider perspective.

The problem identity becomes a spectrum of symbolic codes, social interactions and meaning-making that develops and solidifies the norms of wider society onto the individual (Loseke, 2003; Cerulo, 2000). Here I return to the problem identity formation of the EC user that has been discussed previously in Chapters 4 and 5, not as simply right or wrong, good or bad. I investigate a character that is built from wider claims of behaviour constructed along a line of behaviour identified as ideal and risky, existing with the dual meanings of a pharmakon. The women took on various roles as audience members, but with some women in the focus groups having used the ECP themselves, as stigmatised identity bearers simultaneously. I found the sample used in the focus groups offered a unique perspective on the EC user identity. I explored the ways in which women navigate and interact with audiences and experience the social problem work in action.

6.5.1 The ECP user and responsibility

The EC user identity (outside of the audience members) was identifiable in the women's discussions as they described the various behaviours and individuals they viewed as typical of the EC user. Earlier in this chapter, I examined the risk messages to which the women in the audience have been exposed, and how they recognise problem identity formations. In the case of the ECP user identity, all nine focus groups accepted the ECP user identity conflicted with the 'good contraceptive user' identity and therefore became susceptible to judgement. Here we see similarities in the problem identity formed for ECP user as behaviours of those associated to risk of STI and unplanned pregnancy.

ECP use was associated with unplanned contraceptive behaviour this approach to contraception was described as "lazy". Women suggested this was how the users were portrayed by "society" (Jennifer). Women in Focus Group 9 recognised this wider public frame of the ECP user:

> *Megan*: It's how it's viewed by the public, it's like a lazy form of contraception. Oh, you had an accident or you're just being lazy. You don't want to be on anything else so you're just going for the morning after.
>
> *Holly*: You're not prepared. You're being risky.
>
> *Erin*: It's just a bit stupid.

The ECP user was viewed as a stigmatised identity, linked to 'risky behaviour' and careless attitudes. The women described the behaviours that were associated with "one-night stand" or "sleeping with anyone and not thinking about it" (Claire, Michelle). This problem identity appeared already evident in the women's discourse, in part two around spread of STI. We see here how the ECP user is grouped in the same behaviour category as individuals who exhibit risky behaviour at the risk of STI.

The nine focus groups were able to identify the behaviour as 'stereotyped' or 'stigmatised' behaviour associated with the EC user identity. The majority agreed, however, that this was not a true representation of EC users. The women believed this was "society's view" of the EC user and the reality of women who use and need the ECP would be "unique to the women" needing the ECP (Lizzie, Jenny). The way the women attempted to make sense of this identity formation of the ECP user was interesting, as I observed the ways in which the women in the groups attempted to navigate around the ambiguity and meaning given to the EC user identity. I found because the ECP existed with dual meanings, the behaviour of the women was also viewed under dual meanings. This dual meaning is evident in the women's navigation of the 'responsibilisation' of the EC user.

Some felt the actions of a woman using EC were 'responsible'. Kelly indicated she didn't "see it as irresponsible" She explained:

> At the end of the day it's the fact that you may have messed up on your own pill so you're just taking another pill that is just a stronger dose to make sure you're protected. It's the same thing as you taking the pill every single day, that is just you saying *I fucked up, let's take this pill and hope nothing bad happens*. (Kelly)

On one side, we see how the women can appreciate the ECP as to a solution to a problem. In focus group five, I saw the opposing ideas surface in this exchange between Sarah and Elizabeth;

> *Sarah*: but also, I think it's a little bit irresponsible.
>
> *Elizabeth*: It's not irresponsible. It's actually being responsible for the action that you've done.
>
> *Sarah*: Yes, it's being responsible for the actions but it's being irresponsible before anything's happened.

As the women attempted to make sense of the ambiguity that appeared around the ECP, they appeared to confuse the meaning of responsibility and the use of the ECP. The women agreed that use of the ECP to prevent a pregnancy was a good solution to a bad situation, however, the characterisation of the 'bad situation' was also viewed as preventable. Therefore, although the ECP was viewed as responsible, in the same essence it was viewed as irresponsible because "precautions were not taken" (Jane).

Here we find the ECP user identity takes on two meanings. On the one hand, the ECP is seen as a solution to the problem of unprotected sex, and on the other, it represents that precautions were not taken prior to the sex. This ambiguity around responsibility attached to the ECP was experienced by the focus groups. As Claire explained:

> *Claire*: There's two sides to it; you were irresponsible but then you were responsible for actually going to like the next stage so there's like some
>
> *Jade*: I think if it wasn't a one night stand you'd feel like you'd need to explain yourself, even though I'm sure they've seen loads of people but you'd feel like you'd need to go, 'Oh the condom split.' You wouldn't ...
>
> *Amy*: It's just embarrassing, isn't it.
>
> *Claire*: You've done something you shouldn't.

Although ECP use was accepted as a responsible solution to a problem, the behaviour attached to use of the product represented that of the problem identity. It appeared to mirror the wider "expectations" on women as the women suggested that EC users "need to explain" themselves and their contraceptive behaviour (Jade). For this reason, it was believed that because a woman was not expected to choose the ECP, she would have to justify her reason for use Jennifer explained:

> If someone said 'I had to go and get the emergency...'Like there'd be an expectation that something had happened that you needed to go and get it, not just... 'It was broke. Couldn't be bothered.' There's that expectation that there'd be a reason. Like something had gone wrong. Like you'd done your correct planning procedure and then something had gone wrong and then you needed to get it, not *oh I just couldn't be arsed*. (Jennifer)

The ECP was not viewed as a something women could choose to use; rather it was considered an option used by women when "something has gone wrong". Women explained they would not choose to use the ECP as this would 'defeat the point' of contraception which is "to regulate fertility" (Katie). The shared constructed norm

appeared as contraception was considered as used regularly and in advance, therefore, the EC user was a person who did not maintain the norms in society. This problem framing of the ECP user under two frames created an interesting further discussion as the women in the groups began to identify themselves as ECP users.

6.5.2 ECP users in group

Eighteen of the 33 (55%) women identified as ECP users. This meant at least one person in each group had experience using the ECP. The conversations turned to these women's experiences. These discussions were understood as a reflective addition to the women's roles as story elaborators, but also provided evidence to support the social problem workers' internalisation of wider claims that support their role of vacillating meaning of the ECP on the pharmakon spectrum within the tightrope framework.

I found the user in the focus groups experiences appeared to mirror those of the EC users in Chapter 5. In Erica's focus group, she was the only woman whose experience using the ECP. This meant the story telling role she took on enhanced her position as elaborator as she recounted her experience of judgement, Erica:

> Not judged me but kind of asked me some very harsh questions, like *were you using contraception? Why did you make this mistake?* It was the first time in my whole life I ever made that mistake and she made me feel like I was such a terrible person. (Erica)

Erica, who previously identified strong views about the ECP as an abortion, here explained that the nurse made her feel 'terrible' about her need to use the ECP. This was not because the nurse treated her unprofessionally, but as Erica explained, she "asked some very harsh questions". In Erica's reflection of this encounter, she explained that this impacted her contraceptive behaviour moving forward.

> Yeah, she very much grilled me, so I feel like next time I was probably more careful because I was like I don't want to have to explain to a nurse again why I need to take it! (Erica)

In Chapter 4 I investigated how the nurses felt the consultation was an important opportunity to educate women and quick-start them onto alternative methods to reduce their future use of the ECP. Here we see how the consultation became a deterrent for future use of the ECP, as Erica did not "want to have to explain to a nurse again why" she needed to take it. We find in Erica's account a shared experience to that of the EC users

in Chapter 5, as the similarities in her experience of 'judgment' have been explored previously in the EC user stories. However, in the additional role she takes on, as a story elaborator, she supports the claims that the other audience members believed that women who use the ECP are 'judged' for their use. The focus group offered a valuable opportunity to view how women as audience members interact with claims and experience to facilitate their own meaning making of the problem in hand. This can be further seen in the women's discussions on their reasons for needing the ECP.

