“I pulled it out”: A discursive exploration of narrated accounts on decision-making and power differentials in the prescription and use of long-acting reversible contraceptives

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Abstract

Long-Acting Reversible Contraception (LARC), *viz.,* intrauterine devices, subdermal implants, and injectable contraceptives, are highly effective, long-term birth control methods that limit user action. Alongside the decrease in fertility rates achieved through their mass provision has been their coerced or non-consented administration to marginalised women. These highly effective yet provider-controlled and thus imposable contraceptives have been associated with problematic classed, raced, ageist, and ableist promotions. A critical lens that inquires into their endorsement within clinical practice is thus necessary. The bulk of literature evidencing reproductive injustices in relation to fertility control through LARC technologies emanates from the US and UK contexts. Not much research on the South African context has explored how contraceptive decision-making within clinical interactions shapes LARC uptake despite usage increasing through the years.

Using a poststructural, postcolonial feminist framework alongside a reproductive justice stance, this study explores health providers' and contraceptive users' narrations of the prescription and usage of LARC technologies alongside how such talk emplots women who use, continue, or discontinue using these contraceptive technologies. In addition, the power relations (re)produced in the participants' talk that maintain or constrain coloniality and reproductive justice with implications for certain people's reproductive choices/rights were explored.

To do so, I used data from 72 semi-structured interviews with contraceptive users (51) and healthcare providers (21). A combination of stratified purposive, convenient, and snowball sampling was used to sample the providers and users of LARC recruited within a city, town, and village. To elicit stories about healthcare providers' and LARC users' narrative emplotments in the prescription and usage decisions about LARC, semi-structured interviewing was used. The questions asked were open-ended and loosely structured around LARC technologies, the decisions that cohere around them, and the makers of those decisions. In analysing the data, I fused Parker's (1992) criteria for locating discourses with Barker's (2017) method for determining the potential for emplotment into narratives.

Findings suggest that participants framed contraceptive usage as either a personal, imposed, or shared decision. In personal decisions, the feminisation of contraceptive use emerged, with study, work, and relationship stability statuses requiring participants to solely and prudently

self-discipline towards contraceptive uptake so as to match usage with reproduction desire. When decisions were imposed (subtly or openly), a passive role was assumed as female guardians (mothers, grandmothers, or aunts) recommended, pushed, and coerced health users (particularly young women) towards uptake. While the contraceptive users themselves were placed on the margins in decision-making, resisting the imposed decisions was difficult since participants' "risk" of pregnancy was reportedly foregrounded. Shared decisions pointed to less one-sided accounts of decision-making. These decisions were enacted in relationships and were neither siloed nor imposed. Here, sexual partners, parents, or healthcare providers dialogically negotiated contraceptive uptake, and the possibilities for non-use were availed.

Data from healthcare providers showed that non-use for young and postpartum women was not an option. In addition, healthcare providers either formed alliances with the LARC users themselves or concerned parents to support or push for contraceptive provision. Supportive alliances enabled secret uptake or ongoing contraceptive usage among some contraceptive users, thus resisting pronatalism or one-sided intentions for childbearing within intimate partnerships. These healthcare providers emplotted themselves as empowering contraceptive users. Alliances that pushed for contraceptive uptake were formed with guardians/parents upon menarche or in case the of rape. In overriding consent within these alliances, healthcare providers avoided being rendered responsible or blameworthy for early pregnancies in the face of the constructed risk used to emplot young women. This over-commitment to providing contraceptives has differing implications for women's sexual agency and sexual health interventions.

The data also describe decisions to use contraception as expert-led, patient-led, or collaborative decisions between health users and healthcare providers. Through the information and decision-making was expert-led micro-narrative, a medical discourse constituting use as a necessity and non-use as a risk emerged. A patient autonomy and a my body, my choice discourse informed the information and decision-making was patient-led micro-narrative; here, healthcare providers were either detached or excluded from decision-making as health users assumed more active roles in their own contraceptive care decisions. In collaborative decisions, both parties negotiated (non)use, with LARC users providing their embodied experiences and healthcare providers availing medical knowledge in reaching decisions.

The study argues for a reproductive justice framework to underpin the signifier "fertility control", showing how the threat of degeneration informs responses to reproduction by

identifying and amplifying deficiency and negative outcomes while masking positive outcomes among certain women. It then creates a fertile ground for the re-engineering and recentring of colonialist thinking and its product, the restraining of the agency of fertile beings it renders "less developed".

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List of acronyms

CSSR	Critical Studies in Sexualities and Reproduction
CTOP Act	Choice on Termination of Pregnancy Act (No. 92 of 1996)
DMPA	Depot medroxyprogesterone acetate
FDA	Foucauldian Discourse Analysis
GDP	Gross Domestic Product
HICs	High Income Countries
HIV/AIDS	Human Immunodeficiency Virus or Acquired Immunodeficiency Syndrome
IUDs	Intrauterine Devices
LARC	Long-Acting Reversible Contraception
LMICs	Low- and Middle-Income Countries
LNG-IUS	Levonorgestrel Intrauterine System
MDG	Millennium Development Goals
NET-EN	Norethisterone enantate
PHC	Public Health Facility
PVH	Private Health Facility
PP	Private Practice
SADHS	South African Demographic and Health Survey
SDG	Sustainable Development Goals
SRHR	Sexual and Reproductive Health & Rights
UK	United Kingdom
US	United States
TOP	Termination of Pregnancy

Chapter 1: Contextualising LARC in South Africa

1. Introduction

Unintended pregnancy is a sexual and reproductive issue that affects low-and middle (LMICs) as well as high-income countries (HICs) (Crowley et al., 2019). While an unintended pregnancy can be experienced as a positive outcome for some, it can also be a stressor for many (Crowley et al., 2019). As a stressor, unintended pregnancy is associated with adverse health-related outcomes such as intimate-partner violence, unsafely induced termination of pregnancies (TOPs) (Bitzer et al., 2016; Downey et al., 2017; Miller et al., 2010) as well as higher instances of bleeding, maternal mortality and morbidity (Higgins, 2014; Khan & Islam, 2022). Despite still being common, unintended pregnancy is avoidable; the availability and consistent use of contraception has played a fundamental role in reducing the global rate (Raidoo & Kaneshiro, 2017; Sambah et al., 2022). According to Bearak et al. (2018), there was a decline in the global rate of unintended pregnancies from 74 per 1000 women aged 15-44 years in 1990-1994 to around 62 per 1000 women in 2010-2014. This decrease is the result of improvements in modern contraceptive usage. More recently, the *World Fertility and Family Planning 2020 Highlights* by the (Nations Department of Economic and Social Affairs (2020) United Nations (2020) state that globally, 49% or 922 million women between the ages of 15-49 years used contraception in 2019. Notwithstanding the use of modern contraception and a resultant decline in fertility, unintended pregnancy continues to be problematised globally.

Annually a prevalence of 121 million unintended pregnancies globally occur among women aged 15-49 years (Ticona et al., 2023). Yet, these pregnancies are unevenly distributed around the world, same as how contraceptive uptake varies by global region. For example, contraceptive needs in HICs are met much more often than in LMICs (Bearak et al., 2018; Khan & Islam, 2022; Ticona et al., 2023) with 79% of contraceptive needs met[1] in Northern

[1] Unmet contraceptive need refers to reproductive-age women who, despite their desire to avoid or limit pregnancy, do not use contraception (Coulson et al., 2023). However, its parameters have been problematised within the literature as sometimes placing women within classifications they do not fit, e.g., women who intentionally avoid contraceptive use have also been identified as needing contraception (Khalil & Richardson, 2019). Senderowicz et al. (2023) have thus dubbed the term as misleading given connotations about "unfilled desire to use contraception or a lack of access to a wanted

Europe, the highest rate observed. In contrast, they are met the least in West Africa, as only 14.5% of the region's contraceptive needs are met (Cleland, 2020). A higher prevalence of unintended pregnancy correlates with these low instances of meeting contraceptive needs (Coulson et al., 2023; Wondie, 2021).

Many couples experience pregnancy without the desire to be so, or their intentions might change with their circumstances. Given these nuances in pregnancy and intentions, signifier delineations have been made to avoid misrepresenting and stigmatising pregnancies (Kost & Zolna, 2019). The literature defines pregnancy as wanted, planned, unplanned, unwanted, mistimed or unintended (Kebede et al., 2021; Macleod, 2016a; Mosher, 2000). Researchers such as Kost and Zolna (2019) and Macleod (2016a) problematise how loosely these terms have been used, resulting in stigmatising implications and decontextualised understandings of contraceptive usage. In differentiating between them, unwanted pregnancies are defined as pregnancy in subjects with a desire to stop or avoid childbearing (no future plans for childbearing), mistimed pregnancy denotes conceiving while seeking to defer pregnancy to a later stage (reserved for later) while unplanned pregnancy conjures a conscious aim to avoid pregnancy and yet becoming pregnant; contraceptive failure is included within this signifier (Macleod, 2016a). Unintended pregnancy "tries to capture the extent to which individuals within a population experienced a pregnancy they had not wanted to have at that time or ever" (Kost & Zolna, 2019, p. 6). Although mistimed and unintended pregnancies emphasise the absence of pregnancy intentionality at conception, this does not necessarily make them unwanted pregnancies (Macleod, 2016a). In comparison to mistimed and unintended pregnancies, unwanted pregnancies have been associated with adverse outcomes or are the most likely to end in abortion (Santelli et al., 2003).

In South Africa, according to the South African Demographics and Health Survey (SADHS) (National Department of Health, 2016) conducted in 2016, 7% of women engage in sexual intercourse before the age of 15, 58% by 18 years. By 20 years, 81% are reported to be sexually active. The earliest sexual debut among young women is found within the Eastern Cape, with the median age being 17.4 years. While more young men than young women have an earlier reported age of sexual debut, some young women report their first experience as coerced and

method" (p. 232) that efface the complexities related to defining and determining unmet contraceptive need in less all-encompassing ways.

having occurred without any contraceptive used. In contrast, young women with a later sexual debut often report on a consensual sexual debut and an ability to negotiate contraceptive use (Chirinda et al., 2012; McClinton Appollis et al., 2022).

Unmet contraceptive needs are generally disproportionately prevalent amongst socio-economically deprived (Bearak et al., 2020), teenagers between 15-17 years old (Guttmacher Institute, 2016), and rural women (Jacobstein et al., 2013). In correspondence with this, a higher prevalence of unmet contraceptive needs can be found in the Eastern Cape and Limpopo provinces (the poorest provinces in the country), particularly among adolescent women, while the Western Cape and Gauteng Provinces (the most resourced provinces in South Africa) have the lowest prevalence of unmet contraceptive needs (SADHS, 2016). These trends also reflect an urban versus rural divide with lower access barriers in urban than rural areas. In addition, differences in marital status have been shown: 15% of in-union women are estimated to have an unmet contraceptive need, while 55% use a modern contraceptive measure. In contrast, 24% of sexually active single women have an unmet contraceptive need, whereas 64% use contraceptives (SADHS, 2016). Contraceptive use and non-use thus impact these women differently, with greater use and unmet contraceptive needs among women who are not in unions than in-union women. These statistics conceivably reflect married women's easier access to contraception and the barrier unmarried women face when accessing contraception.

Overall, unmet contraceptive needs have been permeated by disparities determined *inter alia* by region (LMICs vs HICs), gender (male or female), province (Eastern Cape vs Western Cape) and marital status (in-union vs sexually active single women), which have prompted public health imperatives to strengthen provision (Chersich et al., 2017). Ascertaining these contraceptive needs and supplying modern contraceptive technologies to meet this demand, although sometimes through aggressive means (Brown, 2007; Klausen & Bashford, 2010; Morison et al., 2022), has been idealised as essential in curbing sexual and reproductive risks.

Current contraceptive methods include the male and female condom, oral contraceptives, intrauterine devices (IUDs), vaginal rings, subdermal implants, injectable contraceptives, female sterilisation, vasectomy, spermicides, withdrawal, diaphragm, natural family planning, dual methods, and multiple contraceptive uses (Higgins & Smith, 2016). These birth control methods are classified into three broad categories: traditional or modern, and within modern technologies as either short-term or long-acting.

Recently, as a means to improve contraceptive efficacy, many researchers have expressed a growing interest in long-acting reversible contraceptives (LARC) (Blumenthal et al., 2011; Buckingham et al., 2021; Fleming, 2009; Mazza et al., 2017; Ontiri et al., 2019; Winner et al., 2012). LARC refers to birth control technologies that curtail pregnancy without requiring frequent user action. Adolescents, postpartum, post-abortion, and repeat abortion women have been targets of such promotional efforts (Batool & Mazhar, 2017; Cameron, 2014; Glasier et al., 2006; Negash et al., 2022; Sambah et al., 2022). In response, other scholars have advised caution around the over-privileging of effectiveness in promoting LARC owing to contraception's complex history and imposable nature (Downey et al., 2017; Gomez et al., 2014; Grzanka & Schuch, 2020; Higgins, 2014; Morison & Eagar, 2021). For example, "coercion in using these methods has been a serious violation of underprivileged women" (Takeshita, 2012, p. 2). In addition, "when epidemiological data and method effectiveness are the primary evidence, many women's needs are neglected, resulting in a 'one-size-fits-all technological solution' to an issue that is highly personal, contextual, and evolves over time" (Downey et al., 2017, p. 570). Hence, critical scholars have advocated for agency to be foregrounded as a core component for contraceptive uptake and provision that is just (Gomez et al., 2014; Moniz et al., 2017; Morison & Eagar, 2021). As such, this study concerns itself with contraceptive users' and healthcare providers' constructions of decision-making in choosing to use or not use LARC technologies.

Later in this chapter, I outline the arguments made in recent years for the transposition of traditional and short-term contraceptives by LARC technologies, mainly that "they eliminate 'user error' and increase continuation rates" (Bertotti et al., 2021, p. 1). I also discuss the emergence and decline of first-generation LARC. They include injectable contraceptives, subdermal implants, and intrauterine contraceptives (IUD) (Glasier et al., 2006; Higgins, 2014; National Contraception Clinical Guidelines, 2019).

The conversation then centres on the regional and local politics that fuelled the rise and decline of certain contraceptives, broadly, in sub-Saharan Africa and, more specifically, in South Africa. I draw on this history to show the current context of contraceptive provision in South Africa, noting the valuing of contraceptive users' rights as the product of conferences, policies, legislature, and research on a global and local level that have unmasked how structure hinders and facilitates access. I also consider how, despite the multifaceted concerted efforts to centre

the rights of the contraceptive user, research still evidences the realisation of reproductive justice as a privilege of a few.

2. This study

In this study, I explore talk on decision-making around the prescription and use of long-acting reversible contraceptives (LARC), in particular, the experiences of women[2] who use, have used or considered using LARC. I illuminate the various ways contraceptive users constructed themselves as contraceptive (non)seeking or (non)using subjects and how healthcare providers constructed them. Moreover, I investigate the power relations produced in the participants' talk that reinforce or undermine certain people's reproductive choices/rights, that is, the power differentials within decision-making and, importantly, their implications for reproductive justice. The research questions guiding the process are as follows:

a. What micro-narratives and discourses do healthcare providers and women who use, have used or considered using LARC draw on in constructing decision-making when being prescribed, advised or seeking to use LARC?
b. What emplotments into narratives are availed and restricted by these discourses?
c. What power relations are inherent in the micro-narratives and discourses, and how do these influence agency in decision-making?
d. How do the micro-narratives and discourses drawn upon maintain or constrain coloniality and reproductive justice?

This research study forms part of a broader project aiming to produce a transnational inquiry between Aotearoa/New Zealand and South Africa into the decisions around LARC usage and the power dynamics in the prescription process using a reproductive justice lens.

3. Frameworks and approaches

The study is framed by a reproductive justice lens, which denotes a set of interlinked human rights, *viz.,* the right to: (i) have a child, (ii) not have a child, (iii) and raise one's child in a safe, healthy and supportive environment (Ross, 2017; Ross & Solinger, 2017) as well as the right to bodily autonomy, added in later works (Price & Brettschneider, 2017; Seminario, 2021). It seeks to identify, critique and redress the raced, classed and gendered marginalisation experienced by women in purely rights-based approaches to sexual and reproductive health.

[2] The study focuses on the experiences of cisgender women while recognising that the signifier woman can be all-encompassing of all who identify as female.

Rights-based approaches have sometimes been fruitless in doing the transformative and reparative work needed to address how "working-class, black, disabled, and lesbian women have historically had their reproductive decisions restricted and unsupported" (Saunders, 2018, p. 14). To intervene against these marginalisations, reproductive justice embeds a social justice imperative within its framework, thereby using "human rights and social justice … to counter all forms of population control that deny women agency" (Ross, 2006, p. 1). The approach thus appeals to both advocacy and scholarship, highlighting the historical and existing reproductive injustices that have and continue to suspend "rights" and "choices" for particular women, reserving them as a privilege for a few (Price, 2010).

A poststructural lens, based on Foucauldian insights, was also used in the study. Foucault (1977) interlocks power and knowledge – the power/knowledge nexus – thus pointing to the insidious and, at times, overt mechanisms of power that operate through institutions of knowledge, which create particular subjects, e.g., contraceptive seekers/users and medical experts. Informed by discourse, ways of being and acting are simultaneously enabled and constrained for these subjects and thus underpin the interaction. Further visibilised by the lens is the building of truths and how those "truths" injunct subjects to act in particular ways, e.g., as "responsible or disciplined contraceptive users". The workings of biopower thus emerge, which denotes the government's desire to regulate and manage its population through the body where "[m]odern man (sic) is an animal whose politics places his existence as a living being in question" (Foucault, 1978, p. 143).

I used Barker's (2017) notion of the emplotment of narratives into discourse that demonstrates how subjects attempt to (re)create themselves to audiences through narratives. Because the social determines talk, however, the endpoints of participants' narratives cannot be wholly defined by the speaker. The audience affects the telling of the narrative. As such, the approach has important implications for the death of the subject implicit in some renditions of Foucauldian discourse, as it allows for the reconfiguration of the subject and for conflicting discourses to accumulate around particular signifiers (e.g., fertility control).

Lastly, I drew on decoloniality, particularly Ndlovu-Gathseni (2013a, 2013b) ideas around coloniality as a mechanism of modernity that reduces subjects into homogenous categories, thereby producing particular subjectivities in the present seen as surviving colonialism in former colonies. Modern contraceptive technologies can thus potentially present opportunities for medical experts to exert pressures on health users who are dehumanised to non-being status

through the power relations of (neo)coloniality and thus deemed not worthy of reproduction. Violent impositions of contraception, particularly LARC, can posture as modernised attempts at fertility control for providers while evidencing serious denials of bodily integrity and rights for health users (Ross & Solinger, 2017). Poststructuralism as an overarching lens assisted in presenting breaks within this homogeneity by introducing multiplicities in LARC users' and healthcare providers' emplotments in narratives and discourses. The framework aids in pointing out historically defined practices and ways of being that perpetuate or defy inequality and dominion. A discussion on contraception, namely, traditional, short-term and long term, follows.

4. Traditional contraception

Over the years, contraception has assumed various forms, some by present-day standards deemed unthinkable (McLaren, 2022). The advent of modern contraceptives dates back to the 1880s in Europe; before that, abstinence and coitus interruptus/withdrawal were the traditional methods used for birth control (Cleland, 2009). Tamale (2016) endorses this view and expands on the types of traditional birth control methods used in some African contexts in the quote below:

> Prior to the invention of modern contraceptive devices Africans used less effective methods of fertility control, some even posing health risks. For example, they relied on breastfeeding (which suppresses fertility), coitus interruptus (the withdrawal method), anal sex, and used plants with contraceptive and abortifacient properties (p. 188).

High failure rates have been associated with traditional contraceptive methods such as abstinence and coitus interruptus, while concoctions used as abortifacients have sometimes resulted in injuries and even deaths (Bradford, 1991; Haddad & Nour, 2009; Kangaude et al., 2022). In South Africa, amaXhosa teenagers were taught how to avoid premarital pregnancy through the practice of *ukumetsha,* which refers to limited intercourse or non-penetrative thigh sex. The assumption was that humans are sexual beings and sexual gratification should be respected for all ages, including adolescence (Delius & Glaser, 2002). The onus, however, in terms of avoiding pregnancy in the absence of modern contraceptives, was placed on young women.

Access to information on youth sexuality and traditional birth control practices was later constrained with the introduction of Christianity and modernity, which erased previous

contexts of sexual socialisation (Delius & Glaser, 2002). As such, current trends of sexual and reproductive health problems among young people are thus not due to increasing adolescent sexuality but rather the erosion of "traditional" systems of sexual socialisation, thus amplifying silence and a lack of induction to forms of performing sexuality in these communities (Msutwana & de Lange, 2017). This silence, which does not accommodate *ukumetsha* and other traditional contraceptive practices meant to avoid unintended pregnancies, makes the youth susceptible to unwanted pregnancies and STDs.

5. The rise of "family planning"

The rise and fall of the birth rate through conscious means is deeply enmeshed in shifts in ideologies in different locales that have understood contraceptive usage as unthinkable, thinkable, unacceptable, or acceptable (Takeshita, 2004). Therefore, contraceptive (non)-use should be recognised as a subjective and contextual issue rather than a universal good or bad.

The first writings about contraception are believed to emanate from Graeco-Roman and Arabic texts (Cleland, 2009). Elaborate expositions around limiting family size stemmed from an influential essay written by Reverend Thomas Malthus in 1809 in the UK titled, *An essay on the principle of population as it affects the future improvement of society*. This essay was deemed important because "the subject of population not only broached a recurrent and important point of economic policy but also prevailing religious beliefs, mores and the intimate life of families, it was received with passion" (Faccarello et al., 2020, p. 7). Given the sensitivity of the subject and Malthus' religious affiliations, this essay was published anonymously but was still received with great controversy (Dunn, 1998). Nonetheless, the food supply shortages experienced in the United Kingdom (UK) at the time, it is argued, were a strong motivation for his work (Dunn, 1998).

Interpretations of Malthus' work differ. Moral restraint to deal with overpopulation has been considered central to his argument (Cleland, 2020), therefore suggesting a need for abstinence and late marriage until financial resources, framed as needed to provide for children sufficiently, were sourced. Other writers have stated that wide contraceptive use was the root of his argument. However, opposers dispute this, arguing instead that Malthus was against birth control given his religious affiliations (Dunn, 1998). It was immediately apparent that Malthus's ideas were masculinist as they impelled men towards "rational" or "conscious" thought around reproduction by encouraging abstinence to avoid descending into poverty. In addition, they were centred on heterosexuality and reified the importance of sexual relations, albeit delayed, within the confines of marriage (Dunn, 1998).

Neo-Malthusians inherited Malthus' ideas, further propounding contraception rather than moral restraint as an effective intervention around population growth (Klausen, 2010). For neo-Malthusians, "overpopulation is said to be the major reason for the poverty of the 'underdeveloped' countries; overpopulation is the 'malaise' and family planning the remedy" (Mamdani, 1972, p. 13) for curbing population pressures. So-called "family planning" was transforming pregnancy prevention from "responsibility and restraint" (Bracke, 2022, p.94) seen within conscious procreation inherent within Malthusian ideas to "sex as pleasure… [thereby disrupting] sex as procreation" (Bracke, 2022, p. 92). In addition, the introduction of reliable birth control was, especially in Catholic communities such as Italy (Bracke, 2022), seen as a "sexual license" (Cleminson & Souto, 2012, p. 74) that would erode fidelity and restraint when they were previously normalised. However, even though both schools of thought (Malthusian and neo-Malthusian) were different in their means to effect depopulation, they both grounded reproductive decisions in socio-economic status.

These overt linkages between birth control and poverty were pioneered by neo-Malthusians, such as Margaret Sanger (founder of Planned Parenthood in the US), following the expansion of contraception in Europe (Mundt, 2017). Although contested at first due to religious counterarguments that construed birth control as a form of abortion, with continuous advocacy and won litigations, contraception began being widely used to space and limit births in the US (Jacobstein & Stanley, 2013). Critics have pointed out that Sanger's constructions of certain women, e.g., Black women, suggest population control and eugenic thought rather than advocacy for equitable access (Hartmann, 2016).

In recent decades, most countries have bought into the idea of contraception or family planning to address fecundity (Hartmann, 2016). "Family planning refers to a conscious effort by a couple to limit or space the number of children they have through the use of contraceptive methods" (SADHS, 2016, p. 13). However, due to its inherent connotations about the nuclear family and marriage, a growing body of literature has pilloried the previous confinement of contraceptives to marriages, exacerbated by the use of signifiers such as "family planning" argued to be potentially exclusionary to adolescents and unmarried women (Rodriguez et al., 2014). For example, "a girl aged 16 years is not necessarily concerned about planning a family, but she [sometimes] does not want to get pregnant" (Rodriguez et al., 2014, p. e131). Framings

like birth control, planning parenthood and contraception have been deemed more appropriate as they conjure an equitable system for all women.

6. Short-term contraceptives & user error

Short-term modern methods include the male and female condom, spermicides, oral contraceptives, and the vaginal ring. Since these technologies are easily attainable, low cost, and often do not require health providers' involvement, wide-use trends can be found in selected methods such as condoms and oral contraceptives (Tibaijuka et al., 2017). These methods are highly effective with consistent use (Menon, 2020; Wu et al., 2018). This requirement for consistent use makes perfect and typical use relevant, as the measure's full efficacy is matched up against perfect use. Perfect and typical use are indicators that represent trends in birth control use. Compliance and consistency are characteristic of perfect use, whereas typical use introduces user error in real-life situations. Life situations diminish users' ability to consistently comply with their chosen contraceptive regimen, at times resulting in contraceptive failure (Downey et al., 2017; Hubacher et al., 2008; MacPhail et al., 2007; Mbizvo et al., 2014). It is the user action required of short-term contraceptives that make typical and perfect use relevant, categories that are not necessarily found among longer-acting birth control methods.

There is widespread agreement in the literature that perfect use of these user-dependent technologies (short-term contraceptives) is sometimes difficult or tricky (Bahamondes et al., 2018; Harris et al., 2020). As a result, short-term contraceptive technologies are 10-20 times more likely to fail than LARC technologies (Russo et al., 2013). This is because these modern contraceptives necessitate practical day-to-day, week-to-week, or even month-to-month user action (Williams & Fortenberry, 2013). User dependence, such as this, invites forgetting, user error, and being seen and known as a contraceptive user by other people. These are non-compliance behaviours or can lead to non-compliance behaviours. Non-compliance behaviours are seen with barrier contraception (e.g., female and male condoms) and short-term non-barrier methods (e.g., oral contraception, vaginal ring and patches users).

Behaviours among barrier contraceptive users that produce method failure include forgetting to use the contraceptive measure and incorrect use. In addition, design flaws that create difficulties in the insertion of female condoms present as barriers to its perfect use (Higgins & Smith, 2016). Male condom users have associated condoms with limits in spontaneity and pleasure during sexual intercourse. In addition, condoms may be seen as likely to break or be

unreliable, thus increasing couples' susceptibility to STIs and pregnancy (Mulumeoderhwa, 2018). On a more interpersonal level, committed couples have been known to avoid condom use with partners, equating the request to use these methods with unfaithfulness and distrust (Alam & Alldred, 2021). This fear is partly rooted in the male condom's visibility. Moreover, in partnerships that trade sex for gifts, where women often find themselves unable to dictate the conditions for sexual intercourse, negotiating short-term contraceptives such as condoms is impeded (Bhana & Pillay, 2018).

Non-compliance behaviours or beliefs that cause non-compliance amongst oral contraceptive, vaginal ring and patch users include missing pill doses or retaining patches for longer than the required time rather than changing them weekly as needed (Stoddard et al., 2011). At the same time, some vaginal ring users have shown reticence about touching their own genitalia or concern about the ring's expulsion during sexual intercourse (Higgins & Smith, 2016). Contraceptive failure is thus common among short-term contraceptive technology users; this has been dubbed worrisome by some researchers, considering the unparalleled prevalence of oral contraceptive use in HICs (Sundstrom et al., 2015). This high prevalence is due to associations with physical benefits other than pregnancy prevention, e.g., reducing acne and menstrual cramps and regulating one's menstrual cycle. Concerns about the high dependence on short-term contraceptives among users seeking contraceptive benefits from birth control have led researchers to advocating for LARC. For example, Trussell et al. (2013) have advised that a 10% method switch in oral contraceptive users to IUD uptake in the US could yield a $288 million (approx. R4.4 billion) reduction in annual expenditure on pregnancy-related costs (50% of women in the US use oral contraceptives as a birth control method).

High noncompliance-related failure rates are used as justifications for calls by many researchers for more responsible decision-making in reproductive-age women to circumvent sexual and reproductive risks, including unintended pregnancies (Van Der Riet & Nicholson, 2014). Moreover, a growing body of research on contraceptive use has called for the availability of LARC technologies as they are deemed safe, and viable birth control methods for all women (Batool & Mazhar, 2017; Blumenthal et al., 2011; Buckingham et al., 2021; Hubacher et al., 2008; Mazza et al., 2017; Ontiri et al., 2019; Stoddard et al., 2011; Winner et al., 2012).

Over the years, contraception has assumed various forms, some by present-day standards deemed unthinkable (McLaren, 2022). The advent of modern contraceptives dates back to the 1880s in Europe; before that, abstinence and coitus interruptus/withdrawal were the traditional methods used for birth control (Cleland, 2009). Tamale (2016) endorses this view and expands on the types of traditional birth control methods used in some African contexts in the quote below:

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High failure rates have been associated with traditional contraceptive methods such as premarital and postpartum abstinence and coitus interruptus, while concoctions used as abortifacients have sometimes resulted in injuries and even deaths (Bradford, 1991; Haddad & Nour, 2009; Kangaude et al., 2022). This is because these concoctions were "highly unreliable, dangerous and usually poisonous" (Isenberg, 2021, p. 55). In addition, while also prone to failure, much of the knowledge about herbal birth control methods in European countries "died along with the burnt 'witches'" (Isenberg, 2021, p. 56) due to alignments with the Catholic Church. Similarly, the promotion of premarital abstinence through liberal attitudes towards sex play acts between young people known as *ukumetsha* or *ukusoma* (limited intercourse) where contraceptive failure was regulated through the infliction of penalties on young men's families for unwanted pregnancies evidence measures used to circumvent pregnancy among young people in many precolonial isiZulu and isiXhosa-speaking communities. This traditional birth control practice also disappears with the introduction of Christianity and migration in South Africa (Nkosi, 2015). Beyond fertility regulation, globally, postnatal means for limiting the family size are also documented and include infanticides, baby dumping, adoption and early release of children to perform labour duties (Cleland, 2009). Not all the methods mentioned above have been readily accepted by societies; some remain legally unacceptable in most countries.

7. The turn to Long-Acting Reversible Contraceptives (LARC)

The term LARC may be unrecognisable to older generations who are only familiar with first-generation long-acting methods. These earlier technologies, particularly IUDs, were phased

out following adverse side effects, e.g., pelvic infection diseases (PID) experienced by women on *Dalkon Shield* IUDs during the 1970s in the US (Hillard, 2013; Pleaner et al., 2017; Russo et al., 2013; Strasser et al., 2016).

While IUDs assumed many different shapes and forms, the *Dalkon Shield* IUD had a multifilament string deemed a significant contributing factor to bacterial invasion of the cervix, resulting in pelvic infection diseases. As such, in addressing concerns about infections and infertility directly attributable to IUDs, the design of the devices was first to transform (Takeshita, 2012). The T-shaped IUDs became widely disseminated; later, frameless IUDs were developed (Beatty & Blumenthal, 2009; Wildemeersch et al., 2014). Current IUDs are not made using this design; single string/monofilament designs are used (Britton et al., 2020).

IUD use is not new in South Africa. Usage of older versions of the IUD, such as the *Gräfenberg's ring,* was reportedly found in South Africa in the 1930s (Klausen, 2004). In addition, the *Lippes Loop, Margulis Spiral* and *Dalkon Shield* were used in the 1970s within the public sector, e.g., within health facilities in Johannesburg, Soweto (Parle et al., 2018; Spilhaus, 1974). The *Lippes Loop* was deemed the cheaper alternative to the *Dalkon Shield* and thus had a relatively higher rollout (Spilhaus, 1974), even though the *Dalkon Shield* would later be linked to pelvic infection diseases and thus globally disbanded (Watkins, 2021). While IUD uptake did decrease in the US in the 1980s, pharmaceutical companies continued to redirect these contraceptives away from the Global North towards Global South countries like South Africa. Nevertheless, according to Parle et al. (2018), it was the transition to democracy and suspicions about population control that increasingly phased out IUDs in the early 1990s in South Africa, not fears about pelvic infection diseases.

In Europe, however, IUDs remained unaffected by the wide recall and halted distribution seen in the US (Currie et al., 1994). It was only in 1988 that the IUD returned to the US markets in the form of *ParaGard* or the Copper-T IUD. Hormonal IUDs would not be available until 2000, with the *Mirena* or the levonorgestrel-releasing intrauterine system featuring as the widely marketed version of the IUD (Strasser et al., 2016). Similarly, in South Africa, modern variations of IUDs, such as the Copper T380 banded IUD and *Mirena,* deemed innocuous, have since replaced earlier forms of the IUD in the country. This version of the IUD has, beyond delinking its use with pelvic infection diseases, also offered its users non-contraceptive benefits such as treating menorrhagia, managing endometriosis and endometrial hyperplasia (Beatty &

Blumenthal, 2009). However, even with these "positive" side effects, *Mirena* is only prescribed in cases of menorrhagia within the public health sector due to cost (Gutin et al., 2011). IUD users have, though, been argued to experience high fertility levels upon removing the IUD compared to, for example, injectable contraceptive users who sometimes experience delays in returning to fecundity (Robinson et al., 2016).

The first generation of subcutaneously implanted contraceptive technology emerged in 1991 in the US and was called *Norplant* (Watkins, 2010). This subdermal implant could be retained for five years and had six match-size rods that were placed under the skin within the arms of contraceptive seekers (Strasser et al., 2016). Its design and placement were meant to address the shortfalls of IUDs, particularly the risk of pelvic infection diseases (Takeshita, 2004). However, much like the IUD, "the fast rise of Norplant was followed by a precipitous fall" (Strasser et al., 2016, p. 9). This is because the *Norplant* co-existed alongside discourses around women's individual choices and class actions against pharmaceutical companies (Takeshita, 2004). As such, when, for example, incarcerated women received judgements to take up the measures and poor women were coerced to use *Norplant* in exchange for welfare benefits in the US, these discriminative undertones soon stirred many questions about the technology and its place within governmental intentions for population control (Takeshita, 2004). Hence, its manufacture would cease by 2000 (Watkins, 2002).

In place of the *Norplant*, the *Jadelle* and *Implanon,* which are minimal versions of the implant, were introduced. To this effect, while the *Norplant* comprised of six rods*,* the *Jadelle* has two, whereas the *Implanon* is a single-rod alternative (Siraha, 2013). The *Implanon* also differs because *Norplant* and *Jadelle* are levonorgestrel-releasing, but *Implanons* are etonogestrel-releasing (Aradhya, 2007). They were first seen in Indonesia in 1998 and later available in the US in 2006 (Mkansi, 2018). However, only in 2014 was Implanon introduced in South Africa in efforts towards the expansion of contraceptive methods, even though, according to Lince-Deroche et al. (2016), "both Jadelle and Implanon-NXT have been approved for use in South Africa, but distribution has focused on Implanon-NXT" (p. 102).

Injectable contraceptives were used much later in places like the US, while the Global South had a higher acceptance rate. For example, in Zimbabwe, injectable contraceptives in the form of *depo provera* date back to 1969, albeit they would be disbanded by 1981 under two critiques (Kaler, 1998). One more explicit criticism concerns public complaints that the measure is a

neo-colonial tool for population control. The other, more implicit, criticism is that with healthcare providers responding to women's contraceptive needs, males as patriarchs could be potentially undermined in decisions to continue, stop or delay births (Kaler, 1998). However, the demand for *depo provera* was not curbed by this ban as "[w]omen did not switch their loyalties easily to another form of contraception" (Kaler, 1998, p. 372). Instead, *depo provera* gained an underground market until its rehabilitation in 1991 (Kaler, 1998).

In South Africa, *depo provera* use began in the 1960s and peaked in the 1980s, around the time of its uptake in Botswana (Potts & Marks, 2001). However, South Africa was not exempt from the politics around the measure being a tool for racial genocide. As such:

> Stories of coercion and deception associated with Depo in South Africa abounded. There were reports of women who could not get jobs unless they gave their employers medical certificates showing the date they had last had the injection, and of government teams which descended on factories and commercial farms to give injections to the workers. Nurses on these teams who told women about the potential side effects of the drug were supposedly fired on the spot (Kaler, 1998, p. 373).

The obligation for women to use contraception reportedly took a violent turn, particularly during women's entry into capitalist spaces. Private decisions about use or non-use instantly became grounds for evaluating one's employability. This way, wide birth control uptake was celebrated by multiple stakeholders, including employers and governments (Brown, 1987; Kaufman, 2000). As a result, the less contraceptive-using subjects knew about the contraceptive technology and its side effects, the better (Kaler, 1998).

Silently growing alongside *depo provera* was the use of norethisterone enanthate (*nur-isterate*), introduced in 1978 in South Africa (Morroni et al., 2006). A dramatic increase in its use was documented only in the 2000s, whereby a younger cohort of low-income, more educated women reportedly took up *nur-isterate* over *depo provera* based on nurses' recommendations around a superior return to fecundity. Older women, however, continued to prefer *depo provera* (Morroni et al., 2006), possibly based on a lower demand for clinic visits.

While *depo provera* was available as early as the 1970s, it suffered great campaigns against its use in Britain by female-identifying activists within the Campaign Against Depo-Provera

(CAPD) premised on safety concerns (Lambert, 2020). In light of this, it was only approved for use in 1993 in the US. Littlecrow-Russell (2000) points to use as having remained within inner city clinics where young African Americans have remained the predominant users. As such, statements such as the following have been shamelessly made: "Doctors feel uncomfortable saying it's the lower classes taking it but it does seem to suit those who are less educated" (Littlecrow-Russell, 2000, p. 4). Statements such as this fail to account for the systemic creation of subjects who will advance towards certain "preferences" created by their environments.

A revisionist history that has, over the years, attempted to renew or revive interest in IUD and implanted technology use is therefore evidenced by the literature (Takeshita, 2012). To this effect, after accounting for and addressing design flaws, IUDs and subdermal implants returned, with injectable contraceptives remaining the same over the years. These technologies were rebranded as long-acting reversible contraceptives (Pleaner et al., 2017; Takeshita, 2004).

8. Present-day LARC

This section describes the different LARC technologies, *viz.,* IUDs, implants and injectable contraceptives, their duration, uptake prevalence, mechanisms of action and insertion procedures. Many studies omit injectable contraceptives in their definition of LARC. However, these provider-reliant birth control measures that last 60 to 90 days are included in this study. This aligns with the South African National Clinical Contraception Guidelines (2019) and Lowe and Rowlands (2022).

8.1 IUDs

IUDs are characterised into two broad categories: copper-releasing IUDs and levonorgestrel-releasing (hormone-containing) (Stoddard et al., 2011). While some countries disseminate approximately 15 versions of IUDs (Buhling et al., 2014), others have been less enthusiastic about expanding variations. For example, in the US, five types of these technologies can be found, namely, the copper-containing *ParaGard* as well as the four levonorgestrel-releasing alternatives known as the *Mirena, Lileta, Kyleena* and *Skyla* (Curtis & Peipert, 2017). Commonly available forms of IUDs in South Africa include the Copper T380 banded IUD and the levonorgestrel-releasing intrauterine system (LNG-IUS) (Gutin et al., 2011).

Without demanding frequent user action and re-administration, these LARC technologies are effective for 5-10 years (Hubacher et al., 2008) while demanding little maintenance from users

(Beatty & Blumenthal, 2009). As such, Russo et al. (2013) likened them to sterilisation in their failure rates. The LNG-IUS has been considered more effective than the Copper T (Thonneau & Almont, 2008). Hence, "they are second only to female sterilization as the most prevalent method of family planning worldwide (13.6% vs 20.5%)" (Beatty & Blumenthal, 2009, p.561). However, since the LNG-IUS is more expensive, the public health system in South Africa often only offers the Copper T IUD (Gutin et al., 2011). Therefore, the wide use seen in many LMICs except in the United States (Beatty & Blumenthal, 2009) is not evident in South Africa due to cost barriers.

The uptake distribution between regions and countries differs, with reports showing 1.8% uptake in the Oceania region (including Australia, New Zealand, Melanesia, Micronesia, and Polynesia), whereas 27% of IUD users are in Asia. More than 60% of this population of women who use IUDs from Asia live in China due to its previous population control policies (Beatty & Blumenthal, 2009; Benova et al., 2017). Extremely low prevalence rates are also found in many African countries, partly due to the widespread use of injectable contraceptives (Benova et al., 2017) and "continued concern many women have about the morbidity and mortality associated with IUDs resulting (whether they know it or not) from the Dalkon shield experience of the 1970s" (Beatty & Blumenthal, 2009, p. 561).

Insertion of IUDs requires specialised training, and successful insertion is pertinent for preventing "lost IUDs" (Cetinkaya et al., 2011, p. 199). A lost IUD signifies the string of the device being invisible at the entrance of the cervical canal, thus suggesting that the IUD has migrated within the uterus (Cetinkaya et al., 2011). Whether the LARC technology is inserted a few minutes after birth, prior to discharging a patient, or six-eight weeks postpartum all impact the technology's likelihood to remain in place with longer durations to insertion having more desirable outcomes (Escobar & Shearin, 2019; Nahas et al., 2023). However, improperly inserted IUDs result in the perforation of the uterus, infections, ectopic pregnancies, and expulsion (Cetinkaya et al., 2011).

Trained nurses, doctors, gynaecologists, and midwives can insert an IUD. Techniques for inserting them vary; thus, health providers must know the method required. During this process, a pelvic exam is undertaken, and care around maintaining an aseptic environment is practised to avoid infections forming in the uterus later. Local anaesthesia is often used during

the process, particularly among young nulliparous women who often experience pain and discomfort during the insertion process (French & Cowan, 2009).

8.2 Subdermal implants

Three forms of implants can be found in the market: the *Implanon, Jadelle* and *Sino-Implant II*. They are all progestin-only based (Jacobstein & Stanley, 2013). The *Implanon* NXT is the most used form of subdermal implant in South Africa (Patel, 2014). It is usable for three years and comprises a single rod that measures 40 mm x 2mm, containing 68mg of a hormone called etonogestrel (Patel, 2014; Pillay et al., 2017). According to the National Contraception and Fertility Planning Policy and Service Delivery Guidelines (2012), double rod forms of the subdermal implant are the *Sino-plant* and *Jadelle,* which release levonorgestrel into the body. They can be used for four and five years, respectively.

Implants are surgically inserted, with anaesthesia, on users' upper arms beneath the skin. Depending on the type of implant chosen, a small incision that will fit one or two rods is made where the implant will release small amounts of progestin into the bloodstream (Jacobstein & Stanley, 2013). While its removal depends on good insertion techniques, removing the *Implanon* generally requires a 3-4 mm cut at its end, side or middle (Mansour, 2008). Small curved forceps then assist with the removal of the rods. The method used depends on the technology's visibility on the skin's surface. Impalpable implants usually need to be located with ultrasound machines and require more skill from healthcare providers (Mansour et al., 2008). Ultimately, these contraceptive technologies work by stopping ovulation and thickening the cervical mucus (Curtis & Peipert, 2017).

Despite being favoured for the nullification of pelvic exams and medical tests, the secrecy and immediate return to fecundity that they offer (Jacobstein & Stanley, 2013), in South Africa, "the programme which was … considered a huge success seems to be at the verge of collapsing" (Mrwebi et al., 2018, p. 114). The wide dissemination of the subdermal implant started in 2014 (Patel, 2014), and by 2016, 4% of the population was using one for contraception. However, due to experiences of adverse side effects, removals recurrently occur much earlier than the anticipated three-year selling point. Hence, the concern about the method's acceptability as contraceptive users increasingly return to less effective contraceptive technologies (Pillay et al., 2017) and, according to Parle et al. (2018), leading to the name "outplanon" for the *Implanon*.

8.3 Injectable contraceptives

The two common forms of injectable contraceptives used are progestogen-only based, namely, depot medroxyprogesterone acetate (DMPA) branded as *depo provera*, and Norethisterone enanthate (NET-EN), branded as *nur-isterate* (Hofmeyr et al., 2016). Under-resourced areas often are relatively well-stocked with these forms of injectable contraceptives (Draper et al., 2006). *Depo provera* is active for three months, while *nur-isterate* has a lifespan of two months in the female body (Wood & Jewkes, 2006).

Injectable contraceptives are administered deep into the muscles of women. Depending on comfortability, the injection can be inserted into the woman's arm or buttock. A 150mg DMPA and 200mg NET-EN dosage is injected into the patient. Both of these progestogen-based hormones prevent ovulation from occurring with the added activity of altering the endometrial and cervical mucus levels (Draper et al., 2006). During prescription, healthcare providers must be confident that service users are not pregnant when (re)administering injectable contraceptives, particularly if the time lapse between the stipulated date for the next injection has exceeded the grace period (National Contraception Clinical Guidelines, 2012). As such, "women in whom pregnancy has not been ruled out should either wait until their next menses to initiate a method of contraception, or have a pregnancy test done if they miss their next period" (National Contraception Clinical Guidelines, 2012, p. 9).

In the section that follows, I discuss in more depth the context in which LARC technologies emerged within South Africa. This will include conversations around the first organised bodies that defined themselves as providing contraception and the politics they upheld, the subjects who were impelled towards contraceptives by the government or healthcare providers and those who responsibilised themselves towards this labour as well as the policies and acts that have lent themselves to the regulation of birth control.

9. The history of birth control in South Africa

The first birth control clinic in South Africa was established by a society funded by eugenicists in February 1932. Birth control was believed to be a measure for weeding out "unfit reproducers", particularly the poor white minority. It would, according to one of South Africa's early eugenicists, "lessen the stream of recruits to the poor white class" (Klausen, 2018, p. 297). However, wide contraceptive use that precluded classist targeting of poor White women and was inclusive of Black women arose in 1965 and began to peak in 1974 through endorsements by the South African National Family Planning Programme (Parle et al., 2018).

Availing cost-free reproductive health services, broadcasting the wide availability of contraceptives through radio, and the amalgamation of contraceptive services within primary health services were some strategies used (Burgard, 2004). Consequently, a sharp rise in attendance was seen in health centres that offered contraceptive care (Bhuda & Sekudu, 2016). In 1976, two years after implementing the South African Family Planning programme, contraceptive use was between 37% and 50%. Hence, "government expenditure on family planning rose from a small amount in the 1950s to comprise roughly one-quarter of all government spending on health in the late 1980s" (Norling, 2019, p. 365).

A much greater uptake (mainly in the form of oral contraceptives) was evident among White South African women due to superior healthcare facilities designated for them (Bhuda & Sekudu, 2016), albeit a decline in fertility rates among them was perceived as alarming by a government intent on reserving childbearing for White women (Klausen, 2018; Norling, 2019). In comparison, contraceptives offered to Black women were often long-acting and sometimes permanent, e.g., sterilisation. In addition, these contraceptives were sometimes considered unsafe for use and thus banned in certain countries, e.g., *depo provera* (Mkhwanazi, 2014), which in the US was "not approved by the FDA [Food and Drug Administration] until the 1990s" (Takeshita, 2004, p. 42). This ban was, in part, based on the copious amounts of progestin *depo provera* deposited into the body as well as the delayed return to fecundity experienced by injectable contraceptive users compared to those on other forms of LARC (Watkins, 2010). As such, this governmental enthusiasm for wide access to LARC in homelands[3] and other areas designated for Blacks South Africans would be later suspected of being a form of population control strategy for Black people (Bhuda & Sekudu, 2016; Knudsen, 2006).

As a counter to this population control argument, Chimere-Dan (1996) posited that the high demand for contraceptives was only partially related to governmental promotional efforts. She juxtaposes lack of knowledge about the population control policy (29%) with 60% of women indicating ever using contraception and 42% using them at the time of the study to argue for a genuine need that was met by the government rather than a need by the government that was forced upon women. The author discusses the successful implementation of contraceptives in

[3] In efforts to segregate Black and White people, "native reserves', later "homelands" were geospatial areas designated for Black people under apartheid in South Africa (Magubane, 2011).

rural areas in South Africa, particularly the former Transkei, now part of the Eastern Cape, one of the most impoverished areas in the country (and also the location of this study). She is astounded by the wide contraceptive use, given the absence of similar trends in other rural areas in Africa. For example, 89% of reproductive-age women knew about contraceptives, 60% of women in the Transkei had a history of modern contraceptive use, and 42% used contraceptives at the time of the interview. Rather than this being a government population control strategy coming to fruition, Chimere-Dan (1996) argues that the government met a demand, resulting in 58% of women nationally using injectable contraception, followed by 45% using the male condom and 29% of women using oral contraceptives.

Chimere-Dan (1996) makes the following arguments. Firstly, apartheid and migrant labour's destabilising effects on the family offered women conjugal autonomy, including economic and personal decisions such as adopting modern contraceptive technologies. In this light, contraceptive use aided women in adjusting to the social changes, which would see them as heads of households in the absence of their husbands. Chimere-Dan (1996) construes women as independently realising their increased responsibilities in communities with pregnancy "jeopardising" the opportunity to fulfil these added responsibilities. Secondly, the loosening of norms around sexual intercourse outside the confines of marriage became apparent with adolescents progressively having contraceptive needs given their increasing sexual exploration, and contraceptives could be dubbed as empowering technologies supporting this sexual exploration. Thirdly, she attributes the effective use of injectable contraceptives, which are largely invisible and allow for secrecy, to instances where the women offered sexual favours due to financial stresses. This necessitated contraceptives that do not require male compliance. To this effect, contraceptives allowed married women to proffer men sexual favours for financial assistance. Chimere-Dan (1996) ultimately argues that this case of the former Transkei is proof of how the social environment exerts pressure on the reproductive norms of all societies. However, the manner in which contraceptive services operated well within a dysfunctional healthcare system gives credence to the population control argument.

10. Regional politics affecting uptake

A steady increase towards modern contraceptives has been documented in sub-Saharan Africa, from 7% in 1992 to 25% in 2007 (Neukom et al., 2011) and 46% in 2023 (*Statista*, 2024). Though at variable paces, healthcare provision and access improvements can be seen within the region. The high rates of heterogeneity documented show that West (15%) and Central

Africa (12%) have the lowest contraceptive prevalence, while Southern Africa presents the highest prevalence (54.3%) (Ahinkorah et al., 2020) with South Africa reflecting the highest contraceptive usage within sub-Saharan Africa (Bhuda & Sekudu, 2016). Removing barriers to access to commodities brings the quality of interactions with healthcare providers, discussed later, to the fore (Hlongwa et al., 2020).

To account for the lower acceptance of most modern forms of contraception in sub-Saharan Africa, it has been argued that "governments demonstrated little enthusiasm for international offers of population/family planning assistance in the 1980s through the 1990s" (Tsui et al., 2017, p. 4). This view opposes the assertion of contraceptives as imposed and even forced upon LMICs. Instead, cultural resistance against contraception maintained low contraceptive uptake in countries like Zimbabwe and South Africa during that period (Kaler, 1998).

Despite initial difficulties with roll-out, birth control is said to have later gained traction through efforts against the HIV/AIDS pandemic (Tsui et al., 2017). As such, in sub-Saharan African countries receiving developmental aid for the prevention of HIV, contraception was also addressed as an SRH issue. One of the programmatic successes of the interventions included the questionable method-skewing of women's choices towards injectable contraceptives within these regions. To keep up with this demand, these first-generation injectable contraceptives are being supplemented with self-injectable ones known as *sayana press* to encourage continuation (Bendix et al., 2020; Spieler, 2014).

Despite plans for method expansion, *depo provera* has a history of being labelled eligible only if other suitable measures are unavailable. For example, *Depo provera* users are argued to be "twice as likely to acquire HIV as those who used non-hormonal forms of birth control" (Haddad et al., 2015, p. 21). A study conducted by Ngure et al. (2012) in Botswana, Kenya, Rwanda, South Africa, Tanzania, Uganda and Zambia experimenting on hormonal contraception in serodiscordant couples confirmed these findings. Women using injectable contraceptives, particularly *depo provera*, were twice as likely to transmit HIV than women using other contraceptive technologies.

Recently, in the sub-Saharan context, caution and concern have been expressed around prescribing LARC to women due to the increased vulnerability to HIV infection (Morse et al., 2013). This is evidenced by how Morse et al.'s (2013) exploration of the provision of LARC

in HIV-prevalent areas in South Africa and Zimbabwe reports on healthcare providers being reticent and thus resistant to providing LARC in high HIV-risk areas due to biomedical considerations. Other matters that exarcebate this include "official advice against provision of implants to women using the HIV antiretroviral drug, *efavirenz*, [was] issued by the South African National Department of Health (NDoH) in 2014" (Brown et al., 2019, p. 1) where some women living with HIV who used these subdermal implants experienced contraceptive failure and thus became pregnant while using contraception (Mrwebi et al., 2018; Pillay et al., 2017).

Clear guidelines around dual contraceptive use were given to injectable contraceptive users in place of unrestricted access in 2017. In addition, injectable contraceptive users were expected to be informed "about evidence suggesting heightened HIV risk but also about the uncertainty of a causal relationship"(Ahmed et al., 2019, p. 304). Due to the varying results in studies on hormonal contraceptives and HIV transmission, more evidence was required to alter WHO's guidelines on hormonal birth control methods in sub-Saharan Africa and ultimately restrict access to these technologies (Haddad et al., 2015). More recently, the results of the Evidence for Contraceptive Options and HIV Outcomes trial published in *The Lancet* in 2019 by (Ahmed et al., 2019) has disqualified these associations. A further discussion on HIV vulnerability and its associations with hormonal LARC technologies is offered in section 7.6 of the next chapter.

11. From raced-based to classed-based disparities in healthcare

Contraceptives are primarily sourced from government facilities, mainly at hospitals, mobile clinics, and primary healthcare clinics, in post-apartheid South Africa, with private health contraceptive users accessing them from private health centres and pharmacies (Chersich et al., 2017). Male condom use (though used erratically) and injectable contraceptives are reportedly the most used and readily accessible forms of contraception, partly due to the relatively late introduction of other LARC measures such as the subdermal implant and modern versions of the IUD, e.g., the *Mirena* (Fataar et al., 2022; Pleaner et al., 2017; Sullivan et al., 2018). Variable access to contraceptives must be understood within a backdrop of overcorrections of apartheid[4] policies. For example, in post-apartheid South Africa:

> Due in part to historical associations with racialised population control, dedicated contraceptive programmes were deprioritised by the new government. As national

[4] Apartheid is a discriminative policy based on separate development in South Africa that was enacted in 1948 and dismantled in 1994.

> population policies were rewritten and primary healthcare programmes expanded, the range of contraceptives available to women in the public sector was in reality reduced. While a variety of methods continued to be advertised on the walls of family planning facilities, in practice, access to long-acting, reversible contraception, in the form of IUDs, became increasingly rare (Parle et al., 2018, p. 259).

This balancing act by the then-new government left a lag in method expansion that still requires bridging, as healthcare options remained and remain skewed towards limited contraceptive options. However, instead of race determining access, class is arguably the present indicator of access to superior reproductive healthcare commodities.

Current disparities in wealth distribution are pervasive in South Africa and affect all service provisions, including health (Ataguba et al., 2011). Only 8.7% of the country's gross domestic product (GDP) is directed to health care, of which about half serves private health users, who are 16% of the population. The other half serves 84% of South Africans who receive health services, including contraceptive care, from public health facilities (Presidential Health Summit, 2018). As such, a dearth of quality healthcare in the public health sector due to budgetary constraints is often visible, with dissatisfaction common among poor people or people who reside in rural areas due to stock-outs or limited access (Hlongwa et al., 2020), despite healthcare being a constitutional right.

One can argue that the disparities in health provision that benefit a few in South Africa are reconfigurations of public health issues seen during the apartheid era. Comparatively, the majority of the expenditure during apartheid served the White communities, offering quality health care, while the rest of the ten homelands in South Africa, in which Black people primarily resided, were under-resourced and understaffed (Mkhwanazi, 2014). This meant that White South Africans had better sexual and reproductive health outcomes. For example, infant mortality was reported to be 11.5 times higher, and maternal mortality was 31 times higher in Black communities compared to White communities (Mkhwanazi, 2014). In addition, under the fears that "accessible birth control was causing 'race suicide'" (Klausen, 2004, p. 160) within the White community, White women were encouraged to reproduce and dissuaded from birth control use through, for example, tax reductions per child (Macleod & Morison, 2020). In contrast, the growth of the Black population was considered a threat to be reduced through contraceptive availability. Despite the government's plan to increase the fertility rate for White

women, a higher prevalence of contraceptive use was evident among White women (Mkhwanazi, 2014). The fertility rate among White South Africans during apartheid was 3.5 total births per woman, while this rate was 6.5 births for Black women in the 1940s (Burgard, 2004).

12. Healthcare provider/patient interactions in SA

Healthcare quality has undoubtedly introduced significant challenges to contraceptive access, given the collapsing and squalid work conditions commonly found in public health facilities in many LMICs (Jewkes et al., 1998). Regular occurrences of patient neglect, which refers to "the failure of a designated care giver to meet the needs of a dependent" (Lachs and Pillermer, 1995 as cited in Reader and Gillespie, 2013, p. 1), are linked to these working conditions. This patient neglect can be instantiated by how "nurses have been reported to employ humiliation, verbal coercion and even physical violence to assert their authority and control patient behaviour" (Jewkes et al., 1998, p. 1781), especially in public health settings. These settings are commonly under-resourced, and patients who access them are often underprivileged and uneducated (Jewkes et al., 1998). As a result, power differentials between patients and health service providers are reportedly high.