The pharmakon spectrum was used in Chapter 5 to identify the behaviours of EC users on either side of the tightrope and we accepted that some women posed as low and high-risk characters. Charlotte, who explained she took the ECP once, might be viewed on the higher risk scale of the tightrope spectrum. She described to the others in the group how she felt when she needed the ECP:

> You take it when you think *oh shit*, like it is a backup and you think *oh I shouldn't have done that* or ... I don't know, or say if you feel like something went wrong. (Charlotte)

Charlotte explained that in her situation she realised her need of the ECP was because "something went wrong" but went on to suggest, "you don't take it every time you have unprotected sex. Well I don't". In line with the wider claims made in the focus groups about the risk-taking behaviour associated the ECP user, we find Charlotte shared the same identity formation as the high risk behaviour. Charlotte was considered an extreme case compared to other 18 women who believe they had just 'made a mistake' or 'contraception failed' in their stories of why they needed to use the ECP. However, I observed in all the focus group the ECP user story further intensified the women's role as story tellers. This role development of the women in their position as story tellers as well as, the EC users appeared to impact the navigation of meaning from others in certain groups. This was most evident in Focus group 5.

Grace and Elizabeth explained they had both used ECP, Sarah responded with "see I can't understand that." Sarah indicated that she felt there was so many contraceptives available that, "I just think there's no reason they should have to use it. They should be prepared". I asked Sarah to expand on what she meant by the term 'prepared':

> If you're not on anything else minimum carry a condom. I think if you need the morning after pill you're not looking after yourself because the minimum you haven't got is condom with you. I think if you go out now there's no way a girl going into town now does not know the minimum of having a condom in her handbag. And there's no

> embarrassment about having a condom and there's no... the fact that you're carrying one means you're going to have sex. (Sarah)

Sarah expressed high risk aversion, she appeared to channel the wider policy views around the idea of the 'good' contraceptive user as 'pre-planned' and using 'contraception'. I found Sarah was unable to accept that a woman would "need to use the ECP" as the minimum expectation for women was to "carry a condom" (Sarah). For Sarah and others who felt strongly against the ECP being used as an additional contraceptive, they were unable to rationalise why or how a woman could have sex without the use of contraception. These opinions are recognisable as identifying EC use on the curse side of the pharmakon, as they perceived the EC user as displaying 'bad' contraceptive behaviour. As the conversation continued, Sarah explicitly judges the EC users in her group:

> *Sarah*: I don't believe you would go out and have unprotected sex.
>
> *Elizabeth*: Yeah.
>
> *Sarah*: No, you wouldn't.
>
> *Elizabeth*: Yeah.
>
> *Sarah*: No, you wouldn't. No, you wouldn't. Even the minimum you would say to him is, 'Have you got a condom?'
>
> *Grace*: And if he says no you'd probably take the risk.
>
> *Sarah*: No, I don't think you would take the risk.

Here I observed social problem work in action. As an audience member, Sarah was the target audience for wider public health message about sex and risk. In her discussion, I found she channelled the wider risk aversion, as she argued with the women in her group for 'taking risk'. However, Sarah appeared to give meaning to the behaviour identified as 'bad' contraceptive behaviour, as a defence against women's use of the ECP. In her confirmation that she cannot believe why or how a woman can take such risks, she contributes to the wider frame of the ECP user becoming a pharmakon. I found that those who appeared to disagree with EC use were unaware of the moralism that shapes their concerns. However, these audience members appeared to hold vocal opinion on the matter on their perception that the EC users were a risk to their own health. Sarah further supported her claims with "you don't know who you are sleeping with or what you might catch".

Here in Sarah's discussion I observed how EC user are susceptible to judgment on their behaviour. Women as audience members who did not have experience using the ECP we expected to make sense of an ambiguous contraceptive, considered both right and wrong. For Sarah in her awareness of potential risks she was unable to support the other use of the ECP. However, in other groups there appeared to be no issue with women's use of the ECP. These findings do support the framework here used, by investigating the nature of the claims made in the wider macro we consider and explore how they are internalised and further facilitated in the micro. In these conversations I found the two levels of the social problem process do interact and the impact the lived experience of those who come into direct contact with the social problem.

6.6 Conclusion

In an investigation into how wider claimsmaking impacts those who take on the role of the audience, I have found evidence to support the internalisation of meaning at the micro-level of a social problem. Using focus groups, I have observed how women of reproductive age feature in the social problem ECP, as an audience to wider claimsmaking. I conclude the audience members in the social problem process play an important role in the stabilising forces on the pharmakon on the tightrope.

The opening sections of the chapter explored how women are exposed to claims about risk and how they then give meaning to risk associated to sex, such as, STIs and pregnancy. Using this information, I assessed how women make sense of these wider claims and develop these meanings as folk knowledge and symbolic codes. Through this process of meaning making, I found as audience members the women were able to construct behaviour they perceived as 'good' and 'bad' contraceptive behaviour. The significance of these findings suggests that through a combination of wider social problem claimsmaking and exposure to risk aversion in public health, women do indeed make sense of social problems through a process of navigating meaning. In a way that is similar to the conclusions set out in Chapters 4 and 5, the women here recognised the behaviour of good contraceptive users as 'planned' and the bad contraceptive behaviour as 'risky'. However, if we further consider the relevance of the identification of two behaviour constructs, we find in relation to the ECP (in its segregated ambiguous construct as a contraceptive), the women are further expected to navigate dual meanings and make sense of this product against their symbolic codes. In the focus group setting,

I found the women as audience members shared symbolic codes that supported their meaning making processes and internalisation of the wider claims.

All the women that took part in the focus group struggled to categorise the ECP as a contraceptive. Constructed as a contraceptive used as a 'last resort', it was praised as an alternative option of contraception that women might 'need'. However, the after-sex nature of the ECP appeared to conflict with the symbolic codes that structured the meaning the women gave to certain contraceptive behaviour. It was suggested that 'good' contraceptive behaviour was planned and ECP use was associated to women that have taken risks or contraception that had failed. The use of the ECP was not considered by the audience members as something a woman would *choose* to do. In the recognition that there were two distinct meanings given to the ECP as a contraceptive but also the behaviour of the women, I found within the focus group discussion the ECP and its user emerged as pharmakon.

In their role as audience members, the women made sense of claims and stories through the lenses of their symbolic codes, which supported the 'flux' in the pharmakon tightrope. This can be seen in the ideas that surfaced that the ECP was 'good' for women who want to prevent pregnancy but also considered 'bad' as a contraceptive a woman might choose. The symbolic codes that emerged out of risk aversion and public health appeared to shape audience support for the existence of dual meanings given to the ECP. By identifying the behaviour of the EC users under the frame of good and bad, the audience appeared to facilitate the meanings and claims that appear either side of the pharmakon tightrope.

In their interchangeable roles as audience members/story elaborators, the women appeared to participate in the social problem work of claimsmaking. By sharing the 'meaning' they gave to either side of the tightrope with the others in the focus group, they further reinforced the claims that featured under the blessing and the curse. The women viewed each other as trusted knowledge sources, as it was accepted that women's experiences were as trusted as doctors' advice. In their role as storytellers, the women became sounding boards for each other's opinions and as a shared knowledge source; the meanings on either side of the pharmakon appeared to develop. In the process of sharing these meanings, I found the claims stabilised both the ECP and its problem user identity, under dual meanings and on the tightrope as pharmakon.

What I found to be most interesting about the emergence of the EC user as a problem identity was how the women appeared to distance themselves from this construct. With

18 of the women having experience using the ECP, the remaining 15 women were considered audience to the EC stories. The EC audience women appeared give the ECP user identity varied meanings, something I observed as claimsmaking in action. What further surprised me in the focus groups was the intense moralism that emerged in the claimsmaking of the women. Unlike the ECP users and the nurses, the women here as audience members are expected to make sense of claims. I found that in their process of meaning-making, they appear to develop a moral construct of what they value as good and bad, right and wrong. In the investigation into how wider claims impact the audience, I have found that pharmakon problems, with their ambiguous meanings, are susceptible to moralism in a risk aversive culture. By leaving the defining of meaning up to the audience, I found those who live within the problem are expected to navigate meaning on the individual level. This process is impacted by the structure of meaning developed at the macro-level.

In Chapter 3, I recognised that the sample of this participant group would not support the findings as generalizable to wider public views. Although that remains true, what I have found is evidence to support the role and significance of the audience's place on the pharmakon tightrope as both claimsmakers and meaning-makers of the social problem the ECP. The audience members found further support for their ideas from the others in the groups as they shifted between storytelling and audience roles, and I found the women in their groups facilitated the wider claims as they become 'story elaborators' in the social problem process.

Through a process of internalising the claims, sharing the claims and then giving meaning to the claims, the women here contribute to the wider claimsmaking of the social problem. In the case of the ECP, the women's discussions support the process of navigating meaning at the micro-level and this is influenced by the risk aversion in the macro-level. With the aim of better understanding how individuals give meaning to a social problem, particularly when a problem is presented as a pharmakon with dual meaning, I have innovated and developed a new framework that will support the investigation into the social experience of a social problem. As a contribution to the field of study of social problems, the work carried out here offers a new approach to examining the different characters who take on roles within the social problem process. It also indicates there is room for further research into the ways macro-level claims and claimsmaking activities are received and influence the activity of those at the micro-level.

Chapter 7

Conclusion

7.1 Introduction

In this conclusion chapter, I set out to discuss ideas that have emerged from the current piece of research that has sought to develop the sociology of social problems. I begin by highlighting the sociological contribution of this investigation of the social life of a social problem. I emphasise the value of research that has developed a microsociological framework to explore a social problem in a new way. It has been the case, I suggest, that this research has developed sociological work by placing the exploration of the social problem process in the public domain in relation to an exploration of its operation at the micro-level of what I have termed 'the people within the problem'.

Overall, I conclude that the main contribution of this effort has been to bring to light the co-existence of dual forms of moralism that both powerfully influence this social problem, and which operate throughout the social problem process. These can be termed 'traditional' and 'medicalised' moralities, with the latter associated strongly with the new public health approach to managing risk. I conclude that this finding points to the importance of further sociological work designed to attend to the workings of this latter form of morality, the associated regulatory and institutional frameworks, and its effects for the people within the problem. I also recognise that, for the ECP, it is in this area that arguably the most important questions emerge for the future of policy and the associated debates about widening access to ECP.

7.2 Studying a social problem

Through this thesis, I have contributed to the investigation of the formation and impact of a social problem in the public domain, with this part of my work drawing most of all on the insights of Best (2013) and Loseke (2011). The social problem process they explain and explore so comprehensively has been considered for the ECP, and in so doing I have first identified and detailed the social construction of the ECP as a problematic contraceptive in the public domain. I then developed my investigation through researching into how this problem is internalised by those who come into contact with it. I have described my approach in the thesis as a microsociological and I offer the

framework I have developed as an approach to be used to further study the impact social problems have on the lived experience of the people within the problem.

In investigating the formation and construct of the social problem, I have explored how problems come to exist in the public domain under dual meanings. Using the concept of the pharmakon, I have established how social policy creates and sustains ambiguity around a social problem. As a point of departure, it is important to highlight the significance of these findings, as the ECP exists as a method of contraception used by women on a daily basis. Future research might usefully address how and why this contraceptive has come to feature under dual meanings using a wider and more diverse cohort of participants than I was able to, to support the investigation.

My findings suggest that when problems come to exist under dual meanings it ultimately impacts the acceptance of the social problem. This impact has been recognised in this work as the navigation of meanings experienced by individuals, as they make sense of the social problem they come into contact with. These findings suggest that when ambivalent attitudes towards social issues emerge in the public domain, we can explore how cultural pressures develop and impact the way humans differentiate and interact with their own and other's social narratives. I was able to consider this using the pharmakon tightrope as the conceptual support for the investigation.

In further investigations, it will be important to address how social interactions shape and influence identity work within the social problem. By identifying each of my participant groups with specific roles on the pharmakon tightrope, I was able to better understand how they each contributed to the pharmakon's stability of dual meanings, and this is an important contribution made by this study. Figure 8 gives a visual representation of how the different roles work along the tightrope. Using this framework, I was able to investigate both the meaningful navigation and process of 'meaning-making' within the social problem.

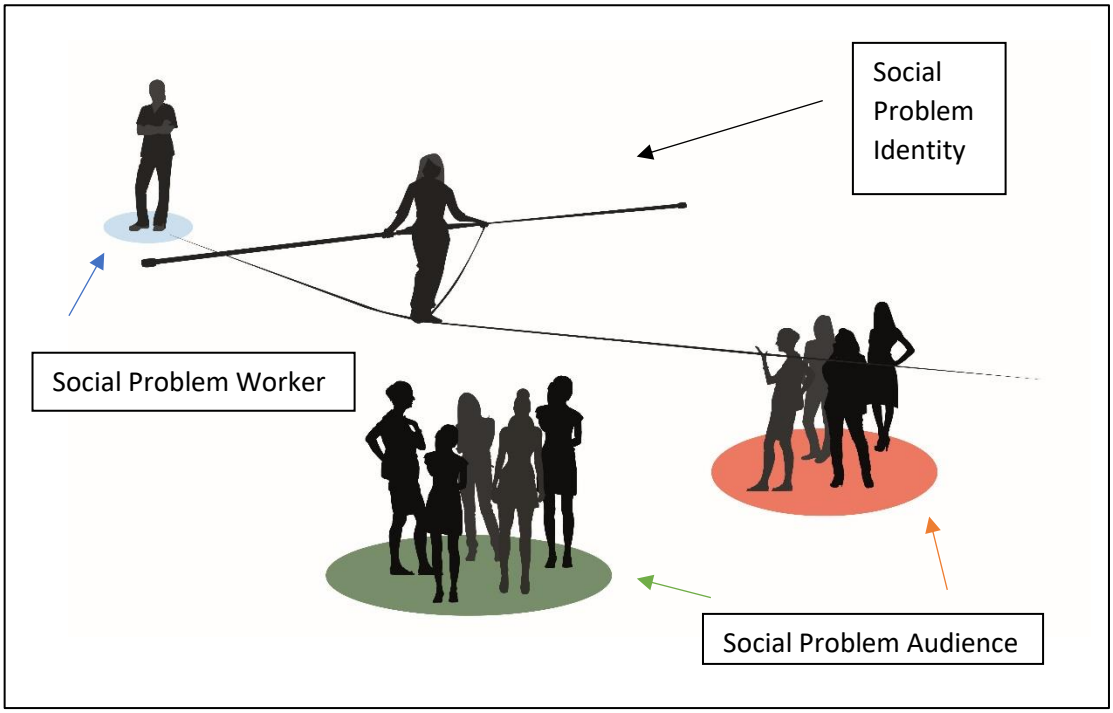


Figure 7 The Social Problem Roles on the Pharmakon Tightrope

Using this framework, other research can further investigate how social problems are experienced by those who take on social problem roles. For example, the *pharmakon* concept might support the investigation into other health problems situated within public health and which can be recognised in the public domain as problems that exist with dual meanings. Recent controversies that have emerged in public discourse around the distribution of the HIV drugs Post Exposure Prophylaxis (PEP) and Pre-exposure Prophylaxis (PrEP) potentially constitute parallel case-studies to the ECP, as both a blessing and a curse. The framework developed here could support parallel research into how individuals give meaning to and internalise messages of risk in these other cases. However, with a new framework comes some limitations.

7.3 The first trial of the pharmakon tightrope

This research presents as the first trial of the 'pharmakon tightrope' as a framework to aid an investigation into the social construction of a social problem. Therefore, it is important to acknowledge that when testing a new framework that not all the conclusions can be ratified without further research. Therefore, in its earliest stages it would be unwise to suggest the framework is adaptable to the study of *all* social problems.

At this point, the data collected supports an investigation into how a policy problem is constructed and experienced at a micro level. Without further testing it would be too

soon to say whether the same framework would be suitable to investigate the current experiences of *all* social problems at a micro level. As the work indicates there are several historical socio-cultural factors that support the frame developed for this particular pharmakon. Therefore, without further testing of alternative problem frames there are some uncertainties around the durability of the framework.

Additionally, the pharmakon framework is suitable for a specific social problem, one that can exist under two distinct meanings and is publicly accepted as ambiguous. As stated in chapter 3 not all social problems are accepted as good and bad, right and wrong, at the same time. This draws further attention to the possibly niche area in which the framework can be applicable.

Previous work into the 'social problems process' such as Best and Loseke, indicate similar formation of individuals within the problem existing at the micro level. Those individuals identified at the micro level of the social problem are recognised as a combination of social problem workers (actors and audiences) and social problem individuals (social problem identity). The tightrope design supports the investigation into the individuals within the problem, however, to test the strength of the framework and the concept of the pharamkon, I suggest further investigation into the specific social problem individual groups. Here the tightrope has worked well for the type of individuals recruited, however, in recognition of the limitations of the sample it may have been a different outcome if the sampling had been more robust. Therefore, I suggest further investigation should occur amongst social problem workers and social problem identity groups.

However, with its infancy comes room for further innovation in its ability to support and contribute to the study of social problems. Further work may adapt the framework accordingly to which area of the tightrope under focus. Testing of the framework in this manner, will allow conclusions to be drawn on the framework's sustainability as a contribution to the field of social problems. Therefore, in order to address the durability of the framework here developed, further testing should explore how applicable the tightrope is to alternative social problems individuals, actors, audience and identity bearers, outside of the specific area of health policy.