Ten years after Jewkes et al. (1998) reported on patient neglect in South Africa, Govender and Penn-Kekana (2008) similarly report on the likelihood of "verbal abuse of patients, particularly when they are accessing, or trying to access reproductive health services" (p. 93). For example, the authors report on sexual violence victims being victim-blamed by health providers, assuming they had transgressed traditional norms of performing femininity. More related to this study, Wood and Jewkes (2006), in a study conducted in Limpopo, South Africa, on women aged 14-20 years, report that health practitioners often imposed injectable contraception upon young adolescents, promoting it as the most effective and reliable measure. Nurses also promoted abstinence among adolescent women and further labelled those who refused as "stubborn" (Wood & Jewkes, 2006, p. 111) for remaining sexually active. This indicates the presence of health providers who render shaping conduct a primary concern rather than meeting patients' needs, thus imposing their own biases and creating a power imbalance.

At the same time, recent studies also demonstrate that healthcare providers can be supportive towards patients, including adolescent contraceptive users (Jonas et al., 2019). In addition, Al-Shamlan et al. (2017) indicate that medical experts can also be victims of physical and nonphysical violence from patients, their relatives as well as colleagues. Early career healthcare

providers have been the cohort in which most cases have been found with victims not trusting the reporting system within their workplaces (Al-Shamlan et al., 2017).

According to Govender and Penn-Kekana (2008), to bridge the gap between healthcare providers and patients, specifically regarding gender, policies around inequality and rights to education for girls can mitigate the power differentials. The motive is to reject environments that silence health users in favour of those that activate all women's voices, questions and concerns (including those of young, disabled and disadvantaged women) about, for example, using contraceptive technologies. Ultimately, this shifts the focus away from the health providers' needs towards those of the health user.

In the following section, I discuss how contraceptive uptake in South Africa is majorly influenced by both global and national policies on SRHR, which have seen revision over the years, allowing for conversations about bodily integrity for all women, including those considered "high-risk".

13. Conferences, policies, guidelines, initiatives and Acts shaping SRH in SA

Globally, historical policies and events that have been pivotal to recognising the potentially oppressive nature of the healthcare provider/patient relationship include the International Declaration on the Rights of the Patient and the International Planned Parenthood Federation (IPPF) held in 1981 and 1992, respectively (Govender & Penn-Kekana, 2008). As mentioned above, encounters between patients and medical experts were recognised as not neutral. For care to be deemed of quality, patients and their needs needed to be inserted and centralised within the conversations.

Patients' rights, and more broadly, women's rights regarding SRHR, were also emphasised at the popular International Conference on Population Development (ICPD) that convened in 1994. Here, participants advocated for a feminist lens in accessing reproductive choices (Govender & Penn-Kekana, 2008). According to Cooper et al. (2016), the Beijing Fourth Conference on Women in 1995 influentially bound women's rights with reproductive health and development and further broadened the scope of reproductive health, thereby continuing the mandate of the ICPD (Cooper et al., 2016). The author adds the Millennium Development Goals (MDGs), Sustainable Development Goals (SDGs), and global Family Planning 2020 as events and initiatives aiming for equality and access.

The MDGs, and later the SDGs, constituted a worldwide pledge to commit to social transformation by addressing societal injustices, moving towards person-centred approaches to access and ensuring the attainment of "the goal of not leaving anyone behind" (de Leon et al., 2019, p. e227). As such, the MDGs (adopted in 2000) have globally and locally impacted the trends of modern contraceptive use (Bhuda & Sekudu, 2016; Haddad et al., 2021). These MDGs aimed to advance eight developmental goals by 2015, including maternal mortality under which contraceptive access is addressed (Patel, 2014). However, according to Culwell et al. (2010), maternal mortality "has seen the least progress of all of the MDGs" (p. S13). Reasons include reproductive health not taking precedence due to budgetary restrictions affecting contraceptive services (Culwell et al., 2010). Therefore, competing demands affect contraceptive availability in LMICs. In the SDGs, adopted in 2015, access is emphasised, and quality healthcare is rendered a crucial foundation for contraceptive provision, which is not seen in their predecessor, the MDGs (de Leon et al., 2019). Similarly, the global Family Planning 2020, according to the *Family Planning 2020: Rights and empowerment principles for family planning* (2014), committed to ensuring the fertility reduction of 120 million more contraceptive users through birth control between 2012 and 2020 (Senderowicz, 2020) and "that human rights are in fact treated as the cornerstone of any family planning effort" (p. 2).

On a local level, pivotal moments for the careful consideration and improvement of SRHR among women in South Africa included the Choice of Termination of Pregnancy Act (CTOP) (No. 92 of 1996), the South African Schools Act (SASA) (No. 84 of 1996) and the Domestic Violence Act (No. 116 of 1998) (Mkhwanazi, 2014). The CTOP Act allows women to terminate a pregnancy upon request within 12 weeks of gestation, thereby recognising women's rights and agency in choosing to reproduce or not (Chiweshe et al., 2017; Mkhwanazi, 2014). The SASA Act was enacted to address broader issues affecting women's reproductive experiences. It would be influential in realising youth's right to education and thus safeguard young pregnant women from exclusion, particularly in light of the increased susceptibility to poverty, unintended pregnancy, gender-based violence, and HIV/AIDS faced by poorly educated women (Mkhwanazi, 2014). Since punitive acts against young women upon pregnancy (e.g., excluding pregnant young women from school) were rendered unconstitutional, gendered imbalances could be avoided.

Implementation of the Domestic Violence Act (No. 116 of 1998) was also considered influential in improving women's SRH in South Africa, given the prevalence of gender-based violence (Mkhwanazi, 2014). These violent acts against women often impede women's ability

to refuse sexual intercourse or negotiate contraceptive use. For this reason, women are thus often at risk of STIs, unintended pregnancies, and unsafe abortions (Mkhwanazi, 2014). Therefore, the enactment of the Domestic Violence Act was expected to empower women by creating channels to report crimes and issuing protection orders in the context of intimate partner violence, often normalised in South Africa (Jewkes, 2002). However, while the legislature around sexual and reproductive health is sound, justice for all women has not been achieved (Morison & Mavuso, 2022).

The creation of youth-friendly (Chandra-Mouli et al., 2015; Chilinda et al., 2014) and male-friendly sexual and reproductive health facilities (Cooper et al., 2016) for expanding access to contraceptives technologies among adolescents who wish for it has been a significant challenge experienced globally but particularly so in sub-Saharan Africa (Ninsiima et al., 2021). In these regions, the youth remain underserved owing to ageist notions about sexuality. Indeed, below are some of the issues that contribute to inequitable access by adolescents, identified by the World Health Organization (WHO) in South Africa:

> Common reasons for this [inequitable access] include fear that health workers will ask them difficult questions, put them through unpleasant procedures, or scold them; or that health workers will not maintain confidentiality. Finally, health services may be 'friendly' to some adolescents, such as those from wealthy families, but may be decidedly 'unfriendly' to others such as those living and working on the streets. Not surprisingly, in many parts of the world, adolescents are reluctant to seek help from health facilities. If they do seek help, they often leave discontented and unhappy with the way they were dealt with; determined not to go back, if they can help it (Ashton et al., 2009, p. 6).

Researchers have identified the attitudes of healthcare providers, communities and knowledge gaps by adolescents as issues needing addressing to ensure adolescents enjoy their sexual and reproductive rights. As such, the establishment of the National Adolescent-Friendly Clinic Initiative (NAFCI) geared towards opening contraceptives to include girls aged 12 years and above is evidence of efforts to supplement legislation to improve access (Bhuda & Sekudu, 2016).

Other such policy drives include the release of the *National Contraceptive Policy Guidelines* in 2001. These guidelines redressed the marginalisation of certain contraceptive users and marked a shift towards more liberatory considerations in contraceptive provision. To do this, revisions of contraceptive policies were undertaken in which quality care, rights and informed

choice were emphasised as essential (Bhuda & Sekudu, 2016; Lince-Deroche et al., 2016). Further amendments were released in 2012 in the *National Contraception and Fertility Planning Policy* and *Service Delivery Guidelines and the National Contraceptive Clinical Guidelines*. The revised policy and guidelines promoted dual protection and saw merit in using contraception to reduce maternal mortality and mother-to-child transmission of HIV. They addressed contraindications in contraceptive use among women living with HIV and the use of hormonal contraceptives alongside other drugs, particularly antiretroviral and tuberculosis drugs (Lince-Deroche et al., 2016). More importantly, they also foregrounded choice for men and women in contraceptive decision-making alongside removing barriers to contraceptive access for all ages (Bhuda & Sekudu, 2016). As argued by Lince-Deroche et al. (2016), "access to contraception has become a de facto proxy indicator for access to sexual and reproductive health services" (p. 96).

There is an urgent need for high-quality contraceptive counselling in South Africa and globally to ensure women's reproductive rights are informed and unbiased, even among young people, whose circumstances are often considered unique (Raidoo & Kaneshiro, 2017). As such, the 2019 *South African National Contraception Clinical Guidelines* address issues of equality, side effects, and barriers and provide guidelines on contraceptive counselling, particularly about LARC technologies. It is stated that "while there are many advantages to LARCs, informed decision-making and balanced, unbiased counselling is critical. It is also of paramount importance to consider all methods of contraception (barrier, short and long-acting reversible and permanent methods) in the context of the client's life and needs" (National Contraceptive Clinical Guidelines, 2019, p. 6).

While the above-mentioned much-celebrated conferences, legislative changes, initiatives and policies allow for a critical reflection on the reproduction of women, authors should refrain from referring to oppressive population control strategies as a phenomenon that ended post-1994 (Hendrixson, 2019) or after the enactment of liberatory laws such as the CTOP Act (Mavuso, 2017). More subtle strategies for population control are currently in existence. For example, the way in which programmes such as the global Family Planning 2020 initiative capture the language of the post-ICPD shift towards equitable rights and quality health access and yet evaluate success through fertility reduction casts doubt about the implementation of a rights-based approach (Senderowicz, 2020). This is because birth control targets such as those stipulated in a country's MDGs are argued to have a bearing on the prescription of contraceptives. In the quote below, Hendrixson (2019) discusses governmental quotas as

potentially exerting pressure on healthcare providers to encourage uptake among clients to breakeven with unmet contraceptive needs.

> When there is a lag between contraceptive availability and the number of individuals who wish to access it, demographic goals should not be imposed on family planning providers 'in the form of targets or quotas for client recruitment' in order to increase dissemination rates (Hendrixson, 2019, p. 787).

Contraception targets thus show bias; they impel those in authority to work towards attaining them, sometimes in unconstitutional ways. For example, Senderowicz (2019) identifies the incentivising of contraceptive provision to achieve micro and macroeconomic goals, which also function as a risk to women's reproductive agency. Identified incentives are not necessarily gratuities or monetary gifts. Instead, "numbers are used as a principle (sic) way to evaluate health centers and that there are even informal competitions at the district and provincial level to see who can get the best numbers" (Senderowicz, 2019, p. 4). Hence, system-centred approaches to contraceptive provision such as this that subtly attempt to limit barriers to contraceptive use at all costs, teetering on coercion are problematised in the literature (Saunders, 2018; Senderowicz, 2020).

14. The missing context

A problematic assumption previously identified by Hayter (2003), but one that persists, is that "compliance by women is a universally positive outcome in contraceptive counselling and therefore measures to increase it are the key aims of clinical practice" (p. 12). Guided by this view, fertility reduction and the responsibilising of contraceptive users are intertwined, after which contraceptive failure and non-compliance are problematically rendered as the contraceptive user's doing. In this individualisation, the influence of the contexts in which contraceptive users are embedded is stifled. In addition, the polarised categorisation of certain bodies as operating within the bounds of perfect use and others as operating outside is created; those operating outside are problematised as "risky and troubling" (Downey et al., 2017, p. 540). Moreover, compliance-centred talk can promote paternalistic models of counselling in which medical experts are invited to dominate the conversation and direct contraceptive users, thereby creating passive and compliant subjects rather than dialogically tailoring conversations towards contraceptive users' needs (Senderowicz, 2019), which include non-use as a valid decision.

Saunders (2018) argues that decision-making that overstates the role of the individual as freely choosing contraceptive methods does little to acknowledge the structures in which the decisions are enacted. Therefore, the subject's ability to freely choose and the implications of such choices require critique. That is, how has structure determined contraceptive users' decisions? In light of these considerations, a critical stance must be maintained in considering how LARC technologies are promoted by the literature, policymakers and health practitioners, which the study seeks to do. The bulk of literature that has advocated for a critical lens in the promotional efforts of LARC within policy and clinical practice emanates from the US and UK context (Brian et al., 2020; Gomez et al., 2014; Hayter, 2006; Higgins & Smith, 2016; Manzer & Bell, 2021) Not much research on the South African context has explored how contraceptive decision-making inside and outside clinical interactions shapes LARC technology uptake despite usage increasing through the years (National Contraception and Fertility Planning Policy and Service Delivery Guidelines, 2012).

Most South African studies have avoided investigating modern contraception from a decision-making perspective. Research has primarily focused on knowledge, attitudes, and perceptions towards contraception (Adeniyi et al., 2020; Chimere-Dan, 1996; Gutin et al., 2011; Mandell et al., 2021; Mrwebi et al., 2018), yet advancements in literature towards agency can be seen in HICs. This research trend reflects how the global South has been framed as lagging behind the rest of the world in upholding ideals around small families, thereby paving the way for overt and subtle imposition of contraception (Takeshita, 2004).

More recently, a growing literature investigating decision-making and agency vis-à-vis birth control provision and use in South Africa has been found (Hayer et al., 2022; Margherio, 2019; Sullivan et al., 2018). The bulk of these qualitative studies that do explore decision-making in South Africa focus on condom use (Ndinda et al., 2017) or, more broadly, reproductive decisions, which include abortion decision-making (Chiweshe et al., 2017; Mavuso & Macleod, 2021; Willan et al., 2020). Contraceptive decision-making has thus been explored once pregnancy and abortion have occurred. These studies report on health users being pressured toward some form of contraceptive post-abortion and, more often, LARC technologies (Brandi & Fuentes, 2020; Chiweshe et al., 2017; Mavuso & Macleod, 2021). Options towards non-use are often omitted (Mavuso & Macleod, 2021), with LARC technologies "framed as the only responsible contraceptive option" (Mann & Grzanka, 2018, p. 334).

Research has also centred on motivations, intentions and preferences around contraceptive use postpartum among women living with HIV (Adeniyi et al., 2020; Mandell et al., 2021; Marlow et al., 2015; McTigue et al., 2022; Towriss et al., 2019). This research has identified factors affecting decision-making, such as learning one's HIV status (Marlow et al., 2015), preferences for injectable contraceptives over other forms of LARC (Adeniyi et al., 2020), and partner influence on decision-making (Mandell et al., 2021).

Inquiries into agency within interactive spaces include that by Maharaj and Cleland (2005). In a study titled *Women on top: The relative influence of wives and husbands on contraceptive use in KwaZulu-Natal,* the authors conducted a survey investigating couples' stances on contraception and the implications for uptake. Despite spousal disapproval in some couples, the authors report on women significantly taking on this decision-making. Marlow et al. (2014) explore contraceptive users' and nurses' perspectives on family planning promotion postpartum in KwaZulu-Natal and report on nurses' over-interpretation of contraceptive guidelines. The authors express caution about the sexualisation and the resultant coercive counselling techniques used to enforce contraceptive uptake among postpartum women.

Fataar et al. (2022), Hayer et al. (2022), and Margherio (2019) have also researched contraceptive agency. Fataar et al. (2022) report on healthcare providers as the facilitators and inhibitors of women's rights and preferences despite the value placed on consistently allowing agency. Hayer et al. (2022) frame contraceptives as a moving target, arguing that contraceptive users need the freedom to continue to decide. Margherio (2021), in exploring use among adolescent modern contraceptive users in Agincourt, South Africa, reports that women often assume responsibility for contraceptive use. The author, however, also complicates the notion of agency among subjects who are assumed to be able to refuse sexual intercourse in the context of partners who demonstrate aversiveness towards condoms. Subjects must be proactive and remain alert to condom bursting or stealthing by male sexual partners (the clandestine removal of condoms during sexual intercourse) or, where the male sexual partner disapproves, conceal contraceptive use. Decisions about contraceptive use, pregnancy and abortion are identified by the author as being decided upon by weighing the costs and benefits of various factors such as accessing contraceptives and disclosing sexual activity and side effects. However, the author does not sufficiently locate agency within the structural constraints under which this agency is enacted. The notion of situated agency, discussed in chapter three, can resolve these tensions.

15. Defining contraceptive decision-making

Decision-making, as it relates to contraceptive prescription, has been defined as an endpoint in which clients reach a conclusion about the choices offered. Information sharing is expected to precede this decision and not vice versa. This includes information about side effects and efficacy-related information that, when shared, facilitates the production of informed subjects (Hayter, 2006). As such, decision-makers have also been likened to economic man. "What is an economic man like? He has three properties: (a) He is completely informed. (6) He is infinitely sensitive, (c) He is rational" (Edwards, 1954, p. 381). Formulated in this way, economic man recognises decision-makers who, with all the information needed (informed), are fully aware of what decisions to avoid (sensitive) and, thus, bestowed with such knowledge, enact decisions that best suit their needs and preferences (rational). This is because they know the consequences of each decision path (Edwards, 1954).

Neoliberalism has also recognised the same economic man, also known as *homo economicus,* regarding choices and decision-making. Neoliberalism connotes an individualised, rational, enterprising subject who, through consumption, enacts decisions and choices on commodities within a privatised marketplace (Hamann, 2009). *Homo economicus,* then, is the active subject who self-fashions and maximises his own well-being within a neoliberal government rationality. However, the well-being of the community is also tied to his decisions. Thus, the cost-benefit analysis he is obligated to consider, and its outcomes are not consequential to him alone. Instead, poor outcomes are rendered individual failure, typical of economic deviants (Macleod, 2002). In so doing, contextual issues that hinder individual access to "suitable" choices and decisions are concealed since "those who fail to thrive under such social conditions have no one and nothing to blame but themselves" (Hamann, 2009, p. 38).

Some authors have also defined decision-making as age-specific, with adolescents often presenting as deficient and likely to be influenced by peer pressure. As such, adolescents' ability to decide, which includes weighing multiple odds and subsequently enacting a choice, is understood as attained with practice, whereas it is reached in adulthood. That is, it is only later in their adolescence that young people obtain this ability (Commendador, 2010). Correspondingly, studies have drawn on biomedical research to question and even prove adolescents' decision-making ability as inferior, contributing to reduced agency (e.g., Govender et al., 2020). Govender et al. (2020) argue the following:

> The social emotional system, involving the amygdala matures more rapidly than the prefrontal cortex (cognitive control system). As the prefrontal cortex is still developing, adolescents may make decisions and solve problems guided by the amygdala, a portion of the brain responsible for emotions and emotional behaviours, leading to increased reward seeking (p. 2).

Scientific information such as the above can influence health promotion messages or policy implementation. As a result, this may inform parents' reasons for directing rather than guiding young adolescent women's contraceptive behaviour (Commendador, 2010) or healthcare providers selecting birth control methods on young adolescent contraceptive users' behalves and further undermining their ability to choose. Mkhwanazi (2006) and Macleod (1999, 2003) problematise the constructions of the "vulnerable" teenager with Macleod (2003; 2020), arguing that these are rooted in colonialist discourses, which construed adolescence as a distinct developmental stage and not synonymous with motherhood. This results in decisions often being socially managed by others while young people's decisions are second-guessed, criticised and condemned regarding contraceptive use. A polemic construction of good and bad decision-makers is thus produced, one that includes not only young women but also poor, migrant women and people living with disabilities.

Contraceptive decision-making is defined as a deeply contextual process encompassing various issues, including side effects, but not limited to them (Downey et al., 2017). For example, values, relationship stage (Downey et al., 2017; Madden et al., 2015), bleeding preferences (Fataar et al., 2022) and sexual debut (Commendador, 2010) all impact contraceptive decision-making. While these indices that affect preferences can now be considered significant, women have not always been endowed with the right to resist decisions enacted on their behalf around contraceptive use. Personal preference, which looks unique for most women, is why one-size-fits-all counselling does not have a place in preference-sensitive matters such as birth control. However, Saunders (2018) cautions against the overstating of contraceptive users' agency within decision-making as "women's seemingly private choices are intertwined with others, policy, structures, and the public" (p. 264).

16. Chapter guide

Chapter 2 of this dissertation presents scholarship on LARC. I begin by setting up the importance of LARC through a discussion of the drawbacks of traditional and short-term birth control methods and practices, which have created the demand for LARC. I also acknowledge

the scepticism with which the topic has been understood through debates on whether the widespread use of LARC represents population control or empowerment strategies. The uncritical promotion of these technologies as a one-size-fits-all answer to health users' reproductive needs, in turn overlooking their imposable nature, is discussed in relation to postpartum, young and post-abortion women. I then discuss inequitable access due to structural barriers, which privilege a few. In later sections, I discuss different identifiable models of contraceptive counselling. To do this, I begin with an exploration of the history of counselling within sexual and reproductive health. Literature around decision-making models as either provider-controlled or patient-controlled is explored, as well as the call for these decisions to be neither provider-centred nor patient-centred, but a shared decision between both stakeholders follows.

Chapter 3 discusses women's and healthcare providers' constructions of the decisions to use LARC technologies through the theoretical frameworks that undergird this study, namely, reproductive justice, Foucauldian discourse analysis (FDA) and decoloniality theory. Reproductive justice advocates for the entrenchment of reproductive rights for all, showing how rights to use and refuse contraception can be reserved for those with privilege. FDA, through the notion of the power/knowledge nexus, demonstrates how the subject is imbricated in power relations informed by discourses that define the subjects as either the patient or medical expert, which have implications for ways of being and acting. I also draw on Ndlovu-Gatsheni's (2013) notion of coloniality of power, knowledge and being to reflect on how discourses and the micro-narratives produced by the participants within the interview context extend or disrupt coloniality.

Chapter 4 serves to explain the methodological steps taken to gather and analyse the data on contraceptive users' and healthcare providers' micronarratives around using and prescribing LARC. I begin by explaining the methodological commitments of a Foucauldian discourse analysis. I follow this with Barker's (2017) notion of the emplotment of discourses into narratives. I show how combining the methods (FDA and emplotment) allows for the creation of a looser, more active subject that is not so predefined within dominant medical discourses. I then state the research aims and questions that this inquiry was centred around, followed by an explanation of the sampling strategies for obtaining healthcare providers and LARC users and the characteristics of the sample that was ultimately yielded. Steps for data collection and analysis are discussed. Furthermore, the ethical considerations that were made, how methodological rigour was upheld throughout the study, and reflexive notes are discussed.

Chapter 5 is one of three analytical chapters. It focuses on the discourses underlying contraceptive users' micro-narratives about the decision to use LARC technologies. I begin with discourses used by contraceptive users who owned the decision to use contraceptives. Later sections explore data from those who constructed decisions as enacted on their behalf, as well as those who defined the decisions as shared decisions or who decided against contraception in fear of stigma. The emplotments allowed and disallowed by the talk are also analysed. Findings suggest that decisions to use contraception are personalised or externally imposed, but also personal decisions to not use contraception, as well as shift contraceptive responsibility, could be private or shared. In individual decisions to use contraception, health users, through a self-responsibilisation discourse, owned the obligation and circumstances under which contraceptives had to be sourced. Other role players were framed as not having a bearing on such user-determined decisions as the decisions were understood as having utility for the contraceptive user. In externally-enacted decisions, contraceptive uptake was negotiated in forceful ways by female guardians through adolescence-as-transition and risk discourses, which emplotted the young women as "too young" and at "risk". Shared decision micro-narratives drew on a medical discourse in which users' embodied experiences were depicted as conditions to maintain or shift contraceptive duty through talk within their intimate partnerships. In addition, mentorship discourses were used within parent-child relationships to support and guide young women through dialogue and to share parents' own experiences towards LARC usage while careful not to impose or coerce use. A traditional femininity discourse informed the personal decision not to use contraception.

In **Chapter 6,** healthcare providers' constructions of contraceptive users' decisions to use LARC are explored alongside the emplotments availed and restricted by the talk. The analysis begins with exploring micro-narratives around the healthcare users seeking contraception. Micro-narratives around the contraceptive provision follow it. Findings suggest that decision-making within contraceptive counselling encompasses a collective of other decision-makers that can occlude agency in the strict sense. For example, through a planning parenthood discourse, the secret use of contraception was given a positive spin. Such secret use reportedly resisted pronatalist pressures experienced by women who expressed no interest in childbearing or wanted to stop or delay childbirth in the context of sexual partners who desired fatherhood. Many healthcare providers also drew upon a male reproductive pardoning discourse to exclude men from contraceptive decisions and place responsibility upon females. Healthcare providers also leveraged risk and adolescence-as-transition discourses to exclude young women from

decision-making over their bodies or to support contraceptive provision among non-consenting women. Within this talk, alliances between the female guardians and the providers, where the young women were depicted as untrustworthy and vulnerable to "bad" influences and therefore required interventions from female guardians (and providers), were apparent.

Tensions in contraceptive provision were also evident in stories of provision. Through rights and choice discourses, healthcare providers were emphatic about decisions to use or not use contraception, remaining patient-centred. However, issues around limited uptake created the space for certain contraceptives to be omitted from the consultation space, thus constraining choice while oversubscribing particular measures. In addition, some healthcare providers were reticent around allowing certain women, e.g., young and postpartum women, access to certain choices, thus pointing to directive counselling practices.

In **Chapter 7,** I discuss findings around health users' contraceptive counselling experiences. To do this, I explore the resultant power struggles between the medical practitioners and contraceptive users using three emergent micro-narratives: information and decision-making was expert-led, information and decision-making was patient-led, and the information and decision-making was collaborative. The expert-directed decision-making micro-narrative maintains unequal power relations by inhibiting bi-directional information exchange, which places the healthcare provider at the centre of the conversation while the client assumes a peripheral role. Decisions are thus enacted by the medical expert on behalf of the patient, drawing on biomedical discourses, thus precluding agency. The patient-led decision-making micro-narrative emphasises the patients' agency; this way, the health user plays an active role in all decisions. She, through questioning, tailors and structures the conversation towards the desired contraceptive measure and thereby, at times, forecloses information-sharing on other contraceptive technologies. In turn, the healthcare provider is construed as responsive to the requests made by the client. As such, minimal input from the healthcare provider is required, and decision-making is consequently left to the client. Lastly, the embodied experiences contraceptive users contend with are valued, while healthcare providers' expertise and knowledge offered through the provision of the chosen regimen, care and information sharing are also given precedence in the collaborative decision-making micro-narrative. Medical experts and contraceptive users are thus partners in decision-making within this configuration of provider-patient relationships.

In **Chapter 8,** I review the findings in chapters six, seven and eight in relation to the research questions undergirding the study and existing literature on contraceptive use. To do this, I summarise how participants within the two datasets deployed discourses and micro-narratives in constructing decision-making about contraceptive use, while also stating the narrative emplotments and relations of power availed and constrained by the talk. This summary is followed by a discussion of acts of resistences health users showed in certain micro-narratives. I argue that the absence of similar acts of resistances in healthcare providers' accounts point to an over-commitment to providing contraception. The study's findings are also compared and contrasted with the existing literature on contraceptive use. I end the chapter with a postcolonial, consideration of how signifiers, such as fertility control within the data create binaries in which certain women feature as less developed and thus not deserving agency, as well as a conclusion section, which contains a discussion of the implications of my research and of future studies.

Chapter 2: Situating LARC

1. Introduction

The lowest fertility rates due to wider contraceptive use within sub-Saharan Africa are found in South Africa. Nevertheless, discrepancies in access within the country are prevalent with, for example, urban/rural divides that require bridging (Margherio, 2019). Structure, therefore, denies certain women access to modern contraceptives in places with high contraceptive prevalence rates; at the same time, uptake can be coerced. That is, inequality acts as a barrier to access to use and enables the domination of some women, denying them the right to non-use of contraception. However, Margherio (2019) also states that even though coercion can be identified in contraceptive users, agentic users who have rejected the obligation to accept modern contraceptives they do not desire can be found. Despite this heterogeneity, low contraceptive usage among those who desire modern contraceptives is a common issue globally (Blumenthal et al., 2013; Cahill et al., 2018; Cordero et al., 2019; Hayer et al., 2022).

Research links low contraceptive usage with mistimed or unwanted pregnancies, citing failure to use birth control while sexually active among women in their twenties as resulting in an 85% likelihood of pregnancy, with this likelihood being 90% for adolescents (Sundstrom et al., 2015). High fertility rates are thus shored up by absent or low contraceptive use (Cleland, 2009). It will, however, become increasingly clear that high fertility rates and their regulation through contraceptive provision as a common good available for all who need it is misleading. Instead, slippages in decision-making as an individual and a societal one affect certain women's interactions with contraceptive services and, ultimately, their reproductive destinies in governmental drives towards creating the desired population.

In this chapter, I discuss literature on the rise of contraceptive use, situating the discussion around constructions of birth control as either population control or empowering reproductive technologies. Following this, I focus on the different promotions of LARC and the overenthusiasm that can lead to coerced provision among "high-risk" women. The acceptability of the methods when considering sexual pleasure, bleeding patterns, fertility, and STI vulnerability is evaluated. I then turn to the accessibility of these technologies, explicating the different barriers of central concern regarding LARC. In later sections, I review the literature on contraceptive counselling. In so doing, I explore various contraceptive counselling models, situating decisions as predominantly either expert-led, patient-led or collaborative.

2. LARC as empowering

While short-term contraceptives have had longevity within markets, the focus has moved to one-time-intervention methods that, once placed or inserted, circumvent pregnancy over extended periods (Takeshita, 2012), i.e., LARCs. Apart from offsetting the necessity for user action, the long-acting nature, effectiveness and invisibleness of LARC technologies have often been identified as empowering components of these reproductive measures, particularly at their inception (Takeshita, 2012). LARC technologies, unlike their short-term counterparts, allow women to limit fertility with accuracy over extended periods. For example, Copper T IUDs can be retained for 10-12 years, while *nur-isterate*, a type of injectable contraceptive, is effective for eight weeks. In addition, when used perfectly, these contraceptive technologies promise a less than 1% likelihood of pregnancy, thus proving highly effective (Winner et al., 2012). Some researchers have thus likened them to sterilisation (White et al., 2013; Winner et al., 2012). As such, many women in Anglo-Saxon locales, inspired by choice rhetoric discourses of the 1970s, and later women in African, Asian, and Latin American countries inspired by state interventions (Cleland, 2009), could "enjoy sex freely without the fear of unwanted pregnancy" (Tamale, 2016, p. 118). That is, a waning of the dread associated with unintended pregnancies by some women could be experienced through these contraceptive technologies (Takeshita, 2012). McRobbie (2007) adds that this enabled the forging of a new sexual script:

> On the condition she does not reproduce outside marriage or civil partnership, or become the single mother of several children, the young woman is now granted prominence as a pleasure seeking subject in possession of a healthy sexual appetite and identity (p. 732).

LARC technologies' invisible nature also contributes to the notion of these measures as empowering, particularly since the IUD is placed inside women's uteri and implants and injectable contraceptives are placed and inserted respectively in users' arms and subcutaneous muscles. This way, users are endowed with privacy as certain people are not privy to information about contraceptive use (Sargent & Kotobi, 2012). Contraceptive decisions can exclude interpersonal relationships (Bedrov et al., 2021; Saunders, 2018). For this reason, researchers have associated LARC technologies with confidentiality or secrecy (Biddlecom & Fapohunda, 1998; Francis & Gold, 2017) and hailed them as offering women previously unavailable reproductive choices and decisions.

The power to regulate one's fecundity, alongside the obligation to do so in silence for some women, points to issues of patriarchy and gender inequity, reinforcing the notion that agency is enacted within structural constraints (Margherio, 2019; Sullivan et al., 2018). For example, some married women and young women, respectively, have needed to mitigate gendered and intergenerational power dynamics. Indeed, Tamale (2016) reports on contraceptive decision-making historically necessitating written consent from husbands between the 1950s and1980s, informed by presuppositions about men as heads of households who determine all decisions. Contraceptive uptake could thus not be independently made by women who desired to do so. However, in a study conducted in Malawi, Kok et al. (2020) report on healthcare providers quietly (sometimes after hours) assisting married women with contraception without their husbands' knowledge. These were deemed as private arrangements with other men's wives with the potential of, upon discovery, ending in divorce (Kok et al., 2020). Healthcare providers can, thus, given the invisibility of LARC technologies, also collude to allow women to choose alternative reproductive destinies for themselves discreetly.

In light of the grace healthcare providers sometimes show young women in concealing contraceptive use (Chilinda et al., 2014), Wood and Jewkes (2006), in a study conducted among adolescent women in South Africa, also reported that by concealing usage, some adolescent women could circumvent pregnancy despite having sexual partners who desired parenthood. These young women's choices and decisions were thus not limited to those made by their partners, as they could make alternative ones without their partner's knowledge. However, some male partners, in response, reportedly used physical violence or discarded the women's clinic cards to impregnate their contraceptive-using partners (Wood & Jewkes, 2006).

This affirms the assertion that "women in some societies who contracept against the wishes of their husbands [as well as sexual partners] or in-laws take considerable personal risks since angering them could lead to domestic violence and divorce" (Takeshita, 2012, p. 2). According to a study conducted in Malawi on married women, other outcomes of the decision to secretly use birth control include abandonment (Kaneka & Mturi, 2015). Despite this, Tamale (2016) notes the "subversive acts of agency demonstrate the extent to which women will go in the exercise of sexual autonomy" (p. 119).

In exploring the motivations for the secret use of contraceptives in Malawi, Kaneka and Mturi (2015) assert that behind concealed LARC use was an attempt to fulfil women's desire for wider spaced births, which would allow them to lose the weight gained during pregnancy.

Other beenfits include the resumption of sexual activity following the traditionally restricted period, which is the period of pregnancy and childrearing (6 months – 2 years). Secret delaying of births was also interpreted as a buffer against infidelities by their husbands, understood as maintained by bans in sexual relations during pregnancy and postpartum (6 months - 2 years). Small interpregnancy intervals thus created more opportunities for infidelity. In addition, secret contraceptive use could be a proactive response against pregnancy during periods of instability and conflict within the relationship. However, most women in the study distanced themselves from the hidden use of contraception, framing it as disrespect to one's husband and a cover-up for the secret contraceptive users' extramarital affairs (Kaneka & Mturi, 2015). Contraceptive use is thus not only policed by sexual partners who desire to claim, control, and time reproductive decisions on their own accord. Women in other studies have also shamed its private use, identifying it as denigrating the family rather than women determining their reproductive destinies (Lowe, 2016b).

Apart from intimate partnerships and the potential inequities inherent in these relationships, research also states that young women can quietly administer LARC technologies without their parent's knowledge (Harden & Willig, 1998; Margherio, 2019). This can be representative of attempts to retain cultural assumptions of "sexual innocence" (Furstenberg et al., 2017; Gyan, 2018; Makhaza & Ige, 2014; Wood et al., 1997) and to avoid parental disapproval of sexual activity, posing as sexually innocent instead (Gyan, 2018). As such, Sweeney et al. (2015), in their study conducted in Ireland, found that some young females were anxious about parental responses to contraception; some were ashamed of using them, so they privatised use. Similarly, Bhuda and Sekudu (2016) report on secret contraceptive use among young women in South Africa, and link it to cultural beliefs about sexual activity outside the confines of marriage as unacceptable.

While secret uptake can be a healthy choice or decision, as LARC uptake indeed contains a defensive aspect to oppressive conditions, due to its invisibility, researchers have also questioned whether this muted resistance is indeed empowerment (Morison et al., 2022). In addition, a growing body of research has argued that the promotional work around contraceptives as empowering often uses the technologies to gloss over the fundamental structural issues that need to be addressed, which include that "men often remain in control of decisions regarding fertility due to pervasive traditional norms" (Trombley, 2022). In other words, in regarding the secret use of contraceptives as an act of resistance or as empowerment,

the system of patriarchy remains unchallenged, albeit reproductive preferences are met. A split in conceptions of secret contraceptive use as empowering is thus evident in the literature.

Beyond gendered and intergenerational relations and the inherent silent resistance, contraceptive users' embodied experiences of LARCs have been considered central to their acceptability; for example, some women associate LARC use with the freedom to control their reproduction. However, Zeal et al. (2018) and others argue that LARC curtails women's sense of reproductive freedom when they consider the chances of infertility linked to using contraceptive technologies (Bornstein et al., 2021; Wood & Jewkes, 2006). There is scepticism among some women about the reversibility of these contraceptive measures, which do not entirely allow all users to feel free or empowered while using the technologies.

In further problematising the contraceptive measures, some users have reported "anxieties about hormonal contraception disrupting their 'natural' bodies" (Hoggart & Newton, 2013, p. 197), thereby rendering contraceptives "foreign bodies" (Zeal et al., 2018, p. 29) that disrupt bodily processes. Some researchers have endorsed the copper IUD, a non-hormonal alternative to avoid the introduction of hormones into the body. As a result, some users have received these forms of IUDs with enthusiasm, with maintaining a well-regulated menstrual cycle as some of the benefits associated with use (Burns et al., 2015). However, the menorrhagia (heavy-bleeding) copper IUDs induce in some users can be understood by tying in the "notion of the 'leaky body', whereby leakage (in this case menstrual bleeding) is seen as symbolic of women's lack of control over their bodies" (Hoggart & Newton, 2013, p. 196).

LARC technologies have also signified a transfer of control from the woman to the healthcare provider, particularly regarding insertion and removal, given the medical expertise required (Higgins, 2014; Morison et al., 2022; Yirgu et al., 2020; Zeal et al., 2018). Therefore, in addition to the side effects experienced, contraceptive users often experience loss of control because of the contraceptives' imposable nature, whereby contraceptive provision can be an intervention by others rather than a decision or choice to which they have consented (Gomez & Wapman, 2017).

In response to the debate of contraceptive technologies as empowering or disempowering, Takeshita (2004) avoids this polarisation and contends that contraceptive technologies are neither liberating nor disempowering. Instead, the ascribed meanings are significantly influenced by the politics of the time and place. As a result, reproductive choices are often made within the frame of discourses present at a given time, influenced by interventions by

others or by one's reproductive desires (Takeshita, 2004). The next section discusses the domains of negotiation in which LARC technologies have been made and their bearing on decision-making and agency.

3. LARC and responsibilising of women

Lowe (2005), Saunders (2018), Watt (2001), Wigginton et al. (2016) and many others are critical of interventions that have purely targeted women to educate, alter perceptions around contraceptives and encourage uptake, thus construing reproductive health as synonymous with women. Yet, the development of contraceptive measures such as IUDs, implants and injectable contraceptives that offer women more reproductive control, including encouraging women to supply male condoms before sexual intercourse, demonstrate that reproductive-age women are increasingly held accountable for sexual encounters (Lowe, 2005).

"Ideas of 'uncontrollable' male sexuality continue to enforce/reinforce women's responsibility for contraception" (Lowe, 2005, p. 77). In turn, male unwillingness to use contraceptives or share the contraceptive load is normalised (Saunders, 2018). In common with Lowe (2005) and Saunders (2018), Dalessandro et al. (2019), in their study conducted on college men in the US, found unspoken expectations and subtle tactics used to maintain the taken for granted assumption that contraceptive use is a female responsibility. To do this, males avoided conversations about birth control before and after sexual intercourse, thus implicitly opting out of contraceptive duty. The authors referred to this male silence and responsibilisation of females as "strategic silence". This deference of contraceptive duty stands in opposition to the reproductive control by some males, as seen in section 2 of this chapter.

Responsibilising women can challenge patriarchal structures by endowing users with agency in determining their reproductive outcomes or asserting choice, as already stated. Yet, the expectation of women to gatekeep pregnancy can intensify the individualisation of vulnerabilities and sexual and reproductive health problems. Responsibilising women is further problematic for the following reasons. Firstly, in rendering women sexually responsible in enacting the decision to use birth control, men are conversely constructed as an absent-presence in contraception (Lowe, 2005). This strengthens traditional notions of women as sexually passive and "rational" decision-makers in sexual matters while conversely construing males as unable to control their sexuality and assume contraceptive responsibility. Secondly, an assumption is made that women do not struggle with exerting overt (as opposed to covert) control over contraceptive use. For example, research suggests some women struggle to

negotiate contraceptive use with their partners, particularly in relationships that exchange gifts for sex (Madiba & Ngwenya, 2017; Moore et al., 2007). Thirdly, responsibilising women brings forth debates about contraception as a medical versus a sexual good for women: the impact of contraceptive technologies on a woman's health and sexual functioning is not often considered, whereas it is carefully considered for men (Higgins & Smith, 2016). For example, while "advertisements for male condoms and erectile dysfunction medications highlight sexual pleasure and enjoyment as the product's main selling points, few erotic scripts of contraceptives used by women exist in mainstream culture" (Higgins & Smith, 2016). Therefore, women are expected to assume contraceptive responsibility despite the consequences on their sexual functioning. Lastly, according to the findings of a study conducted by Lowe (2005) in the UK on heterosexual women's contraceptive use, women who claim they are in control of their sexuality often foreground their partners' sexual interest when considering contraception, even when they claim not to discuss contraception with their partners. Hence, Higgins and Smith (2016) argue that "contraception is not always a tool of individual feminist empowerment; it can also be used as a means of social control and disempowerment" (p. 430).

In response to the feminisation of contraception, there is a growing body of work that explores the absence of males in interventions investigating knowledge, attitudes, and perceptions around contraceptive use (Hardee et al., 2017; Littlejohn, 2021; Tuloro et al., 2006; Yue et al., 2010). While male inclusion in birth control is expected to be beneficial, in an article titled *Would women trust their partners to use a male pill?* Glasier et al. (2000) explore women's views of male hormonal contraceptives in Cape Town (South Africa), Edinburgh (UK), Shanghai, and Hong Kong (China). The study found that most women were enthusiastic about males sharing the contraceptive load. However, issues around whether men would use contraceptive technologies reliably arose, particularly among women in South Africa and Shanghai. This distrust continues to feminise contraceptive uptake. Notwithstanding this, given that sex is often coerced in South Africa and condom use is a complex negotiation process (Jewkes et al., 2009), caution in involving men in controlling women's fertility and reproduction is probably wise.

4. Contraceptives as a form of eugenics

While contraceptive use can be assumed to be a female issue, not all females are expected to reduce their fertility or allowed to remain fertile. Throughout history, various states and organised bodies have astonishingly monitored, evaluated and intervened in certain women's

reproductive practices, encouraging and discouraging use accordingly. As such, "minority groups" such as people living with HIV, people with disabilities, sex workers, young, socioeconomically disadvantaged, LGBTQI, and incarcerated people have been denied this right to bodily integrity. Reproductive coercion of this sort can be traced to eugenicist projects with attempts to manipulate and design populations that would limit traits deemed "undesirable" (Kathawa & Arora, 2020; Klausen & Bashford, 2010; Ross & Solinger, 2017; Stepan, 1991).

Eugenics denote population control strategies for "race improvement" by advocating for selective breeding (Klausen & Bashford, 2010). These practices have increasingly "generally been seen as a dark chapter in the history of early twentieth-century medicine, a tragic instance of medicine overreaching itself" (Garton, 2018, p. 22). But, to various degrees, eugenics continues to operate in both old and new ways, as will be seen. Common reasons for this desire to selectively sift out certain reproductive patterns by preventing those deemed "undesirable" or "burdensome" and encouraging those culturally constructed as "desirable" within the population (Klausen, 1997) have centred around the elimination of certain biological traits in the population as well as considerations about the mothers' mental capacity to care for children (Nkala-Dlamini & Twala, 2022). To achieve these goals, eugenics assume many forms, for example, forced sterilisations, coerced contraceptive uptake, and selective unions, alongside elitist women being given tax relief in exchange for higher parity (King, 2001; Macleod & Morison, 2020).

Forced sterilisation of women with mental and intellectual disabilities is identifiable in the literature with the signifier "feeblemindedness" (Klausen, 1997) used to medicalise and later revoke reproductive rights in people with intellectual disabilities (Carey, 2003). In addition, families have also been known to sterilise family members living with disabilities due to concerns about their susceptibility to sexual abuse or sexual victimisation (Amborski et al., 2022; Plummer & Findley, 2012; Wu et al., 2018). Mthembu (2022) also reports on nearly 30 years of forcible sterilisations among women living with HIV, with the earliest documentation being in 1997 in South Africa. Another illustration of this sterilisation is evidenced by unconsented sterilisations of lower-income, Black female prisoners in the US (Gomez et al., 2018). Women of colour were coerced into sterilisation, paid or given welfare benefits for using IUDs to lower the Black population in the US (Higgins, 2014). In addition, in the 1980s, the questionable promotion of the *Norplant* (a subdermal implant) and sometimes even coerced provision among African-American women was also evidenced (Zeal et al., 2018), which Brian

et al. (2020) identify as a form of soft sterilisation or stratified reproduction, according to Moniz et al. (2017). At the root of these violations is the notion that these subjects are "unfit" to reproduce; thus, someone "healthier" is expected to take on this role.

However, in New Zealand/Aotearoa, it is argued that eugenics was not based on "race betterment". In fact, "miscegenation" between the Māori and Pākehā (European) citizens of Aotearoa was encouraged (Wanhalla, 2007a). Instead, classist notions fuelled the eugenic movement with middle-upper income Pākehā (European) women encouraged to reproduce to curb the dominance of "defectives" or the "feeble-minded", seen as lower-income reproducers and those living with mental disabilities within the population (Spencer, 2018). This followed a decline in the birth rate among middle-upper-class women (Wanhalla, 2007a). Despite this, the invisibility of Māori women in policies and regulations points to subtle attempts at marginalisation (Green, 2011; Morison et al., 2022).

In South Africa, profiling certain women as more eligible than others for contraceptive use is rooted in the country's pre-apartheid and apartheid history. In explaining the rapid expansion of modern technologies in the country, Klausen (2004, 2018) and Burgard (2004) respectively argue that the "undesirable" growth of lower-class Afrikaans-speaking women was deemed as representative of the degeneration of the white race and thus curbing births in this cohort would address this so-called "poor white problem" during 1930-1939. This targeting and encouragement of "inferior poor whites" (Horwitz, 2007, p. 615) to limit their fertility set the scene for the roll-out of modern contraception, in particular, imposable injectable contraceptives in the homelands and other areas designated for Black South Africans when the Black population was deemed to have exceeded the government's carrying capacity in the 1960s-1980s (Burgard, 2004). As such, before 1994, "long-acting injectable contraceptives were strongly promoted for black women, particularly in rural areas, while the oral contraceptive pill, a more reversible method, was promoted for white women" in South Africa (Cooper et al., 2004, p. 71). Critics argue that availing short-term contraceptives to this cohort was a strategy devised "to hold onto white minority rule" (Bhuda & Sekudu, 2016, p. 122). By 1998, 64.5% of Black women were using injectable contraceptives, with 23.4% using oral contraceptives soon after democracy, while only 5% of White women were using injectable contraceptives, and 65.3% were on oral contraceptives (Burgard, 2004).

Beyond state constructions of women's reproductive capacities as plastic and thus manipulable, other power relations have been identified by (Mkhwanazi, 2014), who asserts that:

> Women were coerced into contraceptive use either by health workers who decided on their behalf or by women's employers who made an injection of depo-provera a condition of employment. Sterilisation, another popular method used by black and coloured women, was irreversible. This method was prone to abuse: coercion was not rare and, at times, it was carried out without the woman's consent (Mkhwanazi, 2014).

These reproductive injustices are thus not only governmental attempts to impose on certain women's reproductive choices and circumstances. They also point to asymmetries in healthcare provider/service user and employer-employee relationships, where marginal women were believed to contribute to "undesired" births that could be curtailed by imposing permanent and long-term birth control measures. As such, Hill Collins (2000) argues that "where social class, race, ethnicity, gender, sexuality, and nationality comprise intersecting dimensions of oppression, not all mothers are created equal" (p. 55). While Hill Collins is speaking to the idealised mother within the US, studies show that the quintessential mother in South Africa has historically and presently been rendered White and middle-class (Macleod & Howell, 2015).

Despite critiques concerning the history of fertility control, according to the literature, subtle efforts to coerce marginalised women to use contraceptive technologies such as LARC persist. The "unchecked enthusiasm" (Gomez et al., 2014, p. 217) of population control "can quickly become coercion" (Brian et al., 2020, p. 313). For example, the findings of a study conducted by Higgins et al. (2016) in the US demonstrate that women sometimes experience an inability to reject LARC measures. Provider bias can be unremitting during prescription (Senderowicz, 2019). Hence, Gubrium et al. (2016) in the US argue that "from their inception, LARC methods have been employed in abusive and unconstitutional ways" (p. 19). Despite this, many researchers and policymakers have expressed oblivion about the imposable nature of LARC technologies (Takeshita, 2004). They reinforce the lack of transformation and imposition that plagues LARC prescription and use, thus proving that women's agency is constantly threatened or at risk by these modern contraceptives' availability. Yet, in promoting any contraceptive measure, women's contraceptive needs and the circumvention of infringement on their reproductive agency or bodily integrity should be prioritised (Gubrium et al., 2016).

5. Network influences

Several studies have shown that LARC use is influenced by perceptions, beliefs, attitudes and, at times, misconceptions of contraceptive users' networks such as parents (Makhaza & Ige, 2014; Wood & Jewkes, 2006), sisters, in-laws (Islam, 2020), peers (Murphy et al., 2017),

sexual partners (Hawkey et al., 2018) and healthcare providers (Mahoney et al., 2021). The users' perceptions and reproductive preferences do not always dictate the method to be used. Research also indicates that certain age groups lean more on social networks than others. As such, "social networks are key in contraceptive decision-making among young women" (Mahony et al., 2021, p. 758).

The sources sought out by contraceptive seekers are expected to provide information about different aspects of contraceptive technologies, e.g., experience-related information is often sought from family and peers. In contrast, unbiased information on side effects and the advantages of LARC is sought from medical experts (Mahoney et al., 2021) and "women's priorization of embodied concerns regarding contraception, particularly side effects… reflects the tendency for patients to draw from embodied knowledge to guide their medical decision-making" (Berndt & Bell, 2021, p. 614). Research conducted on social networks, though, goes beyond doctor/patient, kinship and friendship dyads to include neighbours, colleagues, and other citizens with whom contraceptive users have formed weak or strong ties (Islam, 2020). The main focus, however, is on parents and peers in the sections that follow.

5.1. Parental avoidance of sex talk

While parents, particularly mothers, can be instrumental in endorsing contraceptive uptake (Bell et al., 2020), Makhaza and Ige (2014) posit that parents often conflate broaching sex talk with curiosity about sex or sexual debut. As a result, a tendency to avoid sex talk to solicit abstinence or delayed sexual onset among adolescents can be found in some parent-child relationships. The ultimate goal is the preservation of "sexual innocence" and, by implication, circumventing pregnancy (Makhaza & Ige, 2014). While "abstinence from sexual intercourse is a healthy choice for adolescents, 'abstinence only' as a single option is flawed" (Commendador, 2010, p. 147). This is because such interventions can be unrealistic about the efficacy of prohibiting sexual intercourse before marriage. Inefficacies are reflected in how, for example, declines in adolescent pregnancy have often been a product of improved contraceptive use rather than regulation through abstinence-only interventions (Macleod & Feltham-King, 2020). As a result, even though abstinence-only interventions evidence a shift from silence around sex talk, harm reduction interventions are considered more empowering due to their willingness to provide information on possible actions when and if young people become sexually active. In addition, harm reduction in contrast to the "zero-tolerance attitude, pointing to absolutist principles relating to behaviour" (Horanieh et al., 2020, p. 425) inherent

in abstinence-only interventions normalise the explorative nature of young people and the risks sometimes therein such as STIs and unintended pregnancies (Horanieh et al., 2020).

Research shows a tendency to gender the polarised debate between abstinence-only and harm-reduction interventions. For example, a study by Marshall et al. (2021) conducted in the US shows that although parents favoured abstinence, they spoke about contraceptive use with their children, mainly their sons. In contrast, abstinence-only talk was used to sanction female adolescents' sexual subjectivities towards chastity and away from sexual desire, reserving desire for males. Similarly, Akers et al.'s (2010) study conducted in the US has shown that adolescent males are encouraged to use condoms or inspired to be contraceptive-using subjects.

When parents do consider broaching topics of sexuality with female adolescents, there is confusion around the appropriate age for sex talk and how comprehensive this conversation ought to be (Pariera & Brody, 2018). In addition, a study by Mwaisaka et al. (2021) conducted in Kenya found that sex talk could be broached following pregnancy to avoid a repeat pregnancy. These studies show that parents experience tensions about communicating "too early" or communicate "too late". Other parents have defined menarche as the opportune moment for sexual and reproduction talk with female adolescents. As such, Wood and Jewkes' (2006) study conducted in Limpopo, South Africa, reports that adolescent women's mothers encouraged and even coerced adolescents into taking contraceptives at the onset of menarche, which is a problematic way of negotiating contraceptive use.

In addition to the gender and age of the child or adolescent, the parent's level of education and their cultural embrace of contraception has also been identified as partially contributing to parents' willingness to discuss sex talk. For example, research by Makhaza and Ige (2014) conducted among tertiary students in South Africa found that parents' level of education was associated with a higher likelihood of birth control usage among students. The more educated a student's parents were, the greater the likelihood of LARC use. Ahinkorah et al. (2020), in a quantitative study on birth control decision-making capacity and use in sub-Saharan Africa, report on the importance of the cultural acceptance of contraceptives by parents and other influential figures as an important precedent to use. They argue that the higher uptake of contraception in Zimbabwe compared to Angola rests not only on efficient services and higher female literacy but also on cultural acceptance by parents and others.

Research, however, shows that in the absence of parental sex and contraceptive talk, teenagers seek sexual advice and information from peers, which can often be erroneous (Makhaza & Ige,

2014). Notwithstanding this, peers have been identified as, at times, a favourable source of information historically (Shah & Zelnik, 1981) and presently (Makhaza & Ige, 2014), with wider channels of communication enabled (Wood & Jewkes, 2006).

5.2. Peers filling in gaps on sex talk

The strict, value-laden conversations or avoidance of sex talk altogether noted as some patterns of response by older figures are often disrupted by conversations with peers. Makhaza and Ige (2014) state that adolescents often prefer having sex talk with peers as opposed to formal structures such as health providers, teachers, and parents. This preference stems from their ability to relate to their peers' experiences. Formal structures such as medical experts are seen as knowledgeable yet unrelatable subjects, according to a study by Melo et al. (2015) in the US. However, unlike Melo et al. (2015), Sweeney et al. (2015) state that healthcare providers often share inadequate information about contraceptives. As a result, the young women sought information from their friends, which further privileges peers. Therefore, friends' experiences with particular contraceptive measures were often influential in the choices enacted by contraceptive users.

Similarly, Wood and Jewkes (2006) found that mothers, teachers, and nurses often gave adolescent women little and vague information about menstruation and sex in South Africa. As a result, friends were often referred to as a better source of information. However, crucial medical information such as how to avoid conception and what behaviour is risky tended to be lost, thus increasing the susceptibility to unintended pregnancies (Wood & Jewkes, 2006). For example, the women in the study believed that pregnancy occurred only through multiple sexual encounters with a partner. That is, unprotected sex with numerous partners could not lead to conception, as only sustained sexual relationships resulted in pregnancy. This lack of medical information led to the incorrect use of government-supplied contraceptives. For example, some women took oral contraceptives like emergency contraception and thus would ingest them after sexual intercourse. In contrast, others feared weight gain associated with oral contraceptives and would take fewer than required. Many women expected pregnancy following missing a single dose of pills. At the same time, some doubted the user-friendly nature of the female condom and assumed a significant likelihood of forgetting to remove one following sexual intercourse (Wood & Jewkes, 2006). Therefore, even though peers feature favourably as a context for conversations on sexual and reproductive health issues and allow adolescents secrecy concerning contraceptive use, these conversations require a level of regulation.

5.3. Provider bias

Many research participants construe healthcare providers as benevolent subjects with whom a relationship of trust is often established (Yirgu et al., 2020). As a result, some participants reported a level of satisfaction with the healthcare services provided and the competency of medical experts (Yirgu et al., 2020). However, provider bias or interactional barriers have also been documented in the literature (Amico et al., 2017; Berndt & Bell, 2021; Chilinda et al., 2014; Fataar et al., 2022; Higgins et al., 2016; Mann et al., 2022; Ugaz et al., 2016). In tending to the contraceptive needs of certain women, some healthcare providers have recurrently used coercive prescriptive processes in the dissemination of contraceptives (Gomez et al., 2014; Gomez & Wipman, 2017; Higgins, 2014; Senderowicz, 2019; Wood & Jewkes, 2006) or avoided prescribing desired measures to certain women.