Consequently, the tightrope framework is offered as an original contribution to the current study of the social construction of the social problem. As the conclusions drawn from this research indicate, there is room for further research into the micro lived experience of those I have termed as *people within the problem.*

7.4 A moralised social problem

Chapters 1 and 2 outlined the safety and efficacy of the two hormonal contraceptive pills used to prevent a pregnancy after sex. As contraceptive products, the ECPs have the ability to both prevent a pregnancy and suit the lifestyle of women who may not need or want to use hormonal contraception on a daily basis (as their intended use in the original development stages). In Chapter 5, this construct of the ECP appears to be unconsciously used by the women as ECP users. I found the ECP appeared to have been used by many women as a solution to other issues related to the 'regular' hormonal contraception and the 'side effects of hormones'. However, I have found this construct, (the ECP as a solution) does not appear possible in today's current climate of risk aversion.

Unable to address this as a point of enquiry in this thesis, I suggest there is room for further investigation into the concerns that emerge around women's ability to use and choose contraception. In addition, suggest it important further research consider the real-life impact 'side effects of hormones' have on the contraceptive decision making of women. I found when speaking to women a number of issues emerged that impacted the meaning they gave to their decision to use contraception.

A common theme that emerged in all the discussions with women was the 'male contraceptive pill' and how women felt the contraceptive decision-making was not 'fair'. I found the frame given to the pill in its earlier years as "a dream come true" (Marks, 2010 p. 210) freeing women to make autonomous contraceptive decisions, was not maintained by women in 2017. Women appeared to support the idea that ownership of their contraceptive autonomy would be better suited to male contraceptive pills. This is not something I have been able to explore in this thesis, however suggest this development could be associated the previously noted under researched area of the 'side effects of hormones' featuring as a burden on women. Further research is needed to better address women's experiences of making autonomous contraceptive decisions and the findings from this work support this.

The work indicates health policy plays a significant role in the strained autonomous relationship women have with their contraceptive identities. Using the ECP as an example we find, the ECP is a contraceptive that could be chosen by women to use and have at home; however, tension in medical moralism that surrounds it as a contraceptive counter its ability feature as a contraceptive option for women.

Traditional moralism emerges in the work initially with the concept of the pharmakon. Plato first introduced the term *pharmakon* as a process of managing the 'unknown' and the 'unmeasurable' risk of the reading had on the public (Furedi, 2012). Pharmakon as a concept supported the management of behaviour, as reading was posed by the elites as a potential moral problem, with the side effects unknown, culture was controlled. In the case of the ECP, a similar pattern of paternal control emerged. I have found the ECP is regulated based on the same 'unknown' potential risks that is posed by women's sexual behaviour against a wider health promoted behaviour.

Traditional moralism is also evident in the history of contraception, where womens contraceptive options have been open to public debate as a cause for moral concerns. Policy has previously chosen to pacify public concerns about the consequences of immoral and moral behaviour associated to sex and contraception. Evident in the 1967 policy regulations supporting only married women being able access contraception, as a matter of upholding traditional values. In review of the 1967 National Health Services (Family Planning) Act, 'risk' was addressed as the consequences of women's contraceptive decisions pose to moral order. We find traditional moralism appears established in public discourse and impacts women's autonomy. Over 40 years after the 1967 Act, the review of 2001 ECP legislation found similar concerns raised about women's access and use of the ECP.

However, in an era of 'safe sex' and New Public Health, risk and behaviour management are not overtly driven by traditional moralism. Contemporary health policy approach addresses social problems through the medical lens; however, we find similarities in how the problem emerges. Through the medicalisation of contraception and with-it contraceptive behaviour, policy has opted to regulate women's fertility control options, not as a matter of 'health' but rather in the aim to manage the risk posed by women's behaviour. Evident further by DR X in Boots' refusal to lower the cost of the ECP as not wanting to 'incentivise inappropriate use or misuse'. In cohesion with the findings from the social problem workers, the nurse, we find the medical construct of the problem appears to support the moral behaviour management of women. These concerns, raised 40 years apart, differ only as the current framing appears as a part of health policy and supports the delivery of health promotion initiatives. The medical moralism recognised here emerges in the same context of the Greek term *the pharmakon*, as a concern about the 'unknown': the ECP is framed as a potential problem in need of management. We find previously established traditional moralism that once managed the behaviour of women

appears once again intruding on the autonomy of women in the shape of medical moralism.

Medical moralism features today, via health promotion and policy targeting the behaviour addressed as 'risky' or 'problematic'. With public health policy driven towards managing risk, this creates a suitable environment for pharmakon to exist. The ECP is framed under an ambiguous structure of potential risk, and as a post-coital contraceptive it poses as a threat to the preferred and health-promoted contraceptive behaviour. These findings bring to light the ongoing conflict and tension that emerges around the concern of uncertainty and the prospect of risk in health policy today. Using the framework, we can better understand how policy environment supports the existence of pharmakon but also the experience of individuals navigating wider moralism. Overall, I conclude that the main contribution of this effort has been to bring to light the co-existence of dual forms of moralism that both powerfully influence this social problem, and which operate throughout the social problem process. These can be termed 'traditional' and 'medicalised' moralities, with the latter associated strongly with the new public health approach to managing risk

7.5 The ECP as a policy problem

As I noted at the outset, this PhD was funded as part of the ESRC's policy pathway, and the question of policy runs through the investigation. It appears in my assessments of the social problem in the public domain; shaped the design of data collection, through my decision to interview nurses employed as public health workers; and so emerges as a key aspect of the analysis provided of the people within the problem.

In my historical review of hormonal contraception as a social problem, I discussed that, almost 70 years on from the initial introduction of the pill, contraception continues to remain problematised in policy. The pill, under its construct as a blessing, was noted as potentially a significant contribution to the empowerment of women, with the promise it would help foster their autonomy and 'sexual freedom'. However, it found these promises to be denied by a policy field that emerges as organised around a constrained understanding of women's choice, and which operates in practice to limit the exercise of choice and autonomy.

My finding is that the ECP exists in a field of policy driven by the regulatory power of health promotion and risk prevention. I found the dual meanings that construct the ECP as pharmakon are stabilised by forces that maintain the ambiguity that surrounds all

contraceptives. I accept that in a different world, under different claims-making processes and consequent outcomes, the ECP's dominant meaning would be as a solution to wider problems. Under the pharmakon concept, however, I establish how cultural contradictions formulate around contraception instead, which means it is constructed simultaneously as a problem to be managed. I showed how, in the current approach of sexual health, this problem comes to be embodied as the women and her 'risky' behaviour identified through her 'inappropriate' use of ECP

Promises of liberation associated with hormonal contraception in this way co-exist with moralised preoccupations about the consequences for women associated with 'risk-taking behaviour'. The tension between 'traditional' moralism and 'medicalised' moralism noted above emerged most strongly and obviously in this aspect of the research, with implications for those seeking to widen access to ECP as a public health good.

I have found the ECP is set apart from all other contraceptives, and, on balance, the workings of 'medicalised' moralism are just as, and probably more, important that those of 'traditional' moralism in making sense of this situation. For those concerned to shift the balance and alter the pharmakon in favour of 'blessing', addressing its naming as 'for emergencies only' is a good place to start. However, this thesis suggests that, ultimately, it is a shift in the balance forces that currently lead to the construction of women as a type of curse, by merit of their risk-taking behaviour, that will make most difference.

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Appendices

Appendix 1. Interview Schedule: Sexual Health Nurses

Interview Schedule - Semi Structured interviews with Health Professionals (HP)

Participant information

Age:

Gender:

Job Title:

Place of work:

How long have they been in their position:

Tell me a bit about your work, what got you first interested in sexual health?

1. The ECP and their Job

Can you explain to me how distributing the ECP fits into your line of work?

- Follow up questions how often do they give the ECP to women. Does the ECP play a significant part in their job?

From your own experience of distributing the product how would you describe the role of the ECP?

- Follow up questions on the categorization of the ECP alongside other methods of contraception? Is it an acceptable method of contraception or not?

Can you explain how a consultation with a women needing the ECP might go?

- Follow up question what are the important questions to ask a woman who needs the ECP and how does their response change the way you might deal with the situation?

2. Risk and safety of ECP

As a health professional what are the risks of the ECP?

- Follow up question are the risks associated to the behaviour or to the product? If they are associated to the behaviour then why is it the product receives such bad press?

When completing a consultation with a women needing the ECP how do you outline the risks?

- Follow up question during the consultation are the risks of using the ECP used to promote other methods of contraception?

What would you say to a woman who chose to use the ECP?

- Follow up question should methods of contraception be chosen by a woman or should they go by health professional guidance?

3. Access to the ECP

Kent Community Health Trust have a scheme that allows women to access the ECP for free from certain Pharmacies if they are under 30, how has this scheme affected your work?

- Follow up questions do you encourage women to use these schemes? Should they be available to women of all ages?

Are you aware that NICE guidelines indicate women are able to access the ECP in advance if they should need it? How do you feel about increased access to the ECP?

- Follow up questions discuss the BPAS campaigns of increasing access. Who will benefit from the schemes?

From your own experience distributing the product what do you think is a barrier to women accessing the ECP?

- Follow up do you ever promote the ECP in other consultations if not why?

In your opinion how would having the ECP available to women as an off the shelf product affect women's behaviour?

4. Women's behaviour

From your experience can you describe for me the most common situation why a woman might need to use the ECP?

- Follow up question in your opinion what is the reason for these situations and how would you describe the behaviour?

From your experience distributing the ECP would you associate the ECP use with any particular behaviour?

- Follow up questions is this behaviour described as responsible or irresponsible?

In regards to methods of contraception how would you describe responsible contraceptive decision making?

- Follow up discuss should women have the option of contraception to fit their life style?

In your opinion how would you describe the meaning of practicing safe sex?

- Follow up is there a cause for concern with people not planning their sex by their contraception? How does this affect men?

Research indicates that the ECP does not affect levels of abortion or unwanted pregnancy, in your opinion and from your experience why would you say this is the case?

- Follow up is this directly linked to the women using the product? Or is it a cause for concern on the behaviour?

Research also indicates that increased access to the ECP does not encourage risky sexual behaviour or the numbers of STI's in women. From your own experience would you agree or disagree with these findings?

- Follow up is the association to risky behaviour and the ECP an issue of stigma or is it a true representation of the women using the ECP?

5. The ECP

Can you describe for me or give of an 'emergency' situation?

- Follow up question If we consider the name 'emergency contraception', do you feel in your opinion that the women who are using the ECP are in an emergency situation?

- Follow up question of the fertility of women and the timing of menstrual cycles is a huge factor affecting in the risk of pregnancy, is this something to consider when advising women on their choice of methods of contraception?

In your own opinion would you class the ECP in the same category as other methods of contraception?

- Follow up question the original design of the product was to give women who do not have frequent sex the option not having to take a cycle of OCP, how would you feel about giving women this option?

There are many misconceptions of the ECP being an abortion, how do you feel about this in your line of work?

- Follow up question in the consultations do you discuss this with women who come to you for ECP?

Appendix 2. Interview Schedule: Women EC Users

Interview Schedule – Women Semi Structured interviews

Participant information

Age:

Gender:

Relationship status:

1. Contraception history

In regards to methods of contraception which methods have you used in the last year and how reliable have these methods been for you?

- Follow up questions on any methods that failed or were unsuitable for them and why?

Can you explain how you have chosen your methods of contraception in the past?

- Follow up questions do you feel it is important to preplan your contraception? How long would you say you think about your contraception before having sex?

How do you feel about methods of contraception suiting lifestyle?

- Follow up on whether women feel they are able to freely choose their methods? And what decision making goes into choosing methods.

2. ECP use time and experience

How many times have you used the ECP?

- follow up question on how this method has fitted in with other methods and whether previous use has changed lifestyle or choice in methods of contraception.

Can you tell me a little about the last time you needed to use EC? can you please describe why you needed to use the product?

- Follow up question on what contraceptive decision making occurred prior to this particular situation. Did you know you ECP was available before you had sex on this occasion? If so do you think it impacted decision making?

Can you please describe your experience of accessing ECP on this occasion?

- Follow up questions on the health professional's response to the participant and how easy/difficult it was to access.

During your consultation how did the health professional make you feel about needing ECP?

- Follow up question on the participants personal experience. Was the participant made to reflect on their behaviour and if so how did they do so? Was being/acting responsible mentioned to them?

On your last occasion did you discuss any potential risks, to you or the product?

3. ECP and Safe sex

How much did you know about ECP before going to get it on the last occasion?

- Follow up question, do you talk about EC with friends or family?

Can you remember the first time you heard about ECP and in what context this was in?

- Follow up question, before your own experience did you ever hear of others using ECP? If so how was there experience discussed?

Some women say they believe there is some judgment or stigma attached to using ECP, from your own experience do you agree or disagree?

- Follow up question, do you feel your experience was judgment free? Have you ever heard of women experiencing judgment when choosing to use the ECP, if so in what context was this discussed?

What does the term safe sex mean to you?

- Follow up question, can you remember the first time you were exposed to a discussion on safe sex? In what context did this discussion occur? Would you describe it as positive or negative discussion

When talking about safe sex, how would you describe the discussion on contraception and safe sex?

- Follow up, do you think there is a difference between talking about contraceptive options for men and women?

4. Pregnancy and STI

How would you describe your awareness of your own fertility?

- Follow up question on the participants understanding of the risk in the menstrual cycle and timing of sex in relation to pregnancy.

On the occasion you needed to use the ECP would you say you were at risk of pregnancy?

- Follow up on how the participant manages/tracks periods. If so how high was the risk of pregnancy?

On the occasion you needed to use the ECP would you say you were at risk of STI?

- Follow up on how they understood their risk was it due to the partner or their own behaviour? If so did they have a sti screening?

5. ECP as a method of contraception

During your consultation how was the ECP explained to you?

- Follow up questions was the ECP discussed as another method of contraception or something separate to other methods? Was the ECP seen as a good or bad choice of contraception?

How much do you feel you know about the product? Timing or risks? Can you give any examples?

- Follow up on where the participant received information about the ECP from school or friends? Did the Health professional explain the difference between ECP and abortion?

In your opinion how would you class the ECP? As a method of contraception or in a separate category?

- Follow up on how the does the participant feel about being able to choose the ECP as a method?

Appendix 3. Interview Schedule: Focus Groups

Focus group interview schedule

Participant information

Number of participants:

Age range:

Location:

1. Methods of contraception

As a group I would like for us to discuss the different methods of contraception available and what we know about them separately as methods.

- Follow up questions what is it that makes a method of contraception practical? Should methods of contraception suit lifestyle?

In regards to managing and tracking menstrual cycles and fertility are women aware of their own risks of pregnancy?

- Follow up question is risk of pregnancy still a factor affecting women? Or are their greater risks or no risks at all because of access to contraception?

2. Acceptable contraceptive decision making

As a group I would like for us to discuss the meaning of 'safe sex', what does this mean to each of you?

- Follow up questions pre planning contraception is that considered as being responsible? Are women expected to pre plan sex?

What would you describe as sensible contraceptive decision making?

- Follow up questions are the certain costs to using or not using certain methods of contraception? Is it ever seen as responsible to not use contraception?

3. Sexual behaviour, attitudes and morality

Sex is a part of day to day life, is it not? So do you think that there is still a 'taboo' around sexual behaviour?

- Follow up questions are there particular sexual behaviour that can be considered social problems? If so should they be addressed?

Are there stereotypes of sexual behaviour if so can anyone give any examples?

- Follow up questions are these negative stereotypes towards women's behaviour? How do methods of contraception align with these stereotypes?

Are there right or wrong ways to have sex? If so what are they?

- Follow up does using contraception constitute to right sex?

4. Realities of using Contraception

How accessible are methods of contraception these days?

- Follow up question can and do all women have the right amount of access or are there still barriers?

Is it ever acceptable to have a contraceptive accident?

- Follow up questions would you ever describe contraception use as an emergency?

5. The ECP

What do you know about the emergency contraceptive pill?

- Follow up questions, how often can it be used and when should it be used? Do the women know where it can be obtained from?

What are your opinions of the ECP?

- Follow up questions should women have advance access to the product? What do you think would happen if the ECP was available off the shelf?

How would you describe the behaviour that has led to the need of using the ECP?

- Follow up questions is using the ECP responsible? Is there stigma attached to using the ECP?

Would you agree or disagree that the ECP is a method of contraception?

- Follow up questions are there misconceptions about the ECP being an abortion? How is the ECP promoted to women?

  (give out leaflet on the ECP from Family Planning Association)

I would like all the group to take a minuet to read over the leaflet on the ECP.