Provider bias can exist in many forms. It can be directed towards particular methods or particular women. Method-related biases include healthcare providers steering/directing contraceptive-seeking women away from or towards certain measures and omitting information about certain LARC technologies. To this end, a study conducted by Credé et al. (2012) in Cape Town, South Africa, using postpartum women living with HIV, found that medical experts often counselled them about sterilisation rather than IUDs and other LARC technologies. Similarly, Wesson et al. (2008) report that while Kenyan healthcare providers trust the efficacy of IUDs in their habitual practice, they avoid prescribing them to clients. As a result, knowledge about LARC methods, such as IUDs, as effective and viable alternatives remains low. This lack of recommendation and prescription of IUDs in Kenya has resulted in promotions with the tagline “A new look at IUDs” (Wesson et al., 2008). Similarly, Sundstrom et al. (2016) speak on the tagline “Keep Calm and LARC On” in promotions of LARC in the US. They, too, problematise healthcare providers’ reluctance to prescribe LARC, construing medical experts as at the interface of redressing conceptions about the safety of IUDs (Sundstrom et al., 2015).

Nevertheless, positive attitudes were also identified among some healthcare providers in Ghana (Osei et al., 2005). These health workers constructed copper IUDs positively, describing them as cost-effective and non-hormonal alternatives that would leave women’s monthly menstrual cycles, to an extent, unaffected. Yet, others were concerned about the prolonged and heavy bleeding associated with non-hormonal IUDs (Osei et al., 2005).

Beyond attitudes about the contraceptive measures themselves shaping information sharing and ultimately access to certain technologies, healthcare providers can also show bias towards certain women. To instantiate this, ageist notions have been known to fashion the kind of care young contraceptive seekers receive. At times, healthcare providers render adolescent contraceptive users as not consumers in their own right but as "children" (Chilinda et al., 2014). In examining the content and quality of contraceptive counselling in Ghana, Osei et al. (2005) used simulated clients, representative of a broad spectrum of contraceptive users, to document healthcare providers' attitudes to prescribing IUDs. This sample of fake clients included adolescent women pretending to be married and seeking to delay births. Findings indicate that myths and biases attached to IUD use surfaced, e.g., the exclusion of nulliparous women based on fears about infertility, suspicion about multiple partners, and the inherent susceptibility to STIs (Osei et al., 2005).

In addition to provider refusals based on age, prescription can, according to Ugaz et al.'s (2016) study conducted in Bangladesh, be fuelled by healthcare providers' religious beliefs, which present as limitations to ensuring informed choice about the full spectrum of contraceptive technologies during contraceptive counselling. In the study, many healthcare providers also expressed cultural beliefs, such as the need for women's husbands' input in the enactment of contraceptive choices. As such, some medical experts would refuse prescriptions if the women's husbands opposed the use of particular LARC technologies. Many husbands were more inclined to opt for short-acting contraceptives over LARC (Ugaz et al., 2016). This suggests that husbands' opinions can be valued over women's decisions and choices over their bodies. It also shows that, at times, it is not contraception itself that is refused or denied by spouses but rather LARC technologies (Ugaz et al., 2016).

6. Coerced provision

Apart from withholding certain contraceptive measures, the over-recommendation of LARC technologies to, say, disabled, Black or poor women is proof of the "continued threats of stigma, shame, coercion, and implicit biases" (Roberts et al., 2016, p. e13) that have often plagued the individual experiences of women vis-à-vis birth control. There can, therefore, be dangers associated with access, which point to ongoing population control antics despite efforts to transcend historical inequalities and reproductive injustices. In their study conducted in the US, Manzer and Bell (2021) report on unrelenting medical experts who vetoed contraceptive users' decisions towards non-use by coercively prescribing birth control methods. These healthcare providers delegitimised abstinence as a practice and further framed women as

noncompliant contraceptive users. This ultimately visibilises young, unmarried and minority women's troubles with enacting choices.

Other cohorts cited by the literature as often susceptible to this coerced contraceptive provision are postpartum (Senderowicz, 2019) and post-abortion contraceptive users (Mavuso, 2017; Mavuso & Macleod, 2021). Although these are not the only cases of coercive power relations in provider-service user relationships, they importantly portray the "tensions about choice and care" (Boulos, 2015, p. 114). These instances of coerced provision are discussed next.

6.1. Forced provision of LARC among postpartum women

Holden et al. (2018), Moniz et al. (2017), Wilson et al. (2013), and many others construe the insertion of LARC postpartum as beneficial to increasing the uptake of contraception and, in turn, lessening unintended pregnancies. This is because 40-57% of women report having unprotected intercourse postpartum, and 70% of pregnancies that occur within a year postpartum are unintended (Stuebe et al., 2018). Moreover, postpartum LARC insertion is deemed ideal because women who opt for this do not require an additional healthcare visit (Stuebe et al., 2018). Instead, healthcare providers can insert the contraceptive technology shortly after childbirth if this is the contraceptive seeker's choice. Hence, researchers have referred to the lack of counselling towards LARC technologies in postpartum women as a "missed opportunity" (Bergin et al., 2012, p. 694).

Research also shows that postpartum contraceptive counselling can result in coercion since users typically desire birth spacing or do not want another child. As such, healthcare providers have been reported, at times, to deny and dismiss women's options to choose by choosing on their behalf (Senderowicz, 2019). While this denial of bodily integrity at a clinical level could be viewed as "well-intentioned appeals to help women and families, LARC promotion efforts—especially immediate postpartum strategies—raise important questions about the state's role in regulating reproductive practices, particularly those of society's most marginalised: young, poor, racial-ethnic minority women" (Brian et al., 2020, p. 313).

This top-down regulation can relate not only to avoiding repeat pregnancy but also to restricting choice around the type of contraceptive. For example, in South Africa, postpartum women are often offered injectable contraceptives (Adeniyi et al., 2020), particularly those with a history of using them (Towriss et al., 2019). The latter study, titled *The injection or the injection? Restricted contraceptive choices among women living with HIV* point out that administering injectable contraceptives is such a common practice in the country that some healthcare

providers have referred to it as the "fourth stage of labour" (Towriss et al., 2019, p. 223). To this end, 74% of health users in the study took up injectable contraceptives postpartum. As such, other contraceptive technologies are often unknown and undesired by many service users accessing public health hospitals. This way, prior use determines continued use and further limits opportunities for discussing choice and creating awareness about the wide variety of existing contraceptive measures, even among women intending to method switch (McTigue et al., 2022). In doing so, the choice remains limited to injectable contraceptives. However, Adeniyi et al. (2020) frame the wide choice of injectable contraceptive use as an improvement from the previous assumption that tubal ligation was the only "sensible" decision and even an obligation among postpartum HIV-positive women. This shift was caused by, *inter alia*, the availability of antiretroviral therapy (Ezeanolue et al., 2010).

Postpartum contraceptive counselling has been problematically found to be often non-interactional and brief. Therefore, according to Towriss et al. (2019) and McTigue et al. (2022), some women assume they must accept LARC use, which undermines postpartum women's ability to forge contraceptive pathways for themselves. Hence, there is an "urgent need for nuanced postpartum counselling that upholds right-based (sic) contraceptive use in the postpartum period, including women's right not to use a method if that is their choice" (Towriss et al., 2019, p. 10). It is for this reason that, according to Wilson et al. (2013), postpartum initiation of contraceptives has been associated with high rates of discontinuation and method switching, pointing to intolerable side effects and, at times, use of contraceptive measures to which postpartum users did not fully consent. Similar to postpartum women, many studies advocating for wider LARC use have targeted adolescent women (Potter et al., 2014; Stevens-Simon et al., 2001).

6.2. Forced provision of LARC among adolescents

WHO (2022) states that globally, half of the 21 million pregnancies among adolescents aged 15-19 reported in LMICs were unintended in 2019, with some ending in unsafe abortions. Those who choose to keep the pregnancies have been argued to face poor health outcomes; for example, according to WHO, "in low- and middle-income countries, complications of pregnancy and childbirth are the leading cause of death in young women aged 15–19 years" (p. 7). In light of these concerns, a proliferation of research that promotes birth control among adolescents, medicalising adolescent pregnancies as a period of vulnerability with a variety of complex social and health challenges is evident within the literature (Hopkins, 2017; Todd & Black, 2020). As such, adolescent births have also been pathologised as a deviation from the

natural progression that considers adolescence as not adulthood nor childhood either and thus not suited for the category of "fit" mother (Macleod et al., 2020). Wide contraceptive use, at all costs, has thus been rendered the antidote to all adolescent pregnancies, with strategies such as proactive contraceptive provision considered.

Recently, research by Duncan et al. (2019) has advocated for what they term proactive contraceptive provision to teenage women to curb unintended pregnancy among adolescents in New Zealand. Key differences from traditional contraceptive models in proactive provision include adolescents being persuaded towards birth control before being sexually active. Therefore, sexual debut and contraceptive needs would not undergird contraceptive provision. In so doing, adolescents would be targeted with full method options and encouraged to enact choices. Duncan et al. (2019) liken this intervention to vaccination, such as vaccination for the human papillomavirus (HPV), which is not user-dependent or voluntary but provided to adolescents at schools. Programmes that offer immunisation through schools such as this have been successful. Hence, Duncan et al. (2019) suggest that contraceptive provision has always needed this kind of intervention.

Counterarguments about proactive contraceptive provision include concerns about severe side effects for users. Subjecting women to these side effects without need can be counterproductive, but the authors consider method switching an adequate solution (Duncan et al., 2019). However, research shows that healthcare providers are sometimes reluctant to remove LARC measures (Biggs et al., 2020; Hoggart & Newton, 2013; Yirgu et al., 2020).

Similar to research findings on some postpartum women, discontinuation is common among adolescents, particularly those prescribed the IUD (Wilson et al., 2012). While these women desire to limit or space births, they can be underprepared to deal with the side effects of the sometimes coercively provided contraceptive measures (Towriss et al., 2019). Equally problematic is the over-enthusiastic selling of LARC as the "hottest new thing out for youth" (Biggs et al., 2020, p. 248) by healthcare providers, a strategy that appeals to the language used by some young people. Yet, containing within it bias and coercion.

6.3 Forced provision of LARC among post-abortion women

While termination of pregnancy is a contentious and polarising issue, many countries have conceded to decriminalising it, thereby allowing agency to women who decide to discontinue their pregnancies for personal reasons within the contexts they are embedded (Berer, 2017). Several countries still allow abortions under certain circumstances, with others aligning more

towards restrictive laws. Although legislation has often appeared as the only hurdle concerning accessing safe abortion, research shows that unsafe terminations of pregnancy can be prevalent even in countries where abortions are legal and contraception is easily accessible (Chiweshe et al., 2017; Mavuso & Macleod, 2021). The legislature only addresses part of the problem; abortion stigma premised on religion and culture can universally maintain shame among women who terminate their pregnancies (Hoggart et al., 2013; Macleod, 2009).

South Africa has decriminalised abortion and has the highest reported use of contraceptive technologies in sub-Saharan Africa. Yet unsafe abortions and unintended pregnancies are still widespread (Chiweshe et al., 2017). In relation to my study, researchers have stressed the importance of making LARC a viable option for post-abortion and repeat-abortion women (Mestad et al., 2011; Thompson et al., 2011). On the ground, this has produced instances of reduced agency in decision-making with medical experts, at times coercively steering women towards LARC measures (Chiweshe et al., 2017; Mavuso, 2017). Within these encounters, medical experts are framed as "the last line of defence for unintended pregnancies and future abortions; when reproductive subjects 'fail' in their 'responsibility' to manage their own sexual and reproductive health, healthcare providers must intervene" (Mavuso & Macleod, 2021, p. 560). This insistence and the use of directive counselling practices are undergirded by anti-abortion discourses, which render terminations of pregnancy as inherently wrong and LARC as the remedy that disables repeat pregnancies and the possible need for further abortions. This way, autonomy is imbricated within morality discourses and thus unquestionably denied (Mavuso & Macleod, 2021). Despite social and public health discourses impacting decision-making within medical expert/health user relationships, particularly for postpartum, adolescent and post-abortion women, the impact of the technology on the material body affects the method's acceptability among its users.

7. LARCed bodies

According to the National Contraceptive Clinical Guidelines (2012), injectable contraceptives can cause amenorrhea, menorrhagia, irregular bleeding, weight gain, acne, headaches, a decrease in bone density, mood swings, and delayed return to fecundity among their users. Subdermal implants can cause infrequent bleeding or prolonged bleeding, headaches, reduced libido, breast tenderness, and mood changes. Copper T IUD users report the potential for expulsion, heavy bleeding, cramping and anaemia. In contrast, *Mirena* or LNG-IUS users also note the potential for expulsion, lighter and/or infrequent bleeding, acne, headaches and breast tenderness.

Despite this, some side effects are experienced as positive when they diminish the experience of physical sensations generally described as uncomfortable. These include causing lighter menstrual flows, less cramping and bloating. Negative side effects often promote dissatisfaction with use; these include, although not universal to all users, headaches, weight gain, and mood changes (Stevens, 2018). Some of these side effects are short-term and can disappear within the first few months of use, whereas some are long-term. However, these side effects, either negative or positive, short-term or long-term, determine the acceptability and, ultimately, decision-making about contraceptive technologies.

Many known long-term and short-term side effects related to use are not mentioned in the South African National Contraceptive Clinical Guidelines (2012). They are even more redacted in the 2019 National Contraceptive Clinical Guidelines. Readers are simply referred to the book WHO (2018) *Family Planning: A handbook for providers*. To this end, these guidelines neglect the effects of injectable contraceptives on sexual functioning, e.g., decreased libido. This error is not corrected in the revised guidelines released in 2019. Contraceptives are desired and undesired for a range of reasons, including their design and positioning within the body, as well as the effects they produce within the body once inserted. These all contribute to the method's acceptability, which I discuss in the sections that follow.

7.1. IUD and implant acceptability

The IUD is the most discussed LARC technology in relation to acceptability in the literature (Higgins et al., 2015; Takeshita, 2004; Wesson et al., 2006; Van Zijl et al., 2010). While aggressively promoted, there is scepticism around the immediate placement in postpartum and post-abortion women (Mesfin & Wallelign, 2021) and adolescent women (Buckingham et al., 2021), partly due to its chances of migrating. Some women have indicated concern about inserting these devices into their uteri (Osei et al., 2014); some concerns and scepticism centre around introducing hormones into the body and susceptibility to pelvic inflammatory diseases (Hoggart et al., 2018), particularly in nulliparous women (Zimmerman et al., 2021).

In their study conducted in the UK, Hoggart and Newton (2013) state that while there are high percentages of discontinued implant use, some women opt to tolerate the side effects to ensure reproductive control. Therefore, removing the implant was a difficult decision to enact due to the convenience associated with its use. Hence, some women in this study experienced guilt over their bodies' inability to tolerate the side effects. Upon discontinuing use, a reported

distrust in LARC technologies was evident and contraceptive users resorted to less effective contraception (Hoggart & Newton, 2013).

7.2. Impact on sexual pleasure

Many contraceptive users take up birth control without knowing its effects on their libido, which may shape continuation and discontinuation (Higgins & Smith, 2016). This points to a deficit in attending to sexual pleasure, for which research on contraceptives has been criticised (Higgins et al., 2015). That is, "while contraception is explicitly about sex, LARC promotion discourse remains particularly silent about sex itself, including what effects LARC has on sexual pleasure" (Brian et al., 2020, p. 316).

Studies have, however, demonstrated that contraceptive users tend to prioritise men's experiences regarding sexual functioning and pleasure. For example, Sundstrom and Baker-Whitcomb (2015), in their study conducted in the US, state that some IUD users' apprehension was around the possible discomfort associated with their sexual partners feeling the string during sexual intercourse. In addition, in a study conducted by Osei et al. (2005) in Ghana, women in a focus group discussion reported the fear that their sexual partners would suspect that the IUD was a love potion used to coerce their sexual partners to remain within the relationship. Other issues reported as affecting acceptability and, in turn, decision-making include the effects on menstruation.

7.3. Impact on menstruation

Bleeding patterns have been a priority for many contraceptive users (Amico et al., 2017). As such, some women reportedly prefer copper IUDs since they contain no hormones (Higgins et al., 2015). Yet, bleeding among non-hormonal IUD users can be prolonged and heavy, albeit expected to decrease throughout use (Hubacher et al., 2009). While some women discontinue use, others attempt to tolerate these contraceptives longer (Hubacher et al., 2009). This reduced bleeding associated with use has led to hormonal IUDs being used to treat menorrhagia when prescribed in the public sector in South Africa (Gutin et al., 2011).

Contraceptive users who show concern about the impact of LARC technologies on their menstrual cycle, with both IUDs triggering either amenorrhea or dysmenorrhea, have, as a result, preferred oral contraceptives, which often make bleeding and cramping lighter (Higgins et al., 2015). Compared to the copper IUD, the hormonal IUD (*Mirena* or LNG-IUS) has been associated with more efficacy and less bleeding but is more expensive and thus less accessible in resource-poor areas (Hubacher, 2015).

Implant users have also reported irregularities in bleeding. For example, in a study conducted by Hoggart et al. (2013a) in the UK, irregular bleeding was the main reason for discontinuing an implant. In their study conducted in Ghana, Osei et al. (2014) report that while women experienced side effects such as continuous bleeding over long periods due to specific contraceptive measures, having a supportive partner sometimes encouraged continued use despite the side effects.

7.4. LARC and infertility

Considering the injuries and infertility some women experienced from IUDs, in the past, the implant was introduced as a LARC method that would lend itself to adolescents. This is because age and parity in the past contraindicated the use of the IUD (Takeshita, 2012). Therefore, health practitioners deemed nulliparous women unsuited to choose and ultimately use IUDs. This mistrust in the safety of IUDs resulted in them being recommended mainly to multiparous women wanting to stop childbearing (Burns et al., 2015; Takeshita, 2012).

Studies have shown concerns about the reversibility of LARC technologies (Sundstrom et al., 2018; Mwaisaka et al., 2021; Zimmerman et al., 2022). That is, what effect on the material body with regards to fecundity do LARC technologies have, and can they be reversed? Fears about infertility or delays in returning to fecundity associated with LARC use have also undergirded decisions on birth control use (Mwaisaka et al., 2021). Apart from the contraceptive users showing concern, various people in their lives may also be fearful about the return to fecundity. For example, a study by Wood and Jewkes (2006) conducted in South Africa reports on women who made associations between contraception and infertility. Similarly, nurses reportedly cautioned service users about infertility as a side effect of injectable contraceptive use, while some mothers discouraged their daughters from using these contraceptive measures.

Osei et al. (2014) report on the value of fertility in Ghana, which can deter some women from taking up LARC. As such, the relationship stage and the couple's parity can determine the type of contraceptive couples use. For example, the study shows that as relationships progressed and became more committed, couples reverted to traditional or short-term forms of contraceptives, which are less effective despite the couple being certain about avoiding childbearing. Correspondingly, upon marriage, women would discontinue using modern contraceptive methods. Reliable contraceptives, e.g., injectable contraceptives, were often sought only following a pregnancy. The authors also report that women were often reluctant to

use LARC measures such as IUDs and implants due to personal concerns about infertility (Osei et al., 2014). On the other end of the spectrum, Wood and Jewkes (2006) report that women sometimes wanted to prove or retain their fertility. As a result, discontinuing contraceptive use and becoming pregnant were experienced as a sign of love and commitment.

7.5 LARC and STI vulnerability

According to Khu et al. (2013), of the global rate of HIV incidences, 68% are found in sub-Saharan Africa; Dwyer-Lindgren et al. (2019) cite 71%. Most of these individuals are of reproductive age (Wekesa & Coast, 2015). In addition, females account for 60% of the HIV prevalence within the region (Morrison & Nanda, 2012), and women between the ages of 15-24 years for 80% of new infections (Karim & Baxter, 2019). Various factors undergird these gendered differences, including male reluctance to get tested for HIV and refusal to use a condom. In relation to this study, susceptibility to HIV infection is often exacerbated by the reduced condom use evidenced by many LARC users (Murphy et al., 2021). Hence, most studies around contraception advocate for the dual use of contraceptives, mainly a long-acting method and a barrier method such as a condom, to avoid unintended pregnancy and HIV contraction or transmission (Ngure et al., 2009). Yet, according to a study conducted in Kenya by Wekesa and Coast (2015), only 15.3% of individuals living with HIV were using dual contraceptive methods. These low rates of condom use are caused by beliefs that condoms are burdensome and reduce sexual pleasure during sexual intercourse (Makhaza & Ige, 2014). In addition, dual contraceptive use is complicated because, according to Lowe (2005), committed couples often avoid using condoms with the request equated with unfaithfulness and mistrust. Furthermore, dual methods can be impossible in partnerships that trade sex for gifts where women often find themselves unable to dictate the conditions for sexual intercourse, e.g., the use of condoms (Lowe, 2005).

Dual contraceptive use is, however, meant to align with one's reproductive desires. For example, research shows that upon discovering their HIV status, some women have previously expressed the desire for childlessness; later, many have decided to reproduce (Marlow et al., 2014). HIV, thus, has little bearing on women's fertility intentions (Baylies, 2000; Harries et al., 2007; Marlow et al., 2012; Mthembu, 2022). As such, periods of contraceptive non-use are expected and possibly periods of intentionally choosing to limit family sizes through contraceptive use to realise these reproductive goals (Baylies, 2000). Despite this, some researchers argue that the use of hormonal contraception also contributes to the spread of HIV, thus making the prevention of HIV and unintended pregnancy conflicting goals of sexual and

reproductive health (Haddad et al., 2015). In the section that follows, I discuss contraceptive measures that have had clinical guidelines barring certain women as medically illegible to use them. First, I discuss the under-recommendation of IUDs and later turn to the over-prescription of injectable contraceptives to particular women.

7.6 LARC & HIV

The suitability of the implant among women living with HIV has been mentioned in the literature (National Contraception Clinical Guidelines 2019; Patel et al., 2017; Stalter et al., 2022). Its effectiveness is diminished by interactions with the antiretroviral drug called *efavirenz*. The drugs alter steroid levels in the body (Leticee et al., 2012). Clear indications about users' medical eligibility to use the implant have been given (National Contraception Clinical Guidelines, 2019).

Recommendations about the IUD, according to the WHO (2015), include that LARC users with a high likelihood of STIs "generally should not have an IUD inserted until appropriate testing and treatment occur" (p. 77). While these provisions specifically exclude women with a current or an increased likelihood of STIs, in the study by Osei et al. (2005), healthcare providers extended these recommendations. For example, they discouraged prescription among nulliparous women under the assumption that these women have multiple sexual partners and are thus at risk of infections. This dissuasion has also been reported on by Credé et al. (2012) in South Africa, where healthcare providers promoted other measures, including sterilisation over IUDs among women living with HIV. Similarly, Morse et al. (2013), in exploring the provision of LARC in HIV-prevalent areas in South Africa and Zimbabwe, found that health providers tend to be restrictive about providing LARC. Therefore, while Maharjan et al. (2023) have dubbed IUDs safe to use, misconceptions about women's suitability are often not debunked but exacerbated by medical experts. While this risk of HIV contraction has arguably been associated with combined hormonal contraceptives, the most alarming results were found in injectable users (Haddad et al., 2015), which is concerning given the continued widespread use of injectable contraceptives in sub-Saharan Africa.

The injectable contraceptive technology, *depo provera,* has, since the 1990s (Sathyamala, 2022; Ungchusakm et al., 1996), also been under question about its relationship with HIV contraction in users. Ungchusak et al.'s (1996) research on the determinants of HIV infection among sex workers in Thailand found "a nearly fourfold increase in HIV seroconversion, even after adjusting for all other measured risk factors" (Ungchusak et al., 1996, para. 18) among

injectable contraceptive users. Similarly, reviews by Morrison et al. (2015) and Polis et (2016) report a 40-50% likelihood of HIV acquisition among hormonal contraceptive users, particularly *depo provera* users, compared to "women not using hormonal contraceptives. This group included sterilised women, women using condoms (consistently or inconsistently), women using non-hormonal intrauterine devices or diaphragms, and women not using any modern contraceptive method" (Morrison et al., 2015, p. 4).

In light of these findings, Haddad et al. (2015) argue that premature decisions to rescind widely used contraceptive technologies such as injectable contraceptives can have more detrimental ramifications than addressing the problem. Therefore, a focus on informed decision-making in LARC users, as well as the stringent promotion of dual contraceptive use, remains the ideal answer to addressing the tensions in HIV and contraceptive services (Haddad et al., 2015; WHO, 2019; Williams & Fortenberry, 2013). Similarly, Morrison and Nanda (2012, p. 2-3), in agreement with Haddad et al. (2015), state the following:

> Active promotion of DMPA in areas with high HIV incidence could be contributing to the HIV epidemic in sub-Saharan Africa, which would be tragic. Conversely, limiting one of the most highly used effective methods of contraception in sub-Saharan Africa would probably contribute to increased maternal mortality and morbidity and more low birthweight babies and orphans—an equally tragic result.

Dual contraceptive use has recurrently been presented as an optimal line of defence around the drawbacks some women face. Accordingly, a comparative study by Khu et al. (2013), conducted in Rwanda and Zambia, found LARC users more likely to use a barrier method consistently than women who relied solely on the barrier method. As such, Khu et al. (2013) argue for the importance of interweaving HIV services with contraceptive services.

The varying results in studies on hormonal contraceptives and HIV transmission set the scene for the establishment of the Evidence for Contraceptive Options and HIV Outcomes trial, widely known as the ECHO trial in 2012, which sourced its funds from the Bill & Melinda Gates Foundation. The main priority of the consortium, later joined by WHO, was to resolve the debate on the alleged unsafety of *depo provera* (Sathymala, 2022). Considering the prevalent use of *depo provera* in sub-Saharan Africa, the ECHO trial sampled participants in South Africa, Kenya, Zambia and Eswatini. Seronegative women who had no history of hormonal contraceptive use in 3 months were randomly assigned to use either *depo provera*, a copper IUD, or an implant for 18 months. While cognisant of the unfeasibility of the recension

of these contraceptive measures, the ECHO trial on 13 June 2019 concluded no significant risk for high infection among hormonal contraceptive users, including *depo provera* users (Hapgood, 2020). As such, evidence on the effects of *depo provera* on women's susceptibility to HIV has been disqualified (Hapgood, 2020). In consequence, "WHO relaxed the Medical Eligibility Criteria for DMPA-IM use among women at high HIV risk in August 2019" (Hapgood, 2020, p. 357). In the 2022 WHO *Family Planning: A global handbook for providers*, women living with HIV are encouraged to use injectable contraceptives, preferably with a barrier contraceptive method.

Despite revisions about the eligibility of *depo provera* use, other researchers have challenged these results (Sathyamala, 2022), while others argue that there was misinterpretation of results even by multilateral bodies such as WHO (Hapgood, 2020). Given the implications on policy and health users' lives, it is argued that the "active promotion of anti-natal technologies, such as long-acting injectable contraceptives, which are inherently hazardous and life-threatening, indicates the reverse, from 'letting die' to 'making die'" (Sathyamala, 2022, p. 131). Multilateral bodies like WHO, it is argued, are actively choosing reduced pregnancy rates over women's lives in the global South.

It has been demonstrated above that various individual, material and social conditions may make the decision towards use, non-use or discontinuation of LARC technologies challenging or easy. In the following section, I turn to barriers around LARC technologies that restrict access for those willing or seeking to use contraceptives. Understanding the relationship between access and decision-making is essential to avoid individualising socio-political and contextual issues, particularly in sub-Saharan Africa, which is already struggling to expand contraceptive uptake (Pleaner et al., 2017). Barriers to LARC access are discussed next.

8. Conceptualising indicators for barriers to access

Barriers to contraceptive use that recurrently hinder the access of many women have been well documented by the literature (Benova et al., 2017; Bhuda & Sekudu, 2016; Chandra-Mouli et al., 2014; Hall et al., 2016; Kelly et al., 2019; Mbizvo et al., 2014; Mishra et al., 2017; Pritt et al., 2017; Robinson et al., 2016; Wood & Jewkes, 2006). These studies demonstrate that access is entangled in various individual and social factors that impose on decisions by making certain or all contraceptives out of reach for contraceptive seekers. For example, Bhuda and Sekudu (2016) conducted a study in South Africa exploring women's perceptions of contraceptives alongside the termination of pregnancies. The study found that while women were often aware

of the availability of contraceptives, accessibility was sometimes an issue, thus making a social issue into an individual one. In addition, when contraceptive needs could be met, inconsistent use, cultural beliefs about sexuality, and some healthcare providers' culturally insensitive attitudes played a role in the decision to use or not use contraceptives (Bhuda & Sekudu, 2016). These conditions present as barriers that create an inability to enact certain decisions despite the expansion of contraceptive methods and accessibility.

The term "unmet need for contraceptives" originates in demographic studies from the 1970s; it was formulated to identify and quantify women who wished to circumvent pregnancy but were not sufficiently proactive about this through modern contraceptive use (Cleland et al., 2014). Prior to this, the KAP-gap (knowledge, attitudes, practices) was the reference used to denote barriers to contraceptive provision and uptake using surveys (Bradley & Casterline, 2014). Knowledge, attitudes, and practices were the indices identified as needing to be filled for greater prevalence in contraceptive uptake during the 1950s. The KAP gap and unmet need for contraceptives have been the quintessential tools used to quantify and determine barriers to access among potential contraceptive users who desire to limit or space births and are not using birth control and are thus "at risk" of pregnancy. Built on the idea of supply and demand, both measures seek to close the gap among contraceptive users expressing the need for birth control (Hayer et al., 2022).

In using the KAP gap, "the assumption is that, by improving knowledge about and access to contraceptive methods, organized family planning programs can overcome these cultural, attitudinal, and other obstacles and bring reproductive behavior within the 'calculus of choice'" (Westof, 1988, p. 225). Demographers directed the limiting of pregnancies to couples who were certain about their desire to avoid, stop or space births (preference) by improving knowledge and attitudes that would lead to practices of consistent use of contraceptives. However, studies have found that couples expressed intentions to use contraceptives yet, in practice, avoided use (Mamdani, 1972; Sedgh et al., 2014; Westoff, 1988). Thus, knowledge and attitudes do not necessarily translate into practice.

A major pitfall inherent in KAP surveys was the quantification of women who wanted to limit births; birth spacing with its continuation and discontinuation patterns was left unaddressed. Birth spacing does not signify an unmet need for contraception. Rather, discontinuation of contraceptive use in this cohort represents the desire to reproduce. Consequently, the KAP gap model increasingly became no longer helpful (Casterline & Sinding, 2000; Westoff, 1988). The

term unmet need was widely used in its place. It could bridge the gap between demographic conceptions of contraception informed by population control with feminist, female empowerment imperatives established at the ICDP in Cairo (Takeshita, 2004).

In light of the nebulousness and problematics inherent in the term contraceptive need, work around unmet contraceptive needs has been nuanced to explore strong motivations to eschew pregnancy to more accurately bracket off non-users (Sedgh et al., 2014) and further extended to include spacing births. Despite the established parameter for contraceptive use being choice or desire, some issues identified with the KAP gap have also been inherent in the unmet needs of contraception model. For example, countless fecund women were still identified as having an unmet contraceptive need despite their specified disinterest in using contraception to avoid pregnancy (Takeshita, 2004), therefore signifying uncertainty about the limits of the term "need". Variations in definitions are evident. For instance, unmet contraceptive need in the SADHS (2016) is defined as barriers to contraceptive use among women who desire to space or limit births. However, this definition is extended to include "women who report that their current pregnancy or birth in the last 2 years was mistimed or unwanted" (p. 16) and breastfeeding women not using contraception. Adding current mistimed pregnancies and postpartum amenorrhea following an unplanned pregnancy functions to measure the outliers inherent in unmet need – women who may not describe themselves as having an unmet need. Identifying contraceptive preferences or individualised needs, which include women's decision not to use contraceptives rather than attempt to coercively close the gap between met and unmet needs to meet governmental population control targets, has been the position of many critical scholars (Takeshita, 2004).

In further interpreting the tendency to identify non-users as always having an unmet contraceptive need, Mahmood Mamdani (1972), in his book *The myth of population control: Family, caste, and class in an Indian village* reports on politeness as a key issue in a study conducted in Manipur, a village in India. Contraceptives were politely received but then not used. On the other end of the spectrum, however, is contraceptive failure, which signifies deciding to use contraception and becoming pregnant (Bradley et al., 2011), thus presenting as an unmet contraceptive need in its own right. A much-neglected reason for contraceptive failure is stress and depression, according to Hall et al. (2013), particularly in contraceptive methods that require frequent user action. This suggests that contraceptive provision should also consider women's emotional and psychological functioning in decision-making (Hall et al., 2013). Beyond individual preferences and behaviour, reasons for this disjuncture between

reproductive preferences and behaviour can be based on structure or cultural attitudes, which I turn to next.

9. Structural barriers to access

Structural issues, which are outside the control of the individual, have been reported to infringe on contraceptive needs. For example, systemic failures, often prevalent in impoverished areas, undoubtedly underpin unfavourable sexual and reproductive health outcomes. They present as physical distances, limited options, cost, and lack of provider training. These systemic barriers are discussed below.

9.1 Physical barriers to receiving care

The proximity of healthcare facilities has been identified as affecting continuity in contraceptive use (Shiferaw et al., 2017). For example, Skiles et al. (2015), in a research study conducted in Malawi, reported a higher probability of injectable contraceptive use in rural areas because of the distance to healthcare facilities. Therefore, women opted for longer-term contraceptives to avoid frequent trips to healthcare facilities. While long distances can be relative, Shiferaw et al. (2017) report on a distance of about 4km on foot travelled to access healthcare by many women in their study conducted in Ethiopia. As a result, this cost of accessing healthcare facilities has been known to produce inconsistent use and sometimes discontinuation among women who desire continued contraceptive use.

This is not to say that health users always prefer accessing the closest health facilities for their health needs (Skiles et al., 2015). Issues of confidentiality, especially for young people, including fears of being seen at the healthcare facility by community members or breaches of confidentiality by healthcare workers, have been known to cause young contraceptive users to access contraception in environments located further than the nearest healthcare facility to retain privacy (Ezenwaka et al., 2020). However, also noteworthy is that this need to access long-distanced facilities, either due to facilities not being easily accessible or as a personal choice, attaches financial costs such as transport costs to an otherwise freely accessed commodity through the public health system in many LMICs (Chimatiro et al., 2022). As such, socioeconomically disadvantaged and young women determined to use these contraceptive technologies can face structural and financial barriers to contraceptive use due to the scarcity of healthcare centres and the shame experienced for having a contraceptive need (Ezenwaka et al., 2020).

9.2 Provider training

Competence in inserting and removing LARC technologies enables and constrains women's ability to choose them (Fataar et al., 2022), albeit training skills have also been expected to cascade from an experienced healthcare professional who has attended formal training (Panday, 2018). Despite deficits in training, installing some LARC technologies requires much more skill among medical experts than short-term contraceptives. For example, short-term contraceptives necessitate frequent user-action from contraceptive users; medical experts are thus obligated to provide women with instructions detailing effective use, but no clinical technique or skills are required. In contrast, LARC technologies are user-independent methods that promise rare demand for user action after administration by a trained medical expert. At the same time, a level of specialisation from medical experts is necessary for placing implants and IUDs (Fataar et al., 2022; Pleaner et al., 2017). Injectable contraceptives are LARC forms requiring the least specialisation— hence, the overdominance in the provision of injectables seen in LMICs. This dominance promises to be further exacerbated by the availability of self-administered forms of injectable contraceptives (*sayana press*) that are becoming increasingly popular (Bendix et al., 2020; Spieler, 2014). However, what is important to note is that the technical competence of healthcare providers plays a significant role in recommending some LARC technologies. Therefore, limited uptake in relation to some forms of LARC is not always a product of low acceptance by users. Instead, contraceptive users can be at the mercy of their healthcare systems in exercising choice.

An example of a lack of training and, as a result, limited access is reported by Sweeney et al. (2015) in their study conducted in Ireland with contraceptive users, general practitioners (GPs) and pharmacists. This research demonstrated differences in information sharing during contraceptive counselling depending on the type of healthcare provider. For example, general practitioners (GPs) were often more inclined to prescribe oral contraceptives over LARC technologies to health users. In addition, LARC methods were often only partially subsidised by the Irish government; as such, GPs in service for more than ten years were unwilling to incur the cost of acquiring the necessary training to administer LARC technologies. This meant that, on the one hand, GPs in practice for less than five years often gained training during their medical training and thus could insert LARC technologies. However, due to low uptake, their skills did not develop. On the other hand, GPs in practice for more than ten years were often unable to insert LARC technologies and were not pressured to learn. Method choice thus rarely progressed further than oral contraceptives. Hence, one sampled general practitioner referred

to oral contraceptives as a "euphemism for contraception" (Sweeney et al., 2015, p. 8). Referrals, though, were made for service users who specifically desired LARC methods.

In the same study, pharmacists reported an inability to prescribe. They preferred to dispense the requested contraceptive measures, with GPs providing counselling on the requested measure, particularly given their (pharmacists') sometimes-busy practices. Others provided leaflets and brochures containing information on contraceptive users' desired methods (Sweeney et al., 2015). In another research study, Ugaz et al. (2016) found that many public and private medical schools were not teaching about IUD insertions in Bangladesh. In addition, around 50% of students doubted their efficacy. This doubt reportedly lowered following the intervention of the study.

Scarce skills are not purely a barrier or hindrance to the administration of LARC technologies; their removal also demands provider training. As a result, lack of training can present a barrier to removing no longer desired measures, thereby obligating women to retain LARC technologies past their intended periods due to a shortage of skilled staff, according to a study by Yirgu et al. (2020) conducted in Ethiopia. Lack of training, thus, presents a systemic barrier to health users' desire to discontinue or method-shift to other forms of contraception.

With the problematisation of unintended pregnancies, public health facilities may include non-specialised healthcare providers in the provision of contraceptives (Manzer & Bell, 2021). In practice, this has manifested an inability to accurately draw on biomedical information to support contraceptive users' decisions to use or not use contraceptive methods. Therefore, contraceptive users have often filled in the gaps by seeking this information themselves (Hyde et al., 2016; Yee & Simon, 2010). Contraceptive users have been known to conduct their research on the desired contraceptive measures (Manzer & Bell, 2021). Thus, the biomedical information offered by medical experts is not always desired, or it can supplement that which contraceptive users have sourced from alternative outlets such as the internet.

9.3 Considerations in remote and low-resourced areas

Notwithstanding the above, in balancing the need for access, Takeshita (2004) argues for caution to be exercised in promoting IUDs in LMICs, particularly in remote areas, as constrained use is not merely dependent on a lack of skilled personnel who can place them. Complications requiring resources can also occur, e.g., uterine wall perforation and STIs. Therefore, medical resources must manage such contingencies and avoid infertility or death.

This includes screening anaemic women and those with histories of STIs and pelvic infection diseases to mitigate contraindications before prescribing IUDs (Takeshita, 2004).

Despite this need for screening described by Caddy et al. (2014) as best practice, "blind" insertions occur. These are justified as lessening the barriers to IUD use by Goodman et al. (2008). Yet, IUDs do induce a variety of side effects, such as pelvic pain, abnormal uterine bleeding and uterine perforations (Mhlanga et al., 2019) and managing the possibilities of these bodily responses is always a concern, especially so in rural and under-resourced areas. The development of side effects usually results in method switching in well-resourced areas (Barden-O'Fallon et al., 2018) but can prompt discontinuation in rural areas (Hossain, 2005). "While not inherently negative, discontinuation can indicate less-than-ideal method selection due to availability, cost or other barriers" (Higgins et al., 2020, p. 1).

9.4 Cost of LARC technologies

Morison and Eagar (2021) state that LARC technologies can be uncritically considered cost-effective on a population control level, thus assisting the government in decreasing social grant dependency and poverty reduction costs. Early studies that affirmed this include Mavranezouli's (2009) comprehensive review of contraceptive method costs, showing how short-term contraceptives often seem cost-effective. However, they prove to be more expensive due to user error that often results in unintended pregnancy, costing the US more money. As a result, Mavranezouli (2009) frames LARC and sterilisation as the most cost-effective methods, followed by hormonal contraceptives and barrier methods. Limiting barriers to these measures is thus construed as the ultimate solution towards decreased state spending.

LARC costs to the individual user have been reported as a barrier associated with uptake; often, contraceptive users are uncertain whether their medical aid covers the entire procedure (Sundstrom et al., 2015). Therefore, medical aid schemes determine women's decision-making as conditionalities may be attached to attaining certain contraceptive measures. This has also been identified by Manzer and Bell (2021) in their study conducted in the US, evidencing that contraceptive users are sometimes compelled to pay out of pocket to access the desired measures to address medical insurance coverage gaps and allow more options. Similarly, fully subsidised contraceptive technologies vary in New Zealand; while costs are kept low, users can be required to pay out-of-pocket (Morison et al., 2022). Private health users in South Africa face similar cost-related issues as in other countries, where some medical insurance does not fully subsidise contraceptive care for all technologies (Lince-Deroche et al., 2016). Hence,

contraceptive users can choose less effective and less desired methods owing to their inability to access certain options due to coverage gaps (Manzer & Bell, 2021). Brian et al. (2020) also problematise how medical insurance promotes LARC as first-line technologies but keeps mum about the cost of their removal. This silence is said to have a knock-on effect on the technologies' removability. Users are thus again deterred from use (Becker & Polsky, 2015) or sometimes obligated to use contraception they are no longer satisfied with using.

Barriers faced by young users include being covered under one's parents' insurance. This has been identified as a limit to confidentiality for some women. As such, some adolescent women in the US have been found to "opt to receive services through publically funded sources or forgo using their parents' insurance altogether" (Raidoo & Kaneshiro, 2017, p.3).

In efforts to eliminate costs, according to Jacobstein and Stanley (2013), pharmaceutical companies have made several efforts to increase the availability of implants in the public sector. In the US, Bayer HealthCare, for example, has reduced the cost of the *Jadelle* implant by 50% to increase dispersion into LMICs (Jacobstein & Stanley, 2013). In addition, due to high unmet contraceptive needs in sub-Saharan Africa, 13200 implants were donated to the region in 2005 and 2.5 million by 2011 (Reproductive Health Supplies Coalition, 2011). Similarly, Jacobstein and Stanley report that "from January 1, 2009, to December 31, 2012, more than 9 million implants valued at over US$190 million [approximately R3 006 976 100,00] have been shipped to developing countries—87% to sub-Saharan Africa" (2013, p. 11). As a result, in Rwanda, for instance, 1 in 25 women used an implant in 2005, and 1 in 7 used it in 2013. The structural barriers mentioned within this section highlight contextual issues that affect health users. In the following section, I discuss the immediate context for contraceptive counselling and its influence on health users' ability to make certain decisions.

10. Contraceptive counselling

How exactly a contraceptive method was prescribed and what exactly was said has increasingly come under scrutiny in recent literature (Ali & Tran, 2022; Dehlendorf et al., 2015; Fataar, 2022; Fulcher et al., 2021; Morison et al., 2022). The content and quality of the contraceptive counselling encounter are being explored. In the next section, I review the literature on contraceptive counselling and the implications of importing a clinical term into sexual and reproductive health. To do this, I discuss the genesis of counselling within sexual and reproductive health. I also review the different models of contraceptive counselling and evaluate their impact on decision-making that is deeply rooted in upholding agency for the

contraceptive user while also classifying them as either provider-driven, health user-driven or influenced by shared decision-making models. With the models and tools for decision-making within contraceptive counselling, I show that contraceptive counselling is increasingly defining its parameters, defining what the counselling is, who the subject or subjects being counselled are, as well as who the counsellor who offers the counselling is, and the modus operandi utilised towards reaching decisions.

10.1. Contraceptive counselling

Information sharing (Ali & Tran, 2022), prescription (Arrowsmith et al., 2014), family planning counselling (Palinggi et al., 2021), contraceptive consultations (Hayter, 2003), and approaches to contraceptive provision (Fataar, 2022) are all terms used to refer to contraceptive healthcare encounters. This interaction is defined as responding to clients' contraceptive needs premised on their sexual lives (Fulcher et al., 2021). A think tank hosted in Switzerland in 2019 defined contraceptive counselling as:

> the exchange of information on contraceptive methods based on an assessment of the client's needs, preferences, and lifestyle to support decision-making as per the client's intentions. This includes the selection, discontinuation or switching of a contraceptive method. The key principles are based on: coercion-free and informed choice; neutral, understandable and evidence-based information; collaborative and confidential decision-making process; ensuring respectful care, dignity, and choice (Ali & Tran, 2022, p. 80).

Contraceptive counselling is thus ideally interactive, responsive to personalised issues voiced by the contraceptive seeker and agreeable to their decisions. Health users' ability to respond within these interactions must be preceded by evidence-based information sharing that will occasion informed choices. As such, judgement, manipulation and any other tactics used to encroach on contraceptive users' decision towards uptake, discontinuation and method switching are criticised and even barred from the contraceptive counselling encounter. In the end, contraceptive users who are afforded this are expected to effectively space, time or avoid births and further experience satisfaction (Fulcher et al., 2021).

However, contraceptive counselling encounters have recurrently proved to be problematic. It can often be the healthcare providers' preferences that surface during these clinical interactions rather than the health users' needs (Gomez et al., 2014; Moniz et al., 2017; Morison et al., 2022). In addition, there is little congruence about how to conduct contraceptive counselling

appropriately without falling into inflexible guidelines that overstate the importance of the script— “if not this, then that” which risks downplaying the dilemmas faced by healthcare providers (Fataar et al., 2022) and the personalised experiences and preferences healthcare users share within contraceptive counselling.

The issue is partly caused by the introduction of the concept of “counselling” into sexual and reproductive health from mental health spaces. Since this model is imported from psychology and conducted by expert psychologists, healthcare providers within sexual and reproductive health often need more expertise in listening to their clients. This has undoubtedly been the case in post-abortion counselling research (Mavuso, 2017). Ali and Tran (2022) also add that optimal counselling includes “taking into account the feelings and concerns of the client” (p. 80), suggesting that the psychological dimension is increasingly gaining traction vis-à-vis contraceptive-related work.

The introduction of formal counselling techniques about sexual and reproductive health by healthcare providers was first seen in the United States following the spread of the HIV pandemic. In the absence of an antibody and cure for HIV, pre-test counselling and post-test counselling were developed, in essence, as measures for ensuring that health users “understood the meaning of their results” (Johns et al., 2016, p. 126). An emphasis on informed choice and consent was maintained, albeit counselling would later be shaped around imparting knowledge and encouraging behavioural changes (Johns et al., 2016).

Beyond counselling practices within HIV-related work, primary healthcare facilities have, over the years, increasingly needed to adopt a psychosocial component within healthcare interactions in response to the acknowledgement of the importance of a biopsychosocial approach (Hemmings, 2000). To redress this new function, counsellors often teamed up with other medical practitioners (Hemmings, 2000). Hence, guiding practices to operationalise the counselling would soon be needed. The 2019 South African National Contraceptive Clinical Guidelines prioritise this: "Counselling complements sound clinical care and assists in ensuring that a rights-based, client-focused approach guides contraceptive provision” (p. 19). Given this claim to ground contraceptive counselling within the realm of the client’s rights and needs, I explore who, in what ways and to what end these contraceptive counselling sessions have been operationalised within the literature in the following sections.

Contraceptive counselling encounters tend to be in-person with the contraceptive seeker or a group of contraceptive seekers interacting with a healthcare provider. A third party, e.g., an

intimate partner or parent (Manzer & Bell, 2021), can be indirectly (Santelli et al., 1992) or directly involved in individual contraceptive seekers' cases (Ali & Tran, 2022). In addition, technology can be included in this process, although this is primarily available in HICs (Davidson et al., 2015; Langston et al., 2010). Ultimately, evidence-based information is expected to be shared by the healthcare provider and received and reviewed in relation to the needs and lives of the contraceptive-seeking individual, couple or group (Fataar et al., 2022). To this effect, the healthcare provider guides and does not make decisions for the presenting party (Arousell et al., 2017).

11. Contraceptive counselling models and approaches

There are as many as fifteen different types of approaches to contraceptive counselling mentioned in the literature. These include technology-assisted counselling, balanced counselling, multicultural counselling, peer counselling, group counselling, motivational counselling, structured counselling, attributes-only counselling, the shared decision-making approach, cafeteria approach, tiered-effectiveness, reproductive justice approach, foreclosed approach and the reproductive life planning approach to counselling. Some counselling approaches are synonymic with others, while others have overlaps, connections, and subtle or significant differences. "These tools for communication" (Rodriguez et al., 2016, p.89) will guide decision-making in various ways when operationalised as they should.

Technology-assisted counselling has been widely incorporated into face-to-face interactions, particularly within HICs. This form of contraceptive counselling refers to the presentation of slide shows and video clippings in counselling to aid contraceptive users in their decision-making (Lopez et al., 2016). This technique is rarely used alone. It often supplements face-to-face counselling methods. For example, in structured counselling by Langston et al. (2010) and Davidson et al. (2015), which attempts to provide the all methods of birth control, the technologies and visuals offer contraceptive-seeking people comprehensive explanations of modern contraceptives. Video shown to participants can also include the experiences of women who have used LARC technologies, postabortion (Davidson et al., 2015).

Other counselling models can be clustered into (1) directive, expert-led (often tiered) forms of counselling, (2) patient-led counselling models, and (3) counselling where decisions are shared, thus collaborative counselling models. Decision-making abilities within these models exist within a continuum where, on either extreme, the contraceptive user's or healthcare provider's preferences are explored and met (Biggs et al., 2020; Morison et al., 2022). An interactional

engagement, however, is evidenced by shared decision-making or collaborative decision-making models, which deprioritise healthcare providers' needs but value their provision of medical knowledge to support the health users' enacted choices (Dehlendorf et al., 2014; Morison et al., 2022). In the following section, I discuss how components of the counselling models outlined above constitute expert-led, patient-led or collaborative decisions within contraceptive counselling.

11.1 Provider-driven or directive counselling

Expert-led decision-making is the most common form of counselling, especially in LMICs (Senderowicz, 2019). Usually, healthcare providers introduce their own agendas within the encounters or that of the facility within stock constraints. These agendas may or may not align with the health users' preferences, which are not explored in-depth. In addition, the encounters can be brief and insidious as women can be denied information about the procedure and deceived about their right to refuse uptake. Therefore, the informed consent component that engages the client and their understanding of the procedure to be undertaken and respects their agency in decision-making is evaded or considered pointless. For example, Towriss et al. (2019) have identified this form of counselling among postpartum women living with HIV in South Africa.

Directive counselling practices have also been reported upon by Parle and colleagues (2019) in the event of increased requests for subdermal implant removals in South African public health facilities:

> Healthcare workers developed strategies to stem the tide of requests for *Implanon* removals, including persuasive counselling, referring patients to other facilities for the removal process (in the knowledge that the burdens of transport costs and time might deter them from removing the device), mandatory requirements of a month-long waiting period after the request for removal, and outright refusals. By as early as 2014, women were removing the device themselves. Painful and potentially dangerous, this could involve puncturing the skin at the scarred site of *Implanon* insertion and pushing the device out of the arm (Parle et al., 2019, p. 259).

The quote mentioned above proves that contraceptive counselling occurs within the backdrop of state politics and state spending, which can and does threaten bodily integrity. This is not purely attained by making women retain technologies with which they are dissatisfied but also by placing them in situations where they could self-harm by attempting to remove the

previously chosen or offered technologies themselves. Denying health users medical assistance in removing LARC technologies, defined as not in contraceptive users' best interests or as a "risk", which are inherent within the literature (Amico et al., 2017) can breed other risks.

In their paper titled *The fine line between informing and coercing: Community Health Center Clinicians' approaches to counseling young people about IUDs*, Biggs et al. (2020) identify contradictions between allowing agency and allowing the choice of lower-tier contraceptive technologies. As these technologies are considered lower efficacy measures, providers indicate that use is not in contraceptive users' best interests. Tiered effectiveness models such as these, because of their directive undertones (e.g., LARC-first), disallow and "silence discussion about less-effective methods that patients may find more acceptable and less physically burdensome" (Stevens, 2018, p. 151). This LARC-only, tiered effectiveness approach in South Africa can be evidenced by how choices are often limited to injectable contraceptives in some public health facilities (Fataar et al., 2022; Marlow et al., 2014; Towriss et al., 2019). This form of counselling is a barrier to creating fully informed subjects.

Relationships with healthcare providers are foundational in forming positive counselling experiences that foster compliance, trust and decision satisfaction (Dehlendorf et al., 2015; Ali & Tran, 2022). While this seems like a reasonable and attainable aim at face value, research shows that those considered a minority or "at risk" have been at the receiving end of gross violations of their capacity to decide in interactions with medical experts (Ross, 2006; Ross & Solinger, 2017). For example, healthcare providers have offered these health users little to no choice regarding the ability to refuse or remove the LARC technologies, thus acting in the interests of "public health" rather than the clients' (Ostermann, 2021). As such, there is an imperative to continuously keep contraceptive users' "fertility preferences squarely in the picture" (Casterline & Sinding, 2000, p. 713) through, for one, more symmetrical provider-patient relationships and, secondly, the eradication of directive contraceptive counselling practices. This is especially important because these are not once-off encounters since, according to Hayer (2022), client preferences can be a "moving target" (p. 2). Therefore, health users must be included in directing their contraceptive pathways to allow dissatisfaction, indecision and preference changes despite agendas put forth by governments or the healthcare providers' own beliefs and biases.

Other "provider-driven practices [may] include the provider favouring some methods and discouraging others in the absence of sound medical rationale" (Osei et al., 2005, p. 78). Fataar

et al. (2022), in a study conducted in Cape Town, South Africa, report that healthcare providers can be biased in providing contraception while premising their information sharing on outdated and sometimes incorrect information. In so doing, young women can be denied three-month injectables and deemed more suitable to use two-month injectables due to concerns about a return to fecundity despite young women's preferences.

Research suggests that these practices are rooted in a lack of training of healthcare providers, thus affecting their confidence in administering contraceptive users' desired methods, such as implants and IUDs (Osei et al., 2005). When contraceptive users manage to enact their own decisions, they can be met with mistrust and vetoed by medical experts. For example, in a US study by Manzer and Bell (2021) documenting bias in medical encounters, race was associated with differential levels of trust between health users and medical experts. White health users built trusting relationships that precluded the use of pressure. While problematic, these directive practices are the cornerstone of many contraceptive counselling encounters globally, for example, tiered effectiveness models and, I argue, motivational interviewing. These are discussed below as not necessarily raced or classed but targeting contraceptive users as at "risk" or posing a "risk".

Some researchers have used contraceptive counselling to dispel myths and inspire behavioural change, particularly among postpartum and post-abortion women. As such, some decision-making tools have been developed to do this. These include motivational interviewing, balanced counselling and reproductive life plans. "Motivational interviewing (MI) is a patient-centered counselling style that aims to create a collaborative relationship between counselor and patient. Motivational interviewing uses open-ended questioning, reflective listening, empathic statements, and exploration of ambivalence to elicit a patient's intrinsic motivation for behavior change" (Whitaker et al., 2016, p. 1664). By design, these contraceptive counselling techniques supposedly bridge power dynamics and allow healthcare providers to remain in tune with the patient's needs. However, motivational interviewing can come across as "rehabilitational" aiming to shift and transform behaviours, especially among post-abortion or postpartum women. This is under the assumption that women's second pregnancies can be as unintended as the first. Targeting their behaviours through motivational interviewing is expected to encourage consistent pregnancy prevention.

Balanced counselling and reproductive life planning are similar to motivational interviewing, but specifically, balanced counselling explores the client's attitudes, social norms and

intentions about contraceptive use. Within the reproductive life plan approach, “women are encouraged to proactively identify their reproductive goals and make a reproductive life plan” (Callegari et al., 2017, p. 130). As health promotion tools, they probe into lifestyle practices and encourage adjustments towards decisions and practices that align with the individual’s ideas about their ideal reproductive destinies. This can include the interrogation of contraceptive users by healthcare providers about their methods or failures in regulating their fertility (Tydén et al., 2016). As such, tools such as these have been dubbed as potentially “alienating rather than empowering some women” (Callegari et al., 2017, p. 130). This is because they have been problematised as not open to ambivalence and complexities in understanding pregnancy.

11.2 A call for shared decision-making

According to a study by Kim et al. (2002) conducted in Indonesia, an honest and engaging patient is what contraceptive counselling has always needed. It is “when patients fully disclose their concerns, expectations, and preferences, providers can assess their problems more accurately and offer better advice” (Kim et al., 2003, p. 113). For example, side effects necessitate evaluative inputs and assessment from users. Providers’ inability to acknowledge or even explicitly inform contraceptive seekers and users of their likelihood creates tensions between medical knowledge and embodied experience. Both forms of knowing are essential for decision-making, albeit one (embodied knowledge) has been marginalised (Stevens, 2018). Traditionally, medical knowledge has been rendered an objective and factual science with “the social currency of knowing the ‘truth’ about the body” (Young et al., 2019, p. 340), although other researchers have shown the social and negotiated nature of this science (Foucault, 1978; Lupton, 2012). Embodied knowledge, however, denotes lay knowledge around the direct experiences of health interventions on the body. It is “not simply knowledge of the body, but knowledge dwelling *in* the body and enacted *through* the body” (Craig et al., 2018, p. 329). It is, therefore, a subjective experience. In terms of contraceptive use, this embodied knowledge has been said to also rely on the embodied experiences of others in the interactional spaces in which contraceptive seekers are embedded (Berndt & Bell, 2021; Stevens, 2018). Therefore, contraceptive users base their decisions not only on their desires but also on the embodied experiences of others.