Has reading this information changed anyone's opinions on the ECP? If so why?

Appendix 4. Information Sheet: Sexual Health Nurse

Title: Emergency Contraceptive Pills in the era of 'safe sex'

Brief:

The purpose of this research is to understand the role of the Emergency Contraceptive Pill (ECP) by exploring the experiences of women and health professionals. You have been asked to take part in this research project as you are a health professional that either distributes or sells the ECP to women. You will be asked a series of questions that address your experience as a health professional distributing the product and your experience of working with women who have obtained the product.

What is involved?

The purpose of the semi structured interview is to have an open discussion on your experience as a distributor of the ECP. The interview will be approximately 50-60 minutes long. The interview will be audio recorded.

If at any time during the interview you feel uncomfortable and would like to withdraw from the interview, please inform the researcher and the interview will be stopped with an immediate effect.

Due to the limited funding of the project the researcher is unable cover expenses. If you agree to participate in this research it must be made clear that your participation is completely voluntary, therefore, you will not receive any payment for your involvement in this research.

Benefits from taking part in the research?

All participants taking part in this research are unpaid members of the public. However, by volunteering in this research you will be contributing to the ongoing research development that aims to give a voice to women's real life experiences with contraception and allow for a better understanding of an under researched area in sexual and reproductive health.

Research on contraception is dominated by medical journals and conducted by medical researchers. This is a social scientific research project that will provide a real life documentation of women's opinions and experience of using contraception. By participating in this research you will be contributing to research that could impact wider society and policy in this area.

Risks of taking part?

I have assessed and addressed all potential risks this research might present. With ethical approval received by Cambridge East Research Ethics Committee, the research has been cleared as ethically sound.

Any risks of confidentiality have been addressed in the design of the research. All participants will remain anonymous throughout the research project. Particular sensitivity will be taken into account with the discussion of your own experience as a health professional and the women you work with. You will not be expected to enclose any personal information that you feel will make you or the women you work with identifiable.

In order to maintain anonymity all personal or place names will not be disclosed in the transcription stage of the research and pseudonyms will be used to ensure confidentiality. Data will be stored in a secure location on an encrypted computer and any personal information given will only be accessible to the researcher. These details will be kept on password protected document on the encrypted computer. All data collected will be kept on an encrypted laptop and portable hard drive.

In the event that a participant becomes distressed during interview, the researcher will stop the session and ask the participant to take a short five minuet break. The researcher will speak with the participant after the break and discuss whether they are willing to continue with the session. Should the participant choose to withdraw from the research, the researcher will end the session and all recordings collected that day will be destroyed.

If you should wish to withdraw your participation on completion of the interview, please inform the researcher at the below details and any data collected during your participation will be destroyed and it will not feature in any part of the write up of the research.

<u>Further information</u>

The research is contributing to a PhD thesis in Social Policy at the University of Kent. The researcher was awarded a scholarship to complete the research by the Economic and Social Research Council (ESRC). The project has been reviewed and approved by the school of Sociology Social Policy and Social Research at the University of Kent as well as the ESRC and the South Eastern Doctorial Training Centre.

The anonymous data collected from the research will be donated to the UK Data Archive on behalf of ESRC on completion and submission of the PhD and may be used as secondary data source for other researchers. The researcher will follow privacy protocols created in the development stage of the project to ensure anonymity after the submission of the data collection.

All participants must sign a consent form to confirm their participation in this research project. If after reading this information sheet you are happy to continue your participation with the research, please sign the attached consent form.

If you have any questions, would like any more information or have any concerns please contact the researcher:

Verity Pooke

Email: ecpresearch2016@gmail.com
Tel: 07342281538

For any complaints, or other concerns, please contact:

Dr Ellie Lee

Reader in Social Policy at the University of Kent and Director of the Centre for Parenting Culture at SSPSSR.

Email: E.J.Lee@kent.ac.uk

Appendix 5. Information Sheet: Women EC Users

Title: Emergency Contraceptive Pills in the era of 'safe sex'

Brief:

The purpose of this research is to understand the role of the Emergency Contraceptive Pill (ECP) by exploring the experiences of women and health professionals. You have been asked to take part in this research project as you are a women aged between 18-55yrs who has recently (within the last 6-12months) used the ECP. You will be asked a series of questions that address your experience of using the product.

What is involved?

The purpose of the semi structured interview is to have an open discussion on your experience of being a women of reproductive age and using methods of contraception like the ECP. The interview will be approximately 50-60 minutes long. The interview will be audio recorded by the researcher.

If at any time during the interview you feel uncomfortable and would like to withdraw from the interview, please inform the researcher and the interview will be stopped with an immediate effect.

Due to the limited funding of the project the researcher is unable cover expenses. If you agree to participate in this research it must be made clear that your participation is completely voluntary, therefore, you will not receive any payment for your involvement in this research.

Benefits from taking part in the research?

All participants taking part in this research are unpaid members of the public. However, by volunteering in this research you will be contributing to the ongoing research development that aims to give a voice to women's real life experiences with contraception and allow for a better understanding of an under researched area in sexual and reproductive health.

Research on contraception is dominated by medical journals and conducted by medical researchers. This is a social scientific research project that will provide a real life documentation of women's opinions and experience of using contraception. By participating in this research you will be contributing to research that could impact wider society and policy in this area.

Risks of taking part?

I have assessed and addressed all potential risks this research might present. With ethical approval received by Cambridge Easter Research Ethics Committee, the research has been cleared as ethically sound.

Any risks of confidentiality have been addressed in the design of the research. All participants will remain anonymous throughout the research project. Particular sensitivity will be taken into account with the discussion of your own experience. You will not be expected to enclose any personal information that you feel will make you identifiable or uncomfortable.

In order to maintain anonymity all personal or place names will not be disclosed in the transcription stage of the research and pseudonyms will be used to ensure confidentiality. Data will be stored in a secure location on an encrypted computer and any personal information given will only be accessible to the researcher. These details will be kept on password protected document on the encrypted computer. All data collected will be kept on an encrypted laptop and portable hard drive.

In the event that a participant becomes distressed during interview, the researcher will stop the session and ask the participant to take a short five minuet break. The researcher will speak with the participant after the break and discuss whether they are willing to continue with the session. Should the participant choose to withdraw from the research, the researcher will end the session and all recordings collected that day will be destroyed.

If you should wish to withdraw your participation on completion of the interview please inform the researcher at the below details and any data collected during your participation will be destroyed and it will not feature in any part of the write up of the research.

Further information

The research is contributing to a PhD thesis in Social Policy at the University of Kent. The researcher was awarded a scholarship to complete the research by the Economic and Social Research Council (ESRC). The project has been reviewed and approved by the school of Sociology Social Policy and Social Research at the University of Kent as well as the ESRC and the South Eastern Doctorial Training Centre.

The anonymous data collected from the research will be donated to the UK Data Archive on behalf of ESRC on completion and submission of the PhD and may be used as secondary data source for other researchers. The researcher will follow privacy protocols created in the development stage of the project to ensure anonymity after the submission of the data collection.

All participants must sign a consent form to confirm their participation in this research project. If after reading this information sheet you are happy to continue your participation with the research, please sign the attached consent form.

Should you have any general queries or complaints about the NHS service you have received pleased contact the Patient Advice and Liaison Service (PALS).

PALS, has been introduced to ensure that the NHS listens to patients, their relatives, careers and friends, and answers their questions and resolves their concerns as quickly as possible.

PALS also helps the NHS to improve services by listening to what matters to patients and their loved ones and making changes, when appropriate.

You can contact the Kent Community Health Foundation Trust PALS service:

Tel:0300 123 1807 Fax:01233 667958 Email:kcht.cct@nhs.net

If you have any questions, would like any more information or have any concerns please contact the researcher:

Verity Pooke

Email: ecpresearch2016@gmail.com
Tel: 07342281538

For any complaints, or other concerns, please contact:

Dr Ellie Lee

Reader in Social Policy at the University of Kent and Director of the Centre for Parenting Culture at SSPSSR.

Email: E.J.Lee@kent.ac.uk

Appendix 6. Information Sheet: Focus Groups

Title: Emergency Contraceptive Pills in the era of 'safe sex'

Brief:

The purpose of this research is to understand the role of the Emergency Contraceptive Pill (ECP) by exploring the experiences of women and health professionals. You have been asked to take part in this research project as you are a woman of reproductive age between the ages of 18-55 years. The focus group discussion will address women's opinions and experiences of using methods of contraception.

What is involved?