Littlejohn and Kimport (2017) posit that the uncertainties related to side effects hinder medical experts’ ability to accurately predict users’ likelihood of developing expected bodily reactions. As a result, some medical experts have been reported to use certain discursive devices to

encourage use, e.g., separating positive side effects from those commonly rendered negative, thereafter construing positive ones as highly likely and the latter as improbable (Hayter, 2003) yet also negligible and controllable (Littlejohn & Kimport, 2017). Correspondingly, in a study by Berndt and Bell (2021) conducted in the US, participants reported a desire for contraception and bodily functions to be harmonious. That is, birth control was anticipated to preclude the disruption of bodily conditions considered "normal". Perhaps to match these idealistic expectations from contraceptive users, a large number of studies have shown the problematic downplaying of side effects by medical experts (Dehlendorf et al., 2014; Hayter, 2003; Littlejohn & Kimport, 2017), described as manipulation by Yirgu et al. (2020).

Disparities between what to expect and what will be experienced are created by downplaying side effects. Studies have shown that upon experiencing adverse side effects, healthcare providers use other delay tactics. For example, Biggs et al. (2020) in their study report that before discontinuation or method switching, treatments were given to users, or they were urged to "stick with" the problematic measure despite experiencing negative side effects or having reached the "tipping point" (Hoggart & Newton, 2013, p. 200). Medical knowledge within these interactions is juxtaposed with embodied knowledge over which medical knowledge is expected to establish authority (Stevens, 2018). However, research studies (Gomez et al., 2014; Higgins, 2014; Morison et al., 2022) show that not all are subject to such delay tactics from healthcare providers. Instead, unwarranted raced and classed stereotypes informed this talk, thus framing intolerance of side effects as typical of certain women. However, ultimately, this points to the minimisation and dismissal of contraceptive users' concerns and embodied experiences.

Similarly, with the IUD, Takeshita (2004) documents that from its inception, it has been associated with adverse side effects, habitually left unaddressed due to concerns about population control. Often, distributors of these contraceptive technologies avoided explicitly discussing the risks associated with IUD use, for example, the *Dalkon Shield,* which resulted in large lawsuits. Takeshita (2004) associates this avoidance of medical issues faced by contraceptive users with greed as, despite women's public outcry about the adverse side effects, A.H Robins Co., the supplier of this older and defunct version of the IUD (the *Dalkon Shield),* continued promoting these IUDs, selling millions in the US and abroad in the 1970s (Takeshita, 2004). The above evidences a multi-level refusal to explicitly juxtapose the contraceptive benefits alongside the adverse side effects that can manifest from use. In addition, conflicts between medical knowledge and embodied knowledge are evident.

11.3 Patient-centred counselling

Researchers have advocated for more patient-centred counselling, "which in the family planning field is often referred to as client-centered or woman-centered care" (Holt et al., 2017, p. 135) or recently as user-centred (Morison & Eagar, 2021). The term client-centred is argued to be more appropriate in addressing the gap between healthcare providers and contraceptive-seeking clients (Govender & Penn-Kekana, 2008). This is because the referent "patient" teeters on helplessness and lack of knowledge. At the same time, "client" signifies contraceptive users who are confident of their desires and need unbiased information from healthcare providers to enact informed choices influenced by their situational circumstances. As such, more advantageous outcomes for contraceptive users have been linked with client-centredness, highlighting the assessment of "individuals' specific needs, preferences and prior experiences with contraceptive methods to tailor communication" (Holt et al., 2017, p. 135). This way, situated experiences and individual needs inform uptake in place of availability and provider bias.

However, in negotiating agency, perhaps as an overcorrection, some healthcare providers can abdicate themselves from decision-making, thus leaving this to the health user. This detachment by healthcare providers is meant to avoid coercion in "preference-sensitive decisions" (Chen et al., 2019, p. 178). In their study on health user-centred counselling conducted in the US, Dehlendorf et al. (2014) demonstrate that this detachment had a bearing on provider-patient relationship dynamics. They identify three approaches to counselling cumulatively assumed, *viz*., the foreclosed approach, informed choice approach and the shared decision-making approach, which aim to subvert provider-driven decisions for client-driven decisions.

Within the foreclosed approach, an underlying assumption is that the health user has already decided. Medical experts consequently commonly avoid probing health users on decisions (Biggs et al., 2020). In their study, Dehlendorf et al. (2014) state that discussions on other contraceptive measures were often barred as healthcare providers offered information on the requested technologies and abdicated any stakes in the decisions made by clients. Medical experts were overly enthusiastic about tailoring the conversation towards patients' choices that "even when patients did not express a preference or mention specific methods, providers avoided introducing methods, often by asking about the patient's contraceptive history and encouraging resumption of a previously used method" (Dehlendorf et al., 2014, p. 235). Questions such as "Have you been on anything before?" were a precedent to this foreclosing

of information sharing that would be limited to certain measures. Consequently, medical experts offered minimal explanations of selected measures, including side effects. In addition, side effects were discussed as additional information (Dehlendorf et al., 2014) rather than essential information that could deter enacted decisions. More engagement was found in the informed choice approach discussed next.

Within the informed choice approach, medical experts exude an openness to sharing information on all contraceptive technologies, albeit all decision-making is also left to the client (Biggs et al., 2020; Dehlendorf et al., 2014). This information was imparted even when clients themselves foreclosed conversations towards particular methods. However, Dehlendorf et al. (2014) argue that the additional information shared about other technologies was often decontextualised rather than tailored to suit the clients' mentioned preferences. Methods would thus be mentioned without rationale or in a perfunctory way. Unlike in the foreclosed approach, where side effects were discussed after enacting a choice, in this approach, medical experts discussed side effects before health users enacted their choices (Dehlendorf et al., 2014). The cafeteria approach or structured contraceptive counselling method also works in the same way.

Structured counselling sessions that leave nothing to chance have been found in the literature (Langston et al., 2010). Here, a flipchart, narrated by a healthcare provider, that includes all measures offered is used to guide every interaction. In addition, a sample of each contraceptive in question is presented. While the approach is structured, it is also all-inclusive and thus expected to be non-directive since healthcare providers are encouraged to stick with the script. Therefore, provider bias is minimised. In addition, health users' decisions can be understood as informed choices, given the care taken to discuss all methods and their side effects in easily understandable language (Rodriguez et al., 2016).

11.4 Shared decision-making approach

While a large amount of critical scholarship has advocated for the decision regarding using particular contraceptive methods to stem from women, some research has argued for contraceptive decision-making to be a shared decision between the contraceptive user and the health service provider (Donnelly et al., 2014; Fataar et al., 2022; Morison et al., 2022). As a health communication model, shared decision-making values input from medical experts rather than absolute agency that excludes providers from deliberation and the ultimate decision (Dehlendorf et al., 2013; Morison et al., 2022).

Within shared decision-making, “the health care provider is responsible for contributing his or her medical knowledge, while the patient provides expertise on his or her own values and preferences” (Dehlendorf et al., 2017, p. 452). Due to this framing of health users as partners (Chen et al., 2019) or collaborators, studies have associated shared decision-making with improved reproductive health outcomes, while levels of dissatisfaction have been associated with the other ends of the spectrum, namely complete agency among contraceptive users or decisions enacted by medical experts on behalf of the contraceptive users (Dehlendorf et al., 2017; Morison et al., 2022).

The shared decision-making model resists regarding decisions as provider-centred or patient-centred but as shared by both entities (Dehlendorf et al., 2014). In addition, the provider assumes a participatory role within the shared decision-making approach, where the provision of information is responsively used to cater to the voiced needs of the participant (Dehlendorf et al., 2014). It is said to contain three phases, which are not necessarily linear but often iterative. Phases include information sharing, deliberation and decision-making. (Chen et al., 2019). In Dehlendorf et al.’s (2014) study, providers initiated this decision-making model with an interactive session as they garnered the patients’ reasons for accessing the healthcare centre. What is important to note is the encounter’s interactive nature (Chen et al., 2019).

Dehlendorf et al. (2014) noted that medical experts established rapport with health users regardless of whether they expressed their decisions upfront or not. This included, for example, checking on postpartum women’s well-being and general adjustment. These healthcare providers also provided summaries and comments about clients’ preferences, demonstrating an understanding of their needs and, more importantly, facilitating the decision-making process and rapport. Methods were narrowed with the provider tallying ones that meet the client’s preferences, which were discussed at length until a decision could be enacted. Dehlendorf et al. (2014) mention that rapport was maintained by establishing a joint goal with the clients.

Dehlendorf et al. (2016) devised a survey exploring decision-making in contraceptive counselling. Questions involved asking, “During this visit, who made the decision about what birth control method you would use?”. Respondents thus had to locate their decisions as either belonging to themselves mostly, the medical expert or both. Questions also included “Did your health care provider have a preference for what birth control method you would use?” These questions necessitated yes/no responses. Satisfaction was also measured using questions such as “How satisfied are you with how your health care provider helped you to choose what birth

control method you would use?" with 7-point Likert scale grading responses (Dehlendorf et al., 2016). Findings suggest satisfaction was often prevalent among contraceptive users who had, in a shared way, enacted preference rather than those who were provider-driven (Dehlendorf et al., 2016).

In further understanding and disrupting some problematic dynamics within the contraceptive counselling encounter itself, other methods have been suggested as avenues for amplifying the sometimes-muted voices of contraceptive users in decision-making, such as having trained adolescents as counsellors or experimenting with the provision of contraceptive counselling to a group of contraceptive seekers rather than a face-to-face encounter with just one individual. I discuss these next as iterations of shared decision-making due to the reduced power dynamics.

Peer counselling has been used to inspire the same-day uptake of modern contraceptives (S. F. Wilson et al., 2016). In a study conducted by Bakesiima et al. (2021) in Uganda within a refugee settlement consisting of young South Sudan women, the authors used a randomised control trial to investigate the effects of peer counselling on contraceptive uptake. The treatment group was counselled by three adolescent counsellors who received four hours of training over five days to gain competency in information sharing about modern contraceptives. In contrast, the control group received counselling through the usual channels. Results showed that participants who received peer counselling were more likely to seek modern contraceptives and thus schedule appointments to have them installed by professionals. Similarly, Wilson et al. (2016), in their study conducted in the US, found that adolescent women who were counselled by their peers attributed more positive attitudes towards LARC technologies.

Several scholars have reported on group contraceptive counselling (Adeniyi et al., 2020; Bakesiima et al., 2021; Ferreira et al., 2010). Ferreira et al. (2010) used educational group counselling to make a case for the importance of personalised conversations within contraceptive counselling in their RCT with post-abortion women in Brazil. They report a greater likelihood of contraceptive uptake among intervention group women who had received personalised conversations. In a study by Adeniyi et al. (2020) conducted in South Africa, group contraceptive counselling was offered pre-abortion to all abortion-seeking women to observe immediate insertions of the IUD as compared to delayed insertions. They report more retentions of IUDs among women in the intervention group. Although discontinuations were found, uptake levels were improved compared to when IUD provision was delayed.

12. Coercion and resistance within contraceptive counselling

Although the ability to resist the intersubjective power differentials of provider-driven interactions can be inaccessible for some, not all contraceptive users passively accept recommendations from medical experts. As such, a continuum of responses to asymmetrical healthcare provider/client relationships is noted by Ostermann (2021) and Morison et al. (2022), ranging from passive refusals/resistances to overt refusals/resistances. On the one hand, passive resistance entails subtle strategies such as deflecting or withholding responses that demonstrate that one does not acquiesce to the recommendation or, alternatively, inaction (Morison et al., 2022). In withholding acceptance, an opportunity is created for healthcare providers to offer further elaborations on specified treatments. On the other hand, active resistance signifies interrogating and challenging recommendations made by healthcare providers in consultations (Ostermann, 2021). This includes "actions that postpone or halt acceptance, such as patients' requests for information and repair initiations, or even outright rejection" (Ostermann, 2021, p. 3). While this enactment of agency can disrupt the flow of the conversation, research also shows that it presents an opportunity for patients to reframe and/or explain their contexts. Therefore, better tailoring the recommendation to their situation, often generating higher compliance and outcomes (Ostermann, 2021).

13. Improving counselling quality

In establishing quality in contraceptive counselling, Dehlendorf et al. (2016b) devised the patient-reported interpersonal quality in the family planning scale. This scale observes behaviours such as healthcare provider familiarity with contraceptive measures and the level of warmth exuded at the beginning of the meeting; the health provider's ability to elicit information about the patient's history with contraceptives as well as their preferences; an ability to show empathy during the interview and towards the end of the counselling, allowing of the patient to ask questions; explaining medical terms used; asking questions to deduce whether the patient has understood the information they have been given; and setting a clear follow-up meeting date (Dehlendorf et al., 2016). The study found that participants who were pleased with the interpersonal relationships forged with health providers were more likely to retain the contraceptive measures for longer due to the healthcare providers' willingness to tailor contraceptive provision to users' individual needs rather than a one-size-fits-all approach.

With growing recognition of these power differentials and a need to divest them, ultimately evening out influence in decision-making, one of the interventions taken up in Indonesia was the launch of the "Smart patient" initiative. Contraceptive-seeking clients are required to ask

questions and voice their apprehensions about contraceptive technologies during contraceptive counselling (Kim et al., 2003). However, the study found that more educated women were often willing to engage and be more proactive in contraceptive prescription (Kim et al., 2003). The study also indicated that clients were more likely to engage when less social stratification differences were evident between medical experts and clients. Therefore, contraceptive seekers from lower socio-economic areas were more inclined to engage when the healthcare provider also belonged to a lower socio-economic class (Kim et al., 2003, as cited in Govender & Penn-Kekana, 2008).

According to Reader et al. (2014), patient complaints can be considered opportune moments for providing client-centred health care. While patient complaints can be good indicators of the systematic issues present in a facility, they are also representations of interactive issues rather than deep-seated structural issues. They can also represent emotive accounts of dissatisfaction with the attitudes of particular health service providers. Researchers, however, warn that patient complaints can focus on problems and preclude the provision of solutions. Furthermore, patients must often consider the contributing factors thoroughly (Reader et al., 2014). In the end, however, health users are expected to enjoy contraceptive agency.

Autonomy (Yanos Tadesse et al., 2019; Zeal et al., 2018) and agency (Ostermann, 2021) have been used interchangeably in the literature around contraceptive use, and at times both terms seem tantamount to each other. However, nuances can be found as autonomous beings arguably act, experience and think unencumbered by context, while the contexts in which they are enmeshed determine agentic beings' ability to curate particular experiences and outcomes (Bevir & Richards, 2009). In this way, autonomy denies the backdrop of prior experiences as influencing alternative and novel ways of acting. In addition, it reifies "an individualised, rational economic model of choice" (Morison et al., 2022, p. 228). In contrast, Bevir and Richards (2009) argue that "agency is not autonomous, it situated" (p. 9). It occurs in context.

14. Conclusion

I devoted this chapter to discussing the literature on contraceptive use. The chapter began with discussing the advent of contraceptives and their effect in lowering fertility, more steadily for some countries than others. I then looked into the inescapable debate of contraceptive uptake as either a population control tool or as empowering, a polarising debate from which LARC technologies have not been exempt. The different LARC technologies, *viz.*, IUDs, implants and injectable contraceptives, their duration, the prevalence in uptake, mechanisms of action and

insertion procedures were discussed. I then turned to the advantageous features, such as users' ability to manage their fertility and resist gender inequities and ageist notions that mediate reproductive-age women's capacities to avoid pregnancy, alongside the drawbacks of LARC that include the measures' responsibilising nature. Lastly, decision-making, as affected by structural and attitudinal barriers, was discussed, including contributions and possible biases of health service providers in prescribing LARC. In later sections of this chapter, I centred the conversation around decision-making within counselling sessions, where providers interact with contraceptive users to understand their reproductive needs. The literature shows a move from paternalistic models of counselling, which have been expert-directed, to a recognition of the importance of the consumer as a decision-maker. However, it also shows that detachment in overly strengthening patient-centred decision-making has its own flaws. Therefore, the conversation has advocated for shared decision-making with healthcare providers and contraceptive users as partners, the former offering medical knowledge and the latter offering embodied knowledge.

Chapter 3: Theoretical Framework: Constructing the LARC (non)user

1. Introduction

In this chapter, I present the theoretical framework that undergirds this research conducted on contraceptive users' and healthcare providers' talk about using and prescribing LARC technology. The study is situated within a reproductive justice framework supplemented by a postcolonial poststructural feminist lens. As such, the conceptualisation of the theoretical backdrop begins with examining what it means to uphold a reproductive justice framework when considering women's contraceptive needs. I then provide a brief background on some of the historical conditions that led to the emergence of poststructuralism. The LARC user/healthcare provider interaction within contraceptive consultations is then discussed from a Foucauldian poststructural perspective. Unlike Foucault, who understands the subject as prepositioned by discourse, I draw on Barker's notion of the emplotment of narratives into discourse. Therefore, visibilising a narrative actant structure in which the agent emerges and emplots themselves in various ways when contradictory discourses accumulate around particular signifiers. The notion of the death of the subject found within Foucault (Barker, 2017) will thus be addressed in this way. However, the import of a standalone Foucauldian poststructuralist approach has been identified as problematic, particularly when applied to former colonies such as South Africa. Therefore, I make a case for the use of decoloniality theory, particularly the notions of coloniality of power, coloniality of knowledge and coloniality of being by Ndlovu-Gathseni (2013a; 2013b) to ground the work within the realities of South African contraceptive users and providers' experiences. The micro-narratives and the emplotments afforded by the participants' talk will thus be evaluated for their ability to disrupt or extend the coloniality of power, coloniality of knowledge, coloniality of being and coloniality of gender. I provide critiques of each framework at the end of its sub-section, and an exploration of the significance of combining these lenses concludes the section.

2. The shift from reproductive rights to reproductive justice

In the lead-up to and post-ICDP 1994, research and advocacy around sexuality and reproduction were predominantly approached from a rights perspective, which in itself was believed to be the antidote to population control models around reproduction dominating SRH up to 1994 (Ross, 2006). However, recent literature has established that reproductive rights are

only part of the solution to resisting the constraints that hinder full bodily agency over reproductive decision-making for many women (Ross & Solinger, 2017).

There have been several critiques of the reproductive rights approach. Firstly, its neoliberal emphasis on choice has been deemed highly problematic for the lack of consideration of the situated and structural issues that act as barriers to quality contraceptive access and other sexual and reproductive health services (Chrisler, 2012; Price, 2010). Efforts by the governments to expand reproductive services are often void of the context in which women find themselves, resulting in simplistic initiatives advocating for choice(Price, 2010). Therefore, framing family planning as a "choice" tends to work better in high-income spaces. Yet, women's capacity to "choose" is often unavailable in many poverty-stricken, patriarchal societies. "The framework of choice assumes that all women can, and do, decide for themselves whether and when to have children" (Chrisler, 2012, p. 1). However, women's bodies are often entangled in a range of intersubjective power relations that impede their reproductive rights. Therefore, blanket approach assumptions that a "woman's body is *her own*- that she owns it, controls it, and makes her own decisions about her body, her health, and her relationships" (Chrisler, 2012, p. 1) undeniably conceal the restrictions women endure.

Secondly, women's reproductive rights in high-income areas are often more easily protected than those in low-income areas with limited resources (Chrisler, 2012). Barriers to accessing reproductive rights in many LMICs and for poorer or marginalised communities within HICs are historical and structural. For example, as discussed in the introductory chapter of this thesis, the interests of White women were privileged during the apartheid era, thus resulting in disparities in reproductive health provision in South Africa. This meant that White South Africans had better sexual and reproductive health choices and outcomes (Burgard, 2004). The remnants of such colonialist projects remain in the present (Chadwick & Mavuso, 2021; Mkhwanazi, 2014).

Thirdly, marginalised women's already limited reproductive "choices" are further restricted through capitalism and the notion of economic advancement. Choice often implies "consumerism: a woman seeking to control her fertility could enter into a marketplace of options and select the one she liked best" (Ross & Solinger, 2017, p. 102). Socioeconomic factors thus play a role in privileging certain women with access to these choices and, ultimately, the realisation of desired reproductive destinies while equally presenting barriers to

other women's ability to assert themselves to receive meaningful counselling about effective, desired contraceptive choices (Chrisler, 2012).

Fourthly, the "choice" framework requires women to be aware of their reproductive rights and a community that is receptive to those rights and thus acknowledges them without suppressing women's rights to exercise them (Chrisler, 2012). For example, Mavuso (2014) argues that generational power relations often deny women reproductive choices in South Africa. Being younger often suppresses one's voice and ability to choose. This intergenerational relationship between young unmarried women and older healthcare providers may act as a barrier to women receiving their desired reproductive technologies, thereby undermining reproductive choices for young, low-income women.

Fifthly, even with legislative reform that includes reproductive rights, some women have continued to face discrimination spurred by patriarchy and systems of division. Notions of women's universalised oppression and reproductive rights as a panacea for these oppressions often fail to articulate the nuances of marginalised women's experiences. For example, current concerns about the violation of some women's basic rights, such as the right to reproduction, are often denied, as they are constructed as "illegitimate" mothers (e.g., poor, disabled, incarcerated, Black, young women and sex workers) (Macleod, 2019).

Finally, despite much international work on reproductive rights, they are easily undermined through powerful country policies. The Protecting Life in Global Health Assistance (PLGHA) policy of the Trump administration in the US, for example, is evidence of the power differentials between so-called developing and developed countries that can tacitly undermine a country's progressive laws and policies. A case in point is South Africa's Choice on Termination of Pregnancy Act (CTOP Act), which allows South African women access to abortions on request within the first trimester of pregnancy. PLGHA, with its restrictions on services that NGOs receiving US government funding could provide (no abortion services or referrals for abortion), restricts women's legislative rights to abortion provision, referrals, and counselling in return for developmental aid (Singh & Karim, 2017). This allows upper- and middle-class women the reproductive right to an abortion while denying working-class women the same right due to the reduced freedom of speech of NGOs that offer or disseminate information about the service for free.

In lieu of the above oversights of a reproductive rights approach, a reproductive justice one has often been deployed. Advocates of this approach "point out that the rights agenda is

insufficiently located within context and frequently fails to embed analyses within the multiple power relations, in particular, racialised and socio-economic realities, that structure women's and men's sexual and reproductive lives" (Macleod, 2019, p. 47). This approach is discussed next.

3. Reproductive justice

Conceptual developments on reproductive justice (as both praxis and a framework) date back to post-ICDP dialogues among women of colour who further conceptualised the framework through an organisation called SisterSong (Bhakuni, 2021; Ross & Solinger, 2017). These discussions recognised the intersecting gendered, raced and classed circumstances that varyingly impinge on women's reproductive health (Price, 2010; Ross & Solinger, 2017). "[R]eproductive justice can be described as reproductive rights embedded in a human rights and social justice framework used to counter all forms of population control that denies women's human rights" (Ross, 2006,p. 1). Three core principles define it: "(1) the right *not* to have a child; (2) the right to *have* a child; (3) the right to *parent* children in safe and healthy environments" (Ross & Solinger, 2017, p. 9); and the right to bodily autonomy (Price & Brettschneider, 2017; Seminario, 2021). This emphasis on both the decision not to have and to have children indicates current expansions of reproductive freedom from the early sexual and reproductive health advocacy that recognised women's limited bodily agency vis-à-vis termination of pregnancy – the right not to retain a pregnancy[5]. Recognition of, and thus resistance to, the hierarchy and reproductive politics around what type of woman deserves to parent, use or not use contraceptives was visibilised using the reproductive justice framework. Population control through fertility continues to play out in how some women remain "distinctly burdened by restrictions on their right to have and to raise children" (Morison & Mavuso, 2022, p. 2). Hence, advocates argue that reproductive justice is achieved "when women and girls have the economic, social, and political power and resources to make healthy decisions about our bodies, sexuality, and reproduction for ourselves, our families, and our communities in all areas of our lives" (Reproductive Justice Collective, 2015, p.1). This emphasis on all women and girls seeks to counter exclusionary reproductive politics that have

[5] Reproductive justice has continued to reflect on itself and as a result, SisterSong's Executive Director, Monica Simpson, extended the basic tenets of the theory to encompass the right to bodily autonomy as "new generations of activists expand it [the framework] to include things that are as important to them as the original ones that we talked about in 1994".

refused teenage, poor, incarcerated or institutionalised women rights to fertility and motherhood.

Even though reproductive justice often emphasises the experiences of women of colour, the injustices enacted on White women, such as coercing unmarried women to offer their children up for adoption, are also acknowledged: "[d]efining white unwed motherhood as a psychological disorder, authorities promoted adoption as a mass solution for dealing with the growing number of white girls and women who had sex, got pregnant, and stayed pregnant without being married" (Ross & Solinger, 2017, p. 43). Reproductive justice is, therefore, an inclusive framework that is increasingly expanding its breadth in explaining reproductive politics (Morison & Mavuso, 2022).

Fundamental to the reproductive justice approach is acknowledging how social locations determine, in varying ways, women's reproductive destinies (Ross & Solinger, 2017). For example, all women of reproductive age in South Africa have the legal right to access and use contraception of their choice. There is evidence, however, of underprivileged women being denied the right to choose their desired contraceptive technologies (Fataar et al., 2022; Margherio, 2019). In addition, according to the Sterilisation Act 44 of 1998, South African women have the right to discontinue their fecundity. However, individuals must be fully informed about the inherent risks of accessing this right. Research by Essack and Strode (2012) and Mthembu (2022) has documented the occurrence of coerced and forced sterilisations among HIV-positive women in South Africa. Therefore, the fecundity of women living with HIV has been problematised.

Historical practices of privilege maintain reproductive hierarchies. In some respects, this is achieved through subtle pro-natalist and anti-natalist messages rooted in discriminatory images that "define" womanhood. For example, in *Black Feminist Thought: Knowledge, Consciousness, and the Politics of Empowerment,* Hill Collins (2000) highlights the racialised contradictions in "ideal" femininity:

> If women are allegedly passive and fragile, then why are Black women treated as 'mules' and assigned heavy cleaning chores? If good mothers are supposed to stay at home with their children, then why are US Black women on public assistance forced to find jobs and leave their children in day care? If women's highest calling is to become mothers, then why are Black teen mothers pressured to use Norplant and Depro Provera? (p. 12).

Conversely, upper-class women have historically been criminalised for performing terminations of pregnancies: “In these locations [the US], the mostly white women who came to the attention of the law were accused of murdering not babies, but their own destiny: motherhood” (Ross & Solinger, 2017, p. 44). These infringements on women’s reproductive decisions have sustained debates about reproductive services not always presenting opportunities for female empowerment due to the oppressions and privileges experienced by some women. Hence, Ross and Solinger (2017) argue that “[r]eproductive oppressions stem from a determination to exercise power over vulnerable persons and achieve goals that have nothing to do with the well-being or interests of individual reproducers” (p.6). The attacks on self-determination and tensions around the unfair reproductive destinies of marginal women have led to the call for justice, which connotes fairness, equitability, and respect (Chrisler, 2012; Ross & Solinger, 2017). Taking into consideration the power differentials that continue to impact women’s reproductive decisions when a purely rights approach is adopted, reproductive justice is increasingly being espoused to give insight into the historical and existing reproductive injustices that have and continue to deny certain women bodily agency and integrity (Ross & Solinger, 2017).

This study utilises the reproductive justice lens to view women’s ability to exert control over their desired contraceptive regimens. Fundamental to such agency is making LARC accessible to fully informed individuals who want to use them, but it also necessitates medical practitioners availing and valuing the decision not to use LARC methods or remove them. However, although reproductive justice is a valuable framework geared towards enhancing women’s ability to exert control over their desired reproductive decisions and thus considering the denial of such reproductive oppression, its application is complicated.

The reproductive justice framework has been criticised for being structuralist in its conceptualisation of power, rendering women’s gendered oppression as a matter of structuralist disadvantages and, in turn, aspiring for a utopian society (Bhakuni, 2021). While reproductive justice foregrounds an intersectional approach to power, it has been limited in articulating power relationships beyond women’s social locations (Mavuso, 2017).

As a supplementary lens, Michel Foucault’s analytics of power can be useful in articulating the microphysics of power inherent in healthcare provider/patient relationships that inform the use of LARC. In addition, in his work, he has “create[d] a history of the different modes by which, in our culture, human beings are made subjects” (Foucault, 1982, p. 208). That is, Foucault’s

work can be useful in theorising about the subject positions made available through intersubjective interactions and histories' influence on available and unavailable ways of talk. The section that follows is devoted to conceptualising feminist Foucauldian-based poststructuralism. I begin by discussing the conditionalities that led to the adoption of structuralism within the social sciences. I then show how Foucault's work went beyond structuralist thought to poststructuralism, sidestepping the assumption of "stability" or fixed "reality" inherent in scientific thinking.

4. From structuralism to poststructuralism

Prior to the development of poststructuralist thought, structuralism sought to bring a scientific vocation to social science. Structuralism was primarily influenced by French intellectual thought in the 1960s and 1970s (Lundy, 2013). "Central to this intellectual revolution was the quest for scientificity. Due to its strong affiliation with science and scientific method, early structuralism was able to radically distinguish itself from traditional approaches to society in the humanities and consequently position itself between (if not above) the sciences and the arts" (Lundy, 2013, p. 70). Structuralists asserted that to understand a phenomenon, it should be broken down from the whole to its basic elements (Williams, 2005). Comparisons could then be deduced between its separate elements, thus making clear differences and similarities between the units. As such, one could then discern what something is and is not (Williams, 2005).

Drawing on this logic, structuralism was the major framework many theorists used to understand the world and human behaviour in the social sciences. In psychology, Freud used structures (unconscious, pre-consconscious and conscious) to explore the mind (Miller et al., 2005). Other influential thinkers of structuralism were Claude Lévi-Strauss, Roland Barthes, Louis Althusser, Nicos Poulantzas, Algirdas Julian Greimas, and Tzvetan Todorov albeit some would later upend their ideas to align with a poststructuralist understanding of social theory (Lundy, 2013).

Ferdinand de Saussure is one of the most cited structuralists in conceptualising language and thought. He premised his theory on the idea that "language itself provides us with a way of structuring our experience of the world and ourselves and that the concepts we use do not pre-date language but are made possible by it" (Burr, 2013, p. 48). Therefore, the words we use to refer to objects and those represented have an arbitrary relationship that is solely regularised through repeated use. To demonstrate this, in his theory, he discusses signs, stating that a

"linguistic sign unites, not a thing and a name, but a concept and a sound-image" (Saussure, 1916, p. 105). Therefore, these signs can be deemed as people's cognitive representations when speaking about things. These can be further reduced to a specific spoken sound or text that connotes the referenced object, also known as the "signifier", as well as the object it represents, which is called the "signified" (Burr, 2013). In understanding the relationship between the two words (signifier and signified), de Saussure made explicit the arbitrary nature of the word used to refer to the object, stating that any word would suffice as long as it was normalised. For example, the signifier *depo provera* (an injectable contraceptive method) could have been called a spoon and still evoke the same imagery or signify the same object. However, through repeated use, meanings become generalised within the localities in which people find themselves in their everyday lives (Burr, 2013). In addition, understanding what is referred to when referring to *depo provera* requires knowing its difference from the subdermal implant or other forms of contraceptive measures, thus allowing our "reality" to emerge through talk. "Reality" is, therefore, contingent on the statements or languages we use to construct or create our social worlds.

Despite the importance of his work, de Saussure was criticised for "erroneously" trusting in the fixed nature of signifiers; once a particular word was associated with an object, while the relationship was arbitrary, its meaning could not transform over time. This led to an emerging school of thought that expanded on structuralism by emphasising the "open-ended, contradictory and culturally specific" (McNay, 1992, p. 2) nature of discourse; it was later called poststructuralism:

> 'Post', in this sense, means 'coming after and adding to' rather than 'rejecting'. This argument—that the meanings carried by language are never fixed, always open to question, always contestable, always temporary—is fundamental to poststructuralism and has major implications for our understanding of the person, their identity and the possibilities for personal and social change (Burr, 2013, p. 53).

Poststructuralists argued for plurality or a multiplicity of meanings that can be attributed to a single entity and further asserted that systems can be challenged and even thrown out altogether (Gannon & Davies, 2005). In its "turn to language" in understanding the world, poststructuralism rejects claims of objectivity and "truths".

Michel Foucault is one of the most recognised poststructuralists. After the expansion of discursive inquiry within qualitative research in the 1970s, his approach to discourse has been mainly identified for its emphasis on historical inquiry, also known as a genealogy, power dynamics that emerge through discourse and the subjectification processes that produce subjects. In supplementing a reproductive justice view, locations of power produced in social interactions are, in a Foucauldian sense, products of social power relations and discourses that produce particular subjects. In the following section, I briefly discuss the progression of Foucault's ideas and later focus on his analytics of power, using them to understand the power dynamics inherent in the prescription and use of LARC.

5. Foucault, discourse, truth and power

Foucault's work traced the underlying relationship between scientific disciplines and social practices (Rabinow, 1984). For example, in the *Archaeology of Knowledge*, he explored the histories of systems of thought. He located the continuities, discontinuities, overlaps, and confusions in discourses within the human sciences, thereby arguing that the regularities of science are made possible by discourses, not universal truths. As such, these discourses inform and produce the world around us (Rabinow, 1984).

Discourses have been conceptualised as regular and constitutive language acts used to create subjects and the world in everyday talk. They fashion how subjects see life and how they act, further dictating what can and cannot be said about a particular subject (Foucault, 1972). Due to this, some discourses are dominant or powerful ways of being and seeing the world and are thus experienced as "natural", "normal", "real", and hard to challenge (Arribas-Ayllon & Walkerdine, 2017).

According to Foucault (1972), dominant discourses work to subjugate other ways of talking about phenomena. For example, in his early works, which were largely archaeological, Foucault critiqued the organisation of asylums and clinics. In tracing their histories, he showed how discursive formations of insanity transformed in European countries over the years (Foucault, 1972). He thus thought of "madness as a variable construct, not an ahistorical scientific given, and of madness as an essential part of the history of reason" (Gutting, 2005, p. 50). Historically, madness was not understood as an inability to reason; instead, it was construed as possessing certain wisdom during the Renaissance in Europe. However, the othering of "mad" subjects as irrational took root in the Classical Age (Foucault, 1978). This

new knowledge about "mental illness" eventually subjugated the dominant knowledge of the Renaissance era and was, subsequently, construed as a “truth” (Rabinow, 1984).

Foucault (1980) argues that there is nothing outside of history and society as we are “profoundly enmeshed in social structures” (p. 109). Historical and social truth, for Foucault, is a mechanism of power that is incited through discourse (Foucault, 1977). “There can be no possible exercise of power without a certain economy of discourses of truth which operates through and on the basis of this association” (Foucault, 1980b, p. 93). It is this power, operating through the use of dominant, normalising discourses with which his work is chiefly concerned (Foucault, 1977). For example, in relation to this study, the responsibilisation discourse considers sexually active subjects responsible for contraception. It renders the misuse or decision not to use contraception as irresponsible sexual behaviour, thus locating the problem within the individual and, in turn, effacing the social context within which women are located (Saunders, 2018). These discourses about reproduction are powerful, and they dictate what is “normal” sexual and reproductive behaviour and, subsequently, how women can “do” sex and reproduction. Through discourses, we can understand the microphysics of power nested in everyday talk and larger institutions.

Foucault’s conceptualisation of power exemplifies one of the important ways his ideas differed from Marxism and other traditional ways of understanding power (Arribas-Ayllon & Walkerdine, 2017). Traditionally, power was understood as purely hierarchical, top-down and oppressive. However, Foucault argued that power is ubiquitous or omnipresent and productive (Foucault, 1980c). Therefore, the often one-sidedness and purely oppressive mechanisms of power seen in the Marxist theory were challenged. He asserted that "power is not something that is acquired, seized or shared, something one holds on to or allows to slip away" (Foucault, 1978, p. 94). Power thus could not be regarded as a unidirectional phenomenon that belongs to a certain few bourgeoisie citizens who exercise it on the majority poor. Instead, it also operates at a local level, as it is intersubjective (Foucault, 1982). The decision to focus more on the relational aspect of power rather than power as owned by a single subject allows researchers to observe the impact of power on people's everyday lives. However, although Foucault emphasised the omnipresence of power in the everyday, he did not disavow the presence of larger power structures (Gordon, 1991). Other than complicating the omnipresence of power in everyday life, Foucault's work is also important because he demonstrated that power and knowledge intersect in meaningful ways in what he called the power/knowledge nexus (Foucault, 1977).

5.1. The power/knowledge nexus

For Foucault, “power and knowledge are seen in relational terms as a set of discourses and strategies operating in particular contexts” (Fawcett, 1998, p. 266). Inherent in the quest for knowledge is power, and inherent in power is knowledge. With this notion, he shows that beyond violence, inherent in institutions such as medicine and psychiatry that stand for certain truths about society with potentially divisive politics such as “mad” or “normal” or expert and patient, is power, which determines the kind of subjectivities subjects form. Given this, Foucault (1977) argues that the subject is embedded in an assemblage of discourses and institutions that impact their conduct and thus contain the power informed by the will to truth. That is, certain spaces are deemed as producing scientific knowledge or truths, which, because they have been normalised, permeate the body of “the subject who knows, the objects to be known” (Foucault, 1977, p.27-28).

Gavey (2013), however, argues that there is nuance within this power/knowledge nexus. Some researchers have inaccurately conceptualised this nexus (or *pouvior-savoir* in French) as referring to power as knowledge and knowledge as power. In an interview, Gayatri Spivak asserted that the meaning of *pouvior-savoir* in French does not only refer to power-knowledge, as has been stated by many scholars (Gavey, 2013). *Pouvoir* connotes power but also “carries with it a ‘can-do’-ness” (Gavey, 2013, p. 86), while *savoir* also does not solely imply knowledge but refers to “knowing”. As such, *pouvior-savoir* means "being able to do something, only as you can make sense of it" (Spivak, cited in Gavey et al., 2013, p. 15). In the case of this study, this means that the healthcare provider/ patient interaction, which can be seen as a power/knowledge system, is informed by discipline-specific knowledge of the healthcare provider as the knower and the patient as the consumer of this knowledge. This “making sense” of contraception, sexual relations, and reproductive capacity results in practices (“doing something”) such as healthcare providers’ medical advice about which LARC contraceptive measure is the most appropriate for a woman. This “making sense”, as defined by professional nursing practice, is viewed as superior to the patient’s understanding.

The power-knowledge nexus, therefore, has the following implications. Firstly, it challenges positivist assertions that knowledge and power are separate entities and thus questions if scientific inquiry produces knowledge that can be considered objectively “real” or “true” (Foucault, 1977). Secondly, it demonstrates that instead of construing power as continuously operating on objects and subjects, one should rather see power as constructive as it creates

objects. As a result, Foucault argued that power is not always suppressive; this is further evident in the quote below:

> We must cease once and for all to describe the effects of power in negative terms: it 'excludes', it 'represses', it 'censors', it 'abstracts', it 'masks', it 'conceals'. In fact, power produces; it produces reality; it produces domains of objects and rituals of truth. The individual and the knowledge that may be gained of him (sic) belong to this production. (Foucault, 1977, p. 194).

In the above quote, Foucault argues that power is not entirely oppressive. This is because power constitutes the subject and regulates its behaviours and practices without brute coercion. Therefore, the hold of power on the subject is subtle. Contraceptive decision-making during contraceptive counselling will be conceptualised in the next section, drawing on Foucault's analytics of power and other concepts that underpin its operation, namely sovereign power, disciplinary power, self-surveillance techniques, bio-power, confession and pastoral power.

5.2. Disciplinary Technologies

Discipline and Punish (1977) led to Foucault's genealogical inquiry, which his *History of Sexuality* (1978) volumes later also emulated. He used a genealogical technique that traces the emergence of institutions, which, through discourses of power and knowledge interweaved with the social body, sought to normalise or objectify its population. Foucault used the continuities and discontinuities in history (historical transformations) or "the jolts and surprises of history, the chance occurrences" (Flynn, 2005, p. 34) to theorise about the workings of power in present society (Rabinow, 1984). However, transformations, shifts and revisions of his ideas were evident over the years, as differences can be identified in these two genealogical treatises. For example, *Discipline and Punish* can be understood "as an attempt to analyse the way power works on the body through external controls, and his *History of Sexuality* as an attempt to analyse the way it does through internal controls" (Bevir, 1999, p. 66). His genealogical inquiries explained the move from the objectification to the subjectification of subjects, incited through discourses embedded in particular power/knowledge nodes.

In demonstrating the shifts of power over the body in modern European societies, Foucault (1977) conducted a genealogy on the transformation of the penal system in the Classical Age. To do this, in his treatise *Discipline and Punish*, he evidenced a shift from corporal punishment for criminal activity, informed by sovereignty, to the regulation of the self in the 18th Century and further argued that people are as unfree as those in previous European regimes (Foucault,

1979). That is, while sovereign power's overt and brute force was declining, disciplinary power maintained new forms of control on the body in regulating behaviour (Foucault, 1977). Sovereign power and disciplinary power are explained in the next section.

5.2.1. Sovereign power

Sovereign power is Foucault's closest example of a top-down form of power that represses the subject. In *Discipline and Punish*, the gruesome imagery of the public prosecution associated with sovereign power is laid out. During the eighteenth century in Europe, all crimes were construed as an attack on the King as "the King's body wasn't a metaphor, but a political reality. Its physical presence was necessary for the functioning of the monarchy" (Foucault, 1980a, p. 55). As a result, sovereign power operated through repression and instilling fear. To do this, the punishment had to be inflicted upon the body in the presence of an audience witnessing the power of the sovereign in inflicting pain and taking life.

Over time, however, questions about the efficacy of punishing violence with violence in public were posed. In addition, the direction of the altruism experienced by the spectators was at times not directed to the prosecutor but at the criminal (Foucault, 1977). Foucault argues that avoidance of inflicting harm on the body became important, and hence the rule became "take away life, but prevent the patient from feeling it; deprive the prisoner of all rights, but do not inflict pain; impose penalties free of all pain" (Foucault, 1977, p. 11). Punishment thus increasingly eschewed the use of physical violence and its public nature. This way, the punisher was not steeped in inflicting pain on the criminal. In addition, with this shift from pain to the suspension of rights, the body was no longer the core site of punishment. Justice thus became more about punishing the crime and not the person. Foucault (1977) thereby argued that power no longer required transgressors to the King's rule to be killed but rather that they be normalised through discourse; hence, the birth of disciplinary power in the nineteenth Century in modern European countries.

5.2.2. Disciplinary power

Disciplinary power takes the form of a gaze. Foucault (1977) used what he termed "carceral institutions" (p. 282) to demonstrate these new modes of power and how they discursively shaped conduct. For example, drawing on punishment and the emergence of prisons, Foucault evidenced the intensified involvement of various specialists or professionals outside the monarchy in determining the criminal's sentence. Inherent in this new order that consults institutions such as psychiatry to advise on punishment is the idea that the crimes make the

individual. That is, psychiatry and the juridical system devise sentences that sometimes do not judge the crime but the criminal's soul (Foucault, 1977). "The expiation that once rained down upon the body must be replaced by a punishment that acts in depth on the heart, the thoughts, the will, the inclinations" (Foucault, 1977, p. 16). Punishment now targeted the criminal's mind, hence the formation of prisons that would transform criminals, resembling other disciplinary institutions such as schools, barracks, and hospitals (albeit that prisons would be identified as actually manufacturing criminals rather than rehabilitating or transforming them) (Foucault, 1980b).

Discourses drawing on particular power/knowledge nexuses were used to classify subjects through dividing practices as either “normal” or “abnormal”, “criminal” or “civilian”. An example of these dividing practices in this study is “a responsible contraceptive user” versus an “irresponsible contraceptive user”. Subjects were trained and regulated through monitoring, organisation, and dividing practices, which disciplined bodies towards normalisation, suggesting a move from repressive to productive power, which operates without force. This process is often called the objectification of subjects by the relevant carceral institutions (e.g., schools, hospitals and prisons) (Rabinow, 1984).

Another mode of objectification, which was deemed more covert in its operations of power, was scientific classification, whereby “the body was increasingly treated as a thing” (Rabinow, 1984, p. 10). There was a proliferation of medical discourses— “a corpus of knowledge, techniques, ‘scientific’ discourses is formed and becomes entangled with the practice of the power to punish” (Foucault, 1977, p. 23). For example, when psychiatrists and psychologists increasingly worked in tandem with juridical systems in determining punishment, at first, the mad could not be punished as it was argued that it was not the “normal” being who committed the crime (Foucault, 1977). However, later, those considered mad were not acquitted; instead, they were punished in other ways, e.g., being confined in a mental institution rather than prison (Foucault, 1977). Using science, subjects were monitored and examined and ultimately, categories such as mad and sexually deviant were created. In deploying these pejorative categories, some subjects were deemed as in need of “correction” through psychiatry and psychoanalysis, not punished through the penal system (Hayter, 2003).

Foucault (1977) argued that these forms of power relations operated not only in prisons and mental institutions but were deployed more generally in various institutions. Hence, discourses are said to be “bound up with institutional practices – that is, ways of organizing, regulating

and administering social life" (Willig, 2008, p. 172). They are, therefore, used to construct and maintain existing dominant power relations within institutions that define subjects as, for example, patients or healthcare providers, and these institutions also conversely validate existing discourses about them (Willig, 2008). From this perspective, medical institutions such as family planning clinics ascribe to institutional power, which confers powerful positions onto healthcare providers who are positioned as hyper-rational and accurate in consultations because of the institutional locatedness of the conversations. "Evidenced" by science, the advice offered by healthcare providers often seems unchallengeable. The mechanisms of this power operating through institutions/disciplines are often effective because, by contrast to modes of sovereign power, disciplinary power works through "subtle coercion" (Foucault, 1977, p. 209). Therefore, while sovereign power is public and sometimes violent, disciplinary power is less hostile and more normalising (Foucault, 1977). However, both forms of power operate on the body, albeit the latter is illusive and covert. Nevertheless, the inevitable entanglement of the body in these power relations is evident in both forms, whether subtle or coercive. Foucault thus used the panopticon prison design to show the microphysics of disciplinary power that create self-disciplined and normalised subjects through surveillance.

5.2.3. Surveillance

Foucault's discussion of the panopticon demonstrates how subtle coercion inherent in disciplinary power can be internalised, resulting in subjects who regulate their own behaviour with limited resistance. The panopticon denotes a round correctional facility designed by Jeremy Bentham, representing one of the systems of punishment established in the 19th Century, replacing the violent monarchical punishment inscribed on the body (Foucault, 1977). In this prison, the guard was placed in a tower at the centre of the structure while the prisoners were in cells surrounding the guard's tower (Foucault, 1977). Due to its architectural details, the guard had a full view of the confined prisoners and could thus monitor behaviour at will, but the guard was not visible to the prisoners (Foucault, 1977). Herein lay the strength of the panopticon: since the prisoners could not see the guard, they would self-monitor themselves under the impression that they were being observed or under the gaze of the guard even in the moments when they (the guards) were not as there were limited ways of knowing (Foucault, 1977).

Techniques of surveillance such as this signal a move towards the management and regulation of the mind and body, resulting in "normalised" or disciplined docile bodies "that may be subjected, used, transformed and improved" (Foucault, 1977, p. 138). Therefore, complex

techniques instrumental to the surveillance of the subjects were increasingly developed, exerting a micro and macro-level hold on the body, in which the subjects were complicit. This form of power is called bio-power (Foucault, 2003).

5.2.4. Bio-power

It increasingly became evident that the body can be productive without the use of violence as normalised subjects submit to society's modes of subjection on the body through sophisticated forms of surveillance, which required a "closer… mapping of the social body" (Foucault, 1977, p. 78). In contrast to sovereign power, which was premised on the monarchy's ability to take life, bio-power is representative of the government's investment in letting the population live or "the administration of bodies and the calculated management of life" (Rabinow, 1984, p. 262). Broadly, bio-power designates the government's increasing desire to regulate and manage its population through the body, thus inciting it to monitor its own daily practices, identity and activity through a system of standardisation. It designates "what brought life and its mechanisms into the realm of explicit calculations and made knowledge-power an agent of the transformation of human life" (Rabinow, 1984, p. 266). Its function was twofold. Firstly, at a micro level, it marked governmental intervention on its population, using various disciplinary technologies such as schools, medicine, prisons and the military to make it efficient and productive (Rabinow, 1984). Therefore, bio-power is capitalism's predecessor that, through its statistical knowledge of the population, allowed for a disciplined and productive population that would sync up with this new political system (capitalism). This is because "the human body comes to be seen as a machine, complete with functions and utilities, inputs and outputs, predictabilities and precisions" (Cisney & Morar, 2016, p. 4).

Secondly, bio-power denotes less focus on the biological nature of the body but more emphasis on its ability to be manipulated and regulated. This represents macro-level control of the body using statistics and a rationalisation of the regulation of reproduction, health, mortality, morbidity and the family. The result is that bio-power surveys its population and disciplines it to survey itself, thus producing docile bodies or "subjected and practised bodies" (Foucault, 1977, p. 138), which are obedient to the power and control exerted. For example, work on adolescent pregnancy has shown that healthcare providers mandated by the state use a range of techniques to manage the risk of unintended pregnancy (Macleod & Durrheim, 2002). These strategies include confession, responisbilisation discourses and surveillance, ultimately producing a docile body (Macleod & Durrheim, 2002). This is because "the teenager's body is divided into reproductive organs (which need to be monitored and treated both in a state of

pregnancy and non-pregnancy), and sexual organs (which go through certain "physical growth" stages, and to which access must be patrolled)" (Macleod & Durrheim, 2002b, p. 50)

Similarly, it could be argued that women, particularly those from disadvantaged socioeconomic backgrounds, are governed by being encouraged to comply with LARC regimens until they can link reproduction with employment and are thus able to provide for their children without depending on the state. Placing women on LARC could be an indicator of how the reproductive body is being increasingly medicalised and placed under bio-scientific control (Oksala, 2011). According to Macleod and Durrheim's (2002) research on teenage childbearing conducted in South Africa, this is a form of risk management by the government to avoid the growth of the working class, which is rendered unable to improve life. Therefore, while institutional power intervenes on the individual's body, its surveillance of the body and mind is often masked as enhancing life and exercising individual freedom (Oksala, 2013).

5.3. Foucault on sex

In the *History of Sexuality*, Foucault (1978) conducted a genealogy of sex using the power/knowledge nexus to demonstrate that "sexuality is not an innate or natural quality of the body, but rather the effect of historically specific power relations" (McNay, 1992, p. 3). The role of government in regulating sex and, subsequently, reproduction in the European Victorian era is evidenced in these volumes of text (Foucault, 1978). In the much-cited first volume of the series of books, Foucault uses the repression theory to repudiate the notion that sexuality has always been associated with secrecy, arguing instead that there was a time when sex was exercised shamelessly and vigorously. He further asserts that the desire to repress sex is a new invention that occurred during the 18th Century (Foucault, 1978). This regulation of the population through sexuality is a form of bio-power occurring during the rise of capitalism and resulting from the government's interest in managing the population's bodies and increasing its productivity (Rabinow, 1984). For example, during this time, a privileging of sex within the confines of marriage by the bourgeoisie, the inclination towards sexuality for reproductive purposes and a simultaneous privatisation of sex were documented by Foucault (1978).

> [S]exuality was carefully confined; it moved into the home. The conjugal family took custody of it and absorbed it into the serious function of reproduction (Foucault, 1978, p. 3).

Sex was thus pathologised in other areas, namely with children or between same-sex couples; these were deemed as wasteful forms of sexuality that did not contribute in productive ways to

the new order. Simultaneously with the "sanitising" and repression of sexuality was the generation of discourse that traced the "meeting line of the body and the soul" (Foucault, 1978, p. 20). Foucault, therefore, increasingly uncovered that with the scrutiny of the body through medical knowledge, a bind emerged between sexuality and discourses of knowledge and power. As such, "[s]exuality must not be thought of as a kind of natural given which power tries to hold in check, or as an obscure domain which knowledge tries gradually to uncover" (Foucault, 1978, p. 105). Instead, it is a social construct governed through discourse that produces self-examination and penance among the subjects and among those who transgress the boundaries of what was deemed "normal", "healthy", or "socially acceptable", i.e., the conjugal family.

In interlocking reproduction and sex and further policing it, the exclusion of those who, through subjugated discourses, constrain this order ensues. For example, female sexual pleasure is lost, in the same way as same-sex desire is, when sexual interest is confined to the function of procreation. However, contraceptive use defies notions of sex and reproduction as inextricably linked or as "an important medium for the expression of our being, and the healthy glue that holds together romantic intimate relationships" (Gavey, 2013, p. 79) – a product of the regulatory effects of discourse or discourse as a mechanism of power, which normalises and subjugates certain ways of "doing" sexuality and reproduction. This is because LARC technologies enable sex within both committed and uncommitted partnerships while at the same time limiting the likelihood of pregnancy.

Normative discourses also constrain what is known about contraception (Hayter, 2003). For example, the desire to be sexually active and not use contraception is construed as irresponsible sexual behaviour, while using birth control is construed as self-care (Hayter, 2003). In the case of pregnancy, women who are married, older and in good financial standing are considered fit for parenthood through the deployment of dominant discourses about reproduction, which in turn marginalises procreation that falls out of the confines of the above indices. These current constructions of birth control and reproduction have been normalised and have transformed in many ways throughout the years. Nevertheless, with the "proliferation of the modern categories of an anomaly- the delinquent, the pervert- which the technologies of discipline and confession are supposedly designed to eliminate, but never do" (Rabinow, 1984, p. 21), the categories created for "healthy" reproduction cannot construct a homogenous pregnancy experience (e.g., pregnancy amongst teenagers and sex workers). With this work, Foucault shows how sexuality

operates within regimes of power/knowledge and thus "opens sexuality up to history and change" (Weedon, 1996, p. 119).

While effective, the privileging of the heterosexual married couples mentioned above does not mean that transgressors to this powerful discourse did not exist. Within the emerging pedagogies about sex, Foucault (1978) argues that a proliferation of discourses about other forms of sexualities was produced. This is because sex was increasingly seen as containing important information about explaining the subject and thus became a site of knowledge production that could be investigated through science. Subjectification practices, or a process Rabinow (1984) refers to as self-formation, are the results of these mechanisms of power on the population. This is because subjects were seen as gradually regulating their own conduct and thoughts, with outside figures such as priests or psychoanalysts as facilitators of this process. As a result, techniques such as confession were tools for eliminating "marginal" sexual practices which occurred outside the confines of marriage.

5.3.1. Confession

As a technique of power, confession conscripted subjects "to tell the truth" about their sexual desires, particularly those that defy the confinement of sexuality within marriage, e.g., masturbation, child sexuality, homosexuality or any other way of being subversive to this new order (Foucault, 1978). According to Foucault (1978), the drive towards confession reified the idea that sex talk is shameful and unspeakable. The requirement for people to confess "unbridled" sexual desire or behaviour demonstrates the regulation of sex at a speech level by bourgeois societies.

Confession as a disciplinary technique over the body is a product of pastoral power, "an old power technique which originated in Christian institutions" (Foucault, 1982, p. 782). This Christian-underpinned model describes the dynamic between a shepherd and the flock. Conduct is regulated by shepherds/pastors by obligating sinners to repent, self-monitor, be obedient to the moral guidance offered, and ultimately be delivered to salvation (Rabinow, 1984). Techniques such as confession facilitate this process, wielding power over subjects that produce people who, aided by the pastorate, examine, regulate, and reflect on their own behaviour.

These configurations of power have been identified within education in teacher-student relationships, within health in healthcare provider/patient patients, and within the domestic domain in parent-child relationships in modern societies. In this study, I focus on healthcare

provider-patient interactions as a site in which LARC users, under the medical gaze, are required to confess their misuse or refusal to use LARC in the event of unintended pregnancy, particularly if they are young, underprivileged or unmarried. The section that follows discusses some of the critiques that have been posed about Foucault's work.

6. Foucault criticism

There has been much criticism of Foucault's work. One of the major critiques about Foucault is that he denies his subjects the ability to resist hegemonic discourses completely. Instead, he argues that subjects are only capable of minor transgressions vis-à-vis these dominant discourses. As a result, they never entirely overthrow normalising power because they are "entrapped in the very system of power they are trying to overcome" (Picket, 1995, p. 447). Hence, Foucault does not deem resistance as freedom but as an integral part of power. However, Weedon (1996) argues that Foucault's emphasis on the socially situated nature of discourses allows for resistance in the formation of new discursive positions.

Secondly, Foucault has been criticised for his scepticism of reality and is thus referred to as a nihilist (McNay, 1992). This is because Foucault denies present understandings of the world as real and argues that all discursive practices are subject to history (Macleod & Durrheim, 2002). He further contends that present constructions of "reality" are constantly subject to change (Weedon, 1996). However, some writers suggest that Foucault's work offers an optimistic alternative to the rigid and stable constructions of life as objective and real, offering a multiplicity of conceptions of understanding the world (Macleod & Durrheim, 2002).

Thirdly, many writers have found his work androcentric (Phelan, 1990), claiming that Foucault did not consider gender issues where power can be seen as owned by a single entity or body of people, e.g., White males. Therefore, Foucault's construction of power as omnipresent is construed by some feminist writers as obliterating the movement against the universal oppression of women by men "and thus deprives women of the basis for making any claims against a sexist society" (Phelan, 1990, p. 430). This is because Foucault destabilises the categories of victim and oppressor as he states that a single entity does not own power, but it is omnipresent.

Macleod and Durrheim (2002), however, argue that Foucault's work on governmentality demonstrates that while power is capillary and the effects of it can be seen at a micro-level, e.g., in intersubjective encounters, this power also operates at a macro-level where it informs institutions and thus produces a top-down effect. Merit can be found in how Foucault

recognises these micro and macro-levels of power without privileging one over the other (Macleod & Durrheim, 2002). “Thus, the fact that power is not held by any person or group and does not operate from a centre does not mean that people and groups are positioned equally within it or that global forms of domination cannot be spoken about” (Macleod & Durrheim, 2002, p. 44). An omnipresence of power allows for the application of Foucault's ideas to understand a range of issues that Foucault had not written about, including patriarchy and racial inequity.