The purpose of the focus group is to have an open discussion on women's experiences and opinions on methods of contraception including the ECP. The focus group will be approximately 60-80 minutes long and there will be around 5-8 other woman present in the discussion. The session will be audio recorded by the researcher.

If you are uncomfortable discussing topics such as contraception in a group, please let the researcher know that you would not like to take part in the research. If at any time during the discussion you feel uncomfortable and would like to withdraw from the discussion, please inform the researcher and the focus group will be stopped with an immediate effect.

Due to the limited funding of the project the researcher will not be able to cover expenses. If you agree to participate in this research it must be made clear that your participation is completely voluntary, therefore, you will not receive any payment for your involvement in this research.

Benefits from taking part in the research?

All participants taking part in this research are unpaid members of the public. However, by volunteering in this research you will be contributing to the ongoing research development that aims to give a voice to women's real life experiences with contraception and allow for a better understanding of an under researched area in sexual and reproductive health.

Research on contraception is dominated by medical journals and conducted by medical researchers. This is a social scientific research project that will provide

a real life documentation of women's opinions and experience of using contraception. By participating in this research, you will be contributing to research that could impact wider society and policy in this area.

Risks of taking part?

I have assessed and addressed all potential risks this research might present. With ethical approval received by Cambridge East Research Ethics Committee, the research has been cleared as ethically sound.

Any risks of confidentiality have been addressed in the design of the research. All participants will remain anonymous throughout the research project. Particular sensitivity will be taken into account with the discussion of your experience. You will not be expected to enclose any personal information that you feel will make you identifiable or make you feel uncomfortable.

In order to maintain anonymity all personal or place names will not be disclosed in the transcription stage of the research and pseudonyms will be used to ensure confidentiality. Data will be stored in a secure location on an encrypted computer and any personal information given will only be accessible to the researcher. These details will be kept on password protected document on the encrypted computer. All data will be kept on the researchers encrypted laptop and portable hard drive.

Due to the nature of the focus group I ask that all participants ensure confidentiality is kept on leaving the group. By signing the consent form, you agree to not disclose any information discussed in the group outside of the research.

In the event that a participant becomes distressed during the focus group session, the researcher will stop the group discussion and ask the participants to take a short five minuet break. The researcher will speak with the participant that has shown signs of distress and discuss whether they are willing to continue with the session. Should any participant choose to withdraw from the research, the researcher will end the session and all recordings collected that day will be destroyed. The researcher will inform the group and will rearrange the focus group session for another date. Those participants that would like to attend the alternative date will be informed accordingly.

If you should wish to withdraw your participation on completion of the interview, please inform the researcher at the below details and any data collected during your participation will be destroyed and it will not feature in any part of the write up of the research.

Further information

The research is contributing to a PhD thesis in Social Policy at the University of Kent. The researcher was awarded a scholarship to complete the research by the Economic and Social Research Council (ESRC). The project has been reviewed

and approved by the school of Sociology Social Policy and Social Research at the University of Kent as well as the ESRC and the South Eastern Doctorial Training Centre.

The anonymous data collected from the research will be donated to the UK Data Archive on behalf of ESRC on completion and submission of the PhD and may be used as secondary data source for other researchers. The researcher will follow privacy protocols created in the development stage of the project to ensure anonymity after the submission of the data collection.

All participants must sign a consent form to confirm their participation in this research project. If after reading this information sheet you are happy to continue your participation with the research, please sign the attached consent form.

Should you have any general queries or complaints about the NHS service you have received pleased contact the Patient Advice and Liaison Service (PALS).

PALS, has been introduced to ensure that the NHS listens to patients, their relatives, careers and friends, and answers their questions and resolves their concerns as quickly as possible.

PALS also helps the NHS to improve services by listening to what matters to patients and their loved ones and making changes, when appropriate.

You can contact the Kent Community Health Foundation Trust PALS service:

PALS

Tel:0300 123 1807 Fax:01233 667958 Email:kcht.cct@nhs.net

If you have any questions, would like any more information or have any concerns please contact the researcher:

Verity Pooke

Email: ecpresearch2016@gmail.com
Tel: 07342281538

For any complaints, or other concerns, please contact:

Dr Ellie Lee

Reader in Social Policy at the University of Kent and Director of the Centre for Parenting Culture at SSPSSR.

Email: E.J.Lee@kent.ac.uk

Appendix 7. Consent Form: Sexual Health Nurse

IRAS ID: 199706 Version 1.2 02/09/2016

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM INTERVIEWS HEALTH PROFESSIONALS

Title of Project: Emergency Contraceptive Pills in the era of 'safe sex'.

Name of Researcher: Verity Pooke

Please initial box

1. I confirm that I have read the information sheet dated..... (Version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that taking part in the study the anonymous data collected will be given to the UK data archive. ☐
4. I understand the interview will be recorded. ☐
5. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix 8. Consent Form: Women EC Users

IRAS ID: 199706 Version 1.2 02/09/2016

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM INTERVIEWS WOMEN

Title of Project: Emergency Contraceptive Pills in the era of 'safe sex'.

Name of Researcher: Verity Pooke

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that taking part in the study the anonymous data collected will be given to the UK data archive. ☐
4. I understand the interview will be recorded. ☐
5. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix 9. Consent Form: Focus Groups

IRAS ID: 1999706 V 1.2 02/09/2016

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM FOCUS GROUPS

Title of Project: Emergency Contraceptive Pills in the era of 'safe sex'.

Name of Researcher: Verity Pooke

Please initial box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand taking part in this study will involve being in a group discussion with other Participants. ☐
4. I understand that taking part in the study the anonymous data collected will be given to the UK data archive. ☐
5. I understand the focus group discussion will be recorded. ☐
6. By signing this consent form, I agree to maintain the confidentiality of the group and to not disclose any information discussed in the group outside of the research.
7. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Appendix 10. Confidentiality Contract

CONFIDENTIALITY AGREEMENT

Transcription Services

Emergency Contraception in an Era of Safe Sex

I, _____, transcriptionist, agree to maintain full confidentiality in regards to any and all audiotapes and documentation received from Verity Pooke related to her doctoral study on Emergency Contraception in an Era of Safe Sex. Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio-taped interviews, or in any associated documents;

2. To not make copies of any audiotapes or computerized files of the transcribed interview texts, unless specifically requested to do so by Verity Pooke;

3. To store all study-related audiotapes and materials in a safe, secure location as long as they are in my possession;

4. To return all audiotapes and study-related documents to Verity Pooke in a complete and timely manner.

5. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed) _____

Transcriber's signature _____

Date _____

Appendix 11. Third Party Recruiter Scheme

Third Party Recruiter Brief

Version 1. 06/06/2016

This document outlines what is expected from the role of a third party recruiter

The researcher is recruiting women who have recently taken the Emergency Contraceptive Pill (ECP) (within the last 6-12 months) to participate in a social research project that will contribute to a PhD thesis. When inviting a woman to participate in research she must be the following:

1. Have recently used the ECP.
2. Aged between 18-55yrs old.
3. Considered to be in a stable state. *If the woman in question is distressed or shows signs of discomfort during the consultation it is advised that she is not approached as a potential participant in order to limit any risk of causes or increasing any distress she may be experiencing.*

How to invite the potential participant.

The invitation to participate in the research should occur at the end of the consultation. It is suggested that if you believe the women fits the above criteria that she should be asked to confirm her age, if she fits the age bracket for participants then she should be asked: *Would you be interested in taking part in a social research study on the Emergency Contraceptive Pill?* If the woman says no then do not take the conversation any further. If she says yes, then please hand her the following documents:

1. Information sheet
2. Consent to contact form

Please make sure the woman is aware that she should not feel that she should make a decision about this on the day of the consultation and should she wish to have time to think over the invitation that she should be advised to take home the documents and contact the researcher when she has decided using the contact details on the consent to contact form.

If after reading the information the woman in question agrees to sign the consent to contact form, please take the her signed and dated consent to contact form and hold on to this for the researcher to collect. The researcher will provide you with envelopes to seal the consent to contact forms and a box to keep all signed forms in. This should be kept in a safe and secure place that is not accessible to anyone else but the third party recruiter. The researcher will inform the third party recruiter when she will come to collect the forms, this may occur on a weekly basis.

If after reading the information the woman in question would not like to be contacted but would like to think about it further, please leave her with the information sheet and advertising poster.

If after reading the information the woman in question would not like to be contacted and makes it clear she would not want to participate in the research, please thank her for taking the time to read the information.

The researcher would appreciate if the third party recruiter could keep a record of how many women have been approached and their responses to the invitation. The researcher is asking that the following information to record:

1. Overall how many women have been approached?
2. How many women have signed the consent to contact form?
3. How many women have chosen to take the documents home and think about the invitation?
4. How many women have refused to take part in the study?

This data can be recorded on the separate document titled **Number of women invited to take part**, and it is asked that the recruiter use a tally system to record this information.

If you agree to act as a third party recruiter, please sign the **Third Party Recruiter consent form** to confirm you understand what is expected from you as a third party recruiter. If after reading the brief you would not like to take part please email the researcher as the below contact details, and thank you for your time.

If you have any questions about your role as a third party recruiter, please contact the researcher at the below details.

Thank you for your time it is greatly appreciated.

Kind regards,

Verity Pooke (BA, MA)

ESRC PhD Candidate in Social Policy
School of Social Policy, Sociology and Social Research
University of Kent

Tel: 07342281538

For any complaints, or other concerns, please contact:

Dr Ellie Lee

Reader in Social Policy at the University of Kent and Director of the Centre for Parenting Culture at SSPSSR.

Email: E.J.Lee@kent.ac.uk

Appendix 12. Service User Consent to contact

Consent to contact

Version 1. 06/06/2016

Study title: "Emergency Contraceptive Pills (ECPs), in the era of 'Safe Sex'"

Dear Service User,

My name is Verity Pooke and I am a PhD student at the University of Kent. As you can see from the title, I am interested in speaking to women who have recently used the Emergency Contraceptive Pill and to hear more about their experience of using methods of contraception.

As a women aged between 18-55years who has recently (within the last 6-12 months) used the ECP, you have been identified by the Health Professional as a suitable participant for the above research study.

Please read through the information sheet and see if you would like to take part. Your help with this study will contribute to giving a voice to women's real life experiences with methods of contraception and create a better understanding of women's point of view in this under researched area. If you are happy for me to give you a call or to email you to discuss the study, please complete the section below and return this letter in the envelope provided, alternatively hand it back to the health professional.

Thank you for taking the time to read this.

Kind regards,
Verity Pooke Tel: 07342281538 Email: ecpresearch2016@gmail.com

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Study title: "Emergency Contraceptive Pills (ECPs), in the era of 'Safe Sex'"

I _____(insert name) give permission for Verity Pooke, PhD student at The University of Kent, to contact me by telephone or email to discuss the above study.

I understand that this does not tie me in to taking part in the study and by signing this form I am not consenting to the study.

Signature_____

Telephone number_____

Email _____

Appendix 13. Information Sheet: Telephone Interview

Title: Emergency Contraceptive Pills in the era of 'safe sex'

Brief:

The purpose of this research is to understand the role of the Emergency Contraceptive Pill (ECP) by exploring the experiences of women and health professionals. You have been asked to take part in this research project as you are a women aged between 18-55yrs who has used the ECP in the last 5 years. You will be asked a series of questions that address your experience of using the product.

What is involved?

The purpose of the semi structured interview is to have an open discussion on your experience of being a women of reproductive age and using methods of contraception like the ECP. The telephone interview will be approximately 50-60 minutes long. The interviewer will call you at a time that is appropriate for you on a telephone number that you have provided.

In preparation for the telephone interview participants are asked to limit any possible distractions during the telephone call. It is recommended that you find a quite space with no back-ground noise, suggestions such as the participant home and not in a public place, to limit distractions are ideal. In a room in the home where there is no TV or family members present to ensure the participant is comfortable. It is stressed that the participant should not be in a public place when taking part in the interview to make sure the participant is happy to have an open discussion.

If at any time during the interview you feel uncomfortable and would like to withdraw from the interview, please inform the researcher and the interview will be stopped with an immediate effect.

Due to the limited funding of the project the researcher is unable cover expenses. If you agree to participate in this research it must be made clear that your participation is completely voluntary, therefore, you will not receive any payment for your involvement in this research.

Benefits from taking part in the research?

All participants taking part in this research are unpaid members of the public. However, by volunteering in this research you will be contributing to the ongoing research development that aims to give a voice to women's real life experiences with contraception and allow for a better understanding of an under researched area in sexual and reproductive health.

Research on contraception is dominated by medical journals and conducted by medical researchers. This is a social scientific research project that will provide a real life documentation of women's opinions and experience of using contraception. By participating in this research you will be contributing to research that could impact wider society and policy in this area.

Risks of taking part?

I have assessed and addressed all potential risks this research might present. With ethical approval received by Cambridge Easter Research Ethics Committee, the research has been cleared as ethically sound.

Any risks of confidentiality have been addressed in the design of the research. All participants will remain anonymous throughout the research project. Particular sensitivity will be taken into account with the discussion of your own experience. You will not be expected to enclose any personal information that you feel will make you identifiable or uncomfortable.

In order to maintain anonymity all personal or place names will not be disclosed in the transcription stage of the research and pseudonyms will be used to ensure confidentiality. Data will be stored in a secure location on an encrypted computer and any personal information given will only be accessible to the researcher. These details will be kept on password protected document on the encrypted computer. All data collected will be kept on an encrypted laptop and portable hard drive.

In the event that a participant becomes distressed during interview, the researcher will stop the session and ask the participant to take a short five minuet break. If a break is needed the researcher will offer to hang up and call back after a discussed period of time. The researcher will call the participant back after the break and discuss whether they are willing to continue with the session. Should the participant choose to withdraw from the research, the researcher will end the session and all recordings collected that day will be destroyed.

the case something may come up which means the participant is unable to complete the interview, the interviewer will stop the recording and offer to rearrange the interview to another time that is suitable for the participant. This will be rearranged either on the phone or by email for as soon as possible. Please let the researcher know during the phone call if you feel that you are unable to continue with the telephone conversation.

If you should wish to withdraw your participation on completion of the interview please inform the researcher at the below details and any data collected during your participation will be destroyed and it will not feature in any part of the write up of the research.

Further information

The research is contributing to a PhD thesis in Social Policy at the University of Kent. The researcher was awarded a scholarship to complete the research by the Economic and Social Research Council (ESRC). The project has been reviewed and approved by the school of Sociology Social Policy and Social Research at the University of Kent as well as the ESRC and the South Eastern Doctorial Training Centre.

The anonymous data collected from the research will be donated to the UK Data Archive on behalf of ESRC on completion and submission of the PhD and may be used as secondary data source for other researchers. The researcher will follow privacy protocols created in the development stage of the project to ensure anonymity after the submission of the data collection.

The audio recordings will be kept for no longer than 12months after the date of recording. The recordings will be used for solely transcription purposes and soon after destroyed. If recordings were made on 01/01/2017 – the recording will be destroyed by 01/01/2018.

All participants must sign a consent form to confirm their participation in this research project. If after reading this information sheet you are happy to continue your participation with the research, please sign the attached consent form.

Should you have any general queries or complaints about the NHS service you have received pleased contact the Patient Advice and Liaison Service (PALS).

PALS, has been introduced to ensure that the NHS listens to patients, their relatives, careers and friends, and answers their questions and resolves their concerns as quickly as possible.

PALS also helps the NHS to improve services by listening to what matters to patients and their loved ones and making changes, when appropriate.

You can contact the Kent Community Health Foundation Trust PALS service:

Tel:0300 123 1807 Fax:01233 667958 Email:kcht.cct@nhs.net

If you have any questions, would like any more information or have any concerns please contact the researcher:

Verity Pooke
Email: v.m.pooke-6@kent.ac.uk Tel: 07342281538 Skype: VerityPooke2017

For any complaints, or other concerns, please contact:
Dr Ellie Lee
Reader in Social Policy at the University of Kent and Director of the Centre for Parenting Culture at SSPSSR.
Email: E.J.Lee@kent.ac.uk

Appendix 14. Consent Form: Telephone Interview

Centre Number:

Study Number:

Participant Identification Number for this trial:

CONSENT FORM TELEPHONE INTERVIEWS WOMEN

Title of Project: Emergency Contraceptive Pills in the era of 'safe sex'.

Name of Researcher: Verity Pooke

Please MARK box

1. I confirm that I have read the information sheet dated..... (version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected. ☐
3. I understand that taking part in the study the anonymous data collected will be given to the UK data archive. ☐
4. I understand the interview will be recorded. ☐
5. I confirm I am over the age of 18 years old and my date of birth is (DD/MM/YYYY) .....
6. I agree to take part in the above study ☐

Name of Participant	Date	Signature
Name of Researcher	Date	Signature

this approach