7. Poststructuralist feminism

Much like the notion of femininities, which resists the homogenisation of feminism, assertions about the complementary nature of Foucault and feminism are far from conclusive as there is contestation in the literature. Some feminist thinkers have “suggested that the very foundation of his work is defective for feminists, as it is for all political struggle” (Phelan, 1990, p. 421), further arguing that emancipation within a Foucauldian framework seems implausible and thus a misalliance (Deveaux, 1994; McLaren, 2012). Others have argued that Foucault’s contribution allows feminists to rethink freedom in alternative ways, different from liberal and communitarian thought (Phelan, 1990; McNay, 1992). Hence, he should be considered an ally of feminist thought (McLaren, 2012).

As mentioned in the previous section, Foucault investigated historical discursive constructions and contingencies that led to present “normalities” and oppressions. A gendered account of oppression, particularly concerning women, is missing in his work. Yet his poststructural take on language, subjectivity, power, and knowledge enables an understanding of the implications of these historical constructions of femininity and how they contribute to current women's oppression. “Oppression describes any unjust situation where, systematically and over a long period of time, one group denies another group access to the resources of society” (Hill Collins, 2000, p. 4). Due to the androcentric yet valuable contribution of Foucault's work, feminist writers have combined the central tenets of their work with that of Foucault, forming a feminist poststructuralist theory that seeks to deconstruct the complex power relations in talk, regulated by discourses that uphold systems of oppression (Amigot & Pujal, 2009).

Poststructural feminism endeavours to criticise dichotomous understandings of male and female by troubling essentialised consignments of these categories, thus demonstrating their socially constituted nature and questioning their inevitability (Gannon & Davies, 2005; McNay, 1992). This is because poststructural feminism is “a mode of knowledge production

which uses poststructuralist theories of language, subjectivity, social processes, and institutions to understand existing power relations and to identify areas and strategies for change" (Weedon, 1996, p. 40). It does this through its recognition of pluralities in construing the world and thus allowing transformation in dominant institutions taken for granted as "normal". For example, positivist inquiries entangled in "masculinised knowledge" (Young et al., 2019, p. 340) in the 1970s shored up stereotypical notions around the binaries male and female (Gergen, 2017). Backed up by science, these stereotypes that rendered women inferior became "normative" constructions of masculinities and femininities, thus maintaining women's oppression (Amigot & Pujal, 2009).

According to Weedon (1996), feminist poststructuralist subjectivity presupposes a contradictory subject constantly constructed and reconstructed by discourse, which differs from humanist conceptualisations of a stable and coherent subject. This is because of the principle of the dual operation of language in constructing and resisting certain discourses about a particular subject inherent in poststructuralist thought (Aston et al., 2012). In addition, "at its core, feminist research is designed to seek social justice, to enhance women's voice and influence in society, and to explore alternative ways of understanding the world through women's experiences" (Gergen, 2017, p. 289). Therefore, combining feminism and poststructuralism can be valuable in understanding women's experiences because of the multiplicity of meanings socially constructed in the talk supported by poststructuralism (Arslanian-Engoren, 2002).

However, the transition towards feminist inquiries has not been entirely smooth. Poststructuralism and feminism can be at odds with each other, firstly, due to their dissimilar conceptualisation of power (McLaren, 2012). Many versions of feminism understand power in social interactions as humanistic and top-down, while Foucault understands power as capillary. In Foucauldian-inspired feminism, the totalising and universalising of oppression as binary (the oppressed and the oppressor), with women as docile bodies, are evaded (Aston, 2016). Foucault (1991) instead decentralises power relations. A Foucauldian perspective, therefore, construes women as powerful even in their disenfranchisement, while some versions of feminism may, due to their view of the universality of female subordination, emphasise their disempowerment (Phelan, 1990).

Poststructuralism and feminism, however, can complement each other, which is apparent in tracing history's different understandings of femininity (Sawicki, 1986). Through this, women's

experiences can be seen as varied, and thus, they are not always victims of particular discursive regimes. “It is this recognition that enables us to begin to see how we might change the world” (Phelan, 1990, p. 429). This is because women’s ability to act upon or against power, in essence, resist, becomes apparent instead of historical constructions of them as passive victims who must overcome power exerted by men. This includes women’s ability to determine and realise their reproductive aspirations by maintaining reproductive agency through the use or non-use of contraceptives. This way, essentialist notions of universal oppression are destabilised (McNay, 1992). A feminist poststructural framework would thus visibilise women’s ability to resist patriarchy by (re)claiming reproductive agency.

8. Postcolonial feminism and decoloniality

Postcolonial feminism has explored “intersections of colonialism and neocolonialism with gender, nation, class, race, and sexualities in the different contexts of women’s lives, their subjectivities, work, sexuality, and rights” (Rajan & Park, 2005, p. 53) in many former colonies. Specificities and, in the same breath, multiplicities in constructing experiences and ways of “doing” and being can be captured by the approaches. For example, in the African context, monolithic images of a universally oppressed and hypersexualised woman intimately bound in pejorative historical constructions of Blackness by missionaries and researchers have been questioned and critiqued by postcolonialist scholars (Tamale, 2011). Histories such as these sustain impressions of women in “first world” countries as “secular, liberated, and having control over their own lives” (Mohanty, 1984, p. 353) while (re)positioning women in so-called third world countries as oppressed, risky and with uncontrollable reproductive patterns. Apart from the bifurcation of experiences and the pejorative nature of these classifications, heterogeneity is disallowed, and a gap in postcolonial theory can be filled by opening up spaces for multiplicity.

The homogenisation of people’s experiences into distinct categories is, according to Lugones (2010), a product of modernity. Its claims to civilisation through capitalism contain hierarchies, binaries and categories that, along racial, gendered and class lines, reduced those who were not White, wealthy and male to non-human status (Lugones, 2010). In contrast, Black, poor and females’ “status and relationship to power… was grounded on purely male based forms of power, ethics and morality” (Magadla et al., 2021, p. 518). Homogeneity in its nature is, thus, invisibilising. It rigidly renders all women powerless and their experiences the same. Hence, intersectionality, at the risk of misuse and oversimplification, presented such a turning point in understanding how people’s social locations contained within them different liberations and

oppressions (Crenshaw, 1989; Mendoza, 2016) ones that can be unique for people with seemingly similar backgrounds.

While postcolonial thought provides a profound "situation-specific" focus that allows for heterogeneity (Spivak, 1993), it has been critiqued for the use of "post" in its conceptualisation. Although an anti-colonialist mandate can be found within the referent, inherent within the invocation of temporality are undertones of colonialism as a bygone. Therefore, speaking of a time "after" colonialism (McEwan, 2018), it appears as an oversight around the continuities of the legacies of colonialism within the present. As a result, some postcolonial scholars have hyphenated the signifier to "post-colonialism" (McEwan, 2018) or bracketed the referent to temporality, making it (post)colonialism (Stoler, 2016). However, the slippages between the temporality and criticality when it relates to the signifier, postcolonialism, have been enough to cause dissatisfaction among other scholars, who have thus eschewed it in its entirety. Decoloniality has, therefore, been a worthy contender for some scholars (Mendoza, 2016; Ndlovu-Gathseni, 2013a; Ndlovu-gatsheni, 2013b).

Decolonial theorists assert that tied within the "snares of the colonial matrix of power and the dictates of the rapacious global power" (Ndlovu-Gatsheni, 2013, p. xi) is neocolonialism and a false sense of freedom that mark the futures of former colonies regulated by modernity. Walter D. Mignolo (2007), María Lugones (2010), Sabelo J. Ndlovu-Gatsheni (2013), Catriona I Macleod, Sunil Bhatia and Wen Liu (2020), and Breny Mendoza (2016) all in various ways map systems of dominion by the Global North upon the Global South as well as the continuity of these webs of power. Ndlovu-Gatsheni (2013) captures this through the concept of "coloniality". Coloniality refers to mentalities and global structures that survived the decolonial project within the Global South, thus rendering the present as not free of the legacy of colonialism (Maseko, 2015; Ndlovu-Gathseni, 2013). Postcolonialism, in this sense, is a farce.

Clear delineations between colonialism and coloniality can be found within decoloniality. Colonialism invokes acts in history in which countries were captured by others, and their sovereignty was threatened as the capturer or coloniser imposed its sovereignty upon the colony (Mendoza, 2016). Coloniality refers to remnants of colonialism that survive, thus (re)producing the entrapment of the mind and social relations. Mignolo (2007), building on the ideas of Quijano (1989, 1993), adds that modernity is at the root of "the constant reproduction of 'coloniality'" (p. 450). This is because closely linked to modernity is development, which is said to promise empowerment through the universalisation of Global North ideas (McEwan,

2018) but is also known to use violence to achieve its ends (Mignolo, 2007). In addition, modernity also uses hierarchies and categories to, for example, create race (Quijano, 1993) or grant Eurocentric knowledge with power, conversely, problematically denigrating all knowledge and beings that fall outside the confines of major colonies (Macleod et al., 2020). This is known as the darker side of modernity that decoloniality seeks to expose (Maseko, 2015; Mignolo, 2007; Ndlovu-Gatsheni, 2013).

Decoloniality, according to Ndlovu-Gatsheni (2013), has three underlying principles: the coloniality of power, the coloniality of knowledge and the coloniality of being. Coloniality of power identifies the asymmetries within present societies and recognises the colonial past as its architect. Within the subjectivities produced is a past that created a Zone of Being and a Zone of Non-being. This hegemony grants personhood to the Global North while posing doubt about personhood within the Global South. It also points to the perpetuation of these mentalities in the post-colonial era. Coloniality of knowledge refers to unequal global interchanges that create and maintain the divergent reception of knowledge produced in different geospatial locales. It then legitimises knowledge produced within the Global North and marginalises that produced within the Global South (Macleod et al., 2020). Coloniality of being denotes the dehumanisation and objectification of bodies from the Global South (Ndlovu-Gatsheni, 2013). As such, Maseko (2015) uses the concepts of coloniality of power, coloniality of knowledge, and coloniality of being to explore mine workers' experiences and reports on how modernity has sustained mine workers' non-being status fueled by racial lines in post-apartheid South Africa.

Points of convergence between Foucault and Ndlovu-Gatsheni's (2013) underlying principles of coloniality are in both approaches' tendency to qualify language as instruments with which powerful truths are created and reality emerges. In addition, they use history to interweave the mechanisms of power and knowledge into the social formation of subjectivities. However, both Foucault and Ndlovu-Gatsheni have paid little attention to women's issues, therefore assuming an androcentric nature even though, for instance, "an important lever of the coloniality of power is control of gender, sexualities, and families" (Macleod et al., 2020, p. 295).

Extensions to this work, specifically relating to psychology, can be seen in Macleod et al. (2020), who have problematised signifiers such as "adolescence" within the field, identifying them as inherently amplifying differences and reifying exclusion. For example, Macleod (2003) deconstructs the term "adolescence" in the following manner:

> A person who is not a child but also a child, who is not an adult but also an adult, displays the reproductive characteristics of adulthood, thereby threatening the not adult or child aspect of "adolescence" (Macleod, 2003, p. 56).

In arguing that the signifier is not neutral, the authors track its development, locating it in colonial times. Stanley Hall is recognised as the thinker who conceptualised adolescence as a developmental stage between childhood and adulthood, likening the transition to whole people's transitions from primitiveness to civilisation.

Macleod et al. (2020) argue for the usefulness of the Derridean concept: the "undecidables". "'Undecidables' undermine both the understanding of signifieds as directly connected to signifiers, and the binary polarities that seek to solidify signifiers in particular relations to each other" (Macleod et al., 2020, p. 54). The arbitrary nature of signifiers and the imagined relationship that produces the binary are disrupted by undecidables that slip across binaries, such as the signifier "adolescence". To this end, the authors frame "adolescence" as a signifier "premised on colonialist thinking regarding individual and social development" (Macleod et al., 2020, p. 58). Macleod et al. (2020) draw on the notion of a threat of degeneration, which denotes framing pregnancy at teenagehood as a danger to the social order in the same way primitiveness was constructed as antithetical to civilisation but as threatening to destabilise civilisation.

Fertility control, which refers to "methods by which humans seek to induce, prevent or terminate pregnancy" (Klausen & Bashford, 2010, p. 98), can also be rendered as such a signifier. This is because reproduction has historically moved from being an individual issue to having political significance based on Malthusian ideas around poverty and population growth. That is, a centralisation of fertility as having a bearing on the sustainability of populations has been recognised. Yet, in its regulation through eugenics and state policies, issues around selective breeding make fertility control an undecidability as its control is not stable or a constant but swings towards positive eugenics or dysgenic notions depending on the reproductive subject in question. For example, thinkers like Francis Galton advocated for what were deemed "fitter" members of society to be encouraged to reproduce. Paradoxically, the supposed "'fitter' classes were the most diligent practitioners of birth control" (Klausen & Bashford, 2010, p. 100).

Planning parenthood is, thus, the neocolonial way in which fertility control is regulated; people are obligated to comply with "societal prescriptions that govern who may legitimately become

a parent" (Schwiter, 2011, p. 397). In performing legitimacy, several considerations need to be aligned, and when they do not, a policing of reproduction is expected and occurs. Age, employment, ability and marital status are often considered important indices that allow or disallow the intention to be pregnant or otherwise classify a pregnancy as unintended and requiring intervention to avoid a repeat pregnancy to support or control the subject's fertility. Simply put, a threat of degeneration. In further demonstrating the pluralities within language, yet also centring the subject, I argue for the importance of narrative emplotments.

9. Narrative emplotment

Foucault's (1977) notion of subjectification as a product of the power-knowledge nexus that enables and restrains talk is extended by Barker (2017), drawing on Paul Ricouer's work around how narratives structure human experiences or offer an account of "representations of agents" (p. 397). In so doing, Barker (2017) turns to narratives as devices that contain within them temporality that connects events and actions, as well as narrative plots, which govern "how a sequence of events is made into a story" (Mishler, 2006, p. 3).

The plot, according to Barker (2017), gives events causal and teleological significance by configuring sequences in particular ways such that alternative modes of action seem implausible. More importantly, these plots are constructed by an active agent or actant in a process called the figuration of plots or emplotment. Emplotment "functions as one of what Foucault calls the "dividing practices". These are the techniques by which "the subject is either divided inside himself or divided from others", producing, for example, "the mad and the sane, the sick and the health"" (Barker, 2017, p. 399). In relation to this study, the effects of emplotment can be instantiated by how through a responsibilisation discourse one is emplotted as either responsible or irresponsible for deciding to use, continue using or discontinuing contraceptive use. Ricoeur uses the notion of *mimesis* to capture the narrative structure and ways in which the subject is emplotted within a story.

Mimesis$_1$ is concerned with the "pre-narrative structure of experience" (Barker, 2017, p. 397), which in this study is interpreted as discourses to take up in micro-narratives. At *mimesis*$_2$, the discourses drawn upon in *mimesis*$_1$ configure the subjects in particular ways in the process of narrative emplotment while at mimesis$_3$, the potential for refiguration is acknowledged (Barker, 2017). It is at *mimesis*$_3$ that the subject's agency is realised. Subjects can be creative in their storytelling and shift and change previously narrated emplotments, particularly due to an awareness of the audience to which the story is told. Therefore, beyond Foucault's (1977)

dividing practices which are static and create a decentred subject, the use of dualistic, incommensurable discourses at *mimesis*$_1$ has implications for the emplotment of the subject at *mimesis*$_3$ as these discourses accumulate around signifiers such as fertility control during storytelling.

9. Conclusion

In this chapter, I have offered a conceptualisation of interweaving reproductive justice with poststructural feminism, arguing that this combination provides a useful lens to understand the production of the differential power relations between the LARC (non)user and the healthcare provider in contraceptive counselling. The discussion began with a conceptualisation of reproductive justice, locating its rights-based and justice-based principles. In addition, Foucault's ideas on sexuality, power/knowledge nexus, and how they conceptualise the subject were explicated.

Reproductive justice shows how injustices and inequality prevail even when rights and legislation are in place. We thus recognise that reproductive privilege occurs through maintaining talk and institutions that normalise the dominance of performing reproduction in a particular way over other ways, resulting in the subjugation of those deemed as inferior or risky. Moreover, the reproductive justice framework allows the researcher to observe whether the women's bodily integrity and rights are being respected when deciding to use or not use LARC because of its nuanced understanding of equity and choice in the imperative towards social justice. However, reproductive justice is a relatively new concept and still requires development. Therefore, I drew on Foucault's analytics of power, which understand interactions (e.g., between the healthcare provider and LARC users) as socially produced through discourses of knowledge and power. I incorporate a poststructural feminist lens to circumvent the often-androcentric reading of Foucault. In addition, with the processes of subjection stated above, feminist poststructuralism allows us to see, in the case of this study, the female as socially constructed or a medium of culture, which is controlled and disciplined through discourse (Lovering, 2005). However, the amenability of this control on the body also becomes apparent, thus avoiding the essentialising of women's oppression (McNay, 1992). To avoid the essentialisation of contraceptive users' experiences, I draw on narrative emplotments (Barker, 2017), where dualistic discourses complicate subjects' emplotments. Emplotments of discourses into narratives are achieved in such a way that they are received in a palatable way by the interlocuter's audience. Lastly, I draw on Ndlovu-Gatsheni's (2013a; 2013b) decoloniality theory to evaluate how the micro-narratives and narrative emplotments subjects

draw on violently impose or resist the imposition of colonialist assumptions and homogenous depictions on contraceptive users' decision to use, continue using or discontinue using LARC technologies. There is merit in amalgamating these theoretical lenses. In the next chapter, I discuss the methods used to collect and analyse the generated data for this study.

Chapter 4: Methodology

1. Introduction

This chapter explains the methodological steps taken to gather contraceptive users' and healthcare providers' narrative emplotments on the use and prescription of LARC. To do this, I begin with an explanation of the approach I used to guide the analytic process for this study. This section explicates insights language-orientated approaches such as the Foucauldian discourse analysis extract within talk. It uses the notion of narrative emplotments to understand the potential for subjectification within that talk. I, therefore, outline Foucault's notion of discourse while separating it from other forms encompassed within poststructuralism. After this, I problematise the prepositioning of subjects through a Foucauldian understanding of discourse that results in the death or oversubjectification of a subject. To avoid this, I make a case for using Barker's (2017) notion of the emplotment of discourses into narratives to extend Foucault's approach. This way, I propose a more fluid subjectivity, one that swirls around the limits of discourse rather than remains entirely determined by them. In later sections, I state the research aims and questions that this inquiry was centred around, followed by the sampling strategies for obtaining healthcare providers and LARC users and the characteristics of the sample that was ultimately yielded. I then describe the data analysis processes. Furthermore, the ethical considerations made and how methodological rigour was upheld throughout the study are discussed.

2. Analytical issues

While the emphasis on language as producing "reality" or subjectivity and the world underlines most definitions of discourse, many poststructural approaches have embraced differing theoretical underpinnings and applications (Livholts & Tamboukou, 2015; Taylor, 2015), for example, discursive psychology, the narrative-discursive approach within discursive psychology and Foucauldian discourse analysis. I align with a Foucauldian discourse analysis supplemented by Barker's (2017) narrative emplotment approach.

Discursive psychology and the narrative discursive approach, respectively, conceptualise discourses as interpretative repertoires and discursive resources. Discursive psychology defines interpretative repertoires as "building blocks speakers use for constructing versions of actions, cognitive processes, and other phenomena" (Wetherell & Potter, 1988, p. 172). As a recognisable blueprint, speakers, in a turn-by-turn manner, draw upon them within talk to

construct “reality” and themselves. Interpretative repertoires can thus be identified as action-oriented (subjects achieve things through the talk) and containing within them an interactional focus. Therefore, they hold the active, micro context as a focal point (Burr, 2013), although these interpretative repertoires preexist unfolding social interactions. Taylor and Littleton's (2006) narrative-discursive approach assumes a synthetic form and, by so doing, offers a dual lens into the micro, contextual issues as well as the broader context as producers of “reality”. This is achieved through broadening the idea of discourse by using the referent discursive resources to connote “accumulated ideas, images, associations and so on which make up the wider social and cultural contexts of our lives” (Taylor, 2006, p. 3). Defined in this way, the recognisable forms of talk that make up interpretative repertoires and an active speaker who uses tools to act upon their realities in particular ways become visible.

The narrative-discursive approach moves beyond “discursive psychology’s conception of the active speaker to include her reflections on her ongoing and previous identity work and her awareness of consistencies and contradictions” (Taylor & Littleton, 2006, p. 26). This is because narratives and subject positions within a narrative-discursive approach, discussed in more depth in relation to the present study later, are conceptualised as part of the discursive resources that speakers use to construct a stable and continuous identity within interactions. Put in this way, the micro-context, which pays attention to the stated and previously stated, allows and disallows the “realities” that can be mediated in particular cultural contexts and interactions. However, these realities” still primarily operate within the margins of dominant discourses and scarcely stray from what is deemed sayable. A much less fluid identity is thus afforded subjects by the narrative-discursive approach compared to discursive psychology, a problematisation that is also typical of Foucualdian discourse analysis (Arribas-Ayllon & Walkerdine, 2017).

Discourses in a Foucauldian sense, akin to many language-centred approaches, are premised on a “group of statements” (Foucault, 1972, p. 22) that gain regulatory power upon repetition. They construct reality, or reality emerges through these statements and practices (Macleod, 2002). While this talk is constitutive, it is also recognisable and regulative in that what is sayable and not sayable and what is doable and not doable are rooted in history and continues to shape the subject and the world around it. However, for Foucault, discourses are also intimately bound in power and knowledge; “power and knowledge directly imply one another” (Foucault, 1977, p. 27). Collectively produced social meanings in what we consider as “reality”

or common-sense knowledge are embedded in societal networks, where certain "realities" are favoured or given strength through repetition and some subjugated (Foucault, 1972). They, thus, configure social practices, subjectivities and worlds in a certain manner and are taken as knowledge. In addition, some subjects become custodians of that knowledge and thus are privileged to speak, while others are objectified by that knowledge and denied the opportunity to speak. For example, what is possible regarding reproduction is regulated through current knowledge about fertility. Therefore, in drawing on a responsibilisation discourse in relation to contraception, subjects are conscripted towards certain actions and social practices in which responsibilities are set up in particular ways. Medical experts within interactions will, for instance, have the power to direct practices or social action due to the authority of the knowledge offered by medical discourses. In return, contraceptive users must heed those medically informed directions for behaviour. Both subjects' power to act is thus regulated by the knowledge that exists. "Therefore the power to act in particular ways, to claim resources, to control or be controlled depends upon the knowledges currently prevailing in a society" (Burr, 2013, p. 68). Foucauldian-inspired theorists thus agree that "discourse… acknowledges the active role of language in the production of knowledge and power through text and talk" (Livholts & Tamboukou, 2015, p. 4).

Power, for Foucault, does not feature as "some form of possession, which some people have and others don't, but as an effect of discourse" (Burr, 2013, p. 68). Instead, it "is exercised rather than possessed; it is not the 'privilege', acquired or preserved, of the dominant class, but the overall effect of its strategic positions - an effect that is manifested and sometimes extended by the position of those who are dominated" (Foucault, 1977, p. 26-27). He thereby makes a case for the diffusion of power, where no claims can be made in a top/down manner. It is instead negotiated in relations of power, where all significance around social practices, including those that act upon subjects in oppressive ways, is contingent upon the contexts and institutions in which subjects are nested.

> This means that these relations go right down into the depths of society, that they are not localized in the relations between the state and its citizens or on the frontier between classes and that they do not merely reproduce, at the level of individuals, bodies, gestures and behaviour, the general form of the law or government; that, although there is continuity (they are indeed articulated on this form through a whole series of complex

> mechanisms), there is neither analogy nor homology, but a specificity of mechanism and modality (Foucault, 1977, p. 27).

It is exercised and thus produced through speech acts requiring repetition that render some people mad and others psychiatrists. There, configuring and producing particular "realities" and possible actions. These possible actions are variable over time, the same as how discourses of madness have not been stable but have, throughout history, morphed into their current state. Yet, possibilities for resistance can be found in the need for reproduction, which consistently constrains certain discourses while enabling others. Hence, Foucault (1977) understands power as neither positive nor negative but as producing effects or productive.

However, according to Foucault subjects are construed as prefigured, pre-positioned and subjected by the discourses deployed with no recognition of the subject's ability to manipulate, transform, and contest the subject positions it is offered (Burr, 2013; Kokanović & Flore, 2017). In response, subject positions have been used to centre the subject within discourse (Burr, 2013; Davies & Harre, 1990). According to Davies and Harré (1990), a subject position "is the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines" (p. 51). It connotes the ongoing self-fashioning of subjects through the assumption of certain locales within discourses, and in the end, subjectivities are negotiated and "power relations played out" (Burr, 2013, p. 115). Traditional notions around who has the power within an interaction can thus be upset by the subject positions conferred and accepted within a particular interaction.

A Foucauldian discourse analysis has rejected attempts to humanise the subject such as this. Within the approach, discourse determines objects and the world around us; they also operate within medical models, which configure responsibilities in particular ways, interlocked within a power/knowledge nexus, ultimately producing particular subjects. Barker (2015) provides other avenues for exploring the agency of the subject, and so he, too, problematises this overreliance on the cultural context by arguing that:

> [t]he result is a sort of nonsubject, evacuated of essence and thoroughly determined by history—history which in the modern period, for Foucault, is chiefly composed of rationalized disciplinary and biopolitical techniques, enacted upon the individual body

> and at the population level, as supported by proliferating systems of knowledges of man (p. 394).

Barker (2017) offers a different conceptualisation of positioning to that espoused by Foucauldian discourse analysis. As a counterpoint to this notion of subjectification through and by discourses, Barker argues that the subject "is both highly constrained by discourse, but not fully determined by it" (2017, p. 17). In making this argument, Paul Ricoeur's idea of a "narrative human subject" is drawn on to nuance the subject: "the figuration of plot—emplotment—is not only an activity essential to both the construction and the reading of narratives, but is also an existentiale of human understanding and acting in the world" (Barker, 2017, p. 394). Thus, plots constitute and represent subjects and ways of talking, being and performing possible selves. As such, Barker (2017) draws on narratives as illustrative of our storied worlds and storied lives. Yet, these stories in no way mirror reality. Instead, they are socially constructed.

Conceptions of narratives that avoid their social nature have been accused of creating the impression that narratives "float in a social vacuum. The voices echo in an otherwise empty world" (Atkinson & Delamont, 1997, p. 339). Herein, the storyteller is endowed with too much agency with the underlying assumption of a singular, unified narrative that is not subject to change as the teller recounts the narrative to different audiences. This conventional way of understanding narratives has been associated with a humanist tradition. In contrast, in poststructural traditions, there has been a rise in the scrutiny of the context in which storytellers recount events, circumstances and situations they encounter, thus emphasising "the uncertainties of language" (Squire et al., 2013, p. 4).

However, notably, "humanist and the poststructuralist traditions of narrative research are brought together by their shared tendency to treat narratives as modes of resistance to existing structures of power" (Squire et al., 2013, p. 4). Inquiries into the power differentials between healthcare providers and LARC users in the prescription and use of LARC such as this one are possible in both traditions, albeit assumptions about, for instance, a single and unified subject vis-à-vis a multiple and socially constructed subject presents as essential points of departure (Squire et al., 2013). Similarly drawing on this idea of a multiple, socially constructed subject, Barker (2017), using Paul Ricoeur, notes narrators' attempts to create themselves to their audience through narratives. However, because the social determines the talk, the endpoints of

their narratives cannot be completely defined by the speaker. In addition, "For Ricoeur, both life events and also narratives received are emplotted by the subject, from their position within culture, such that causal and teleological interconnections between events and characters are established" (Barker, 2017, p. 394).

Narratives and temporality are interlinked; according to Ricoeur (1980), temporality is expressible through language, and narratives provide the language with which temporality is achieved. "Temporal order is the fundamental criterion that distinguishes narratives from other genres of discourse" (Mishler, 2006, p. 1). Narrative scholars often express the passage of time by tying together events through the utterances "and" and "so" to show consequence (Taylor & Littleton, 2006). Ricoeur (1980) refers to this as the narrative plot, which he uses to separate lists from narratives. He, however, cautions against conceptions of this temporality as linear. In so doing, he uses the notion of "figuration of plot" (Barker, 2017, p. 394), drawing on Aristotle's idea of *mimesis* (used interchangeably with representation) or "imitation of an action" to argue that what is represented is how subjects fashion themselves and their worlds. Therefore, plots are not purely tools for storytelling but are "also an existentiale of human understanding and acting in the world" (Barker, 2017, p. 394). In this sense, plots place subjects "at the crossing point of temporality and narrativity" (Ricoeur, 1980, p. 171). This process of representation has been known as emplotment. It is achievable through three interpretation stages, *viz*., *mimesis*$_1$, *mimesis*$_2$, and *mimesis*$_3$.

Mimesis$_1$ (prefiguration) is characteristic of "narrative possibility", what is known as sayable, doable and thinkable. It is a "preunderstanding of the world" (Barker, 2017, p. 397). Discourses can thus fall into this category, determined by the "horizon of tradition" (Barker, 2017, p. 397). These discourses act upon people, creating particular subjects with particular subjectivities as "discourse […] drives subjectification" (Barker, 2017, p. 397). However, in fully articulating a subject who is not completely decentred or essentialist but manipulates deployed discourses to claim a stake in subjectification, Barker (2017) extends the definition of discourses to include (micro)narratives that contain plots that represent particular subjectivities and worldviews.

Barker (2017) also notes that stories have implications for the teller. As such, the author adds a moral dimension as important to the agent responsible for an act. For instance, in reciting their contraceptive journeys, the responsibilisation discourse can be seen as offering "an implicit actant structure and potential for teleological emplotment […] operating in *mimesis*$_1$"

(Barker, 2017, p. 398) for health users. Usage of this discourse will emplot them as responsible sexual subjects and emplot healthcare providers within a medical discourse as health experts in *mimesis₂*. Possible discourses in *mimesis₁,* e.g., the accumulation of responsibilisation discourses around the signifier fertility control, have implications for possible emplotments in *mimesis₂.* That is, decisions to take up, continue using or discontinue LARC can emplot health users as "responsible" or irresponsible" sexual subjects through Foucault's concept of dividing practices. However, at *mimesis₃,* Ricoeur offers the opportunity for refiguration. Here, the audience narratives are elicited to are also foregrounded by Barker's (2017) approach, making talk a bidirectional and reflexive process, which is an expansion of Foucauldian discursive approaches. This is because while the listener figures their own plots in listening to the storyteller, the discourses employed at *mimesis₁* by the storyteller contain implications for emplotment at *mimesis₂*, which through Foucault's notion of dividing practices influence how the story is heard and judged. As a result, through refiguration at *mimesis₃,* significant departures from narrated stories can emerge; in turn, the listener "grasps implications of the already established conclusions towards which the narrative inexorably moves" (Barker, 2017, p. 403). Hence, the stories and personal testimonies we tell about ourselves are understood as not structuring themselves but instead as being enabled and constrained by wider socio-cultural ways of talk and contingent upon the audience to whom the story is told. Despite conceptualising narratives as sometimes general and recognisable in the above, they can also be specific or particular forms of narratives known as micro-narratives.

2.1 Micro-narratives within narrative research

Narrative research is a disparate field with disparate definitions of narratives (Bamberg, 2005; Bruner, 2003; Livholts & Tamboukou, 2015; Ricoeur, 1980; Riessman, 2001). Narrative is actually "an umbrella or a portmanteau for so many different genres" (Livholts & Tamboukou, 2015, p. 6). For example, personal testimonies relayed in court, accounts of events within journalism, detailed happenings of subjects' lives told in therapy and depictions of people's everyday lives told by respondents and researchers within social research all constitute forms of narrative (Squire et al., 2013). Loose definitions include narratives as explanatory and constructive elements of experiences and the world that are in question (Squire et al., 2013) or resources for sense-making in social interactions (Burr, 2013). Poststructuralists, in particular, understand narratives as tools deeply influenced by discourse and social interactions used within intersubjective encounters. There is, however, a level of selectiveness in how stories are told, yet they still operate within the confines of possible selves (Bamberg, 2004).

Personal narratives, otherwise known as micro-narratives, are situated forms of narratives shaped by the storyteller's past, present and future (Georgakopoulou, 2006). Stories are told in ways that link the past to the present while planning for the future using the present as a blueprint. They are "primarily conversational resources used in our accounting processes during interaction" (Burr, 2013, p. 146) or relationally specific little stories. According to Riessman (2001), accounts on personal experiences told by participants in interviews count as personal narratives. In addition to their localised nature, micro-narratives are also "provisional, contingent, temporary, and relative" (Barry, 2002, p. 87). Thus, these narratives are not carved in stone but are bound to change. This stands in contrast to dominant discourses or meta-narratives, as micro-narratives are less totalising and allow for plurality in how subjects deploy discourse to (re)construct their life journeys (O'Donovan, 2006).

Barker (2017) uses a Foucauldian-inspired approach to narratives to explore the potentialities for emplotment within conflicting medical discourses in a personal pain narrative in the face of one's audience while understanding the significance of valued end-points on subjectivity. In interlinking discourses and micro-narratives in this way, Barker's (2017) approach understands subjects as both socially and individually orientated as the personal and the social intersect in meaningful ways. I explore micro-narratives used within the data to understand how discourses used by healthcare providers and contraceptive users accumulate around the signifier fertility control, thus allowing and restricting particular ways of managing reproduction. These ways of talk and tellable stories can reconfigure power relations between medical experts and contraceptive users in asymmetrical ways based on assumptions about, say, government spending or parenthood as an event to plan. Hence, I also reflect on the possible coloniality of these micro-narratives and the emplotments. In particular, how do these extend or disrupt the coloniality of power, knowledge, being, and gender?

The semi-structured interview was used to gather these micro-narratives as an interview technique that embraces the co-constructed nature of data rather than assuming the produced talk is a monologue. In addition, semi-structured interviews allow for open-ended and direct questions in my explorations of how medical experts and health users separately make sense of decision-making vis-à-vis contraceptive use through stories.

3. Research aims and goals

This study forms part of a broader transnational research project between South Africa and Aotearoa/New Zealand that aims to investigate contraceptive agency and coercion within

provider/client relationships using a reproductive justice framework in both countries, which were subjected to British colonialism. More specifically, in the present study, I aimed to explore healthcare providers' and contraceptive users' constructions of decision-making around the prescription and use of LARC within and outside of medical interactions, that is, decision-making within a range of interpersonal relationships, including healthcare provider/patient encounters in South Africa. In addition, an exploration of the emplotments availed and restricted by the talk and the asymmetrical power relations produced in and by the talk that reinforce or undermine certain women's reproductive choices and rights, was undertaken. To this end, the following research questions underpin the research process.

3.1 Research questions

a. What micro-narratives and discourses do healthcare providers and women who use, have used or considered using LARC draw on in constructing decision-making when being prescribed, advised or seeking to use LARC?
b. What emplotments into narratives are availed and restricted by these discourses?
c. What power relations are inherent in the micro-narratives and discourses, and how do these influence agency in decision-making?
d. How do the micro-narratives and discourses drawn upon maintain or constrain coloniality and reproductive justice?

4. Methods

To explore the questions mentioned above, I first discuss the sampling and recruitment strategies employed to generate the sample of willing healthcare providers with a history of LARC administrations and women who have been confronted with LARC technologies, whether they chose or refused to use or continue using these technologies. The discussion includes the processes used to obtain multi-level gatekeeper approval from the Department of Health and an account on advertising once gatekeeper approval had been obtained. I then discuss the characteristics of the sample generated within the different geographical spaces.

4.1 Sampling

A combination of stratified purposive, convenient, and snowball sampling was utilised to access LARC users and healthcare providers willing to partake in the study. Purposive sampling, the main sampling strategy, signifies participants being chosen because they satisfy a certain criterion, such as specific community members who are considered knowledgeable with varying opinions on the topic of inquiry (Campbell et al., 2020). The inclusion criteria in

the present study were as follows. For consent-related purposes, all participants had to be 18 years or older to participate. In addition, sampled health users had to be of reproductive age (18-49 years) and must have considered using LARC or be present or past LARC users. Sampling late adolescents, young and middle-aged adults, in terms of LARC users, was expected to facilitate rich data, as participants would be invited to draw on present contraceptive choices, previous ones, as well as the decision-making processes that led to using or discontinuing use of LARC methods. Sampled healthcare providers had to have a history of administering or prescribing LARC to partake in the study. This would create possibilities for more focused stories around contraception and, specifically, LARC to be told.

Purposive samples can, however, be stratified in specific ways by the researcher to include particular preselected categories, e.g., age or different geographical locations (Campbell et al., 2020). As such, the sample was stratified by a healthcare provider/LARC user binary, type of healthcare used by the participants (private or public healthcare), type of LARC technology (IUD, implant or injectable contraceptives), as well as location (city, town or village). Apart from being either a past, present or user considering LARC, participants were also either IUD, implant or injectable contraceptive users. Additionally, keeping heterogeneity and complexity in mind, a city, town and a village were identified as sites in which participants for the study would be recruited. These stratifications were considered useful because diversity in experiences of, for example, contraceptive users and healthcare providers in underserved geographical localities could be captured, thus pointing to varying discursive emplotment possibilities in relation to contraceptive technologies and contraceptive counselling practices in South Africa (Pillay et al., 2017).

Convenience sampling refers to a sample accessed due to its proximity to the researcher and an interest in participating from potential candidates (Bryman, 2012; Etikan, 2016). Some healthcare institutions which provide contraceptive care satisfied this criterion and were thus approached. While the distance was not a major deterrent in recruitment, geographically sampled sites that were relatively close were considered more favourable in the decision about recruitment sites to avoid extreme travel expenses. In addition to the stratified purposive and convenience sampling, snowball sampling was used, a technique for sampling beneficial when anticipated participants are considered "hidden" and thus not easily accessible (Browne, 2005). Snowball sampling refers to asking the sampled participants for referrals to potential candidates

in their networks and friendship circles (Emerson, 2015). This sampling technique was beneficial for recruiting private healthcare LARC users.

At the end of the recruitment process, a sample size of 52 LARC contraceptive users and 21 healthcare providers was yielded. This was a sufficient sample size, given qualitative research's interest in in-depth exploration rather than generalisation and seeking a statistically significant sample. Participants' ages ranged between 18-63 years.

4.2 Recruitment using convenience, purposive & snowball sampling strategies

Different methods were used to recruit the contraceptive users and the healthcare providers because inasmuch as both participants were, at times, recruited at the same venue, different considerations had to be made. For example, healthcare providers were often approached at their overcrowded workplaces; as such, care was required in finding the appropriate moments to reach out to avoid disrupting important conversations with clients or overhearing sensitive conversations.

Three methods were used for recruiting participants. Firstly, a recruitment advertisement, with the approval of managers, was erected at all ten health facilities located in the selected three geographical areas to advertise the study [see Appendix 4]. It stated that participants could send me a "please call me" if they were interested in participating. While the recruitment adverts can be beneficial because "people who respond are already interested in participating in the study" (Hennink et al., 2020, p. 105), it was mainly used to create awareness about the study but was not the primary sampling strategy. This is because recruitment advertisements generally yield low interest in participation (Hennink et al., 2020).

Secondly, I recruited the contraceptive user participants at the end of their clinic contraceptive care meetings. This face-to-face encounter was the main recruitment strategy. I approached the LARC users and healthcare providers mostly individually and introduced the study and my interest in interviewing them. During this encounter, I also had pamphlets about the study that I handed out to the potential participants I approached at the clinic. Therefore, candidates who desired more time to ponder whether to partake in the study or not were offered a verbal account of what participation entailed and a pamphlet with my contact details for them to call or send me a "please call me" text upon deciding to participate.

Thirdly, healthcare providers at the health centres were also given pamphlets containing particulars about the study and asked to disseminate them among patients with a history of

LARC use. I asked the healthcare providers to merely hand the pamphlets to their patients without offering much information about the study. This was to ensure that the voluntary nature of participation was upheld and that interested participants would read the pamphlet and contact me for further details.

Lastly, interviewed LARC users were also asked to recommend other people in their circles and networks who would be willing to discuss their contraceptive journeys in interviews for the study. Often, private health users could also be generated in this way. I discuss the recruitment of the sample of healthcare providers next.

Once the healthcare institutions' managers at public health facilities granted approval, I was directed to the offices of healthcare workers who provide contraceptive care and advised to find appropriate times to approach them and present my study and interest in interviewing them. Most healthcare providers, except hospital participants, were approached and recruited this way. Here, the manager led me to the healthcare providers' tea room and introduced me and the study to the staff, emphasising that partaking was a personal choice and not compulsory. The sample with private healthcare providers was generated through emails sent to a partnership of healthcare workers. Willing participants emailed me back, and we set up an appointment for an interview at their offices at a suitable time. In the following section, I discuss the characteristics of the sample yielded. This includes age, location, parity, relationship status, type of LARC technology used and the language used to conduct the interview. While all healthcare sites from which many of the sampled participants were recruited are located within the Eastern Cape, I present the participants by their geospatial location, starting with the characteristics of the participants I sampled at the Town, followed by the City and lastly discuss the characteristics of the sample obtained in the Village.

4.2.1 Sample characteristics: Town

A total of seven sites were approached for data collection in this Town. Six of these sites were no-fee primary health clinics, and one was a general practitioner's office. As a product of the Group Areas Act that removed all Non-White South Africans from city centres to peripheries based on race, many South Africans still reside in peri-urban areas such as townships and informal settlements (Ndwayi, 2024), as such, the town centre was not the only place from which samples of participants were obtained. For example, three of the seven healthcare institutions that were approached for data collection in the Town were primary healthcare

clinics situated in township areas and the other three primary healthcare centres were located in the Town's centre including the general practitioner's office.

All three of the three primary health clinics sampled in townships were located within low-income areas where unemployment is high; two of these healthcare facilities (sites 1 and 3) predominantly catered to a Black demographic of health users, while the one primary healthcare centre (site 4) was located in a Coloured township and mostly served a Coloured demographic. In the city centre, two of the primary health clinics (sites 2 and 6) were also intended to serve low-income residents but were more dynamic in the demographic of the population they catered for, based on their central positioning, a mix of ethnicities (Black, Coloured, Indian and White health users) accessed these facilities. The remaining primary healthcare clinic (site 7) was situated in an educational institution and largely served a multi-ethnic group of young adults who are students at the institution. The private practice (site 5) was also in the town centre, but it serviced high-income health users. It operated differently from the no-fee healthcare centres as patients sought healthcare at a cost at this facility. As such, it was not as accessible as the public health centres and thus not oversubscribed, and, more importantly, health users had access to any form of contraceptive they were comfortable incurring the cost to initiate use.

Given the overcrowded and under-resourced environment of South African public health facilities, I often could only recruit one or two healthcare providers in each facility. Therefore, an unequal stratification of health users and healthcare workers is evident in the sample. The characteristics of the sampled contraceptive users from Town are listed in the tables below. Participants are grouped by the facility where they were recruited, albeit some were recruited away from healthcare institutions. As such, these participants are grouped, and I state whether they were private or public health users.

Table 1: Contraceptive Users Recruited in Town

Facility	Alias	Age	Race/ ethnicity	Parity	LARC method	Relationship status	Interview language
Public health clinic (site 1)	Babalwa	18	Black; Xhosa	0	IC-Nur	Dating	isiXhosa
	Ntsiki	23	Black; Xhosa	0	Implant	Dating	isiXhosa
	Esihle	21	Black; Xhosa	0	IC-Nur	Dating	isiXhosa
	Siphosethu	23	Black; Xhosa	0	IC-DPMA	Dating	isiXhosa
Public health clinic (site 2)	Lulama	33	Black; Xhosa	3	IC-DPMA	Dating	isiXhosa
	Thandokazi	31	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
Snowball sampling	Sinoxolo	18	Black; Xhosa	0	IC-DPMA; IUD	Dating	isiXhosa
	Tawonga	35	Black; Namibian	1	IC-DPMA	Married	isiXhosa
	Balisa	38	Black; Xhosa	3	Pill; DPMA; Implant	Dating	isiXhosa
	Khanya	29	Black; Xhosa	0	IC-DPMA	Dating	Mixed
	Emma	26	White; English	0	Pill; IUD	Dating	English
	Zimkitha	25	Black; Xhosa	1	IC; IUD	Dating	isiXhosa
	Julie	28	White; English	0	Pill; Implant	Dating	English
	Thabisa	32	Black; Xhosa	2	IC; IUD	Married	Mixed
	Nomawabo	36	Black; Xhosa	1	Pill; IUD	Single	English
	Lunathi	28	Black; Xhosa	0	IC-Nur	Single	Mixed
	Kuhle	25	Black; Xhosa	2	IC-DPMA	Xhosa	isiXhosa
	Abosede	42	Black; Nigerian	2	IUD	Married	English
	Ndivhuwo	25	Black; Venda	0	IC-DPMA	Engaged	English

A total of 19 contraceptive users ranging between the ages of 18 and 42, with a median of 28.2, were recruited in the Town. Most of the recruited participants (17) were Black and either isiXhosa-speaking (14), Venda-speaking (one), Yoruba-speaking (one) or Oshiwambo-speaking (one). Two White English-speaking participants were also recruited in the Town.

Two primary healthcare facilities situated in different but lower-resourced township areas were the sites where the participants were sourced. Four contraceptive users ranging between 18-23 years, with a median of 21.2, were recruited at the first clinic. All sampled participants in this

facility were isiXhosa speaking, never married and nulliparous. Three of the participants were injectable contraceptive users, with one implant user.

Two service users agreed to participate in the study in the second primary health clinic. These participants' ages ranged between 31 and 33 years, with a median of 32 years. They were isiXhosa-speaking, unmarried, parous and used injectable contraceptives, specifically *depo-provera*. One participant had three children, while the other had one child.

Most contraceptive users (11) were recruited away from health facilities. These participants were recruited through snowball sampling. As such, they were referred by participants recruited at the healthcare facilities, and participants met with me for interviews at an office in the Psychology Department. Sampled respondents ranged between 18 and 42 years of age, with a median of 35.1. Of these participants, six were IUD users, one implant user and five injectable contraceptive users at the time of the interview. Four were multiparous; three had two children each, while one had three children. Three had one child each, and the other three were nulliparous. Most participants (10) were dating, while two were married. In addition, most interviews at the town were conducted in isiXhosa, whereas three were conducted in English.

Table 2: Healthcare providers recruited in Town.

Healthcare providers						
Facility	**Alias**	**Age**	**Occupation**	**Sex**	**Race/ethnicity**	**Interview language**
Primary health clinic (site 3)	Brother Lubabalo	36	Professional nurse	Male	Black; Xhosa	isiXhosa
Primary health clinic (site 1)	Sr. Thandiswa	39	Professional nurse	Female	Black; Xhosa	isiXhosa
	Sr. Nozibele	39	Professional nurse	Female	Black; Xhosa	isiXhosa
Primary health clinic (site 2)	Brother Zukisani	43	Professional nurse	Male	Black; Xhosa	isiXhosa
Private Practice (site 5)	Dr. Henning	47	General Practitioner	Female	White; Afrikaans	English
Primary health clinic (site 6)	Sr. Nosipho	35	Professional nurse	Female	Black; Xhosa	isiXhosa
Primary health clinic (site 4)	Sr. Carol	36	Professional nurse	Female	Coloured; Afrikaans	English
	Sr Mesani	60	Professional nurse	Female	Black; Xhosa	Mixed
Primary health clinic (site 7)	Sr. Hazel	58	Professional nurse	Female	Coloured; Afrikaans	English

A total of nine healthcare providers were sampled from seven different sites. Seven recruited medical experts were professional nurses, while one was a general practitioner. In addition, seven of the medical experts were females, while two were males. Sr Thandiswa, Brother Lubabalo, Sr Nozibele, Sr Carol and Sr Mesani worked in township healthcare facilities. On

the other hand, Brother Zukisani, Sr Nosipho, and Sr Hazel worked in urban public health facilities, whereas Dr Henning was in private practice. Interviews were conducted in a combination of isiXhosa and English with Sr Thandiswa, Brother Lubabalo, Brother Zukisani, Sr Nosipho and Sr Nozi, while those conducted with Dr Henning, Sr Carol and Sr Hazel were in English.

4.2.2 Sample characteristics: City

Participants were recruited within five public health centres and one private practice in the City. Four of the public health facilities were primary healthcare centres, while one was a hospital. Three of the primary healthcare centres (sites 9, 10 and 11) were situated in low-income areas, where unemployment was high. The residents within these areas who used the healthcare facilities lived either in houses or squatter camps and were predominantly Black.

The remaining primary healthcare facility (site 8) indicates the move towards racial integration in South African neighbourhoods. It served a mix of ethnicities in a lower-middle income suburb situated within the periphery of the City. The hospital (site 12) was located in the city centre and also delivered services to all ethnicities and both private and public users. The private practice (site 13) was accessible to all health users with Health Insurance or those willing to pay-out-of pocket for the contraceptive technologies.

In the end, twenty-three participants were recruited in the City. Ages ranged between 18 and 49, with a median of 28.1; of this sample, twelve participants were IUD users, eight were injectable users, and three were implant users. Seventeen contraceptive users were Black, while five were White. Most interviews (17) were conducted in English, whereas some were conducted in isiXhosa (16). I outline the sample characteristics of the service users recruited within the various locations in the section that follows:

Table 3: Contraceptive Users Recruited in City

Facility	Alias	Age	Race/ ethnicity	Parity	LARC method	Relationship status	Interview language
Public health clinic (site 8)	Asive	32	Black; Xhosa	1	IC; IUD	Dating	isiXhosa
	Gladys	40	Black; Xhosa	0	IC, implant, IUD	Married	isiXhosa
	Betty	26	White	0	Pill; Implant	Dating	English
Public health clinic (site 9)	Thandiwe	32	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
	Khazimla	18	Black; Xhosa	0	IC-DPMA	Dating	isiXhosa
	Fattima	-	Black; Somalian	-	IC-DPMA	Married	English
	Ntombesizwe	24	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
	Qaqamba	25	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
	Vuyisa	23	Black; Xhosa	0	IC-DPMA	Dating	isiXhosa
Public health clinic (site 10)	Chwayita	23	Black; Xhosa	0	Implant	Dating	Mixed
	Sibabalwe	18	Black; Xhosa	pregnant	IC-Nur	Dating	isiXhosa
	Sandisiwe	20	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
	Zonke	24	Black; Xhosa	2	IC; IUD	Dating	Mixed
Public health clinic (site 11)	Hlengiwe	30	Black; Xhosa	1	IUD	Dating	isiXhosa
	Thobeka	31	Black; Xhosa	1	IC; IUD	Dating	isiXhosa
	Thozama	32	Black; Xhosa	1	IC; IUD	Dating	isiXhosa
Hospital (12)	Zinzi	19	Black; Xhosa	0	Implant	Dating	isiXhosa
	Alejandri	25	White; Afrikaans	2	IC; IUD	Dating	English
Private health users	Andrea	27	White; English	0	Pill; IUD	Dating	English
	Colleen	-	White; English	2	Pill; IUD	Married	English
	Ellen	31	White; English	1	Pill; IUD	Married	English
	Viwe	28	Black; Xhosa	0	IC; Pill; IUD	Dating	Mixed
	Bronwyn	39	White; English	3	Pill; IUD	Married	English
	Helen	49	White; English	2	Pill; IUD	Married	English

The first facility is a PHC situated in a suburb. Three participants were recruited, ages between 26 and 40 years, with a median of 32.6. Two of these contraceptive users were IUD users and parous, while one was an implant user and nulliparous. Only one participant was married, while

the other two were dating. Interviews with Asive and Gladys were in isiXhosa, while the interview with Betty was in English.

Another primary health clinic, but one situated in the inner-city, was accessed to recruit six participants between 18 and 32 years old, with a median of 25.5. All participants were injectable contraceptive users using *depo provera*. Three participants were parous, and the rest were nulliparous. Moreover, sampled participants were mostly unmarried and had the interviews conducted in isiXhosa except for Fattima, who was married and had the interview conducted in English.

The third facility is a primary health clinic in a township. The sampled participants within the facility were between 18 and 24 years of age, with a median of 21.2. Two participants were injectable contraceptive users, and two used the implant IUD. In addition, two contraceptive users were parous, whereas Chwayita was nulliparous, and Sibabalwe was pregnant, reporting on contraceptive failure in the interview. All women were unmarried and had their interviews conducted in isiXhosa.

The fourth accessed facility was also a primary health facility in a township. All three participants were IUD users with the age range of 30-32 years, with a median of 31. In addition, the participants all had one child, were unmarried and had their interviews conducted in isiXhosa.

The hospital represents the fifth facility accessed in the City. The recruited participants' ages ranged between 19 and 25 years, with a median of 22. Both contraceptive users were unmarried. Zinzi was nulliparous and used the implant, while Alejandri was multiparous and recently discontinued using the IUD. She was also unmarried and had her interview conducted in English, whereas Zinzi's was in isiXhosa.

The rest of the sample was recruited through snowball sampling, i.e., approached away from contraceptive care facilities. Sampled participants' ages ranged between 27 and 49 years, median 34.8. All participants were private health users and used IUDs. Two participants were nulliparous, while the rest were parous. In addition, interviews with all the participants were in English except for the interview with Viwe.

Table 4: Healthcare Providers Recruited in City

Healthcare providers						
Facility	**Alias**	**Age**	**Occupation**	**Sex**	**Race/ethnicity**	**Interview language**
Primary health clinic (site 11)	Sr. Litha	29	Professional nurse	Female	Black; Xhosa	isiXhosa
	Sr. Lubanzi	38	Professional nurse	Female	Black; Xhosa	isiXhosa
Primary health clinic (site 9)	Sr. Thami	32	Professional nurse	Female	Black; Xhosa	isiXhosa
Primary health clinic (site 10)	Sr. Zoleka	39	Professional nurse	Female	Black; Xhosa	isiXhosa
	Sr. Phindi	38	Professional nurse	Female	Black; Xhosa	isiXhosa
Hospital (site 12)	Dr. Ndamase	27	Medical intern	Female	Black; Xhosa	isiXhosa
	Dr. Lynn	34	Gynaecologist	Female	White; English	isiXhosa
	Sr. Nombulelo	44	Midwife	Female	Black; Xhosa	isiXhosa
Private Practice (site 13)	Dr Austin	31	General Practitioner	Male	White; English	English

Nine medical experts were recruited to partake in the study within the chosen City. Six sites were visited; five were public health facilities (one public hospital and four primary health facilities) with one private practice. The sample mainly consisted of professional nurses with one gynaecologist, a medical intern and a general practitioner. Sampled healthcare providers were between the ages of 27 and 39 years in age, with a median of 34.6. Nine of the sampled participants were cisgendered women, with one cisgendered man. Two interviews were conducted in English, while the rest were in isiXhosa.

4.2.3 Sample characteristics: Village

Two clinics were approached in a village. One primary healthcare clinic was located in the centre of the village and served low-income residents. The other primary healthcare facility was located in the periphery of the village, near a high school, and predominantly catered to the needs of a younger demographic (mostly adolescents) of Black people. Below, I outline the sample characteristics of the service users followed by the healthcare providers' sample characteristics:

Table 5: Contraceptive users recruited in Village

Facility	Alias	Age	Race/ ethnicity	Parity	LARC method	Relationship status	Interview language
Primary health clinic (site 16)	Buhle	24	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
	Lihle	24	Black; Xhosa	0	IC-Nur	Married	isiXhosa
	Lindelwa	39	Black; Xhosa	2	IC-DPMA	Dating	isiXhosa
	Nandipha	32	Black; Xhosa	2	IC-DPMA	Dating	isiXhosa
	Linda	30	Black; Xhosa	1	IUD	Dating	isiXhosa
	Mihlali	32	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
	Gugu	28	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa
	Zodwa	19	Black; Xhosa	0	IC-Nur	Dating	isiXhosa
	Yamkela	28	Black; Xhosa	1	IC-DPMA	Dating	isiXhosa

All nine sampled participants were recruited in a clinic within the rural area. Sampled participants were between ages 19 and 39 years, 28,4. All interviews were conducted in isiXhosa. They were all unmarried and injectable users except for Linda, who used the IUD and was the only private health user. Esihle and Zodwa were nulliparous and used *nur-isterate,* while the rest of the injectable contraceptive using women used *depo provera*. Lindelwa and Nandipha had two children, whereas Buhle, Linda, Mihlali, Gugu and Yamkela had one.

Table 6. Healthcare Providers Recruited in Village

Healthcare providers						
Facility	**Alias**	**Age**	**Occupation**	**Sex**	**Race/ethnicity**	**Interview language**
Primary health clinic (site 16)	Sr. Vathiswa	63	Professional nurse	Female	Black; Xhosa	isiXhosa
	Sr. Beja	46	Professional nurse	Female	Black; Xhosa	isiXhosa
Primary health clinic (site 15)	Sr. Avela	23	Professional nurse	Female	Black; Xhosa	isiXhosa

Three cisgendered women who are professional nurses were recruited in two primary health clinics within the Village. The sampled nurses were all professional nurses. Moreover, the interviews were conducted in isiXhosa.

Willing candidates were invited to an interview session with the researcher where questions around the prescription and use of LARC were asked [view Appendix 7 & 8 for interview schedules]. As such, two separate interview schedules were developed: one for interviewing the healthcare providers and one for the health users. With the consent of the participants [see Appendix 5A], the interviews were conducted at a time suitable for the participants in a separate room at the health centre, Psychology Department or home of the participants.

5. Data collection

In this section, I outline the procedures undertaken for collecting data for this present study. This includes a discussion on semi-structured interviews as the co-creative technique chosen for gathering information. I also describe the mock interviews to deduce whether the devised interview schedules would effectively produce rich data.

5.1 Interviewing

Semi-structured interviewing was the method used for collecting data among contraceptive users and healthcare providers for this study. Verbal and nonverbal data and localised information are often obtained using this method of data collection (Neuman, 2006). The interviewer engages with the interviewee using a loosely structured interview guide containing questions [refer to Appendix 7 & 8]. van Schalkwyk (2018) and others have argued that "pre-set questions of research interviews capture exactly that—pre-existing views of researchers or

other theorists—instead of participants' own unique perspectives and ideas" (p. 48). The use of narrative-inducing open-ended questions can counter the researcher's influence. However, more importantly, I acknowledge that the narratives produced as knowledge within these semi-structured interviews are a product of interactional work rather than monologues extracted by the interviewer in a one-directional manner (Bryman, 2012). Therefore, the status of both the interviewer and interviewee has a stake in the produced talk (Willig, 2008).

Several open-ended, main questions were asked to gather data, inviting the interviewees to share what they deemed important vis-à-vis the questions. For example, "Please give me a brief history about your use of contraception, detailing what you used then up until now". Typically, in these kinds of interviews, participants will narrate the stories about the timeframe invoked by the question leading up to the present. It is important for the interviewer, throughout the interview, to be a good listener and allow them to narrate with minimum intrusion yet with non-verbal affirming body language such as nods and an occasional "mmmh' to indicate interest (Anderson & Kirkpatrick, 2016). To follow up on the recited narratives, I probed using the participants' wording, thereby "respecting the respondent's meaning-frames, remaining faithful to the order and wording in which they presented their [narratives]" (Hollway & Jefferson, 2000, p. 38). However, since semi-structured interviews are flexible and questions asked during the interview are open to the interviewee's interpretation, more direct questions were also used as follow-up questions.

5.2 Mock interviewing

Mock interviews were conducted using the devised interview schedules as a measure for establishing whether they were suitable for producing interesting insights on the experiences of LARC (non)use and its prescription alongside the power differentials between healthcare providers and health users in deciding to use or discontinue using LARC. In addition, these mock interviews would assist in homing in on the devised questions and establishing if they would generate rich data in answering the research questions. Moreover, they were used to establish familiarity with the questions, learn to follow up on participants' responses, avoid asking leading questions, and build rapport with each respondent during the interview.

I conducted mock interviews with peers from the Critical Studies in Sexualities and Reproduction (CSSR)[6] research unit. Two students from the CSSR were asked to roleplay as

[6] The Critical Studies in Sexualities and Reproduction is a multidisciplinary research unit that uses a critical lens to track progress towards sexual and reproductive health and rights.

either a LARC user or healthcare provider while I played the role of the researcher. Both students were then requested to get into character by offering fake answers to the pre-established questions I asked in each interview. During the roleplaying, other postgraduate scholars and staff from the CSSR unit served as critical observers and provided feedback about what I could alter to elicit rich data.

At the end of the mock interviews, the actors were allowed to state how they experienced the interview questions and the interaction in general. Did they understand the questions? Did they feel heard and safe to express themselves? Both participants reported feeling safe and heard. With regards to the questions, the audience identified long questions, which could be separated into more questions and additional questions that could be asked. The interview schedules were then revised to accommodate the changes.

5.3 Conducted interviews

Interviews were conducted at a time and location suitable for all participants. Many contraceptive users were recruited at reception areas within the healthcare facilities. They were often willing to be interviewed in small office spaces provided by the clinic managers in public health facilities. Other participants were interviewed at their homes, in an office at the Psychology Department, in a car or in a neutral public venue where private conversations would be possible.

Interviews with healthcare providers were conducted in their offices at the healthcare facilities. Scheduling an appropriate time with healthcare workers in often overcrowded clinics was complex. However, this, for me, was a chance to spend time in the healthcare centre and observe. An opportunity for an interview would often surface during the afternoons when most patients had been assisted. In extreme cases, healthcare providers were only available on Fridays, a data-capturing day at some public health clinics within the Eastern Cape.

As a fully bilingual person, a combination of English and isiXhosa was used to conduct interviews, depending on the participants' comfort. With the interviewees' consent, a sensitive voice recorder was used to record each interview to generate accurate notes of the produced talk. After that, each audio recording was transcribed. The generated interviews ranged between 8 and 93 minutes in length. All interviews were then transcribed. Interviews conducted in isiXhosa were only translated into English after the coding process. This will be explained further in the transcription and translation process (section 6.1), which is discussed next within the data analysis section.

6. Data analysis

Analytical procedures used to generate findings from the interview transcripts are discussed in this section. This includes the transcription and translation processes, which are interrelated tasks as the development of hunches and connecting of ideas often can begin in these stages within qualitative research. I discuss the analytical procedures I followed, using Barker (2017), who, through discourses and micro-narratives, focuses on signifiers (such as fertility control) in understanding the discourses that accumulate around the signifier as implicating the narrative structure. More importantly, within this narrative structure is an agent that can emplot themselves in contradictory ways during talk. That is, the actantial structure is not fixed within this approach as the speaker is understood as self-emplotting but also emplotted by the audience. As such, drawing on a planning parenthood discourse, which is informed by the understanding that childbearing requires the practice of planning to be considered "done correctly", thus in narrating having not planned, one risks being rendered an "irresponsible" subject. Subjects can, therefore, pivot towards more desirable emplotments, which afford desirable subjectivities.

6.1 Transcription & Translation

As a native isiXhosa speaker, and since I conducted the interviews, I also transcribed some of the interviews myself. Self-transcription was favourable because it immersed me in the nuances within transcripts and across the data. However, the process of transcription and translation was labour intensive, so a professional bi-lingual transcriber and translator assisted with this labour. Paying heed to participants' preferences indicated in the audio recording consent form regarding third-party access to their interviews, I gave the transcriber access to the audio recordings of participants who gave consent for the interview material to be accessed by third parties. We agreed she would produce verbatim transcriptions of all the interviews, capturing all sounds and background noises. Once all the transcriptions were complete, she would translate the transcripts of interviews conducted in isiXhosa to English.

To establish linguistic and conceptual equivalence between the two transcripts (isiXhosa and English), essential in establishing the study's trustworthiness (Chen & Boore, 2009), we agreed that I would also translate all isiXhosa transcripts into English. We then compared versions of the ones with third-party consent. Disputes were resolved in a meeting. In this meeting, we were open to back-translating and explaining why we had translated text in a particular way. We were also aware of how languages describe the world in different ways. Therefore, there can be disputes about the conceptual equivalence of translations.

Parker's (2005) transcription conventions were used to re-transcribe the extracts chosen for the report to provide the reader with a sense of the tone of the conversation. While transcription is "the act of (re)presenting original oral language in written form" (Bird, 2005, p. 227), transcription conventions are mediums through which the retention of integrity of the original speech as it moves "from something that was designed to be heard into something that is meant to be read" (Parker, 2005, p. 65) is, at least, attempted. However, unlike conversation analysis, which necessitates minutiae representations of speech occurrences (Bolden, 2015; Davidson, 2010), transcription conventions require less detail, "the barest outline of how you might transcribe an interview" (Parker, 2005, p. 65). This was ideal partly due to the translated nature of many of the interview transcripts, which steers the process towards changes in word order, finding concepts equivalent in expressing certain utterances and losing some subtleties. This, in a sense, denies the chosen extracts the same dexterity contained within the verbatim text. For example, there were words that the translator and I struggled to find an equivalent to or had to make adjustments in use. These include *"mntasekhaya",* used by some participants when referring to me in talk (often used to either signify kinship between people or as a term of endearment) or the use of the word "*iifeelings*". At first glance, the latter could be deemed as translanguaging between English and isiXhosa, which happens frequently in everyday language amongst (particularly urban-based) isiXhosa speakers. Yet, its meaning relates to one's inability to access sexual pleasure, understood as diminished by LARC technology use—a reduced libido. References to a reduced libido were also made through the term *bayabanda*, which can be directly translated as "they are cold" in standard isiXhosa. However, participants used it to refer to a lack of sexual desire rooted in contraceptive use; "being cold" appeared to symbolise women repeatedly denying men's sexual advances when using contraception. Therefore, since "anchoring analytic observations in data is… imperative in all qualitative analysis" (Nikander, 2008, p. 225), I do not claim that the text used fully represents the conversations that arose. I use the transcription conventions to add some dynamism to the conversations that were held while completely aware of the plasticity of spoken language as resisting being fully determined by the text.

Parker (2005) states that names or pseudonyms must separate talk between speakers. As such, the represented features of chosen micronarratives included the use of pseudonyms for the interviewees and my initials YN as the interviewee, marking turn-taking in talk between us. In addition, several symbols mark pauses, emphases, interruptions, overlaps, hesitation, lack of clarity and omissions during the talk within the produced text. To this end, I used = signs to

express overlapping talk. Hesitation was represented by round brackets () with the number of seconds indicated for longer pauses. Unlike Parker (2005), who expresses emphasis through underlining that particular utterance, I underlined text to show commonalities in talk across extracts. I expressed emphasis by **emboldening** the particular words used by the relevant participant. Forward slashes represent laughs and brief affirmations I made during the talk, such as yes, mhh, and okay. Square brackets [] introduce additional information, e.g., omitted words or participant information, such as whether the original text was in English [E], in isiXhosa [X] or a mixture of both [X/E]. To indicate whether the participant in question was interviewed at the City, Town or Village or a public or private health user [PBH/PVH] and if healthcare providers worked in primary health clinics [PHC], public hospital [PH] or private practice [PP].

6.2 Coding and the narrative reading of the text

Once the transcription and translation processes were complete, I read and reread all the transcripts to familiarise myself with the data further. The interview transcripts were then coded using NVivo, a software database used to manage qualitative data (Jackson & Bazeley, 2019). I then started generating initial codes about what was happening in each transcript in relation to decision-making. Some of these codes were later merged to form micro-narratives, while others were discarded due to not emerging consistently enough and also not proving to be micro-narratives or discourses.

The study mapped out the micro-narratives, discourses, and emplotments inherent in the data using Barker's (2017) completion of emplotments that conceptualises the subject as an active storyteller, with accounts that can cause tensions in the figuration of plots achieved through the use of conflicting discourses in conjunction with Parker's (1992) seven features for identifying discourses.

Step one required the identification of micro-narratives. Micro-narratives contain a sequence within them, which is represented by utterances such as "then" and "next" to suggest a temporal organisation. They also contain consequences or plots referenced through the invocation of words like "so" to suggest "truth-telling" about events or people (Bruner, 2004).

Step two requires figuring out the horizon of possibility in terms of talk or the "prenarrative structure of experience" (Barker, 2017, p. 397) as *mimesis*$_1$. Here, the discourses used for narrative intelligibility around LARC use were explored. I drew on Parker's (1992) seven basic criteria for identifying discourses. Parker (1992) states that discourses are realised in text, are

about objects, contain subjects, are a coherent system of meanings, refer to other discourses, reflect on their own way of speaking, and are historically located. I outline these steps in the section that follows:

According to Parker (1992), the first feature of discourses requires noting that they are realised in text. He broadens the meaning of text to mean "delimited tissues of meaning reproduced in *any* form that can be given interpretative gloss" (Parker, 1992, p. 6). This way, all symbolic forms, including visual images and spatial arrangements, that can be interpreted (Macleod, 2002) are included. Interviews were transformed into text in the case of this study and thus contained within them discourses.

In the second feature, discourses are said to be about objects. Through their repeated use, "reality", objects, and the world emerge as the effects of discourse with particular significances worked up through talk or text. For example, a discursive object can be a LARC technology. This object can be found as empowering or disempowering depending on the discourse the author of the text or speaker draws upon.

The third criterion is discourses containing subjects. "A discourse makes available a space for particular types of self to step in" (Parker, 1992, p. 9). Therefore, to use a particular discourse is to create particular selves with particular rights that determine what those subjects can and cannot do. For example, in constructing decision-making around LARC technologies, health users can *appear* as the decision-maker or not the decision-maker. The position or emplotment they assume has implications for what is possible for them. This is discussed more in step three as *mimesis*$_2$. Discourses represent a coherent system of meanings in the fourth criterion. They paint collectively held depictions of the world even though these depictions can vary or shift.

The fifth criterion states that discourses refer to other discourses. The invocation of particular discourses calls upon other discourses that affirm or contradict what has been said or done. As certain discourses accumulate around a discursive object, e.g., fertility control, others can be deemed incompatible considering what has been said. Hence, using a particular discourse also invokes what is not said about it and thus binds the subject within that construction. For example, the responsibilisation discourse can construct condom use as necessary to use in uncommitted relationships and LARC use as incompatible. A related discourse, namely the risk discourse, would thus also emerge, emplotting the subject as risky or non-risky depending on how the responsibilisation discourse is deployed.

The sixth feature of discourses states that they reflect on their own way of speaking. Speakers reflect on what has been said and might pivot to achieve a coherent picture of the story they are telling, or they may use hidden meanings (Parker, 1992). Therefore, implicit meanings and absences suggested by discourses are considered important for the analysis. In the seventh criterion, discourses are said to be historically located. They "are not static" (Parker, 1992, p. 15). Instead, they "are located in time, in history, for the objects they refer to are objects constituted in the past by the discourse or related discourses. A discourse refers to past references to those objects" (Parker, 1992, p. 16).

Step three extends the Foucauldian notion of discourses as carrying within them over subjectifying subject positions that locate the self and the other in particular ways by drawing on Barker's (2017) idea of narrative emplotments. For Barker (2017), the interlocutor is an agentic subject with the capacity to emplot itself in particular ways rather than always prepositioned. For example, through responsibilisation, my body, my choice, and planning parenthood discourses that overstate individual agency, participants can emplot themselves as agency bearers, responsible and non-risky subjects. Narratives thus have actantial structures that configure action in particular ways. *Mimesis₂* is the reference Barker (2017) uses to address this level of analysis.

However, when contradictory discourses accumulate around a particular signifier, the potential for emplotment at *mimesis₃* can shift. Therefore, I explore possible refigurations enabled through the power relations implicit in the emplotments and the subject agency enabled or hindered in step four.

7. Ethical Considerations

A comprehensive Ethics Standards Protocol that outlined the procedures for attaining the sample, conducting interviews, and reporting on the findings was completed. Upon addressing the reviewers' concerns, ethics clearance was then granted [see Appendix 1]. The section that follows describes the ethical considerations that guided the study and were thus maintained and privileged throughout the research process, namely, informed consent, anonymity and privacy, no harm and remuneration.

7.1. Gaining access

Gatekeeper approval was sought to enter primary healthcare clinics and hospitals to recruit health practitioners who administer LARC and patients who use LARC within the Eastern Cape Province. Keeping heterogeneity and complexity in mind, a City, Town and Village were

identified as sites in which participants for the study would be recruited within the province. This provided diversity in the sample, although it is important to acknowledge diversity within each geographic location.

Once the sites for data collection were identified, an online application was completed where I sought permission to approach health centres within the Eastern Cape Department of Health (ECDoH) on its National Health Research Database (NHRD). The NHRD acts as a repository and monitoring body for health-related research conducted within South Africa. In the application form, I communicated the research study aims, the potential participants and the health facilities data collection would comprise. The study's proposal and ethics approval letter from the Rhodes University Research Projects & Ethics Review Committee (RPERC) with approval number (PSY2017/63) had to be uploaded with this application [see Appendix 1].

The ECDoH subsequently granted permission to conduct the study with various requests: firstly, to maintain the submitted protocol throughout the research process; secondly, to respect and anonymise the identities of sampled participants; thirdly, to send progress reports throughout the research process as well as the final write-up; lastly, to present the findings of the study to the ECDoH before any other external body [refer to Appendix 2]. I intended to uphold these fair requests throughout the research process, as it is important to recognise participants' and gatekeepers' needs and vulnerabilities (Singh & Wassenaar, 2016). As a result, honouring this agreement was a high priority. After the thesis examination, a research summary will be sent to the ECDoH.

Seeking gatekeeper approval at the district and managerial level was the next step for negotiating access into the healthcare institutions. I thus wrote a letter to the relevant District health offices and the Human Resource managers of the individual health centres and clinics requesting permission to approach the head staff of the various sites to recruit participants for the study [refer to redacted letters in Appendix 3]. Once these gatekeepers provided permission, I approached the individual clinics and hospitals that provided contraceptive care and arranged to meet with the Head of Staff at the facilities. At the meeting, I introduced my study. In addition, I requested permission to recruit participants and erect posters in the facility’s reception areas and other frequently visited or suitable visible areas to advertise the research study.

7.2 Negotiating consent

Participants' consent to partake in the study is the first concern discussed. According to Orb et al. (2001), "the nature of ethical problems in qualitative research studies is subtle and different" (p. 93) vis-à-vis quantitative studies. For example, issues such as how researchers gain access to communities and the power differentials between the researcher and researched have been argued to be of concern (Orb et al., 2001). Participants feeling obligated to partake in studies conducted in their everyday contexts can be the effect of these power differentials. Researchers are thus tasked with balancing this power by ensuring that the participants understand the voluntary nature of participation and that the desire to partake does not mean they cannot revoke their participation in the study. In addition, agreeing to participate should be premised on full disclosure about procedures used, the duration of meetings, and the research aims (Hayter, 2003). More importantly, ethical practice includes making research participation "less binding and more or less consensual" (Hopf, 2004, p. 334).

In keeping with these considerations, at the beginning of all the interviews, participants were offered a verbal explanation of the study's aims, participation, and their right to withdraw at will. Once all aspects of the consent form were verbally discussed, all respondents were given an opportunity to read the participant consent form [see Appendix 5], written in English or isiXhosa, depending on the language each participant deemed the most comfortable in communicating their views. Since many of the interviews were conducted at healthcare facilities, it was important to reiterate that participation was voluntary and that respondents could discontinue participation at will without substantiating their reasons. This applied to LARC users and the healthcare providers as approval to recruit within the facilities was a top-down process hailing from management. As such, it was also essential to assure the participants that the decision to partake would not affect their work relationships (for healthcare workers) or access to services at the healthcare facility (for LARC users).

Permission to record the interviews was also sought from the participants [view Appendix 6 for the recorder consent form]. All participants consented to be recorded, but they were also assured that the recordings were created to assist with accuracy in the transcription process and would not be placed in any public domain. Therefore, while balancing the power between the researcher and participant is an integral part of ethical research practice, what happens to the information and who gains access to it once it has been shared is also a pertinent matter to consider, that is, the right to privacy and confidentiality, which is discussed next.

7.3 Privacy and Anonymity

Concerns about how participants' privacy, anonymity and confidentiality would be addressed to safeguard the interests of the participants were also included in the informed consent form. Anonymity refers to the expunging of personal identifiers and participants' localities from interview transcripts to avoid disclosing the participants' identities, while confidentiality coheres around researchers retaining personal identifiers from third parties who might be involved in the research process. Simply put, "confidentiality means we are obliged to protect each participant's identity, places and the location of the research" (Ryen, 2016, p. 33). According to Macleod and Mnyaka (2018), confidentiality and anonymity are interwoven as anonymity enables or constrains confidentiality.

Opinions around the issue of anonymity and confidentiality vary among researchers. Previously, the assumption was that "effacing" participants in research write-ups was necessary or even compulsory. Yet, Macleod and Mnyaka (2018) question how we consider the needs of respondents "who actively want their identity revealed and their voice heard, or when anonymising might not be possible, or may further disadvantage marginalised populations" (p. 227). Therefore, the conventional assertion about concealing the identities of participants and the capacity to do so becomes a complex endeavour that perhaps requires thorough investigation and input from the participants. However, since many of the interviews were conducted at health facilities with the oversight of healthcare providers and clinic managers, I decided to espouse the conventional anonymising technique in research through pseudonyms to conceal all participants' identities. This also meant altering some identifying details within the transcripts while remaining cautious not to distort the information provided within the data.

Participants were requested to state how they would prefer the audio recordings to be transcribed, namely, without conditions, only by the researcher or that a translator be given access to the audio recording, after which they will be erased once the study is complete. Moreover, consent was sought to re-use the redacted transcripts for secondary analysis by CSSR researchers. As such, participants' responses varied, and their audio recordings were transcribed according to their stated preferences. Lastly, participants were also informed that redacted interview transcripts obtained in the study would be retained in a locked cupboard or password-protected electronic file at the CSSR offices for five years.

7.4 No harm and debriefing

The duty to not cause harm to subjects during the interview process calls researchers to place the participants' well-being before knowledge production. Upholding this principle also required cultural sensitivity towards the participants and emotional intelligence to identify when participants expressed emotional distress due to the elicited narratives. None of the study participants visibly showed distress due to the divulged talk. However, if this had occurred during interviews, I would have discontinued the interview and referred the participant for professional help at a nearby counselling centre. I would have also informed the distressed participant that we (the CSSR research unit) would pay for transportation costs for attending counselling.

At the end of each interview, I asked the participants to voice how they felt about the interview and if they had any questions about participation or the research that needed to be addressed. A common question among healthcare providers was, "Why contraceptive care?" therefore, expressing their confusion about my interest in LARC technologies during a global pandemic, in this case, HIV/AIDS. This project provides further evidence of the assertion that policy and programming's disease focus on HIV, which dominates the field of SRH, has meant that more subtle issues regarding SRH are often glossed over (Fried et al., 2019). On the other hand, some contraceptive users expressed relief as their contraceptive journeys were not often a topic of discussion. A recurrent question among contraceptive users was, "So which contraceptive measure is the best one?" I further discuss these questions that surfaced in the various interviews in the reflexivity section.

At the beginning of each interview, participants were given an opportunity to comment and ask questions about the study. My contact details and those of my supervisor were provided for participants in the consent form to allow them to pose any questions, comments, and suggestions thought of at a later stage. They were also advised to indicate interest in receiving a brief report of results at the end of the research. Participants who expressed an interest in feedback will be sent a short report, which will be written in an accessible and descriptive manner once the dissertation is complete. As such, the participants were asked to provide a trusted postal address on the consent form to which the feedback will be mailed. This address was sometimes the address of a school that was nearby. A message will be sent to the participants informing them that the letter with the feedback from the study has been mailed once the reports are complete and mailed.

7.5 Remuneration

Payment is a contentious issue surrounding research. It is often seen as causing further power imbalances between the researcher and participant and obfuscating the voluntary nature of the study. Having said this, participants were informed during recruitment that they would be reimbursed for their transport and telephone costs related to travelling to and from the chosen interview venue. This was done to avoid participants incurring personal costs in the decision to partake in the study.

In addition, all participants were given a R60 food voucher [approximately $3.12] thanking them for their time at the end of each interview. However, I withheld the information about the token of appreciation from them in the recruitment phase. They were only informed about it when they signed the consent form before the interview. This was done to retain the voluntary aspect of participation in the study while at the same time acknowledging their contribution to the research. Because the women were interviewed in different locations or at times in the same venue but at different times, it seemed unlikely that they would inform each other of the token.

8. Methodological rigour

Qualitative research has been criticised for using less standardised practises than quantitative research, thus resulting in the reduced ability to precisely map out ways to replicate the results of research gathered in often naturalistic settings. In addition, subjective processes largely inform the procedures for generating samples (e.g., nonprobability sampling) and the elicited talk in interviews. Qualitative research has thus had to prove the trustworthiness of its findings. For a while, many researchers explained the validity and reliability of their results. However, these are terminologies of positivist research and thus do not capture the essence of qualitative research. Concepts of rigour in qualitative research, including credibility, transferability, dependability and compatibility, were thus later formulated in this regard (Guba & Lincoln, 1994). These concepts and how they were propounded in the study are discussed next.

The dependability of a study signifies whether the study can be repeated and was established through the systematic documentation of sampling techniques and methods used for generating and analysing the study's data (Tobin & Begley, 2004). Transferability refers to whether the study's findings can be transferred to, e.g., similar locations or types of people. Sampling for the study was conducted in three different geographical locations: a city, a town and a rural area. While the results may be transferable to similar geographical areas, qualitative research seeks to gain rich subjective accounts within context rather than to generalise. Credibility refers

to “the integrity of the conclusions that are generated from the piece of research” (Bryman, 2012, p. 47). The study's credibility was accomplished through peer evaluation in supervision meetings and workshops on the initial analyses with my supervisor, Distinguished Professor Macleod, and Dr Morison, who conducted the parallel study in Aotearoa/New Zealand. In these workshops, we collectively analysed the data, shared our interpretations and substantiated our contributions in ways that were deeply grounded in the data. Preliminary analyses were also shared at work-in-progress colloquia, where members of the CSSR added input and probed interpretations, thus enriching the findings.

9. Reflexivity

Reflection on the research process is an important and defining feature of qualitative research (Gemignani, 2017). It signifies “a self-conscious revelation of my own relationship to the research – the impetus behind it, the personal values and theoretical allegiances framing it” (Fegan, 1999, p. 242). Researchers are called to turn a gaze into their own biases, oversights, and taken for granted assumptions, which possibly have a bearing on the produced report. To do this, I avoid dabbling in realist and humanist language, but instead, I “embrace the negotiated, relational, and socially constructed nature of the research experience” (Gemignani, 2017, p. 186) or regard it as a “constitutive and performative practice” (p. 186) rather than as real.

At the time of the interviews, I was a 27-year-old Black isiXhosa-speaking, reproductive-age, nulliparous, heterosexual female, and a doctoral student with a Master's degree from Rhodes University. I am now also a mother of two children, a customary wife, an employee at an Institution of Higher Learning and an employer to Ntombi, my children’s carer. Throughout this journey, these social locations and identities have shaped and fashioned this dissertation. In reflecting on these social locations, I will first reflect on the relationship with health users and then reflect on my encounters with healthcare providers.

9.1 Between the researcher & contraceptive user

Talks with contraceptive users at certain moments gave me a sense of insider status; in the same way, they offered an outsider status to others. For example, being a young Xhosa woman, at times, may have created relative equality between the LARC users and me, particularly in the public health sector, because barriers in terms of communication were minimised, and we could connect during the storytelling. We could also code-switch between isiXhosa and English. In addition, there were certain shared experiences where I could affirm that I

understood what the participant meant through laughter and nods. Yet, although I felt participants could freely express themselves and connect with me, I was surprised to note that none of the participants, including the healthcare providers, asked me about the contraceptive measure I used when the conversation was over. At first, I thought it was a power issue with the contraceptive users. However, when the health service users did not ask, I started pondering why.

A possible answer could be contained in how, during the debriefing sessions, instead of turning the mirror towards me and inquiring about my contraceptive practices, most contraceptive users recurrently sought my informed opinion about which contraceptive measure would be the best for them. I was uncomfortable with the question for two reasons. Firstly, I am not a medical expert, and thus, I could not facilitate person-centred conversations that draw equally on the contraceptive users' embodied knowledge and biomedical knowledge to reach collaborative decisions. Secondly, it forced me to witness how the women felt burdened by and uncertain about the contraceptive measures they were using. This is evidenced in the extracts below in responses elicited by participants when asked about what they liked and disliked about using their respective contraceptive technologies:

> Khanya: That feeling (reduced libido) for me really isolated. I don't know; I really felt isolated like from the world. I don't know what energies I attract through like me being like, horny I don't know how to put this. [Town, PBH, X/E]

> Khanya: Mhh, I don't like anything because even the promise of non-period did not happen if I was not on Femeul. I just wanted to avoid pregnancy, that was fab [fabulous], but I need to take something else. [Town, PBH, X/E]

> Qaqamba: I don't have any interest in sex [when I'm on injectable contraceptives] (ohh) even during the act, I find that no… so you do find that [contraceptives affect your libido], so after my friend led me to this realisation, I started noticing it more and more and that it wasn't something out of the blue […] So why get the injection if you won't be interested in what you are getting the injection for? [City, PBH, X]

> Lulama: I am annoyed by having to constantly go to the clinic […] That's why I keep discontinuing use. [Town, PBH, X]

The above quotes represent health users' attempts to understand their own bodies in relation to LARC use continuously. While the circumvention of pregnancy is the desired effect, other side effects (such as menorrhagia and reduced libido) and costs were mentioned. LARC users must cope with those alongside structural issues, e.g., long queues at the healthcare facility. As a result, I saw and almost bumped into many women carrying urine samples at some of the public health facilities I visited. This was partly due to the high reliance on injectable contraceptives in these health facilities, which requires users to disprove pregnancy to continue using the measure upon missing their contraceptive dates. The overwhelming magnitude of LARC users who were often expected to undertake this step first was a testament to mistrust borne out of an inefficient public health system that forces and directs contraceptive use towards injectable contraceptives. The same system later shows suspicion towards subjects who suffer from feared side effects and structural constraints that create instability and chaos in continuing the (un)chosen contraceptive technologies.

Notwithstanding how uneasy contraceptive use was for some participants, I generally found conducting interviews with contraceptive users more pleasant than interviews with healthcare providers. This is because the participants were eager to discuss their contraceptive journeys, which they often had to figure out by themselves and required perseverance over unbearable physical sensations. I also noted that in constructing themselves through their contraceptive journeys, healthcare users took great care in presenting themselves as either proactive in seeking of contraceptive care that would be beneficial for many stated reasons or forced into decisions that were, at the time, unnecessary. That meant they were all hyperaware that I was a listener and thus narrated rational accounts through which they all came across as responsible contraceptive-using subjects.

9.2 Between the researcher & healthcare provider

I remember experiencing a distinct feeling of suspicion about who I was and what kind of information I was looking for in some facilities despite having produced my multi-level permission forms. One clinic manager requested that I declare that I was not working for a political party and attempting to gain information about the functioning of health departments under the current governing party. Therefore, assuring management and healthcare providers that the purpose of my visit to the facility was not to assess their performance was important.

In reflecting on the encounters, I think I was seen as a phenomenal Black woman who was completing a PhD in Psychology at a former elitist university. This emplotment came with power and thus requires rigorous scrutiny. For example, many of the nurses, especially in rural areas, were surprised by my age. Some even thought I was younger than I was, which made me seem more exceptional. Therefore, in introducing myself, I felt a sense of pride from many participants, but at the same time, I felt a gap growing between me and my potential participants. But there was also a closing of the gap as participants performed their professionality and knowledge of contraceptives. In doing this, healthcare providers showed me their counselling styles. For example, one healthcare provider showed me a display box that encased different modern conraceptives and another one produced the poster in the picture below.

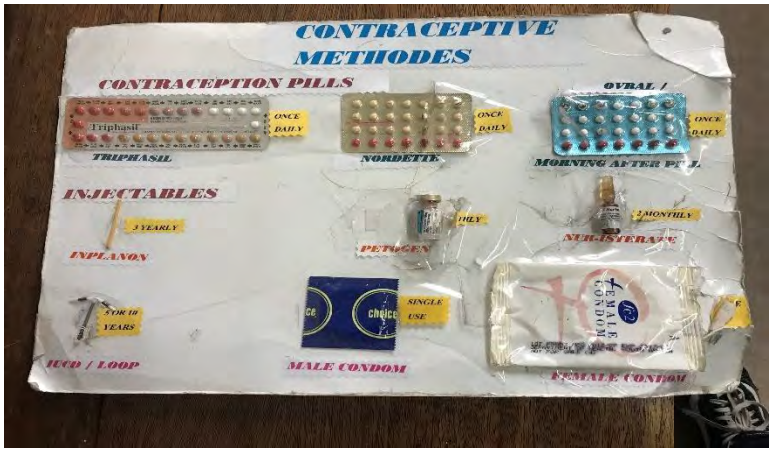

Figure 1: Contraceptive methods illustration board for patients.

Other healthcare providers showed me expired implants in need of disposal, signalling the general lack of uptake of certain LARC measures. Healthcare providers' attempts to prove their dutifulness were seen in how they, though not all, often seemed inconvenienced by the interviews as they took them away from their duty of fulfilling the public health imperative. The interviews also impelled them to protect their praxis, which is complicated by health users being non-compliant and obstinate about their eligibility to use LARC even though they are "too young" or "stuck in their own" ways during contraceptive counselling.

I felt as though my job within the interview space was to contain these stories rather than challenge this over-involvement in women's contraceptive decisions. This decision to silence myself was informed by the idea that challenging the medical experts' practices would cause discomfort and socially desirable responses.

10. Conclusion

In this chapter, I outlined the various procedures used to collect and analyse the data for this study. The chapter began with an explication of a Foucauldian discourse analysis. I then outlined the research questions and goals of the study, followed by the processes used for negotiating gate-keeper approval and the various decisions made for recruiting the sampled participants. The characteristics of the sampled present/past LARC users and medical experts were explained, followed by the procedures for data collection. Semi-structured interviewing with a narrative focus was outlined after that. Following familiarisation with the data, procedures for transcribing, translating, and analysing the data using Parker's (1992) criteria for determining discourse and Barker's (2017) analytical steps are explained. My reflections on my own positionalities during the interviews and the consideration for ethical practices and methodological rigour are also considered.

Chapter 5: Individualisation of and responsibilisation for contraceptive duty

1. Introduction

In their talk about seeking LARC technologies, contraceptive users emplotted four overarching micro-narratives, namely, the "It was my decision", "It was not my decision", "The decision was shared", and "I decided against contraception because of stigma". Contraceptive users who rendered the decision as self-made were emplotted as active decision-makers who played a part in the decision towards LARC usage. When the decision was identified as not theirs, contraceptive users reflected on outsider influence as the contraceptive technologies were passively sought and sometimes coercively administered through decisions made by others, availing non-agentic subject emplotments. However, other contraceptive users relayed accounts cohering around an "in betweenness" by which decisions were collectively made rather than solely by them or exclusively by others. These decisions were enacted following a discussion with what was construed as an important figure, e.g., a sexual partner or a parent, who thus contributed to these decisions. Subsequently, a shared decision was made, emplotting the contraceptive users as supported decision-makers. Lastly, LARC technologies could be avoided altogether due to constructed fears around stigma. This was an individual decision based on assumptions about society's restrictions on female sexual practices, emplotting young women as oppressed decision-makers.

2. "It was my decision"

Many contraceptive users emplotted an "it was my decision" narrative to frame their use of LARC technologies. These participants disregarded or ruled out external influence in decision-making and thus owned the decision to use, continue using, discontinue using or refuse contraceptive use as self-made. The excerpts below in which participants respond to the question, "Did you feel you had a say in the decision-making?" illustrate this:

Extract 5.1

Andrea: Yes, it was me 100%. *[City, PVH, E]*

Extract 5.2

Bronwyn: Yes, no[7], I wasn't forced into doing [it] if that makes sense. *[City, PVH, E]*

[7] "Yes, no" is a specifically South African expression used to express agreement (Wasserman, 2019).

Extract 5.3

> **Betty**: Yes, definitely. I chose to go on the *Implanon* because, you know, she gave me options, and that was the option I chose because of the bad experience I had with the other one. *[City, PBH, E]*

Extract 5.4

> **Ellen:** Yes, it was definitely my decision; I could have gone (.) I was given the option of trying the pill again or… and I was just, I wanted something more permanent, less worrying to remember to take and *ja,* so it was my decision and only mine. *[City, PVH, E]*

In the above, the ability to decide and choose is suggested by the extracts. The use of terms such as "it was 100% me", "I wasn't forced", "I chose", "she gave me options", "it was definitely my decision", and "it was my decision and only mine" evidence agency within decision-making. These participants, who are implicitly rendered consumers and adept in making choices, place the onus for enacted decisions upon themselves. They also reflect on options being availed to them.

A choice discourse, which signifies individual freedom to enact preferences (Nordgren, 2010) and precludes constructions of certain options as coerced by the healthcare provider operates within the text. As such, healthcare providers were emplotted as neutral and assuming supportive roles to the contraceptive users' decisions who, in turn, were emplotted as agentic by the talk. That is, a bottom-up form of counselling was depicted as characterising the interaction: contraceptive users' responses were oriented towards individualistic accounts where personalised choices were made from the options-based talk.

The workings of disciplinary power are identifiable within the extracts, conscripting the health user to regulate their own reproductive practices without coercion (Foucault, 1977). In extracts 5.3 and 5.4, the participants' own experiences and preferences are construed as a knowledge base for the enacted personal decisions rather than as determined by institutions. Such talk emplots the participants as "rational" decision-makers who are not only endowed with free will but making decisions through collecting information, calculating risk and using this information to decide (Paternoster & Pogarsky, 2009). In turn, medical experts are emplotted as allowing such decisions.

The individualisation of decisions and the emergent "rational" being emplotment in contraceptive users' stories is further evidenced in the excerpts below in which participants

were asked about external influence in their decisions towards LARC use:

Extract 5.5

> **Lindelwa**: I went on my own accord; no one encouraged me. *[Village, PBH, X]*

Extract 5.6

> **Buhle**: I was never told by anyone about it. I just went to the clinic and said I wanted contraception, and they asked me if I would like to use the monthly [two-monthly] or the three-monthly injection. I said I wanted the three-month one because I was not going to cope with coming here [clinic] often. *[Village, PBH, X]*

Underlying these elicited micro-narratives is a male reproductive pardoning discourse that either excludes male sexual partners from contraceptive responsibility or downplays their role through omission. That is, health users implicitly disregard their own pressure to take up contraception by normalising and seeing it as unrelated to neglect of the shared duty by their sexual partners.

"The chief function of the disciplinary power is to 'train'" (Foucault, 1977, p. 170). This training into particular subjects, for the most part, conceals or invisibilises the requirement to optimise one's own behaviour for the "supposed" benefit of society by masking it as an exercise with utility only for the user. As such, an absence of external influences is reported upon by Lindelwa in abstract 5.5 as she construes the decision to start using contraception as an individual one, enacted alone to suit her circumstances. Buhle offers a similar line of response in excerpt 5.6 and further elaborates by recreating the healthcare provider-client encounter she experienced. The elicited talk rules out external influence. More user action is alluded to when she reports on the obligation to locate the nearest healthcare clinic and decide between *nur-isterate* and *depo provera*. She tailors her choice towards her own needs by opting for the injectable contraceptive that has a longer duration to "cope" with the self-disciplining required for optimum injectable contraceptive use.

While both participants are emplotted as free, agentic and rational subjects by the talk, they draw on a self-responsibilisation discourse that calls upon subjects to conscript themselves towards certain behaviours deemed healthy, such as birth control use. The self-responsibilisation discourse signifies a split from a mutual obligation between the individual and the state in the enactment of duties. Commitments and interventions classically conceived as belonging to the state shift to an emphasis on individual responsibility placed on citizens or

clients (Kelly, 2001). This way, dependence on the state is limited by and through the creation of "rational", active subjects who manage and regulate their own behaviour within liberal governments. Autonomy and choice are closely related terms to responsibilisation as subjects are incited towards neoliberal choices that "enhance" well-being and health (Juhila et al., 2016) or otherwise deemed as "irresponsible" decision-makers if or when enacted choices place them at "risk" (Kelly, 2001). Therefore, self-responsibilisation discourses are constituted by a subtle obligation.

Buhle draws on a choice discourse by which she assumes the role of a consumer who responds to a market of options in extract 5.6. She is, however, implicitly steered towards injectable contraceptives in the form of *nur-isterate* and *depo provera.* These are reportedly the only offered and ultimately accepted methods, thus, signalling constrained choice. In rationalising her enacted choice, albeit constrained, *depo provera* features favourably given its constructed convenience in relation to the two-month alternative, which increases rather than lessens trips to the clinic, located at a distance. Despite this method bias towards injectable contraceptives, evidenced by the omission of alternative forms of LARC, the healthcare worker is emplotted by Buhle as providing options-based counselling or non-directive counselling. Her use of the terms "they asked me" and "I said I wanted" invoke a dialogical engagement aimed at garnering her preferences rather than constraining choice, thus self-emplotting as an agentic contraceptive-seeking subject.

Within the discourse of choice, some participants also described personal decisions as being made actively and openly within intimate relationships. For example, Zinzi, in the excerpt below, self-responsibilises for contraceptive debut even though her decision is reportedly met with resistance as it starts an argument:

Extract 5.7

> **Zinzi**: Mhh, I told him before that I would like to have one [implant] inserted, but then we started arguing. Then I said, "You see, if you don't want me to have one, rather, we stop whatever we are doing. Let's end things". *[City, PBH, X]*

In the text, Zinzi openly negotiates LARC use. Her use of the utterance, "I would like to have one", points to the use of a self-responsibilisation discourse. However, her partner's response necessitates her to push back against his preferences to exercise agency as non-use is a "risk" she is construed as unwilling to undertake. This talk emplots Zinzi's sexual partner as opposed to contraceptive use, even though Zinzi is a willing LARC user. The absence of a male

reproductive pardoning discourse is visible within this excerpt, unlike the previous ones, as the male partner discourages contraceptive use for himself and Zinzi. It is Zinzi's threat to dissolve the relationship that avails agency and use of the *Implanon*. Nevertheless, since this individualisation of contraceptive responsibility is met with resistance, the talk can be understood as indicative of constrained agency. While Zinzi emplots herself as a willing contraceptive user, she also needs to threaten the sexual relationship in order to overcome her partner's resistance and achieve this agentic emplotment.

The constrained choice within extracts 5.6 and 5.7 highlight how context shapes what is possible for contraceptive users and their agency. I thus use the notion of situated agency to explain the co-existence of choice and nurses' directive counselling practices or male partner opposition. Notwithstanding the reported efficacy, convenience, and long-acting nature of other LARC measures such as the implant and IUD (Zeal et al., 2018), which could potentially suit Buhle better, particularly considering the long distance travelled to reach the clinic, she is limited to two variants of injectable contraceptives. Buhle's ability to act is determined, in part, by the healthcare providers' production, or the actuality, of what can be offered within the facility. Nevertheless, within a discourse of choice and self-responsiblisation, Buhle can depict herself as enterprising rather than stifled by her context. Similarly, Zinzi is able to assert her agency upon threatening her relationship, thus potentially obviating the need for contraception altogether. Her cultural context thus proves malleable as a decision against contraception is transposed by approval or submission by her sexual partner. Therefore, women's capacity to decide is situated within the context rather than unfettered.

Indeed, personal decisions, choices and agency can be deeply enmeshed in contexts that allow or thwart what is possible for contraceptive users. This is in line with Wigginton et al.'s (2018) argument that "contraceptive use is an embodied experience, enmeshed in immediate material and relational contexts" (p. 729). To foreground this, I discuss in the following sections how active decision-making was depicted within a variety of relational contexts, e.g., within intimate partnerships, parent-child, and expert-provider relationships. These interactions were recurrently cited as shaping contraceptive users' decisions to take contraceptives.

2.1 "I didn't tell them"

Many contraceptive users within the study construed contraceptive uptake as an individual decision, one enacted actively yet also purposefully in isolation. Individual decisions can

require concealing to others due to preferences about childbearing within sexual relationships or assumptions about sexual engagement as inherently wrong among young women. As such, the micro-narrative, "I didn't tell them", coheres around the concealment of LARC use or maintaining its invisibility to others, mainly sexual partners or parents. Contraceptive users perform non-use and fecundity within these relationships. First, I discuss this secret use of LARC within intimate partnerships and later within parent-child relationships.

2.1.1 "I didn't tell my partner"

Some of the recruited contraceptive users' male sexual partners were framed as desiring fatherhood and thus pressuring their female sexual partners towards childbearing. The extracts that follow are representative of contraceptive users' who made the personal decision to use LARC in resistance to their sexual partners' reproductive desires to avoid involuntary reproduction:

Extract 5.8

> **Fattima**: Because I wanted to wait a little bit, and just when I wanted to wait, this one [husband] is making me stressed, and I make fast fast children /*both laugh*/. *[City, PBH, E]*

Extract 5.9

> **Vuyisa**: Taking contraceptives? /mhh/ I had a boyfriend last year, and I really like using condoms. I am not gonna lie, but then there is this myth that guys burst condoms, and I am very unlucky because in every relationship I get into, the guy wants to have a baby with me /ok/ I have bad luck. So, I thought about those things, so even though he wanted a child, I didn't tell him I was on contraceptives. *[City, PBH, X]*

In the above, Fattima, a migrant woman, achieves her reproductive desire to space births by secretly using LARC technologies despite a husband depicted as pressuring and stressing her towards childbearing. Secret use of LARC thus centres the contraceptive user's reproductive intentions and lowers the stress, which is implicitly construed as rooted in the possibility of reproduction being outside of Fattima's realm of choice. Particularly, the invisibility of LARC measures lessens the pressure placed on the contraceptive user. A planning parenthood discourse is mobilised to construct Fattima's desire to "wait" or space the births currently rendered as occurring "fast". The planning parenthood discourse highlights fertility regulation by a rational self who aligns procreation with certain conditions and consequences (Wigginton et al., 2016). This regulation of fertility includes birth spacing for women who "plan" to defer parenthood to a later stage while still maintaining the invisibility of this reproductive decision.

A similar instance of resistance is alluded to by Vuyisa. In extract 5.9, Vuyisa's boyfriend reportedly desires parenthood, which she opposes. In secretly taking up LARC measures, i.e., injectable contraceptives, she presents herself as safeguarded from the condom sabotage potentially committed by her boyfriend to meet his own reproductive desires for childbearing. A planning parenthood discourse is advanced by the participant to implicitly express the desire to engage in sexual practices while remaining child-free, albeit her current and past sexual partners are framed as having planned differently since they desire(d) parenthood or operated within a pronatalist discourse, where reproduction is viewed as a desirable outcome of heterosexual intimacy. This suggests that "reproductive decisions made by men do not necessarily reflect their wives' [or girlfriends'] reproductive preferences and may even be directly opposed to those preferences" (Biddlecom, 1998, p. 360). In further supporting her decision towards secret contraceptive uptake, Vuyisa construes herself as not averse to male condom use. Yet, she also questions its reliability in the context of untrustworthy male sexual partners who might "burst condoms". Therefore, planning parenthood, even when done in secret, requires the use of reliable measures. This way, injectable contraceptives feature favourably as, unlike the male condom, her sexual partner cannot tamper with their efficacy, thus restricting her agency through surreptitious impregnation.

The micro-narratives elicited above emplot Fattima and Vuyisa as agency bearers in the presence of an underlying pronatalist discourse used to describe their sexual partners. Pronatalist discourses frame childbearing as an essential and fulfilling developmental milestone expected of all heterosexual couples (Meyers, 2001; Morison et al., 2016). The secret use of LARC, albeit a passive or muted resistance to this pronatalist discourse, provided a liminal space between desiring and not desiring a child for women by limiting chances of conception, without necessitating disclosure about the contraceptive users' reproductive intentions to their sexual partners. This maintenance of a planning parenthood discourse at the juncture of a pronatalist discourse through secret use was enabled by LARC technologies' invisible nature. Consequently, this talk evidences how in women resisting a pronatalist discourse, heterosexual couples may pull in opposite directions.

Inequitable gendered power relations operate in both extracts, overtly in extract 5.8 and covertly in extract 5.9. Both extracts assume that women cannot actively state their disinterest in motherhood, with overt resistance implicitly understood as an aberration. Hence, Fattima and Vuyisa pose as non-users and purely reliant on their sexual partners' contraceptive methods

while actively circumventing the likelihood of conception through secret contraceptive use. This is unlike Zinzi in extract 5.7, who makes her decision towards LARC use known and threatens the relationship to uphold it.

Viwe, in excerpt 5.10 below, equally constructs an account of secret contraceptive use, premising the decision on relations with a sexual partner who is aversive to condom use. To evade constantly negotiating condom use and possibly motherhood, she sought LARC technologies in the form of an IUD. Yet, unlike Fattima and Vuyisa in the previous extracts, whose sexual partners have explicitly stated their desire for parenthood, Viwe shuts off the conversation about parenting by concealing LARC use but does not conceal use in response to opposing reproductive intentions:

Extract 5.10

> **Viwe**: Not that he influenced me, but I knew he didn't like using condoms and didn't understand the whole contraception thing. So, I would say that he didn't know that I was on contraceptives because I knew if I had the loop on, he wouldn't know. I don't like that (.) **at 8 o'clock**, I must jump up [makes imitating movement] and go take the pill /YN *laughs*/ because he's going to eventually ask me what are these pills that you are taking for? It was that kind of information; I'm doing what I am doing for myself and not for him because I don't want a child. *[City, PVH, X/E]*

Viwe foregrounds the importance of concealing decisions about contraceptive use from her boyfriend by opting for invisible contraceptive alternatives. Despite the constructed lack of communication about each other's reproductive preferences, short-term contraceptives such as the male condom and pill are framed by Viwe as disruptive forms of contraception due to their visible nature. This is in light of the male condom, which, as it stands, necessitates negotiation with her boyfriend, who is construed as not liking "using condoms". Constructions such as this "influence the acceptability of certain contraceptives [rendering them] as either facilitating or disrupting how (hetero)sex should be experienced" (Wigginton et al., 2015, p. 181).

In making a case for a suitable LARC technology, Viwe identifies disruptions with oral contraceptive use, given their strict compliance requirement and visibility. Hence, the obligation to account for use is deemed inevitable. In contrast, the loop is considered fitting as "he wouldn't know". Only by emplotting her boyfriend as ignorant about contraception (including the IUD) can Viwe silently enact her willingness to remain child-free, considering

her partner's lack of contraceptive responsibility. The private nature of this decision is re-emphasised at the end of the extract using a "my body, my choice" discourse, which connotes an entitlement to reproductive control over one's body that excludes others (Wigginton et al., 2015), particularly considering the embodied responsibility childbearing bestows upon women. This is evidenced by the utterance, "I'm doing what I am doing for myself and not for him because I don't want a child".

Viwe is evidently also implicitly emplotted in a male reproductive pardoning discourse as while her sexual partner is rendered as focused on sexual pleasure by avoiding condoms and all contraceptive responsibility, she both complies with his wishes and fills this gap in herself through LARC uptake. In so doing, pregnancy remains not viable for her, but she also avoids conflict and being questioned by her boyfriend.

The planning parenthood and my body, my choice discourses locate contraceptive agency within the individual contraceptive users. In this micro-narrative ("I didn't tell them"), however, voluntarism, as it relates to parenthood, is taken up personally, emplotting the participants as rational but secretive agents, given the interpersonal environments in which men are lax in contraceptive usage or even oppose this agency by pushing partners away from planning parenthood. As such, some of the participants indicated they were unsupported by their sexual partners who either showed no concern about other sexual and reproductive health issues beyond pregnancy or, through a pronatalist discourse, required support for their own fatherhood aspirations. Planning parenthood and "my body, my choice" discourses, thus, although arguably empowering, do nothing to undermine a traditional femininity discourse, in which childbearing is mandatory for women and so is the care of the family and children, when emplotted into an "I didn't tell them" micro-narrative.

In constructing their contraceptive debut story, another participant expressed the desire for dual contraceptive use, which can require ongoing LARC use on her part and the retainment of the use of the male condom from her sexual partner.

Extract 5.11

> **Ndivhuwo**: Uhm, that I felt like it was my decision. Like I said, I don't really talk about contraception with friends [it was] only that time when I started taking contraception that I spoke about it with a friend. But my boyfriend doesn't know that I'm on the injection, and the reason why is because I don't want him to think that we can't get pregnant and just leave the condom.

> At the same time, I still wanna protect myself from diseases. That's why I'm not telling my partner that I'm on contraception, so we can still use other methods. *[Town, PBH, E]*

Informing her sexual partner about LARC use was expected to yield resistance around continued barrier contraceptive use. Ndivhuwo's male sexual partner was thus portrayed as only aware of the risk of pregnancy and less concerned about STIs. Therefore, to avoid both these risks, Ndivhuwo used LARC measures in secret. The participant advances a self-responsibilisation discourse to reference an active, personal decision towards avoiding childbearing, while through a responsibilisation discourse, she also incites her boyfriend towards condom use. Ndivhuwo, thus, draws on a responsibilisation discourse in a dual way when compared to the previous health users as she self-responsibilises herself and simultaneously responsibilises her partner for contraception. Yet, the secrecy with which her own conscription towards contraception must happen is a testament to the tactics women must utilise to masculinise contraception or share contraceptive responsibility to achieve particular ends.

One friend (in extract 5.11) is cited as the only other person with whom contraceptive use was discussed. This functions to make contraceptive use intensely private and not always a matter that necessitates discussion with others, including one's sexual partner. Hence, Ndivhuwo adds, "But my boyfriend doesn't know that I'm on the injection". The "but" evokes a comparison between peers and sexual partners, emplotting selected peers as knowing while conversely emplotting boyfriends as not knowing. The utterance, "I don't want him to think that we can't get pregnant and just leave the condom", rationalises and validates these differential emplotments.

Lack of discipline in her boyfriend is alluded to, where interest in purely circumventing pregnancy and unequal investment in preventing STIs through shared contraceptive responsibility is assumed of males. Ndivhuwo, thereby, mobilises a risk discourse to frame her partner's knowledge about her LARC use, threatening his use of the male condom. In this regard, women are emplotted as sexually responsible and rational decision-makers. In contrast, men are emplotted as untrustworthy and non-compliant contraceptive users who are thus not entitled to full disclosure about women's bodies, including birth control use or non-use. The risk against which Ndivhuwo must guard here is her own partner's potentially irresponsible actions.

Tawonga, in the extract below, shows how public use of LARC can cause trouble in relationships, including being considered blameworthy in the event of infertility.

Extract 5.12

> **Tawonga**: Not even having to ask for his consent because, you know, there's one thing about (.) something that I've learnt with the patch that I had. As we got into the relationship, I mean into marriage now, we would find the argument going back to that patch. You created this fertility issue yourself; go fix it yourself because you've been using that patch. Who knows what that patch has done to you? *[Town, PBH, E]*

In the above extract, Tawonga talks about initially using the patch while "not even having to ask for his consent". However, as a visible form of LARC, her use of the patch generated conversations and blame for sterility. In contrast, invisible forms of LARC blur the reasons for infertility. The use of the utterance, "You created this fertility issue yourself; go fix it yourself because you've been using that patch. Who knows what that patch has done to you?" limits all other possible contributors to infertility, including the man's fertility. Instead, the cause is placed squarely on Tawonga's decision to contracept. This entrenches the notion that "the threat of fertility comes from… [a woman's body] … not the man" (Wigginton et al., 2015, p. 735). Thus, the risk of clandestine or non-consensual contraceptive use can be a double-edged sword. It enables women to avoid the risk of irresponsible contraceptive use on the part of their partners but also raises the risk of backlash (such as the fights about fertility cited above) should its use become known or visible. An implicit pronatalist discourse and gendered power relations inform the talk whereby childlessness is depicted as an unwanted "risk" by Tawonga's husband. Hence, the imposition on her to fix the unwanted infertility that emplots the husband as fecund in relation to the participant.

2.1.2 "I didn't tell my mother"

The data suggest that even though the decision towards contraceptive responsibility could be construed as a personal one, driven by the desire to avoid pregnancy, some participants reported the need to exclude their parents, in particular their mother, from this personal decision. As a result, compliance to the chosen regimen often occurred in secret within parent-child relationships. This was sometimes the case even when mothers were framed as the initiators of the conversation or advisers on contraceptive debut, responsibilising their daughters to reduce their "vulnerability" to pregnancy through contraceptive uptake, thus suggesting consent. See below:

Extract 5.13

> **Khanya**: I can't even begin to explain, like to the point where I lost so much blood I almost fainted in town and my mom was like, okay. I didn't tell her that I was on contraceptives cause my mother, my mother even like the idea of me wearing a tampon [to her means] I've lost my virginity because, in her mind, I am a virgin girl. *[Town, PBH, E/X]*

Khanya reports on an active decision to assume contraceptive responsibility and, at the same time, conceal this action. This active decision, however, later induces side effects, e.g., feeling faint and, in the broader transcript, eventually getting hospitalised due to blood loss triggered by menorrhagia or prolonged bleeding, which is experienced by some contraceptive users.

To justify maintaining the secrecy with which the reproductive choice was enacted, Khanya mobilises a traditional young femininity performance discourse to frame her use of contraceptives and tampons as a transgression of "good" womanhood for her mother, emplotted as sexually restrictive. Since being on contraceptives emplots her as "impure", "unchaste", and not "saint-like", she evades this by posing as both a non-user and an abstaining "virgin girl" in her mother-daughter relationship while still being a compliant contraceptive user. This performance shores up the futility of disclosing the medical reasons behind nearly collapsing and the resultant hospitalisation, given that being "sexually explorative" or a "desiring sexual subject" is deemed untenable within her mother-daughter relational context. What is apparent is the cost the participant undergoes for rejecting traditional assumptions about femininity by negotiating an active rather than passive sexuality for herself that is tenable only as far as it is invisible in relation to her parents' sexuality.

Khanya's mother is deemed as opposed to or restrictive of contraceptive uptake and, in essence, sexual exploration. In contrast, Sinoxolo, is encouraged towards usage yet opts for secret use.

Extract 5.14

> **Sinoxolo**: My mom just told me that no just get contraceptives, but to this day, she doesn't know that I'm on contraceptives /ok/. *Ja,* she doesn't know anything. She doesn't know when I started; she doesn't know that I have an IUD. She doesn't know anything, so it was my own personal choice. I went to get it done myself. *[Town, PBH, X]*

Sinoxolo constructs the decision to take up contraceptives as one that her mother initiated. However, the silence and secrecy within the text invoke the need for young women to perform virginity and sexual innocence while at the same time secretly using contraception within mother-daughter relationships, pointing to a traditional young femininity performance discourse. In this way, they avoid conflict while still being able to be sexually agentic alongside

their mothers' "unknowing" emplotments. Hence, Sinoxolo says, ("to this day, she doesn't know that I'm on contraceptives") and "She doesn't know anything. She doesn't know when I started; she doesn't know that I have an IUD. She doesn't know anything". This suggests that young women's secret self-disciplining towards contraceptive use is a norm that is upheld despite being granted permission to be a sexual subject. The section that follows discusses micro-narratives cohering around the positives associated with LARC use.

2.2 "I sought contraception for positive advantages"

The data reveal that inasmuch as contraceptive uptake was premised on an obligation to self-discipline, it also had utility for its users. These were identified as positive advantages, which included avoiding pregnancy, seeking economic empowerment, limiting stress related to pregnancy, allowing spontaneity and sexual pleasure, as well as non-contraceptive benefits, e.g., treating acne or heavy menstrual bleeding.

In this section, contraceptive uptake is recurrently construed as for the participants' own benefit and thus making them appear as placing their reproductive needs first. However, I also note that the planning parenthood and male reproductive pardoning discourse come across as mutually reinforcing within the micro-narratives. As such, the health users increasingly responsibilise themselves for carefully managing the risk of pregnancy through self-responsibilisation, a drive towards *homo economicus*, the conjugalisation of parenthood, psychological, female sexual pleasure and risk discourses. At the centre of this vigilance, was the timing of the pregnancy as not right at the present moment and sometimes ever. Therefore, an inability to perfectly time one's pregnancy for some participants threatened possibilities for avoiding or spacing births adequately within relationships, for fulfilling educational and economic aspirations, for maintaining their mental health, and for obtaining sexual pleasure. Participants find themselves responsible for regulating fertility even when they fail or experience anxiety about the possibilities. All the while the role of males in this labour is ignored or masked. When participants, through medical discourses, rendered their contraceptive uptake as medically indicated, and thus not serving their own needs, they at the same time, provided lenience around men's contraceptive duty. They thus rendered their partners as only sexual partners and not partners in reproductive control.

2.2.1 "I wanted to avoid pregnancy (again)"

Some participants construed contraceptive uptake as an active decision they made to circumvent or delay pregnancy. Events occurring in their lives, such as sexual activity and previous births, entrenched this decision. This is evidenced by the excerpts below:

Extract 5.15

> **Nandipha**: Oh, because I had a boyfriend, and I didn't want to fall pregnant. *[Village, PBH, X]*

Extract 5.16

> **Ndivhuwo**: The reason I chose to be on contraception, uhm, because I didn't wanna get pregnant, that's all. What are the other reasons? *[Town, PBH, E]*

In extract 5.15, Nandipha cites being in a relationship as causal of her uptake of LARC. Having a boyfriend is understood as implying sex and, therefore, the likelihood of pregnancy. Hence, the incitement to self-discipline into an active and compliant contraceptive user to alleviate the "threat" of pregnancy. Ndivhuwo further implicitly claims this is an obvious progression of events by saying, "What are the other reasons?" Within this rhetorical question is the assumption that the desire to avoid childbearing through LARC use is both causal and obvious among contraceptive users.

A self-responsibilisation discourse that demands its subjects to self-fashion into contraceptive-using, rational subjects and further regard this as a decision that will improve their reproductive well-being undergirds both participants' talk. Yet, this pregnancy "threat" is also implicitly framed as belonging to females, given the mention of sexual relationships and the consideration of the one's reproductive preferences. As such, what I term the male reproductive pardoning discourse is advanced by the talk. Within this discourse, talk about contraception revolves around men but rarely includes them or demands action from them. This suggests that women must personalise this responsibility. The talk emplots both participants as responsible and not "at risk" of pregnancy.

Other participants reflected on deciding on LARC uptake following an unintended pregnancy and thus seeking medical advice or healthcare centres.

Extract 5.17

> **Abosede**: My first use of contraceptives was after I got married, and that was after my first child… delivery of my first child. So uhm, no, of my second child, I've got three; so, I had my first child in 2003, and then I had a second one in 2004. So, I was like, this is too close, so after the delivery of my second child in 2004, then I was introduced to the contraceptive by my gynae. *[Town, PVH, E]*

Extract 5.18

> **Kuhle**: We had been chatting [on social media] for a while with Baby [boyfriend], we had missed each other, and so on **and so forth** /claps/. We didn't realise that we were going to fetch [baby's name] [conceive second baby] so <u>just as I thought to go to the clinic. "Let me run and go get the injection". How am I going to get the injection if I'm already pregnant?</u> /Oh/ = How am I going to get the injection? Because the injection is not an abortifacient, it's too late = /Yes?/ When I got to the clinic, checking if I wasn't pregnant. They said, "No, *Sisi,* you are pregnant". *[Town, PBH, X]*

In extract 5.15, Abosede construes the birth space between her first two children as "too close". In problematising the birth spacing and expressing the desire to remedy it in subsequent pregnancies, she is inculcated into an understanding of contraception as the gateway to timing pregnancy by her gynaecologist. She, therefore, advances a planning parenthood discourse that renders pregnancy an event subjects are expected to plan and be "ready" to undertake (Stevens, 2015). This decision thus brings repeat pregnancies to the realm of choice for contraceptive users, albeit it further heightens the individualising nature of this labour.

An active decision to use contraception is also reflected upon by Kuhle in extract 5.18 following the resumption of a relationship and sexual activity. However, she relays an unsuccessful attempt of, in her case, continuing with LARC use following unprotected sex with her partner. Indeed, she is refused the contraceptive measure based on an already existing pregnancy. LARC technologies are thus denied or rendered futile in the event of pregnancy. Her framing of contraceptive technologies further as not abortifacients but as preventative of pregnancy so long as conception has been avoided reinforces the "irreversibility" of her lateness. While Kuhle emplots herself as an active decision-maker to healthcare providers who resist her request, she equally excuses her late seeking of LARC through a story of love and passion ("we missed each other and so on **and so forth** /claps/") in which men feature as an absent presence in contraceptive responsibility.

Both participants implicitly emplot a male reproductive pardoning discourse. Decisions are implicitly relegated to Abosede and Kuhle, and they conformably personalise this duty to achieve "adequate" birth spacing within marriage and stable relationships. Hence, Abosede solely reflects on and frames her interbirth interval as small, and Kuhle says, ("'just as I thought to go to the clinic. 'Let me run and go get the injection'"). However, what is unwittingly also personalised is the onus for an unintended pregnancy. That is, not only is the prevention of pregnancy individualised but its presence as well, which points to how "there is limited

discursive space available for women to positively narrate having no choice; especially in light of the cultural context that values autonomy, independence and planned pregnancy" (Wigginton et al., 2016, p. 737).

2.2.2 "I was still a student and not working"

At the time of the interview, many of the sampled contraceptive users were still studying while others reflected on their younger learner/student years, wherein the decision to use LARC technologies was made. As such, they recurrently maintained that schooling and a poor financial standing disabled the option of reproduction, hence, the individual decision to use LARC measures. Examples are illustrated by the extracts below:

Extract 5.19

> **Lindelwa**: At the time, I didn't want to have a child; I was still in school. Once I completed school, I then stopped using contraceptives. I am not going to say I was planning to have a child, but then I just stopped, then it happened that I had a baby. *[Village, PBH, X]*

Extract 5.20

> **Zinzi**: My mother had a child while she was young, at 19. She had a child at 19, so I don't want to repeat history. I wanted to finish school and then plan if I plan to have a child. I want one now. *[City, PBH, X]*

In excerpts 5.19 and 5.20, pregnancy is construed as atypical during schooling and thus to be avoided. Hence, Lindelwa only avails it after high school completion (extract 5.19). To do so, she replaces the stringent use of contraception with discontinuation, thus leaving pregnancy to chance upon school completion. However, while she discontinues contraceptive use, childbearing is not an actively chosen decision. Therefore, the outcome of this decision, although not disruptive to her schooling, is framed as still surprising "It happened that I had a baby".

Similarly, Zinzi asserts, "I wanted to finish school and then plan if I plan to have a child" after that, she says, "I want one now", implying that basic education completion, rational thought and maturity have now availed the option for pregnancy for her. The talk emplotted both participants as rational and responsible sexual subjects. A planning parenthood discourse, which contains an inherent assumption that "only those who fulfil a prescribed set of requirements are entitled to have a child" (Schwiter, 2011, p. 399), is the discourse drawn upon by both participants. This way, education is implicitly framed as providing access to better employment opportunities, and a disruption to this schooling caused by childbearing denies women the sought-after financial freedom. Hence, being a student\learner and pregnancy are construed as discordant.

In the above excerpts, reproduction is disallowed in basic education; it is, however, also disallowed during higher education in extract 5.21 below:

Extract 5.21

> **Tawonga:** oh *ja*, back then when I was an undergrad student, 3rd year while doing 3rd year I think back then I was 21 years old, so I was involved with this guy, and things were getting out of hand in terms of sexual activities. So, I decided to start off with the injection because I was getting scared of pregnancy, unwanted pregnancy, because at that time, I was still a student, no work and all that. So, I didn't want any distraction in that area, in that area and so I opted for an injection. *[Town, PBH, E]*

Embedded within the decision to take up LARC measures while schooling is a subject that "resemble(s) the rational economic man: *homo economicus*, who is a freely choosing, responsible entrepreneur of the self" (Saunders, 2019, p. 9). As such, Tawonga references the necessity for paid labour to precede the decision to reproduce with failure to align the two deemed as a "distraction" or "failure". Hence, she advances a planning parenthood discourse to emphasise the wrongness of the present for childbearing. Therefore, her financial instability renders her unready for parenthood and responsible for taking up LARC technologies. This is also evidenced in the extracts below:

Extract 5.22

> **Zimkitha**: At that point, I was like, I was scared that ok, this is what's happening. I may be pregnant, and I already had a child; I'm not working, and I still want to do so much with my life. *[Town, PBH, X]*

Extract 5.23

> **Ndivhuwo**: Why did I choose to be on contraception? Uhm I've already explained that it's because I don't wanna be pregnant, I'm not married yet, I'm not financially stable to be able to have a baby right now, so that's why I chose to be on contraceptives. *[Town, PBH, E]*

Once again, participants cite the desire to circumvent pregnancy while financially unstable as having informed their decision to use LARC. In so doing, they weigh the consequences of an unintended pregnancy and thereafter "rationally" enact decisions. For example, a previous pregnancy entrenches the personal decision for Zimkitha with the possibility of a second child and assumptions about an inability to provide for it, presenting as a barrier against her future aspirations.

In extract 5.23, Ndivhuwo problematises pregnancy out of wedlock as not ideal by asserting, "I'm not married yet". She also adds that "I'm not financially stable to be able to have a baby right now". Therefore, she uses the notion of *homo economicus* in conjunction with a

conjugalisation of parenthood discourse to centre reproduction within financial freedom and matrimony. *Homo economicus* requires its subjects to be enterprising and to maximise their utility within society for economic advancement but yet to understand this decision as freely chosen (Macleod, 2002). The conjugalisation of parenthood discourse places value on reproduction within the confines of marriage or, at least, relationship stability with procreation within casual relationships rendered aberrant and shameful (Macleod, 2003; Mavuso, 2017). Put together, the absence of a husband to provide social legitimacy as well as financially and Ndivhuwo's own financial standing support her current decision to regulate the "risk" of pregnancy through contraceptives, thus leaving childbearing in the future. Both participants are emplotted as rational and responsible regarding spacing or timing childbirth.

2.2.3 "I feared pregnancy"

Some participants framed childbearing as not only a "risk" to their desire to limit, space or avoid childbearing, it also presented a "threat" to their mental well-being. Contraception then becomes a practice that frees them from the panic, jitters and unease about the possibility of conception. Carrie, Emma and Lunathi provide illustrations of this in the extracts below:

Extract 5.24

> **Carrie**: Uhm, just not having to stress about falling pregnant /both laugh/ and also, I don't have my period anymore; I can feel when I have it, I still get the pain, but ja, I don't get the other side effects which is great. *[City, PVH, E]*

Extract 5.25

> **Emma:** I was wanting something that was going to be reliable. I think it was something that was reliable. […] It was about having a reliable backup plan for being pregnant, uhm, just in case another condom situation came up. So, I could be like cool. We don't have to stress; I got this, but uh *ja,* it helped me a lot with reliability, knowing that it is going to be there and function well. *[Town, PVH, E]*

Extract 5.26

> **Lunathi**: I started it because I was just like I had this paranoia about pregnancy. Uhm, I had (.) I was pregnant at the beginning of this year, so I had to do an abortion, and it scared the freak out of me /okay/. But it was very early so I, uhm, it was, like it was quite an easy process like I discovered it very early on, so I didn't have to do an operation or whatever. Uhm, so (.) and after that experience, I have gotten very paranoid about getting pregnant again /*ja*/. Uhm, and it's not that I am a person who normally doesn't use condoms or whatever, whatever. Uhm, I I I it was *ja ja,* and I was like (.) and I had broken up with the person, and then I met a new person that I was really excited about and I was like okay, I think I am going to get serious with this person. Uhm, I was like, okay, let me just get on with it. *[Town, PBH, X/E]*

In justifying her LARC uptake, Carrie begins by emphasising the reliability of a chosen contraceptive method as significant for her. This is mentioned against the backdrop of

condoms, which have presented with method failures. LARC technologies, however, obviate the need to "stress" when short-term contraceptives fail. Similarly, Emma frames LARC uptake as having reduced psychological distress by comparison to short-term contraceptives, namely the condom, which in the broader text was constructed as having occasionally been unreliable. As such, both participants draw on a psychological discourse in tandem with a risk discourse, thus construing reduced mental well-being as inextricably linked to the possibilities of unintended pregnancy. Psychological discourses denote people's ways of relating with themselves and the world. This discourse considers one's conduct as either healthy or unhealthy; thus, strategies for more adaptive behaviours and practices must be sought through self-introspection, self-surveillance and self-regulation (Holt & Stephenson, 2006). The uptake of LARC reportedly allowed the participants expressions of healthy emplotments within a psychological discourse.

The psychological discourse, together with a risk discourse, also incites its subjects to adjust conduct, and this is clearer in excerpt 5.26. For example, Lunathi also draws on the psychological discourse to construct mistimed pregnancies as inducing fear when she says, "I had this paranoia about pregnancy". Here, the decision to use LARC is also grounded on the desire to limit this panic and worry discursively linked to an unintended pregnancy. She further cites a recent termination of pregnancy, which she construes as an experience that "scared the freak out of me" to reinforce the decision towards LARC uptake. Hence, she asserts, "After that experience, I have gotten very paranoid about getting pregnant again". Lunathi thus advances a risk discourse to support the incitement to adopt LARC technologies as alleviating this "risk" or threat to her psychological well-being. The talk emplots her as responsible and at ease or relaxed as the possibilities of a repeat pregnancy are circumvented. However, the self-blaming mechanisms of risk discourses pointed out by (Lupton, 1993)Lupton (1993) emerge in the micro-narrative as Lunathi speaks to the injunction to review lifestyle choices, optimise behaviour and self-police through compliance to LARC measures in place of short-term methods. This is alluded to as necessary for reducing anxiety.

2.2.4 "I desired sexual liberation & pleasure"

Sexual pleasure within relationships, both stable and casual, was constructed as desired by participants. LARC technologies thus allowed access to that pleasure as well as spontaneity while limiting the risk of pregnancy following inconsistent or discontinued condom use. For example:

Extract 5.27

> **Gugu**: Isn't it that when you want the business [sexual intercourse], you want it now. The brain will turn on again in the morning when you start asking, "Baby remind me, did we condomise?" And then he's like, "***Yhuuuu!*****" You see?** It's only then [the morning after engaging in sexual intercourse] that you [both] get back to your senses. *[Village, PBH, X]*

In extract 5.27, Gugu speaks to how LARC measures regulate fertility in moments of sexual spontaneity and passion when barrier contraceptives can be overlooked or forgotten. To convey this, Gugu says, "When you want the business [sexual intercourse], you want it now", an urgency for sexual pleasure is relayed within the micro-narrative within which short-term contraceptives discursively cannot feature. A female sexual desire discourse where sex is centralised as equally wanted by female subjects rather than given to please a male sexual partner undergirds the talk.

This talk emplots Gugu as agentic and "free" to sexually explore. However, although the extract points to "erotic scripts of contraceptives used by women" (Higgins & Smith, 2016, p. 418), a risk discourse also underlies the talk as the shock depicted as expressed by the sexual partner ("***Yhuuuu***") and the notion of "getting back to your senses" imply the absence of contraception as denoting the presence of "risk". She reinforces the unintentionality of not using barrier methods by asserting that "The brain will turn on again in the morning when you start asking 'Baby remind me, did we condomise?'". This portrayal of the brain as turned off and the need for a reminder suggests preoccupation elsewhere, in this case, giving or receiving pleasure rather than on barrier contraceptive use. As such, the user action required with condom use, is implicitly understood as contributing to their forgettable nature, when Gugu asserts, "Did we use a condom?". LARC technologies, however, allow for more passivity as their functioning precludes user engagement in each sexual act and further remain reliable when desire is aroused and one's capacity to remember is diminished. She, thereby, affirms the notion that LARC measures grant their users sexual spontaneity as these contraceptive technologies allow access to sexual pleasure and spontaneity without the "risk" of pregnancy.

Unlike Gugu, who forgets to negotiate condom use with her partner, the desire to discontinue condom use for sexual pleasure is reflected upon by Khanya in the text below.

Extract 5.28

> **Khanya**: Oh, I started this year, uhm, so I was in this relationship, not even a relationship but a "situationship". Why? Because we are young and free, and we do the most delirious things in the name of freedom. So, I was seeing this person, and I really just did not want to use a condom anymore, so I went on a [long-acting] contraceptive. I went on the three-month depo [provera],

> uhm, the injection from the clinic. Uhm, I started in March, *ja* let me say March, April, May, June, *ja* I started in March. *[Town, PBH, X/E]*

Khanya cites the desire to avoid condom use as premising her decision to seek LARC technologies. Her account, however, also contains ambivalence about the suitability of LARC measures within non-committed sexual relationships as she first refers to the non-romantic sexual relationship responsible for her contraceptive uptake as a "relationship" and later refigures this utterance by utilising the signifier "situationship". The change in framing is spurred by "the idea that sex is part of a loving commitment between a man and a woman and should lead to bringing up a family" (Hollway, 1984, p. 65), which is encapsulated by a have/hold discourse.

A have/hold discourse places value on monogamy and retaining romantic relationships. In contrast, a situationship resists this form of discourse due to its noncommittal nature as it signifies a casual sexual arrangement with another. Therefore, both parties are not bound to monogamy and can engage in sexual relations with others (Douglas, 2018). By implication, the discontinuation of condoms and uptake of LARC within this type of relationship's configurations is an anomaly— not to be expected.

Khanya overcomes this by emplotting a female sexual desire discourse, which connotes contemporary constructions of sex as "a natural harmless urge that not only men but women experience" (Hollway, 1984, p. 66) when she posits, "Why? Because we are young and free, and we do the most delirious things in the name of freedom". The use of the terms "young and free" points to an agentic self located outside of the constraints of societal, political and historical rationalities. However, this defiance of the have/hold discourse and deployment of a female sexual desire discourse sit uncomfortably alongside each other as one dictates commitment in the long-term, and the other seeks pleasure without commitment, which invites a risk discourse. Hence, Khanya questions the decision as "delirious" and/or "irrational". Reserving condomless sexual intercourse for monogamous relationships is also deemed as limiting to one's sexual freedom by Khanya, even though "condomless sex… symbolises important meanings such as trust, love and intimacy" (Moran & Lee, 2012, p. 162). Therefore, active decision-making and disciplined LARC use are sometimes not limited by traditional sanctions around appropriate and inappropriate domains for reproduction and trust, although participants can struggle with tensions in maintaining this emplotment.

2.2.5 "I used the pill for other benefits: skin, menstrual regulation"

Many of the sampled LARC users' contraceptive journeys in the private healthcare sector began with oral contraceptives, a form of short-term contraceptive to remedy a biological issue seen as uncontrolled, for example, acne and heavy bleeding. As such, the contraceptives were consumed for cosmetic purposes or regulating menstruation rather than circumventing pregnancy. Extract 5.29, 5.30, 5.31, and 5.32 are illustrations of this:

Extract 5.29

> **Ellen**: So, it was more for my skin, I had like proper teenager skin, so the pill I went on as much as it was being on a contraceptive, it controlled the hormones, which then controlled the breakouts, and then I just pretty much stayed on it because I wanted to be safe. *[City, PVH, E]*

Extract 5.30

> **Colleen**: I started when I was 18, in grade 12, I started with a normal pill, and I started for my skin, one of the reasons probably the main reason. I was on that until I was 30, so 12 years, and then I got married, and I had my kids close together, I didn't have anything in between. *[City, PVH, E]*

Ellen and Colleen attribute contraceptive debut to alleviating acne. They thus frame their hormones as off-balanced and requiring regulation. Instead of constructing the body as the site of reproduction, a medical discourse is used to construct the body as the site of cosmetic improvement. In this way, contraceptive uptake is implicitly framed as unrelated to their sexual functioning but rather medicalised. Both participants thereby advance a medical discourse, which through scientific knowledge legitimises its credibility by asserting, "It was for my skin" or "I started for my skin". The participants could also thus assume emplotments of "sexual innocence" and "chastity". This is in complete contrast to many contraceptive users in the public healthcare sector whose contraceptive debut was premised on a self-imposed or externally imposed need to circumvent pregnancy associated with sexual debut or suspicions about sexual debut (See section 3 discussed next).

Continued use of oral contraceptive measures for birth control is later legitimated, although there is an avoidance of alluding to sexual debut explicitly. For example, Ellen states that "Then I just pretty much stayed on it because I wanted to be safe". Similarly, Colleen, in extract 5.30, says, "I was on that until I was 30, so 12 years, and then I got married, and I had my kids close together, I didn't have anything in between" and thus refers to the cessation of contraceptive use upon marriage. However, contraceptive use for birth control purposes before marriage is also omitted in the text, thus demonstrating the lack of need to account for sexual experiences and resultant contraceptive needs that precede the marital union (because of the medicalised

skin condition).

Nomawabo and Julie also reflect on similar trajectories as Ellen and Colleen in the extracts below:

Extract 5.31

> **Nomawabo**: Okay, my doctor, not even my dermatologist. I think it was a GP. Yes, a family doctor recommended it because I had such bad skin (.) bad acne. So, she suggested that I go on *Yasmin*. It didn't work but I tried it for about two years or so and then I stopped using it because I thought, okay, no it's fine. Then I went back [to it] when I was sexually active, I thought, okay, one form of contraceptive that I can use is *Yasmin* because I hate needles, so I didn't like to be on [the] injection. I was diligent enough with the thingy [pill]. *[Town, PVH, X/E]*

Extract 5.32

> **Julie**: I think I actually started with the pill when I was about 15 or 16 /okay/ and then I initially went on for my skin. It wasn't purely for contraceptives at that point, obviously, as I got older, then I started engaging in sexual activities /yeah/. It was helpful that I was already on, and I think between the ages of like 15 and I got my first... the *Implanon*, implant when I was 19, so between that and 19, I was sort of on and off it. *[Town, PVH, E]*

A medical discourse supports the decision to utilise oral contraceptives despite Nomawabo's reflection on no improvement in her acne, which yields discontinuation of use. Yet, there is a constructed convenience associated with this contraceptive uptake that later benefits Nomawabo and Julie's sexual functioning by preventing pregnancy. Both participants, due to their experiences with skin problems, could assume "knowing" emplotments when the desire for sexual exploration later arose. They were able then to use this knowledge base when making decisions about more long-acting contraceptive technologies such as the *Implanon* for Julie later.

Emma mobilises the medical discourse in taking up oral contraceptives to regulate her period rather than skin problems in the extract below:

Extract 5.33

> **Emma**: Oralcon *ja,* and so that's how I got onto it because I was so distressed that my period was skipping. And for a long time, it was about keeping my period regular, and now my period is super regular uhm and but it was also like a reason to be on the pill because that's why I told my parents that "Oh no, I am just on the pill" /YN *laughs/* because in first year you're still like mmmm don't want to tell my parents that I am sexually active, kind of thing, so I was like it's just because my period is like…*[Town, PVH, E]*

In the above extract, Emma problematises the irregularity in her menstrual cycle, constructing it as distressing, thus pointing to the non-contraceptive benefits of birth control measures, which have also been seen to "free women from menstruation" (Wigginton et al., 2015, p. 180). Additionally, for Emma, the medicalisation of contraceptives proves instrumental in shaping the discussion around contraceptive use by negating the obligation to disclose sexual debut or sexual exploration to her parents. She could thus also assume an "innocent" or "chaste" emplotment.

In the next section, I discuss externally-driven decision making. Here, decisions were given direction by someone other than the contraceptive users themselves. In addition, non-use was removed from the realm of choice, in direct contrast with the construction of subjects as active decision-makers seen in the sections above (2.1 and 2.2). Instead, passive or compliant subjects are constructed.

3. "It was not my decision"

This section discusses micro-narratives cohering around other people assuming decision-maker roles in women's contraceptive debut. These decision-makers recurrently consisted of female guardians, i.e., mothers, grandmothers, or aunts, who recommended, pushed and even coerced participants towards uptake. Notions of a problematic adolescent sexuality, drawing on developmental discourses, were propagated to exclude contraceptive users from decision-making. Therefore, to structure their reproductive destinations by regulating or limiting their reproduction, LARC technologies were forced upon young health users. However, although the contraceptive users themselves are placed on the margins of decision-making, their ability to transcend the imposed decisions varied among the participants.

Developmental psychology, in its uncritical form, has been majorly influential in determining how the lifespan of individuals is understood (Burman, 2016). In particular, its "stages of development" are the product of research by which theorists like Piaget, Freud, Vygotsky, Hall and others charted off certain "crises" as typical of a specific age and to be traversed for developmental milestones to be met (Parker, 2015). As a result, using these concepts and theories, adolescence, for example, has been flagged as a period of transition that must be crossed prior to childbearing, paid labour, marriage and other "milestones" associated with adulthood (Burman, 2016). In the data, as seen below, transgressions to this order produced a policing of reproductive decisions with parents assuming an "expert" or "knower" role vis-à-vis the contraceptive users.

Macleod et al.'s (2020) notion of a threat of degeneration helps us understand how the signifier "adolescence" is instrumental in explaining the problematisation and policing of adolescent fertility. They locate the colonialist development of the "adolescence-as-transition" discourse. The equation of the movement from childhood to adulthood with the movement of so-called primitive societies to civilised ones meant that the transition to adulthood was shifted from social processes and inductions to internal processes within the individual. This individual development to rational adulthood is always under a threat of degeneration to more child-like or primitive urges. Thus, the adolescence-as-transition discourse upholds constructions of this age group as fledgling, "immature" or not "fully" adult. Therefore, since it is culturally reserved for adulthood, young people becoming pregnant is deemed as an individual problem that is inevitably negative, including in how it affects the collective. Hence, both parents and healthcare providers can share the decision to attempt to resolve this threat through enforced LARC provision.

3.1 "I was coerced by my mother/aunt"

Some participants reported on the use of coercion by their mothers and aunts to incite contraceptive debut. Usage was thus deemed non-negotiable. To ensure this, these parents accompanied the young women to the health facilities to survey and monitor the contraceptive debut, framed as beneficial for the participants. Examples are provided by the extracts below:

Extract 5.34

> **Alejandri**: My mother, she told me, and she took me to the clinic because I was obviously on that level /*laughs*/. *[City, PBH, E]*

Extract 5.35

> **Viwe**: There is a lot happening, you don't condomise, you are not on contraceptives. She assumed. Yes, I was not on contraceptives then… My mom is a nurse by profession, so she said I must go and get the injection. She took the day off and got me to get the two-monthly, two-monthly injection. There is one for two-months and one for three-months, I don't remember. That was in 2000 and what? While I was still doing grade 12. *[City, PVH, X/E]*

Extract 5.36

> **Lulama**: I wrote and signed. I wrote on a clinic card. Worst of all, I wasn't supposed to be getting the injection because I didn't have a boyfriend, you see. I wrote on it using a pencil then one of my brothers noticed that I didn't go there [clinic] and that I just wrote for myself /YN *laughs*/. "She wrote for herself!" So, then they took me straight there [clinic]. *[Town, PBH, X]*

The use of surveillance in structuring behaviour and practices towards particular ends is evidenced in the above extracts. For example, in reporting on being instructed to take up contraceptives by their mothers Alejandri, Viwe and Lulama indicate that these decisions were based on observations and discoveries made. Being "obviously on that level" is cited by

Alejandri. In the broader text, Viwe premises her decision on the discovery of a friend's pregnancy test, by her mother, in her school bag, while Lulama, in extract 5.36, reports on recurrently coming home late in the evening during her adolescent years. In each case, though with a unique transgression of "good" womanhood, surveillance is used to achieve a standard decision, which is coerced contraceptive use. Consequently, these constructed "troublesome" behaviours not only emplot them as "desiring" sexual subjects and at "risk" of pregnancy, but they also invite concern and intervention.

A risk discourse, which denotes the likelihood of harm or damage, thus construing pregnancy as a detrimental outcome that must be reduced (Lowe, 2016) for adolescents alongside the adolescence-as-transition discourse, is a thread running through the extracts. The adolescence-as-transition discourse is a developmental discourse that considers adolescence as a period of transition that, while preparing for adulthood, precludes actual "adult" activities such as reproduction. Young women's reproductive capacity is thus problematised as a precedent for various negative experiences (Macleod, 2011). This way, pregnancy for adolescents can be rendered a "risk" or "threat", requiring prevention at all costs. Hence, the injunction towards not only contraceptive debut but also to be accompanied by their parents so as to monitor the uptake of the relevant LARC measure. This constructed need to survey uptake points to parents' awareness of the possibilities of resistance and such external pressure to avoid the risk of pregnancy while young is met with laughter by Alejandri in extract 5.34. This suggests that, in hindsight, she can appreciate the emplotment of a risk discourse and adolescence-as-transition discourse in crafting a narrative of coerced contraceptive uptake.

Unlike, Alejandri who is amused by the emplotment within a risk discourse, this risk is denied by Viwe who emplots herself as being fashioned as "risky". This utterance, "She assumed" expresses her dissatisfaction with the non-voluntary nature of the decision towards LARC usage and the conferred emplotments. Despite this, the ability to resist the decision or decide for herself is constrained through, firstly, the deployment of the adolescence-as-transition discourse, which renders her deficient at parenting, naïve and a bad decision-maker, and, secondly, the conflation of "mother" and "professional nurse" emplotments that combine a parental and medical gaze upon her body – both claim authority and knowledge and ultimately limit the possibility of resistance.

In contrast to Viwe, resistance against both the risk discourse and the coerced decision is

evidenced in excerpt 5.36 as Lulama implicitly draws on a "my body, my choice" discourse, which signifies the wherewithal (albeit clandestinely) to exclude external pressure in reproductive decision-making and exert personal agency (Wigginton et al., 2016). To do this, she reports on posing as a compliant injectable contraceptive user by presenting a fake clinic card with fake nurse's signatures to her mother as proof of acquiescing to the forced contraceptive uptake. Here, we see Lulama as a strategiser rather than a docile or passive recipient of LARC. The participant further argues, "Worst of all, I wasn't supposed to be getting the injection because I didn't have a boyfriend, you see", therefore implying that contraceptive use is superfluous when women are without the "risk" of pregnancy. However, maintaining this secret resistance or contraceptive non-use in the micro-narrative is threatened by her brother's detection of her fake clinic card and decision to inform the family.

While on the margin, her brother uses surveillance to regulate Lulama's sexuality and reproduction by scrutinising her clinic card and later disclosing her contraceptive non-use to the family, thus counteracting her ruse or claim to be a disciplined contraceptive user. In light of this, her mother accompanies her to the clinic to ensure contraceptive debut is initiated, which evidences the overt coercion or sovereign power wielded in some parent-child relationships by older women upon younger women as a tactic to control fertility. The talk further points to sanctions placed over women's bodies, which denies them full agency.

Unlike other participants, Zonke, in excerpt 5.37 below, expresses extreme discomfort about being side-lined in the decision to initiate contraceptive use. See below:

Extract 5.37

> **Zonke**: As soon as they found out that I had a boyfriend, I think I was 12, my mom said I should go to the doctor, our GP. She did not tell me why. When I arrived at the doctor, I was given an injection and when I asked what it was for, they said it (.) that it's a flu shot […] Now you know our aunts are always in our business. So, one time my aunt was scolding me about boys and all that stuff and said, "Just because you are on the injection" […] I was so upset because I didn't even know what sex was at that time. *[City, PBH, X/E]*

Zonke's mother's discovery about her boyfriend at the age of 12-years is construed as the motive underlying her unconsented contraceptive debut. False medical information is used to administer injectable contraceptives disguised as a "flu shot" by the family doctor. The family doctor is, thus, framed as colluding in this subterfuge that marks her contraceptive debut. It is only through being scolded by her aunt about transgressing the rules of engagement with males, where presumably even contraceptive debut does little to lift the strictures around engagement

with the opposite sex for women, that Zonke discovers her contraceptive user status. Zonke's talk is underscored by a risk discourse alongside a male sexual drive discourse, which together feminise contraceptive usage through emplotting young women as "at risk" of male conquests. In addition, these decisions to associate with boys are not purely understood as transgressions of parental rules but also serve as evidence of sexual desire, which must be stifled for women.

To resist such emplotments, Zonke draws on a traditional femininity discourse by which she introduces her own sexual history by asserting that she "didn't even know what sex was at that time". In contrast to the traditional young femininity performance discourse, through the traditional femininity discourse, the participant does not frame this as a performance used to assume more viable chaste sexual emplotments within mother-daughter relationships. Instead, she uses it to take up emplotments of sexual "innocence", thus expressing her lack of readiness for sexual exploration and further delegitimising and problematising her own coerced contraceptive debut. Here, again, the regulation of young women's reproduction as a precautionary measure against pregnancy upon witnessing romantic or platonic friendships with males is evident. Women's denied agency within this reproductive decision is particularly informed by "the view of the female body as maternal" (Denbow, 2015, p. 153). As such, consent and choice are, at times, constrained for young women, with little to no opportunity to challenge this disavowal of bodily integrity due to the adolescence-as-transition discourse, which problematises adolescent pregnancies and, in essence, talking about sex.

In the excerpt below, Zonke discusses the active role her mother played a second time in ensuring her use of contraceptives subsequent to the violent uptake narrated in extract 5.37, which Zonke, in the broader text, indicates that she resisted by discontinuing use.

Extract 5.38

> **Zonke**: They made the decision again. I just found myself being injected again. *[City, PBH, X/E]*

The narrative creates hierarchy through the juxtaposition of "I" and "them" as the administration of the LARC measure is construed as "done" to her rather than "chosen" by Zonke, pointing to the use of sovereign power, which uses force, coercion and authority to create particular subjectivities.

In the above section, we see how despite the participants' own constructed lack of need for contraceptives, tensions about the engagement in behaviours understood as underpinning sexual debut complicates their ability to refuse contraceptive usage decisions. These

behaviours were deemed by female guardians as pointing to illicit sexual exploration yet contrasting sharply against the young women's constructed "chaste" or "innocent" selves. A clandestine "my body my choice" and traditional femininity discourse temporarily disrupted constructions of these young women as "at risk" and offered emplotments for resistance against coerced contraceptive uptake. This resistance did not align with non-use as a permanent decision but validated non-use as suitable during periods of no sexual exploration or virginity. In addition, not only was there an absence of choice and consent, but within women's subordination to parent-dominated decision-making is a taken for granted assumption that this is a responsibility that young women will, with age, be satisfied with or appreciate.

Zonke, in extract 5.37 above, indicates that contraceptive debut was coerced ("as soon as they found out that I had a boyfriend"). Participants emplotted three events/behaviours as precipitating contraceptive coercion on the part of female guardians: having a boyfriend; menstruation; being "out there". These are discussed in the sections that follow.

3.2 "Coercion because I had a boyfriend"

The data reveal that other participants reported on their parents (mothers) premising the decision towards contraceptive use upon their romantic relationships. In situating the participants in heterosexual relationships, the threat of pregnancy was implied. Hence, the participants were responsibilised for avoiding this "risk". Less of the reported mismatch between the participants' behaviours or practices and the externally enacted decision seen in section 3.1 is reflected in this section. In other words, an implicit admission of needing contraception is evident, although methods used to encourage LARC use were still coercive. See the example below:

Extract 5.39

> **Sibabalwe**: My mother told me to [seek contraceptives]. I was hiding the fact that I was dating, and she finally saw for herself. *[City, PBH, X]*

In the above extract, contraceptive uptake is negotiated upon discovering Sibabalwe's romantic relationship. Her failed attempt at concealing the relationship and ultimately maintaining her agency on contraceptive use or non-use is thus revoked as pregnancy is taken for granted as inevitable by her mother. As such, her mother's discovery emplots her as a sexually desiring subject and lacking agency. Once again, a risk together with an adolescence-as-transition discourse, which endows adults with authority to optimise young people's behaviour, e.g., enforce contraceptive usage, is mobilised. This discourse works through the logic that young women do not desire parenthood while they are physically fertile; they remain mentally "too

young" and "unfit" to mother a child. Therefore, they are "children" and "not adults" and ultimately not legitimate mothers (Macleod, 2003). This way, they are vulnerabilised and emplotted as "unknowing" and oblivious to their own risk or danger, while older women are the "knowers" and "experts".

While Sibabalwe acquiesces to the top-down decision and becomes a contraceptive user, Thandokazi, in the extract below, reflects on an unsuccessful attempt at initiating contraceptive use:

Extract 5.40

> **Thandokazi**: By the time I went to get the injection (.). My mother told me to get the injection because I had a boyfriend. Just as I got there… as they were taking tests, I found out that I was already pregnant. *[Town, PBH, X]*

Similar to Sibabalwe, Thandokazi's decision towards contraceptive debut is initiated by her mother, grounded on the presence of a romantic relationship. She is, therefore, emplotted as sexually desiring and an "at risk" or "endangered" subject and henceforth obligated to act against this risk of pregnancy by taking up contraception. While Thandokazi acquiesces to this instruction or imposition, she is denied the contraceptive technology due to a positive pregnancy test taken before the contraceptive provision. These kinds of narratives feed directly into the "risk" discourse, thereby reinforcing coerced contraceptive debut.

3.3 "Coercion because of menstruation"

Several contraceptive users narrated the onset of menarche as the prime reason behind the coerced decision towards contraceptive uptake. "Menarche marks the beginning of the biological capacity to bear children" (Finer & Philbin, 2014, p. e271). As such, the material body was deemed mature; thus, sexual exploration was tacitly considered inevitable by parents. To avoid pregnancy, mothers imposed proactive contraceptive uptake on their daughters. Within the generated micro-narratives, women were arguably "at the mercy of their reproductive biology" (Meyer, 2001, p. 737) as the first menstrual cycle, a biological development was associated with risk. For instance, the following participants said:

Extract 5.41

> **Asive**: With the *petogen*[8], you know when we are growing up /*laughs*/ then when you start getting your periods, they [parents] say go and get the injection so that you don't get pregnant. *[City, PBH, X]*

[8] According to Towriss et al. (2019), petogen is a "generic equivalent to Depo-Provera" (p. 220).

Extract 5.42

> **Siphosethu**: I started after I had started menstruating. I was told that when you start menstruating, you have to go and get the injection. I didn't ask any questions; I did what the elders told me to do. *[Town, PBH, X]*

Extract 5.43

> **Gladys**: I started with *nur-isterate.* I think I was in high school then. I'm just not sure which grade I was doing or standard. *Ja,* I think… immediately after I started my periods, and I guess it is because our parents did not want us to fall pregnant before finishing school. So, my mom, because of something she knew and how she was raised, she said I must go to the clinic and get contraceptives, so they gave me the *nur-isterate*. *[City, PBH, X]*

Extract 5.44

> **Yamkela**: I didn't even know what menstruation was. The whole time I was thinking, I'm so scared. "***Yhu,* what is this**?" Then I showed my mother. My mother said, "No, you must go [to the clinic]". I didn't know why, but I went. I thought to myself, maybe it's because I'm menstruating, that's why I must go, and that's how I went. *[Village, PBH, X]*

In extract 5.41 above, Asive attributes the decision regarding contraceptive uptake to the onset of menstruation, which is implicitly construed as a period of "risk" of childbearing among young women. LARC use thus manages this "risk". An adolescence-as-transition, which implies a continual progression towards maturity – yet not entirely achieved as the subject is still "somewhat a child" – underlies the talk. Participants were implicitly emplotted as physically mature, fertile and possibly sexually desiring subjects, yet also "too young" and "immature" to enact their own decisions or even to know why they needed the injection. In addition, Asive's mother mandates a particular contraceptive measure, injectables. Self-determination is thus denied in terms of consent to use contraception, and the type of contraceptive technology itself is imposed upon young women. In the extract, Asive's utterance, "You know when we are growing up", normalises the story as a common experience all young women face.

The limiting of agency in the decision-making accomplished through the use of an adolescence-as-transition discourse is also evidenced in excerpt 5.42. Siphosethu constructs an account of being steered towards proactive contraceptive uptake by "elders". In so doing, she is "told" and decides not to "ask any questions", thus implying that the incitement by parents\elders to take up contraceptives upon menarche is both unquestionable and indisputable. This works to emplot her as acquiescent, "unknowing", and lacking agency, albeit her parents "know".

Comparably, Gladys marks contraceptive use as initiated "Immediately after I started my period". Advancing an adolescence-as-transition discourse, the decision is premised on her parents' desire to circumvent an unintended pregnancy before school completion, as menarche

supposedly introduces the "threat" of pregnancy. This conveys a sense that motherhood is a disruption to education. In further mobilising the adolescence-as-transition discourse and the passive role in decision-making it affords its subjects, Gladys also says, "So my mom because of something she knew". This emplots adolescents as novices who need guidance from adults who know. Unlike Asive and Siphosethu, whose parents injunct them to seek injectable contraceptives, Gladys is directed simply to access contraception by her mother but offered injectable contraceptives by healthcare providers at the clinic.

In extract 5.44, the risk discourse is more implicit, while the adolescence-as-transition discourse that marks the "natural progression and growth between the child and adult state of being" (Macleod, 1999, p. 144) is overt. For example, when Yamkela alerts her parents to menarche, she is told to "go to the clinic". However, contraceptive debut, sexual intercourse and pregnancy do not feature in the talk, thus masking the "risk" of pregnancy alluded to by Asive and Gladys in excerpts 5.41 and 5.43. The mother's directive gives the impression that menstruation itself needs medical intervention. Her silence on the implication of menstruation, avoided through the non-contextual directive towards contraceptive debut, indicates the tensions around menstruation, sexual activities and motherhood. Like the other participants, Yamkela emplots herself as innocent and unknowing, therefore acquiescing to the decision.

3.4 "Coercion because I was 'out-there/forward'"

Some young women narrated stories about being framed as "out-there" and thus at risk or in danger of male conquests, requiring intervention. I define being out-there or forward as denoting engaging in behaviours and practices deemed indicative of sexual desire – a stray from "good" womanhood (Ndabula et al., 2020). Therefore, these young women are not contained within the domestic space where females must passively (not) perform sexuality but are rather out-there where they can or might express sexual desire, unrestricted or uncontained by guardians. Synonymous with being out-there was an inherent "threat" of pregnancy, one that female guardians used to justify limiting women's agency about LARC uptake. To prevent this constructed risk of pregnancy being, "out-there" or forward was associated with female guardians encouraged LARC uptake. For example, Kuhle, Linda and Babalwa illustrate this in the extracts below:

Extract 5.45

> **Kuhle**: *Sjoe*[9]*,* I started using contraception when I was still staying at home, still a virgin. (*Mhh*) Because I was that forward child. That forward child. I wasn't dating or anything, but I was forward and was always friends with boys. I was friends with boys, so my grandmother thought no. *[Town, PBH, X]*

Extract 5.46

> **Linda**: It's not like I liked boys, but at the time (.) I didn't like them, you see. But there were some boys I used to chat with. So, she thought, "Oh okay, the girl is a bit 'out-there'". So what needs to happen is, you see, I don't want her to fall pregnant while young. You know, even if I did have a boyfriend, I was not sleeping with him. But because I don't talk to my mother about these things people do, she told me to go and get contraceptives. *[Village, PBH, X]*

Extract 5.47

> **Babalwa**: I don't want to lie; being on contraceptives never came to my mind /mhh/. The person who made me start using contraceptives was my mother. She saw my forwardness and suspected something. But I hadn't started doing anything. I started using contraceptives when I was 18 years old and then decided to continue with my mother's ways. But in the end, I have seen that it is good for me. It will protect me from many things, like pregnancy but mostly against infections. *[Town, PBH, X]*

In extract 5.45, Kuhle identifies the coerced contraceptive uptake as a misinterpretation of her lively demeanour and friendships with boys. This is characterised as evidence of sexual desire, sexual debut and thus "risk", which she resists in her storytelling, despite accepting the externally mandated contraceptive debut. However, no space is allowed for her to dispute the decision within the talk, even though she emplots herself as a virgin and as having formed friendships with boys and not sexual relationships. Similarly, Linda's reflection in extract 5.46 begins with a confessional account on the "innocence" of her encounters with boys when she says, "It's not like I liked boys, but at the time… I didn't like them, you see. But there were some boys I used to chat with". A risk discourse is thus deployed, rendering liking and interacting with boys as introducing a heightened likelihood of unprotected sexual intercourse with them and the resultant "risk" of pregnancy regardless of Kuhle's and Linda's descriptions of their relationships with boys as platonic. These relations with boys thus erode both participants' ability to perform sexual "innocence" and "purity" and, by implication, the ability to refuse contraceptive use.

Implicit within these micro-narratives is the concomitant use of a male sexual drive discourse that "sees men as sexually insatiable" (Hollway, 1984, p. 63) and a traditional femininity discourse. These are opposing gendered discourses that emplot men as "sexual predators" and

[9] An Afrikaans expression used to convey surprise, relief or exhaustion.

adolescent women as “prey” and “sexually non-desiring” subjects. An inability to challenge this narrow definition of men/women relations is implicitly referenced, particularly because of the absence of sex talk in Linda’s mother/daughter and Kuhle’s grandmother/granddaughter relationship. In addition, this silence also presents a barrier to collaboratively negotiating use/non-use of contraceptives since the capacity to prove one’s sexual “innocence” through a frank discussion is restricted within the configurations of these relationships. Non-shared decision-making is thus maintained by this absence of sex talk. At the same time, sustained friendships with males and the possibilities of sexual exploration are implicitly considered appropriate or palatable to parents when preceded by contraceptive usage, which suggests that female sexual desire is regulated but not denied.

These young women are not alone. Abeyasekera and Marecek (2019) point out that, in adolescence,

> indeed, daughters typically experience more restrictions on their movements, more monitoring of their companions, greater enforcement of segregation from males, and a narrower range of acceptable activities than they had experienced prior to menarche. This is in contrast to boys for whom advancing maturity leads to loosened strictures (p. 161).

Transgressing these strictures or engagement in what was rendered as suspicious behaviour was used to emplot the adolescent women as culpable for the parent-driven decision-making and thus bolstered the reduced equity or non-shared decision-making in contraceptive debut.

A similar account can be seen in extract 5.47 whereby, in constructing the onset of her contraceptive journey, Babalwa posits that prior to being incited by her mother to use them, contraceptives were not yet a consideration for her. This suggests a recognition that contraceptives are meant to be contemplated and ultimately decided upon by the potential user. Nevertheless, the opportunity is denied as behaviours that are in contrast with a traditional, passive subject were used as evidence of sexual desire and exploration. In this case, “my forwardness” like in the above micro-narratives, arouses suspicion about sexual debut and consequently prompts the onset of contraceptive use. A traditional femininity discourse that associates “good” womanhood with “passiveness” and “subservience” is implicitly invoked here, one that being “forward” disregards.

Babalwa accepts her mother’s decision, albeit she “hadn’t started doing anything”. Therefore, as by now established, contraceptive uptake is not always an individual decision; it sometimes requires its users to act in accordance with others’ needs even when being this ideal

contraceptive using subject is not who these participants desire to be. Babalwa, however, also maintains that there is futility in questioning one's mother's motives; rather, continuing with "mom's ways" is wise. As such, towards the end of the extract, her mother's proactive involvement in her contraceptive debut is construed as beneficial considering the later onset of sexual activity and desire to avoid unwanted pregnancies. Intergenerational power dynamics are evidenced within the micro-narrative as mothers are emplotted as "knowers" and decision-makers. In contrast, young women must be subservient recipients of decisions and choices enacted over their bodies, which they can, in time, learn to find value in and accept.

In the extract below, Babalwa uses the intergenerational gap found within this relationship to construct sex talk as unviable and to further shore up the unilateral decision-making inherent in some mother-daughter relationships as inescapable given the strictures around appropriate and inappropriate discussions in mother-daughter relationships.

Extract 5.48

> **Babalwa** [town]: She should have asked me first if this outgoing nature of yours, do you use condoms and all that stuff? Do you have a boyfriend? Maybe that's what she should ask me */mhh/* so that's another thing I would say, but you wouldn't talk about things like that with your mother. *[Town, PBH, X]*

Upon further reflection on her obfuscated agency in decisions around contraceptive debut, Babalwa reports on a missing, though significant, conversation that should have preceded the decision. In so doing, she challenges the mobilisation of the risk discourse and its resultant "at risk" emplotment conferred upon her by calling for a closer investigation into the behaviour associated with sexual debut by her mother. In so doing, questions such as "Do you use condoms and all that stuff? Do you have a boyfriend?" are presented as much better prompts for risk calculation and decision-making. The desire to assert one's agency in the encounter is suggested by posing these questions in the interview setting. However, the constructed silence about sexuality within their mother-daughter relationship reportedly hinders the ability to articulate one's preferences. Hence, Babalwa later explicitly negates the possibilities of such supportive conversations that can encourage openness and limit directive contraceptive debut through the utterance ("you wouldn't talk about things like that with your mother"). She, thereby, closes the opportunity for dialogue and active decision-making. Implicit within this is an assumption that an attempt to collaborate in one's decisions regarding sexuality and reproduction is inherently "wrong". As such, agency must be taken up in indirect ways rather than direct ways: ways that are not forthright but passive and discreet.

4. "The decision was shared"

The data show that some contraceptive users were willing to share decisions around contraceptive usage. As such, these decisions were enacted consultatively, unlike within the previous emplotments where agency solely belonged to the health users or their female guardian. Within this micro-narrative, participants cited accounts of including their sexual partners in contraceptive responsibility or their female guardians in their contraceptive decisions. For example, as shown below, women's personal decisions to use birth control could be renegotiated in intimate partnerships by mobilising medical discourses to render the technologies medically contra-indicated. This prompted changes in contraceptive responsibility or the masculinisation of contraceptive responsibility whereby male-centred contraceptive measures such as vasectomies emerged as suitable contraceptive options. Some mothers were, in parent-child relationships, cited as dialogically negotiating LARC uptake with their daughters. That is, these female guardians were reportedly, open to inputs from health users about the decision rather than issuing closed-off directives to young women.

4.1 "We both wanted contraception"

The description of less one-sided accounts of decision-making is depicted here. In contradistinction to the decisions enacted alone, secretly or coercively seen in previous sections, these decisions are made within partnerships. Participants thus did not neglect to inform their sexual partners about contraceptive uptake. Hence, the decision can be understood as a shared decision, with which contraceptive users often sought positive personal gains. Colleen and Thabisa's micro-narratives around continued contraceptive responsibility within their partnerships and possibilities of method-switching after using the IUD are reflected in the extracts below:

Extract 5.49

> **Colleen**: Not getting my period is one of the biggest [motivators], and secondly that my husband, he would never admit it, but he is a little scared of going for a vasectomy. I think it's a male thing; maybe, I don't know. I have no idea. So, at the moment, even if he had a vasectomy done, I would still keep the Mirena *ja,* so that's all /*laughs*/. [City, PVH, E]

Extract 5.50

> **Thabisa**: No, we are happy with the two kids we have, but it's just that I think I want him to; we both want the vasectomy because I really cannot put myself through that again, you know. I've had two operations, and I still suffer from backaches, so I don't want to. I really (.) I'm really not eager to try for a third one. *[Town, PVH, X/E]*

Colleen speaks of amenorrhea as a side effect that absolved her husband from the possible

obligation to undergo a vasectomy, despite his openness to the procedure. Yet, Colleen advances a medical discourse, which binds reasoning within scientific knowledge thereby considering it neutral, apolitical, and unconfounded by culture (Lupton, 2012). She does so to express satisfaction with assuming the contraceptive load within her relationship and thus renders shifting contraceptive responsibility unnecessary. This suggests that contraceptive usage can extend beyond the chosen LARC method's birth control benefits, thereby nuancing LARC usage as not always a response to males who avoid sharing the contraceptive load.

At the same time, Colleen frames the vasectomy as unacceptable. To do this, she characterises it as an invasive and painful contraceptive option for males that her husband is ("a little scared of") even though he is emplotted as willing to undergo the procedure. She later emplots all men as fearful of vasectomies through the utterance, "It's a male thing". This undermines vasectomies as a viable male-centred contraceptive option, nullifying the opportunity for male contraceptive responsibility or the masculinisation of birth control. The participant entrenches her decision towards the end of the excerpt by expressing contentment and a likelihood for continued use of the *Mirena* despite her husband's potential vasectomy. That is, Colleen accepts that her husband may or may not have a vasectomy. Importantly, though, extract 5.49 suggests that the participant and her husband spoke about contraception and the possibility of his taking responsibility beyond condom use, thus pointing to shared decision-making.

Thabisa's narrative evidences another instance of the negotiation required to reach the shared decision of shifting contraceptive duty in heterosexual relationships. First, she draws on a medical discourse to problematise the side effects she experienced using the IUD and, in the broader text, further expresses the desire to remove it. Secondly, Thabisa frames the embodied experiences related to childbirth as having manifested chronic back pain, thus forestalling the option for a third child. As a result, a joint decision to shift contraceptive responsibility within the relationship is reached through the consideration of a vasectomy to limit childbearing. This shifting of contraceptive responsibility is achieved through the preamble about side effects and chronic back pain. This way, the contraceptive non-use is construed as a form of self-care, rather than an "irresponsible" decision given her inability to continue emplotting herself as the self-disciplined contraceptive user.

Thabisa later complicates the shared nature of this decision by asserting that "I think I want him to [get a vasectomy]". Herein, she resists the feminisation of contraception by imposing

the contraceptive duty on her husband emplotting herself as the active decision-maker and muting her husband. She, however, later refigures her account of non-shared decision-making to a "oneness in talk" (Dixon & Wetherell, 2004, p. 176) through the utterance, "We both want the vasectomy because I really cannot put myself through that again, you know". This way, her husband dialogically chooses the vasectomy instead of agreeing to it. This suggests that non-use, albeit rendered an individual choice, requires much explanation and rationalisation to be deemed feasible and responsible for women. Extract 5.49 emplots Colleen as a "satisfied LARC user" and her husband as a supportive, willing, yet fearful contraceptive user. Conversely, Thabisa is a supported but unsatisfied LARC user, while her husband is a supportive and willing contraceptive user in extract 5.50.

4.2 "My mother and I spoke"

Contraceptive uptake could also be negotiated in collaborative ways within parent-child relationships for some participants. The extract below illustrates this:

Extract 5.51

> **Zinzi**: She's the one who advised me that when I get this one removed, I must get another. My mother is like a mentor to me because every time we sit and chat, either about things around the house or my future. Sometimes she tells me about her experiences growing up. So, she told me she recognises the step I took towards getting an implant, and she knows it can make you sick and so on. "When you notice something wrong, call me so I can send you money to go to the doctor so that you remove this one and insert another one". *[City, PBH, X]*

Zinzi's account evidences a more open, dialogic, and supportive relationship than previous extracts. This is because a conversation opens up a discussion of contraceptive uptake, and it includes self-disclosure about her mother's experiences as well. Therefore, her mother does not claim mastery over Zinzi's body. Instead, she uses her own life experiences as prompts for dialogues about sexual and reproductive health. This micro-narrative thus emplots a mentorship discourse, in which the mentee is not coerced into a particular action, but rather guided through dialogue and the disclosure of the mentor's experiences. To do this, the mother affirms Zinzi's personal decision to take up contraceptives and further creates space for engagement and continued contraceptive use. In addition, Zinzi's mother responsibilises herself for supporting Zinzi by providing financial assistance for method-switching, if needed. As such, Zinzi is, through a mutual responsibilisation discourse, injuncted to be unrelenting in some sort of contraceptive uptake. The shared nature of the decision-making is visibilised by the implicit promise to keep the communication lines open and continue using contraception. The talk emplots her mother as supportive and Zinzi as a supported LARC user.

Despite many participants reporting being placed under pressure and an absence of sex talk or dialogue about contraceptive uptake, Esihle and Thabisa's decisions were parent-driven but dialogical and not forceful. See below:

Extract 5.52

> **Esihle**: She said we won't tell her when we are ready [to engage in sexual intercourse], so she is asking me to go then. *[Town, PBH, X]*

Extract 5.53

> **Thabisa**: I think it's because she got pregnant at a very young age, so she was scared that I would fall into the same routine, trap or something. I don't know what to call it. Then she was scared I would follow in her footsteps and fall pregnant at a very young age. So, I thought because I wanted to make my mother happy, then I started, but not that I was sexually active at the time, I wasn't. *[Town, PBH, X/E]*

In the above are pre-emptive accounts about contraceptive uptake that implicitly consider the exact moment of contraceptive need as unknown. Hence, mothers negotiate contraceptive debut to meet the spontaneity of sexual debut and its inherent "threat" of pregnancy. Mobilising a risk discourse, Esihle's mother reportedly points to her own inevitable exclusion from knowledge of Esihle's sexual debut by virtue of being her mother, and hence she (the mother) renders proactive contraceptive provision suitable. This utterance does two things; firstly, it normalises young women's sexual behaviour as illicit; secondly, despite little opportunity for negotiation in the text, Esihle's mother is construed as asking/requesting her to access LARC measures, thereby introducing the chance for non-use. Thabisa also evidences a negotiated debut premised on her mother's experiences of early childbearing. These micro-narratives indicate less angst and ambivalence about decision-making despite both participants being emplotted as at "risk" of pregnancy. What is also implied is that contraceptive uptake is certainly not always an individual choice as some mothers, insofar as guiding the process, do play a central role in contraceptive debut without the use of sovereign power.

5. I decided against contraception because of the stigma

The participant in the extract below reflects upon an active decision to avoid contraceptive debut altogether:

Extract 5.54

> **Siyasanga**: I don't want to lie, my dear, because (.) Yes, I did experience that [curiosity about contraception], but because I live with my mother. I live with my mother and my little brother. So yes, we were there, and there were many of us when I was still at school. So, I live with my grandmother and a thingy used to come, a mobile clinic with nurses used to come to our village since we don't have a clinic. So, they used to arrive at this other house close to my home. It's not

> too close, but it's also not that much of a distance, so it [mobile clinic] used to be stationed there. I don't know (.) my mother used to like going there because the people who live there are related to my family. [Speaks in the third person] Now Siyasanga is embarrassed because people stand in queues there. There are people who are sick there, and then there are people who are there for the injection, so it was like that. So now I was asking myself if I stand in that queue, people at home don't know about this [sexual practices]. If I stand there, they will ask, "What's up now?" Why am I getting contraceptives? Do you see what I mean? So, I decided not to. So, I didn't do those things, and I decided to give up rather. *[Village, PBH, X]*

Sexual exploration for young women can often be illicit and so practised on the fringes to avoid parental oversight (Ndabula et al., 2020). Yet, seeking contraceptives can be framed as a "public admission of sexual activity" (Wood & Jewkes, 2006, p. 113). In line with this, Siyasanga, in the above extract, premises the decision to abstain from sexual exploration and, by implication, contraceptive use on the possibilities of being discovered as a contraceptive user by her family and community, conceivably through queuing at the primary health mobile clinic. This invokes a traditional femininity discourse as gendered expectations and socially produced meanings about the repression and restriction of female sexuality are alluded to by the participant. She thus frames parental oversight, particularly in the absence of youth-friendly reproductive health centres as contraceptive services are offered in primary health centres in her village, as embarrassing. This not only emplots her as "sexually innocent", but it also constrains her option of contraceptive uptake as associating with the facility "would mean that she is having sex, which is constructed as transgressing parental rules rather than, say, being responsible" (Harden & Willig, 1998, p. 436-437). To resolve these tensions about sexual curiosity and contravening parental rules, Siyasanga actively decides to abstain from sexual exploration and consequently distances herself from contraceptive use. This evidences the ways in which relational contexts interweave with personal decisions.

6. Conclusion

The analysis shows that the decision to take up contraceptives was, at times, an active, individual one reportedly enacted by some participants without direct influence from other relational contexts. Through a choice and self-responsibilisation discourse, healthcare providers reportedly assumed neutral emplotments towards contraceptive users' needs while the health users used their desired technologies and took up agentic and rational being emplotments during contraceptive counselling. However, as social beings embedded in a myriad of contexts that exert influence on their reproductive decisions, women's individual choices and the freedom to decide about contraceptive (non)use was replete with the

sociocultural meanings that facilitate and limit what is possible in the contexts in which they are nested. For example, participants who self-responsibilised themselves towards contraceptive usage could also enact a choice discourse within constraining conditions where healthcare provider biases denied them fully informed consent.

The individualisation of decisions was also achieved through secret use of contraceptives in intimate-partnerships. This way, young women were able to child space or remain child-free in the event of condom sabotage and the inability to insist on condom use. Through the emplotment of a planning parenthood discourse, self-responsibilisation or a "my body my choice" discourse, participants were able to respond clandestinely to their partners' desires for childbearing expressed through a pronatalist discourse. Secret use of LARC was also used to conscript men towards condom use to avoid STIs and to prevent blame for infertility. These contraceptive users assumed emplotments of rationality, sexual responsibility and agency while their sexual partners were emplotted as ignorant. In parent-child relationships, a traditional young femininity performance discourse was used by health users to affirm the concealing of contraceptive debut in both sexually permissive and restrictive mother-daughter relationships to self-emplot as sexually innocent and their parents as unknowing.

LARC technologies were construed as having utility for their users. As such, positive advantages were identified as enabling the personal decision to use LARC. A self-responsibilisation discourse, emplotted alongside other discourses, was the common thread throughout this micro-narrative. For example, through a planning parenthood discourse, basic education, higher education or even marriage could be attained while restricting childbearing before the achievement of these societally desirable goals. At the root of this restriction was the idea that improved financial well-being brought upon by school completion or marriage before childbearing offers women better reproductive outcomes, thus opening women who do not meet these "criteria" up to policing. These participants emplotted themselves as rational and responsible subjects. Failure to "plan" was inextricably linked to reduced mental well-being caused by mistimed pregnancies; hence, the use of a psychological discourse where LARC use emplotted the women as at ease and free of the "risk" of pregnancy upon LARC use. Decisions towards LARC usage also allowed women access to sexual pleasure, whereby forgetting or discontinuing condom use was enabled through a permissive sexuality discourse. Yet, the risk and have/hold discourses also presented tensions in women's ability to uphold these framings. Through mobilising medical discourse, the personal decision towards

contraceptive use was also medicalised by some participants as regulating menstrual flow and offering cosmetic benefits aimed at bettering women's appearances. A common thread contained within personal decisions to use contraception was the implicit reference to pregnancy as "risk", "threat" or "danger" to be avoided. Hence, I conclude that the individualisation of contraception through the reference to risk and danger bestows all harms of contraceptive non-use upon the health users.

When the decision towards contraceptive use was framed as an external one, parents, particularly mothers, were cited as the decision-makers who coerced women in their present or younger years towards the adoption of LARC. Although parents, through risk discourses, identified the threat of pregnancy among the young women, the contraceptive users identified themselves as not needing the prescribed LARC technologies. Despite this, behaviours such as forming romantic or platonic friendships with males and recurrent patterns of returning home late at night during adolescence were identified as warranting intervention through coerced contraceptive provision. The legitimacy of these markers of "risk" is made questionable by the participants' assumed sexual innocence emplotments. In their own defence, participants often emplotted themselves as "chaste" or "sexually innocent" suggesting sexual inactivity. As such, contraceptive uptake while sexually inactive was rendered non-beneficial. Hence, some participants recited stories about clandestinely resisting contraceptive uptake by falsely pretending to have taken up the sexual advice and initiated uptake of LARC measures through a "my body my choice" discourse. However, other participants were escorted to the health facilities by their guardians to provide support or ensure that contraceptive uptake was initiated, whereas others showed no resistance to this reduced agency. A developmental discourse, in particular the adolescence-as-transition discourse was used to render early pregnancy and education as mutually exclusive. Beyond their individual sexual practices, menarche was used by female guardians to encourage proactive contraceptive provision. When used alongside a risk discourse, the adolescence-as-transition discourse warranted the young women's restricted agency in decision-making as these contraceptive users were framed as in relationships with boys and out-there. Transgressions of "good womanhood" could be claimed where not only were participants considered "too young" or immature to parent, they were implicitly construed as "too young" to understand this "risk" related to their behaviours. As such, agency was revoked. An overarching "damage" argument was made for externally mandated decisions.

Contraceptive uptake was emplotted as a shared decision by some participants. Here, contraceptive duty was negotiated collaboratively with sexual partners through a medical discourse where usage was affirmed or refused using “real” physical effects. Shared decisions also followed discussions in mother-daughter relationships. Here, responsibilisation discourses were used to initiate contraceptive use but more dialogical approaches were used to negotiate LARC uptake. In contrast to the contextless, coercive decision-making found in parental unilateral decision-making, parents, among these contraceptive users, cited their own unintended pregnancies or those happening in society to frame their requests (which the young women could resist). They emplotted themselves as supported and their mothers as supportive.

The data suggest the use of a traditional femininity discourse to tell stories about decisions to not use contraception. In this talk, buildings and other signifiers such as clinics and mobile clinics that offered contraception were deemed as markers of sexual exploration for young adolescent women. As a result, being seen by elders accessing these services was rendered as a scourge on their ability to take up subject positions of ‘sexual innocence’ thus resulting in abstinence and non-use.

Chapter 6: Alliances and the provision of LARC use at all cost

1. Introduction

Clinical decision-making is a central component of contraceptive usage. Decisions made within the clinic space result from relationships formed between medical experts and health users (Saunders, 2018). Health users enact contraceptive decisions not solely and wholly in silos but within relationships. This chapter explores healthcare providers' constructions of the decision to use LARC technologies alongside the discursive emplotments within narratives such talk avails and restricts. Two overarching micro-narratives inform the analysis: stories of users seeking contraception and stories of provision. I begin with stories of seeking. Here, descriptions of the contexts within which contraceptive users' decisions to access contraceptives were made or resisted as outlined within information counselling interactions are explored. Later sections detail healthcare providers' ways of responding to contraceptive users' decisions to use or not use contraception and their modus operandi of negotiating the kind of contraceptive counselling they deem the most supportive to their health users in stories of provision.

2. Stories of contraceptive seeking

This section is concerned with micro-narratives used to construct users seeking to use contraceptives. As such, the sampled health practitioners provide the contexts in which women arrive within the healthcare centres or the circumstances that led them to seek contraception. It will increasingly become evident that potential users at health facilities are not always people who want contraceptives. They sometimes do not want them but are pushed towards them by significant others or dissuaded from usage but seek these LARC technologies despite their disapproving contexts. As such, the stories of people who enacted the decision alone, those who played a primary role, and those whose roles were muted are referenced within the talk. In response, healthcare providers either helped the contraceptive seekers or helped the contraceptive users' significant others by honouring the request for contraception.

2.1 "She hides contraceptives/clinic visits"

The data show that some healthcare providers endorsed the secret use of contraceptives in constructing certain women's contraceptive journeys. This micro-narrative constructed the uptake of birth control as, occasionally, women's ways of secretly resisting involuntary reproduction to shore up their male sexual partners' desire for parenthood. This is shown in

extracts 7.1, 7.2 and 7.3 below, which are responses to a question about whether the healthcare providers have encountered contraceptive users who reported on contraceptive uptake as suggestions or decisions made by their sexual partners:

Extract 6.1

> **Sr Phindi:** I once came across, I once came across, there was one lady with five children, and she used to hide her clinic card. She said the man didn't want her to be on contraceptives; already, she has five kids, right? So now she was saying she had to sneak out to come to the clinic, such that she even used to hide her clinic card. That's the kind of problem she had. Can you see she has five kids, and the man still wanted more? *[City, PHC, X]*

Extract 6.2

> **Sr Thandiswa**: I have never heard of such a thing [shared decision-making around contraceptives]. What they do say, though, is that "My boyfriend said I must not come and get the injection because he wants to have a child". For example, when you are asking, "Wow, you're going for three whole months without coming to get the injection, what's happening?" Then they say, "No, my boyfriend says he wants a child". *[Town, PHC, X]*

Extract 6.3

> **Brother Zukisani**: You do find, you do find secrets in thingies in affairs [relationships] because the man is desperate for a baby and you don't want, so you tip-toe and get contraceptives and then remain quiet about it. The man is busy trying [for a baby] here. *[Town, PHC, X]*

Sr Phindi, Sr Thandiswa and Brother Zukisani's responses about male involvement in the contraceptive counselling centre around the secret use of contraceptives where not only are men excluded from decision-making, but users must hide the trace of contraceptive use. The differing childbearing desires within intimate relationships described as "The man wants more", "My boyfriend says he wants a child", and "the man is busy trying", reportedly compel the health users to avoid openly discussing their reproductive desires and to become and remain active contraceptive users, albeit secretly, to resist motherhood.

In making a case for sexual partners who discourage rather than encourage LARC usage, Sr Phindi, in extract 6.1, reconstructs an encounter with a woman who secretly takes up contraceptives and places her clinic card out of sight to avoid further births. This way, failure to conceive is implicitly attributed to biological reasons, including the man's (in)fertility, rather than her covert LARC uptake. A planning parenthood discourse undergirds the talk whereby having five children is viewed as enough or "too much", thus requiring the subject to stop childbearing through reliable contraceptive technologies. In contrast, the man's desire for more children is seen as unreasonable, and the woman's actions in light of her husband's opposition as rational. In not questioning the need to hide the card, Sr Phindi acknowledges patriarchal

relationships in which overt resistance is either impossible or not wise. Implicit in this construction is the possibility of violence. This is articulated in Gqola's (2015) notion of the female fear factory, which identifies women as weaker than men and, therefore, safe to violate. In so doing, Sr Phindi emplots the health user as a mother of five children and a secret contraceptive user. In turn, she emplots herself as the keeper of contraceptive secrets, as supportive and an ally in women's resistance against unreasonable pronatalism. She also injuncts me to express sympathy and recruits me to this allyship by repeatedly asking me, "Can you see she has five kids?" towards the end of the excerpt. The strength of a planning parenthood discourse is in its emplotments of reproductive beings as either performing reproduction "well" or having "violated the norm" and the obligation to regulate further births when "relevant". This is evidenced by Sr Phindi's confidence that the health user in extract 6.1 needs help.

In excerpt 6.2, Sr Thandiswa also undermines the notion of male involvement in contraceptive uptake by stating, "I have never heard of such a thing". As a counterpoint, she also cites encounters with women who report being dissuaded by their sexual partners from contraceptive usage. In such cases, circumventing childbearing was also achievable purely through secret contraceptive uptake rather than open, dialogical conversations about one's reproductive desires. Therefore, a planning parenthood discourse operates alongside a pronatalist one within this secrecy as their male sexual partners desire parenthood, which implies an injunction for the health users to discontinue birth control use. To fulfil their own desire, LARC users discreetly ignored this request but complied poorly with their contraceptive regimens. This demonstrates how "the right to choose not to procreate" (Meyer, 2001, p. 736) is tainted, producing, instead, the silent jostling of the couple's reproductive preferences.

Similarly, in extract 6.3, women's concealment of their fertility decisions is construed as not an uncommon occurrence by Brother Zukisani. To evidence this, he juxtaposes the presence of a man "desperate for a baby" and a woman who avoids explicitly refusing childbearing, thus deciding to "tip-toe" and seek contraceptives to resist this pronatalist discourse. Implicit in the narrative is a woman's duty to break the silence by communicating her desires to remain child-free to avoid his futile attempts at conception to "the man". By emplotting contraceptives using patients as sometimes secretive and men as victims of circumstance, women's silent resistances to reproduction are rendered as not challenging patriarchal dominance and inequality but as women's refusal of their duty to childbearing and a mockery of men's fertility and will to

fatherhood. Both Sr Thandiswa and Brother Zukisani are emplotted as by standing witnesses to contraceptive secrets.

Resistance against pronatalism, as seen in the previous micro-narratives, is also reported in the following micro-narratives. However, unlike the earlier excerpts, reasons for opposing LARC usage are proposed. Cultural myths, race, nationality and religion are emplotted along with a male sexual drive discourse in describing male desire for LARC non-use. See below:

Extract 6.4

> **Sr Mesani**: No, they never mention it [partner influence in taking up contraceptives] instead they say when you ask them why you didn't come last time, and they say, "No, I don't want my boyfriend to know that I'm using family planning".
> **YN**: Why, Sister? Why do you think so?
> **Sr Mesani**: Why? I ask them why, and they don't know. It's because they, you know, some other men have got the myth that when you are using family planning, especially those who have already have children, they are going to have a loss of libido. Like, in isiXhosa, they [men] say *bayabanda*[10], they are cold [not sexually desiring]; they are not as hot [sexually desiring] as they used to be when they are using family planning. They have got that myth. With the Coloureds, they [men] always say, "No, we want more kids, so don't use family planning, so don't inject". *[Town, PHC, X]*

Extract 6.5

> **Sr Nozibele**: I usually notice those who come to the clinic and actually hide that they have are the Somalians, Muslims who have local partners.
> **YN:** Oh, international [partner], okay.
> **Sr Nozibele**: So, they are against family planning in those countries, and the lady will be South African. They know that they don't want another baby because you already have….so they do it on the side /Oh, interesting/. They can get it inserted so that the foreign partner doesn't know, /mhh/ I don't know whether they are Muslims or what, but they are from Somalia, and what's this other place? So, they do not believe in contraceptives, and so their partners have to follow that as well, but if they date a South African, the lady just does it secretly. *[Town, PHC, X]*

In extract 6.4, Sr Mesani begins by constructing male involvement in contraceptive uptake as an uncommon occurrence; male partners, instead, can dissuade use, thus affirming Sr Thandiswa's talk in excerpt 6.2. In the face of this resistance, contraceptive users reportedly missed contraceptive appointments or became inconsistent contraceptive-using subjects. However, Sr Mesani complicates this by basing the conditions in which healthcare providers respond to women's secret requests for contraception on racial lines. In making racial delineations, Black and Xhosa men are described as dissuading use in parous women due to a reportedly observed suppression of libido triggered by LARC in its users. These narratives

[10] The term denotes a reduced sexual libido caused by LARC usage.

avail a male sexual drive discourse for amaXhosa men in which they are emplotted as desiring sexual subjects, whereas LARC users lack a sexual drive. In contrast, a pronatalist discourse is availed for Coloured men who reportedly discourage LARC use for multiparity.

In excerpt 6.4, Sr Mesani's use of a pronatalist discourse to describe Coloured men as valuing multiparity is first framed as a shared decision: "We want more kids". However, towards the end of the extract, this supposed "shared" desire for more children is denied through the secret use of contraception. This is suggestive of ways health users and their partners present contradictory instructions during contraceptive counselling and the adjustments healthcare providers must make to ensure they serve the interests of their service users. This also highlights how this clandestine usage of LARC maintains the muting of decisions to opt for fewer children or childlessness when childbearing is valorised in this way.

Similarly, in extract 6.5, Sr Nozibele identifies secret contraceptive use in interfaith and cross-national partnerships, where non-Muslim South African women access LARC technologies secretly to uphold their desire to discontinue childbearing without overtly challenging their partner's constructed beliefs about contraceptive use. A religious discourse, which can operate the same as a pronatalist discourse in its encouragement of births, is used to "cast reproduction as a Goldy mandate" (Morison, 2011, p. 188) - God, in this case, refers to Allah. Within a religious discourse, contraceptive use obstructs God's or Allah's plan. However, according to Sr Nozibele, LARC technologies' invisible nature allows health users to "plan" differently by secretly regulating births rather than piously giving their bodies to reproduction. This emplots the women as active, secret contraceptive users while emplotting their partners as seeking parenthood yet "not knowing" that their requests have been denied.

Inherent within the above extracts are gendered power differentials that can manifest in heterosexual couple relations, which are referenced when healthcare providers assert, "the man didn't want her to be on contraceptives" and "but the man still wanted more". The narrators, therefore, advance a pronatalist discourse to constitute the male subject's authority in the desire for multiparity as significant and, by implication, obligate female partners to avoid contraceptive use. As a result, the contraceptive-seeking woman's reproductive agency or the wherewithal to overtly refuse childbearing is construed as limited or taken for granted as impossible. Yet, the planning parenthood discourse that takes advantage of LARC technologies' invisible nature recurrently allows women to choose differently for themselves.

Therefore, affirming that "women have […] eluded husband's demands, and bargained with healthcare providers in order to protect their physical health and regulate reproduction in ways that suit them" (Takeshita, 2015, p. 1).

While the woman's unwillingness to bear children is at the root of the above micro-narratives whereby partners forbid or dissuade contraceptive use, there is also enthusiasm to provide contraception among healthcare providers. As such, they emplotted themselves as empowering health users or "an ally of a woman's quest for reproductive self-determination" (Takeshita, 2015, p. 1) within the present micro-narratives. Healthcare providers' will or commitment to consistently provide LARC technologies, even in precarious or coercive conditions, becomes increasingly apparent in later sections, particularly in the contraceptive counselling of contraceptive users deemed "at risk".

2.2 "Men are not involved"

Many health providers interviewed in this study construed the decision to use contraceptives as often not involving males. That is, the obligation to access contraception and uphold contraceptive responsibility in the long term was depicted as feminised and further personalised by the health users as an individual decision that did not concern males. Men were, in this way, tacitly not considered long-acting contraceptive users in their own right and thus expected to play a subordinate, secondary role in contraceptive decision-making, particularly in unmarried couples. See responses below, which were elicited to a question that probes whether males are involved in the decision to seek LARC measures:

Extract 6.6

> **Sr Phiwe**: Gosh! No, I haven't had a case like that. No, I have never had a case where someone says their boyfriend encouraged them to [seek contraceptives]. *[City, PHC, X]*

Extract 6.7

> **Sr Beja**: No, I haven't had a case like that. *[Village, PHC, X]*

Extract 6.8

> **Sr Nosipho**: The partner? Uhmm, no, no. *[Town, PHC, X]*

Extract 6.9

> **Dr Fiona**: Interestingly, not a lot. *[Town, PP, E]*

In extracts 6.6, 6.7, 6.8 and 6.9, the healthcare providers negate the construction of male sexual partners as involved or instrumental in LARC uptake. This way, LARC users are emplotted as present and males as absent or, at the very least, muted. Thus, men's reproductive preferences are scarcely mentioned in contraceptive counselling, which indicates a responsibilisation discourse where LARC use is a female issue and, thus, non-relational. This imposition, by implication, also personalises the care work related to childbearing.

In the extract that follows, Sr Thenjiwe provides more information about this absence in contraceptive uptake:

Extract 6.10

> **Sr Thenjiwe**: Contraception is a woman's responsibility; otherwise, I don't think men think there is a need. It really just depends on you as a female. What do you want? *[Town, PHC, X]*

Much like the responses in the previous extracts, Sr Thenjiwe reifies the notion that men are not "significant actors in fertility and contraceptive decisions" (Fennell, 2011, p. 498). In so doing, she advances a responsibilisation discourse that expects women to forge and maintain reproductive well-being. In turn, these women are afforded emplotments of responsibility and vigilance while men are emplotted as non-compliant and irresponsible by the talk elicited by Sr Thenjiwe.

The elicited talk also assumes that males are not invested in preventing pregnancy when she posits, "I don't think men think there is a need". This signals the operation of the male reproductive pardoning discourse, where a lack of reflection and thought about contraception and, by implication, parenthood is assumed as natural for males (and therefore pardoned) yet centralised as significant for females. As such, males are an "absent presence" (Lowe, 2005, p. 76) in reproductive responsibility within the male reproductive pardoning discourse. This discourse is interlinked with the male sexual drive discourse, where male and female sexual preferences supposedly oppose each other, with men emplotted as active, hypersexual subjects and women as passive recipients of sex. In response to these "biological" drives, women are expected to resemble the "coldly rational, shrewdly calculating, adult [White] male" (Meyer, 2001, p. 739) in circumventing childbearing in a way that is unduplicable in other areas of their lives. In tasking women with the gatekeeper role to men's "irrational" and "biological responses" to sex, men are pardoned for reproductive outcomes, while full culpability or blame is placed squarely on women. Therefore, to assume a responsible sexual emplotment that is

reflective, rational and in the know of what they want, women are impelled to be disciplined, contraceptive-using subjects.

While many healthcare providers consistently constructed men as outsiders to reproductive decisions during contraceptive counselling, other healthcare providers were reticent in actively dismissing the role of sexual partners in decision-making. See below:

Extract 6.11

> **Dr Lynn**: I don't recall any women requesting LARC because their partners thought it was a good idea. /mhh/ They may have kept that to themselves /okay/ I've had women who definitely her and her partner decided they didn't want to fall pregnant, and that's why she's here for long-acting but not specifically the partner suggested it. *[City, PH, E]*

In extract 6.11, Dr Lynn suggests that women may have active decision-making partners who play a direct role in the contraceptive regimen used but possibly do not disclose this information in counselling. As such, she emplots men as muted and women as active decision-makers. Instead, what is understood as a joint decision in heterosexual relationships are decisions against pregnancy that then, through a responsibilisation discourse, obligate women to manage fertility by accessing LARC technologies. Implied in this is that decision-making about the specific contraceptive technology is unimportant as a topic of discussion as the women will determine this for the couple, which points to an implicit male reproductive pardoning discourse. The assumption, however, compromises the possibilities for shared stakes around contraceptive usage.

In extracts 6.12 and 6.13 below, Dr Austin and Brother Zukisani elicit failed attempts at masculinising contraception as they speak in contradictory ways about male involvement in contraceptive uptake. These healthcare providers rendered males as simultaneously present and active in the decision-making but also absent and deferring. When asked about contraceptive users who mention their partners' suggestions and preferences in contraceptive counselling, Dr Austin and Brother Zukisani provided the following responses:

Extract 6.12

> **Dr Austin**: *Ja,* we've had quite a few, but to be fair, when it comes to... /*laughs*/ I think the females have their heads [better] turned on than the males do /*both laugh*/ so they [men] are not worried. Whereas in, in, but I have had a few, but I must say not as much as I thought it would be, you know, there is not, it's almost like I think because, from a male's perspective, the males think that the ladies have it under control, it's covered. So, I've had only 1 or 2, but other than that, it's not an everyday thing that I've experienced. I must be honest, *ja*. *[City, GP, E]*

Extract 6.13

> **Brother Zukisani**: There are those [men] who say they don't want a child, and so thingy she must use contraceptives because you cannot rely on male condoms. Male condoms can burst, and then they [women] will have to get something called the morning-after pill. Then they keep coming here. The morning-after pill is not a family planning method, so it's better if there is a [long-acting] method that she is on, you see. /mhh/ Because you can't rely on the male condom, the male condom can burst. *[Town, PHC, X]*

In extract 6.12, reflecting on his experiences as a medical expert, Dr Austin normalises cisgendered men's involvement in birth control use by saying, "*Ja*, we've had a few", but later refigures this account through the following utterance, "not as much as I thought it would be". Assumptions about equal responsibility are implied initially, although inequitable responsibility is later insinuated. To support this pivot from his original assertion about joint decision-making, he adds that "females have their heads [better] turned on than the males do" and that "males think that the ladies have it under control, it's covered". Dr Austin attributes this to a general "lack of sensibility" in men and "astuteness" in women that encourages vigilance about birth control. He, therefore, mobilises a male reproductive pardoning discourse wherein contraceptive "irresponsibility" is not something bestowed upon males by females. However, males tactically take it for themselves through deference or "strategic silence" (Delassandro, 2019, p. 773). As a result, the participant fails to maintain this micro-narrative of shared decision-making by essentialising women as more aware of the "risk" of pregnancy. This emplots women as "sexually responsible" and men as "sexually irresponsible".

Brother Zukisani also constructs a contradictory account of male involvement in contraceptive decision-making in extract 6.13. In the micro-narrative, men who explicitly express their interest in being child-free are construed as active in the decision-making around condom use, but not necessarily other contraceptives. Brother Zukisani says, "There are those [men] who say they don't want a child, and so she must use contraceptives because you cannot rely on male condoms". Within this utterance, men are emplotted as decision-makers concerning reproduction but limited to short-term barrier methods, likely to result in contraceptive failure. This, thus, emplots them as "at risk". Hence, Brother Zukisani concludes, "She must use [long-acting] contraceptives".

Two assumptions are contained within this deference. Firstly, through advancing a male reproductive pardoning discourse, long-term contraceptive uptake is framed as a female responsibility. Failure to take this responsibility further conscripts women in emergency contraceptive use. Secondly, the systemic failure that disadvantages men by limiting them to

short-term contraceptives with less efficacy is depicted as contributing to their deferring to women rather than them intentionally deferring by choice. These two assumptions reinforce the significance of LARC use as an active decision a woman must enact, particularly considering Brother Zukisani's rigid construction of morning-after pills as not a family planning method and, thus, something to be avoided. LARC use is therefore constructed as convenient for women for two reasons. Firstly, in assuming the contraceptive load, numerous health centre visits to access plan B alternatives to avoid the "risk" or possibility of parenthood can be minimised. Secondly, by taking up female-controlled LARC technologies, which are tacitly construed as more dependable, women can assist men, particularly those who have emphatically articulated their reproductive plans, to uphold their desired reproductive preferences.

Sr Carol argues below that women may use male involvement in contraceptive use as an excuse:

Extract 6.14

> **Sr Carol:** They come for a pregnancy test, and then we offer contraception as well. Because obviously, if she's nervous, but now, if she's negative, then we'll obviously offer contraception as well. And then, she's like, "No, my boyfriend [says he wants a child.]" but sometimes I do think it's them [contraceptive users], but it's just that they don't wanna say it out like "I don't wanna use anything". Sometimes, look, we can educate as much as we [can] about being, you know, like child spacing and all that, but then sometimes they actually want to have, they want to fall pregnant. *[Town, PHC, E]*

While men are said to defer or feminise contraceptive use in the previous extracts (6.12 and 6.13), Sr Carol frames contraceptive users as dishonest subjects who deflect blame by construing their sexual partners as the reason for their erratic uptake of contraception. Sr Carol does not believe them, finding male involvement in contraceptive decision-making unfathomable or unlikely. In doing so, she draws on a male reproductive pardoning discourse, suggesting that, in the context of the contraceptive counselling session, women cannot outright refuse contraceptive uptake and, therefore, need an excuse. In reality, she suggests they desire to have a child(ren).

This suggests that the choice of pregnancy among certain women is "shaped and restricted by community norms around reproductive behavior" (Takeshita, 2015, p. 2), which can deny some women the opportunity to enact what is deemed as "bad reproductive decisions" by gatekeepers like healthcare providers. Hence, in the text, contraceptive users can be reticent about openly sharing their reproductive intentions and decisions in contraceptive counselling. Therefore, in

what can be seen as a missed opportunity to offer contraceptives following a negative pregnancy test, healthcare users frame their own reproductive intentions as their partners' to avoid complex negotiations with healthcare providers. While healthcare providers are emplotted as experts who educate, contraceptive users are emplotted as lying, untrustworthy and inconsistent contraceptive users. As such, an injunction for them to confess is implied within the text.

Most health providers reported a relative absence of sexual partners in contraceptive decision-making. However, there was a glaring presence of parents in decision-making in further storytelling prompted by the question about shared decision-making about LARC use in heterosexual relationships. These micro-narratives are discussed next.

2.3 "It's the parents (mothers) who push them"

While the question about the role played by sexual partners was not explicitly asked in relation to adolescence and young adulthood, the responses elicited by the healthcare providers were often representative of this period. As such, sexual partners were framed as not involved in contraceptive decision-making among most young people; instead, the parents, particularly the young women's mothers, assumed this role. In these instances, young women were often emplotted as desiring sexual subjects or vulnerable to sexual conquests initiated by males. Hence, their decision-making capacity and agency around contraceptive use and non-use were seen as limited. This signals a shift from the individualised decisions in sections 2.1 and 2.2 to more passive decision-making capacities. At the root of this push are constructions of adolescents as having reached menarche, inconsistent condom users, "out-there", or as at risk of sexual violence. The advancement of a risk discourse, which "focuses upon risk as a consequence of the 'lifestyle' choices made by individuals" (Lupton, 1993, p. 427), is, though implicit, evidenced in the micro-narratives. These discourses can be at odds with each other. The risk discourse emplots women as "mature" and "fit to conceive" and, therefore, needing to take responsibility to overcome this risk. In contrast, the adolescence-as-transition discourse emplots teenage women as "immature" and "unfit to parent". Put together, these discourses emplot the adolescent as a victim of "early maturation" or "precocious" as the body is deemed prepared for reproduction earlier than social expectations.

In this section, I show how healthcare providers leverage these risk and developmental discourses to exclude young women from decision-making over their bodies or to support coerced contraceptive provision among non-consenting women. Within this talk, alliances

between the female guardians and the providers, where the young women were depicted as untrustworthy, vulnerable to "bad" influences and therefore requiring interventions from female guardians (and providers), were apparent. However, these medical experts were also caught in tensions while doing so.

2.3.1 "Not partner but parents"

Healthcare providers reported that parents, rather than partners, played active roles in steering young women towards birth control usage. The following excerpts are examples of this:

Extract 6.15

> **Sr Zoleka**: No, it's the parents that push them, not their partners. *[City, PHC, X]*

Extract 6.16

> **Sr Thami:** No, that's rare. Children usually come alone or with their parents. It's rare for them to come because their partner suggested it. *[City, PHC, X]*

Extract 6.17

> **Sr Avela**: There aren't any who have been sent by their boyfriends. They are usually sent by their parents. *[Village, PHC, X]*

In extracts 6.15 and 6.16, 6.17, the healthcare providers negate the involvement of males in contraceptive uptake. In their responses, the word "No" by Sr Zoleka and Sr Thami implies certainty and no ambiguity. Female guardians and young females assume the labour of "undoing" the threat of pregnancy. This "undoing" includes parents' "pushing" young women to take up birth control in directive, coercive and non-relational ways rather than negotiating uptake through open dialogue and advice.

In extract 6.18 below, the involvement of sexual partners in contraceptive counselling is also construed as unlikely. Instead, contraceptive-seeking women are framed as jointly or coercively reaching decisions about contraceptive use within kinship ties.

Extract 6.18

> **Sr Nozibele:** Not so much the partner but parents. It's mostly parents, and the child would say... I would ask her, "Are you sexually active?" "Do you know what the injection is?" "No, I don't know". "Why are you here for the injection?" "My mother said I must come get the injection". It's always an older person from home who has noticed that she comes home late, who has noticed that she hangs around certain older people and so is scared that anything can happen. *[Town, PHC, X]*

Extract 6.19

> **Sr Phindi:** It's these children, it is these schoolchildren who will say, "It's my mother" when I ask… when I ask for myself. We chat because we chat with them, you see. So, I will ask, "Wow, girl, you already have a boyfriend?" or "You have a boyfriend?". Then she says, "No, it's my mother." Then I'll say, "What did she notice?" Then she says, "My mother said I must come." Sometimes I will ask if she has started menstruating, and she will agree. "So, you decided you must find yourself a boyfriend?" and then she says, "My mother said I must come". *[City, PHC, X]*

Sr Nozibele, unlike Sr Zoleka, Sr Thami and Sr Avela in extracts 6.15, 6.16, and 6.17, uses a gradual progression in reporting on the role played by parents in contraceptive uptake. She starts by saying, "Not so much the partner", followed by, "It's never the partner", which refigures the previous assertion that males are present, albeit infrequently, within this decision. Later, she entrenches the constructed unfamiliarity of male involvement and resultant passive emplotment of males in contraceptive decision-making through the utterance, "It's always an older person from home". To do this, a set of not only patronising but also personal questions, which are atypical of contraceptive counselling encounters, are asked to construe young women as lacking in knowledge and agency in the decision to seek LARC measures, for example, "Are you sexually active?", "Do you know what the injection is?", "Why are you here for the injection?". The LARC user's pattern of response, "My mother said I must come get the injection", reveals a demand to seek not only contraceptives but a particular measure, injectable contraceptives. This serves to counter the healthcare provider's emplotment of the young woman as a "risky" subject who is already sexually active or decided to find a boyfriend soon after menarche. Instead, she (the young woman) suggests that she is engaging in a dutiful practice (heeding her mother's advice) rather than a rebellious act.

In pivoting towards decision-making as more apparent in parent-child relationships rather than intimate partnerships, Sr Nozibele and Sr Phiwe draw on a risk and an adolescence-as-transition discourse in which they reinforce parents' directives and decisions as rooted in observations. They compile "evidence" to use against young women to prove their susceptibility to the "risk" or "threat" of pregnancy while immature. This is evidenced by using the referents "children" or "child" to construct the contraceptive seekers. In emplotting young women as fledgling, "immature", "young", "not fully developed", and "juvenile" beings who need intervention from an adult to enact these decisions, the active role played by mothers in the contraceptive uptake is qualified or rendered relevant as it assumedly supports a "deficiency".

In decentralising the contraceptive user and centralising the mother as the decision-maker, a "sexually innocent" subject emerges in young women's reported utterances in the contraceptive counselling sessions. However, Sisters Nozibele and Phiwe are sceptical of this micro-narrative in which young women depict the directive towards contraceptive uptake as both contextless and pointless. Hence, towards the end of the excerpt, Sr Nozibele posits that "an older person from home who has noticed that she comes home late, who has noticed that she hangs around certain older people and so is scared that anything can happen". This way, she bolsters the necessity of the contraceptive provision as the guardian's reported observations of the young woman's behaviour emplots them as "at risk". Given this, the coercive nature of the decision towards contraceptive debut is normalised on the basis that a woman returning home late conjures romantic meetings with boys and associating with older peers conjures exposure to open and frank talk about sex, sexual exploration and sexual desire. This occasions the following utterance: "So [the mother] is scared that anything can happen", which entrenches the advancement of a risk discourse through which sexual exploration or the increased vulnerability to an unintended pregnancy is implied. In conferring emplotments of vulnerability on the young women, their reduced agency in contraceptive uptake is validated as a benign, protective act rather than a denial of agency.

In extract 6.19, Sr Phiwe also draws on an adolescence-as-transition discourse to accuse the young women of engaging in sexual practices "reserved for older people". Protestations against this framing implicitly emplots "these schoolchildren" as untrustworthy even though the health user repeatedly resists it by invoking her mother's injunction, "My mother said I must come". Sr Phiwe's repeated charges convey some incredulity to the young woman's assertion that she is there simply on the mother's instruction. Instead, she wants contraception because she is naughty. While Sr Phiwe initially emplots herself as a confidante— "We chat"— instead of acting as a confidante, her story suggests an inquisitor. She sees it as her duty to get the young woman to confess to having a boyfriend. Her rendition of the young woman repeatedly refusing the injunction to confess emplots the young woman as obstinate and untrustworthy rather than "sexually innocent".

Sr Mesani constructs a counter-narrative wherein young contraceptive seekers are not always sent by their parents to seek contraceptive technologies. Instead, they represent their own reproductive desires and needs to healthcare providers under the guise that these are directives from their parents to avoid talking about their sexual selves with healthcare providers. See below:

Extract 6.20

> **Sr Mesani:** They are like, "No, Sister. I don't know, but I know they said the two-month one". And then you must, you know, you must meet them halfway because they don't know, and they are children. And when you ask them the reason why they want an injection, they say, "No, my mother said I must come". And I say, "What do you say? […] "No, I want an injection". "Why?" "My mother said I always go out with friends and I come home late." and then I say, "Do you have a boyfriend?" […] "No, sister, I don't have a boyfriend" And then I say, "Your mother? (.) Why, when you're coming home late, tell me the truth". And then you must try and be fair here. "Tell me the truth so that I can help and explain to you". "Yes, Sister, I have got a boyfriend". "Did you sleep with your boyfriend?". "No, Sister; once, Sister". And then there are those who are bluffing, "Once, sister". And then, you must start educating and explaining that injection is not going to help you to not have STIs. It's just going to help you not to fall pregnant, but if you didn't miss your date. If you miss your date and then come late, you can be pregnant even if you are using the injection because now you are coming three or five days after to get your injection. It's out of your system already. *[Town, PHC, X]*

In refuting the unnecessary imposition of contraceptive uptake by female guardians, Sr Mesani argues that young women must take responsibility for seeking LARC. This inquisition around the young women's reasons for accessing the healthcare facility requires the contraceptive user to confess to behaviours that necessitate LARC usage. Consequentially, the incitement to tell the truth garners information about her sexual relationship, prompting the emergence of a risk discourse where the health user is emplotted as not only at "risk" of pregnancy that heightens upon missing contraceptive appointments but also at "risk" of STIs. This suggests that while contraceptive users may attempt to distance themselves from self-disclosure about their sexual and reproductive practices, healthcare providers can break these boundaries to personalise contraceptive counselling conversations.

2.3.2 Surveillance of "suspects" by (female) guardians

Healthcare providers reported responding to parents' requests and pleas about the eligibility of their daughters for contraceptive uptake. In describing their interactions with parents and young health users, they subtly cited these parental requests as following a period of surveillance in which behaviours such as having social circles that include young men and having social commitments that prompt them to return home at night were identified. This depiction achieves a certain goal—it construes the adolescent women as having crossed a boundary. It justifies contraceptives being reactively sought out on their behalf, given the cultural value around the maintenance of their childlessness in their teenage years. However, this decision created tensions for some healthcare providers and could be secretly resisted and denied by some contraceptive users. The extracts below are representative of this:

Extract 6.21

> **Brother Lubabalo**: Sometimes they are being pushed by their parents because their parents are suspecting something in them [adolescents], then they come brought in by their parents saying, "May I please get contraception for my child because I suspect this and that". Sometimes, it's not even that they are being pushed. It's just that the parent is encouraging the child to use contraception at an early age so they know that there is something like it. *[Town, PHC, X]*

Extract 6.22

> **Sr Thami**: Some are usually brought by their parents to the clinic because they have seen certain behaviours in them, and they try to protect them from pregnancy […] So they try to hit two birds with one stone. It's better she gets birth control then she can use condoms; if she can, condomise. If she doesn't want to, then there is nothing we can do about that. *[City, PHC, X]*

In both extracts, decisions about contraceptive use are represented as a product of speculations, guesswork and hunches about the young people's sexual practices where a period of surveillance and appraisal of sexual debut precedes decision-making. Upon being identified as "guilty" or, at the very least, "suspicious" of sexual engagement, young women were coerced towards LARC use. A risk in conjunction with an adolescence-as-transition discourse informs the talk as the threat of pregnancy is individualised, albeit decision-making ability is denied. In responding to this "risk", the parents undertake an organised effort, which can be coercive, to decrease the possibility of pregnancy. These efforts are viable purely by discounting the young women as naïve, ignorant half-adults who must accept this decision with deference due to age. This talk emplots parents as rational beings, whereas contraceptive users are risky sexual subjects and passive recipients of contraceptives.

Brother Lubabalo later advances an adolescence-as-transition discourse and discards the risk discourse by asserting that parents assume educator roles and impart knowledge about fertility control to ignorant adolescent subjects. In so doing, he frames young women's contraceptive uptake as not always a product of "being pushed" but, on occasion, encouragement that is not premised on behaviour interpreted as "problematic". Likewise, Sr Thami also reneges on the use of coercion by arguing that parents can force pregnancy prevention through LARC technologies. Condom use, however, requires user action. It, therefore, disempowers parents by limiting them from trusting the young women about its ongoing use rather than enabling them the opportunity to regulate and coerce its use, too.

The following extract represents another instance of the limits of coerced contraceptive provision and the tensions healthcare providers face in responding to the needs of the health user over those of a third party. When asked about compliance among women whom their

parents exclude in decision-making, Sr Thandiswa responds in the following manner:

Extract 6.23

> **Sr Thandiswa**: They [the contraceptive users coerced by their parents] are the ones that you must try and reach (.) and ensure that they understand so that they can come back. Some of them do come back, and some don't come back, obviously.
> **YN**: Since they were sent to begin with…
> **Sr Thandiswa**: Some do not come back, and some do come back when they discover at home that they did not come. When you ask them, "*Haybo*[11], why didn't you come?" She will say, "No, I don't have a boyfriend, Sister; I don't understand why I must get an injection". *[Town, PHC, X]*

Without parental oversight or a sexual relationship, some contraceptive users will, according to Sr Thandiswa, deem continuing with contraception as unnecessary. A cost-benefit analysis reinforces this alluded to towards the end of the extract: sexual intercourse is expected to precede LARC uptake, not vice versa. As such, the role of contraceptives in "protecting" the body is deemed superfluous for abstinent contraceptive users. This way, for contraception to continue, the decision must be re-enacted by a female guardian within the family. Notably, Sr Thandiswa also mobilises an adolescence-as-transition discourse that assumes an immature mind yet an at-risk body that adults must protect. In so doing, she depicts herself as not a healthcare provider who purely provides to those who seek the commodity; instead, she is also an adult who inculcates and educates young women to accept the decision enacted on their behalf by their parents. She, thereby, personalises the labour of explaining the relevance of unconsented contraceptive uptake among resistant LARC users who silently oppose their parents' decisions by being erratic in LARC use for their own benefit. Hence, young people are emplotted as oblivious, "unknowing", or "miscalculating" their own "risk" of pregnancy by the talk while healthcare providers are the "experts" and "arbiters".

To avoid muted resistance by young health users or to keep coercion intact, different techniques of surveillance may, according to Sr Avela, be used by some female guardians to ensure compliance in young contraceptive users:

Extract 6.24

> **Sr Avela**: Their grandmothers can see that these are things that do happen to their neighbours. Because there may have been a neighbour's kid who is pregnant who is the same age as mine, and mine lives with me. And for me to avoid the responsibility of raising a child, she must come to the clinic and get contraceptives. Most of them are sent by their grandmothers. It's rare to find those sent by their mothers. It's the grandmother who says, "Little girl, let's go to the clinic together. I am going to go get my treatment, and you must go get your contraceptives". And they

[11] An isiXhosa expression used to convey shock.

> will come with her [grandmother] holding her hand so she gets the injection. The grandmother will keep the card, and she will be checking. They sometimes say, "My grandmother keeps my card". She [grandmother] will keep checking and say, "It's your date now, go". *[Village, PHC, X]*

Multiple ways in which surveillance may be used to restrict young people's fertility are reported in the above extract. Firstly, motherhood duties are understood as extended to the grandmother if a teenager becomes pregnant, thus emplotting them as "surrogate mothers". This is evidenced when Sr Avela says, "Mine [granddaughter] lives with me, and for me to avoid the responsibility of raising a child, she must come to the clinic and get contraceptives". Secondly, a heightened responsibility to manage this risk of pregnancy among adolescent women is identified by Sr Avela. These representations are underpinned by the adolescence-as-transition and a risk discourse shoring up the increased pressure to shape young women's feminine subjectivities by retaining their identities as nulliparous, specifically considering their embeddedness in contexts where peers, as it stands, frequently experience unintended pregnancies. Strictures are thus established to regulate the behaviour of these young adolescent women emplotted as "at risk" or needing contraceptives. Hence, Sr Avela asserts, "It's the grandmother who says, 'Little girl, let's go to the clinic together. I am going to go get my treatment, and you must go get your contraceptives'". Here, the incitement of young adolescents to consistently use contraceptives is achieved through aligning appointments for the young women to access birth control and the grandmother to access chronic medication. A gaze is thus achieved, and this form of surveillance functions as an antithesis to the resistance against coerced contraceptive debut or uptake seen in previous cases.

In locating care work responsibilities on female guardians, agency is deemed irrelevant as young women's "poor" decisions affect the female guardians' mothering duties and social statuses. The threat of degeneration is explicitly evident here as the grandmother is constituted as proactively attempting to avoid the burden of child-rearing, particularly given that teenage mothers already exist within the neighbourhood. This emplots female guardians as knowers and young women as immature and inept in assuming motherhood duties; hence, through proactive contraceptive provision, a coerced but disciplined contraceptive user is produced.

Sr Avela further states that for increased surveillance and monitoring compliance, clinic cards were retained and reminders issued by guardians for subsequent clinic appointments. Asymmetries in power are disguised by the dissimilar yet shared responsibility (albeit non-

shared decision) to comply with one's medicinal or contraceptive regimen as both the young woman and the grandmother are disciplined towards maintaining a medical regimen.

2.3.3 "Female guardians negotiating with healthcare providers"

Contraceptive debut was reported, as indicated above, as being informed by young women's biology and behavioural practices. While these discussions around contraceptive uptake were reportedly enacted at home, a private space, the negotiation process would sometimes spill over to public spaces, i.e., healthcare facilities and thus include healthcare providers. In these instances, female guardians incited healthcare providers directly to prescribe contraception. For example:

Extract 6.25

> **Sr Thandiswa**: First-time users are usually young children, let's say maybe someone who is 14 or 15. Mostly, they are brought by their parents, maternal or paternal aunts. But the person they spend the most time with. They usually say, "I can see that she is a bit out-there now, and she has started getting her periods, so what can you give her to prevent pregnancy besides the condom?" Because these children are not consistent with the condom and so most of the time, its people like that. It's young children who are first-time users. *[Town, PHC, X]*

Being mandated by parents to prescribe LARC technologies to young women is narrated on in the above excerpt. Sr Thandiswa reinforces, rather than challenges, this active decision, "These children are not consistent with the condom". This implicit use of the risk discourse evidences how this "threat" of pregnancy is not only individualised (her pregnancy) but also collectivised (we saw her vulnerability). The healthcare providers' collusion with the female guardian affirms the collectivisation of young women's so-called vulnerability.

A similar line of response is evidenced by Sr Nosipho's talk in the excerpts below:

Extract 6.26

> **Sr Nosipho:** There are other young children who come with their mothers to get injected /both laugh/ "Inject her, nurse" while she does not want to get injected, and the child will say, "No, but I am not sexually active". Others then, others then are brought in to get the injection because maybe they have heavy bleeding, so she gets irritated by going on her period, as I said earlier. *[Town, PHC, X]*

In the above extract, Sr Nosipho suggests that mothers give healthcare providers direct instructions, "Inject her". Although the young woman is emplotted as protesting against and expressing her disinterest in contraceptive uptake, there is no indication that Sr Nosipho would

refuse contraception in such an instance. The adolescence-as-transition discourse is implicitly deployed to subject young people to their parents' decisions due to the supposition that young women will fail at decision-making due to their age. In addition, the use of the signifiers "children" and "child" implicitly emplots contraceptive users as unworthy decision-makers and further erodes the significance of the response "No, but I am not sexually active" uttered by the adolescent woman, which Sr Nosipho avoids addressing. Instead, she subtly shifts the conversation by providing another example of contraceptive consultations that include parents and exclude contraceptive users.

The desire to control a heavy menstrual flow is at the heart of the parental involvement in this second cited case. As such, a medical discourse is mobilised to privilege the body's response to injectable contraceptives, which can induce amenorrhea. Amenorrhea, in the extract, is presented as a desirable side effect that treats the contraceptive user's reported "heavy bleeding" and soothes the irritation caused by "going on her period". The significance of this medical discourse is in its emplotment of the parent and healthcare provider as "knowers" and the young adolescent woman as ignorant. The young women's reduced capacity for decision-making is validated. That is, unlevel power relations and the sometimes-coercive nature of certain women's contraceptive debut are justified as potentially beneficial for contraceptive users because LARC technologies can be geared at regulating bodily processes beyond just pregnancy.

2.3.4 "Mothers fear risk brought on by violence"

Some healthcare providers construed proactive contraceptive uptake as the prevention of unwanted pregnancies in cases of sexual violence. To bolster this decision, behaviours that pointed to resistance against the seclusion of women from public spaces (such as arriving home late) and the inability to supervise young women constantly were used to substantiate the heightened vulnerability to sexual violence. This is illustrated by extracts 7.27 and 7.28 below:

Extract 6.27

> **Sr Nozibele**: She comes home late; she might get raped in the streets. Most of them say they're doing it just in case. *[Town, PHC, X]*

Extract 6.28

> **Sr Thandiswa**: The reason grandmother brought you here is so that if you would sleep [have sexual intercourse] with your boyfriend, you don't fall pregnant or maybe that it happens that you get raped, you don't get pregnant, you see? *[Town, PHC, X]*

These healthcare providers' talk contains a stranger danger discourse, which refers to an external threat of sexual violence and resultant panic about the constructed threat. Talk of this

nature creates a "private-public divide that suggests the private arena is safe" (Cowburn & Dominelli, 2001, p. 400). This notion, however, is not buoyed by the statistics, which instead imbricate sexual violence with familiar relationships rather than strangers (Biss & Geist-Martin, 2022). In mobilising this discourse, healthcare providers ascribed emplotments of risk upon young women with men as the source of this "risk". The construction of young women as the target of this "risk" is later nuanced by the utterance "just in case" in extract 6.27 or "maybe that it happens" in extract 6.28, which emplots contraceptive users as possibly not vulnerable to the "threat" but obligated to accept the "risk-proofing".

Sr Thandiswa further instantiates this risk of sexual violence in cases with young women living with disabilities:

Extract 6.28

> **Sr Thandiswa**: Okay, there is a case with a handicapped child that I remember. She was born... she can't talk for one, she cannot use her hands, but she can walk. She is one of those people who have short feet, so everything tends to depend on her mother. She is now grown; she is a teenager. I think she is 18 or 19 so she stays with her mother and her grandmother. Her mother works, and her grandmother is old, so her mother has that fear (.) Oh wait, and her uncles. So, her mother has that fear that here in the township, there might be people [who sexually violate her], and it seems like (.) She thinks there are already people (.) She can see [that something is happening]. So, she regularly brings her for family planning, but the minute she sets foot into the clinic, she starts crying. *[Town, PHC, X]*

The narrative coheres around a young woman with disabilities whose mother decides to initiate contraceptive use to circumvent pregnancy in the event of sexual violence while she (the mother) is at work. Sr Thandiswa draws on an adolescence-as-transition discourse to construct maturation when she says, "She is now grown; she is a teenager. I think she is 18 or 19". Hereafter, the danger is constructed by framing her as residing with her grandmother in the daytime, who is rendered old and implicitly emplotted as an inadequate carer. The suggestion here is that there is insufficient surveillance to prevent the suspected crime. The danger is later amplified through the construction of the young woman living with her uncles, who are excluded from the care work and may pose a threat. Sr Thandiswa also invokes the stranger danger discourse by making a case for the young woman as needing defence against violent sexual acts occurring within the community.

Sr Thandiswa's speculative accounts are later reinforced by the assertions that incidents of sexual violence are already ongoing ("like she thinks there are already people") relayed by the mother in contraceptive counselling. In response, she (the mother) reportedly renders forced

contraceptive use as the best defence against the "risk" of pregnancy while ignoring the sexual violence itself. Beyond the by-standing witnessing of sexual violence perpetuated by Sr Thandiswa and the young health user with disabilities' mother, the encounter is also problematic for its coercive nature, evidenced by the health user's displays of emotional distress during all contraceptive counselling appointments.

3. Stories of contraceptive provision

In this section, participants reflect on their ways of responding to contraceptives being sought and their priorities and reservations in providing and prescribing birth control technologies. Healthcare providers thus lay out the process of decision-making. In addition, the subject who accesses healthcare facilities for contraception is indirectly defined, and the information health users should supposedly receive alongside the offered contraceptive measures is clarified.

The data reflects how contraceptive seeking and provision should not be taken for granted as a straightforward process where a contraceptive user seeks and the healthcare provider provides. This is because there were tensions around agency that required negotiation by some healthcare providers. For example, the agency of some users was prioritised in some cases over others. Nevertheless, non-use was discouraged within all the interactions. Therefore, in encouraging use at the expense of agency, the health workers consistently reflected on providing contraceptives to both willing and unwilling contraceptive users, drawing on risk and adolescence-as-transition discourses.

3.1 "I face dilemmas"

Extract 6.29 below represents healthcare providers who expressed ambivalence and discomfort around the sometimes-coercive injunctions by mothers to "risk" proof young women from early pregnancies.

Extract 6.29

> **Sr Nozibele**: All I do is explain about what they [mother and daughter] are here for. The only time I can say I struggled is with the ones that have been forced and have come physically with their mothers to the clinic. And you know she's not interested in hearing what I have to say. *Ja,* not necessarily because of anything [or not because she is upset with me], but she just doesn't want the injection, but her mother has brought her to the clinic to inject. /*Ja*/ So when I explain, she is not interested. She doesn't want to hear it. *[Town, PHC, X]*

Sr Nozibele indicates she struggles with this mismatch between the young woman and her mother regarding wanting LARC. In this conflict, the young woman is emplotted as obstinate or stubborn – "She's not interested" and "She doesn't want to hear". Despite this, it seems that

Sr Nozibele continues with the contraceptive counselling: "I have to say"; "when I explain". This suggests that she complies with the mother's injunction to at least try to administer contraception, regardless of the "struggle" she alludes to in the micro-narrative. An adolescence-as-transition discourse underlies the talk, whereby young women are pushed towards becoming contraceptive-using subjects by adults to prevent pregnancy at the cost of agency. Their voices are silenced by being younger, and protestation is met with further injunctions. Given how Sr Nozibele overrides the lack of interest, the young contraceptive user's protestations are construed as signs of "immaturity" rather than claiming agency. Sr Nozibele is emplotted as obligated to provide contraceptives, while the contraceptive user is emplotted as resisting uptake and thus as an unwilling contraceptive user.

Within the extract below, it is the provision of contraceptives to women below the age of sexual consent that is deemed at issue. In contrast, the disavowal of the woman's bodily integrity due to lack of consent to the use of contraceptives is overshadowed.

Extract 6.30

> **Sr Vathiswa**: No, a difficult case for me is having a child who is 12 years old and already menstruating and being required to give her the injection. She has come with her parent to the clinic, and she's 12 years old. That case was difficult […] The parent can see that she doesn't sleep at home, so I must inject her. She is 12 and is already menstruating. The law says we must start administering birth control to children at 15 years, so how am I safe from the government because now I am caught in a dilemma? It's the government, the parent and me. […] But I injected her because if she falls pregnant, she will have a baby, and it will sit here [points to womb] in the womb. *[Village, PHC, X]*

In the extract, contraceptive responsibility is rendered obligatory for women upon menarche and possible "risky" behaviours such as not sleeping at home. Implicitly drawing on an adolescence-as-transition discourse, Sr Vathiswa deems the governmentally regulated[12] acceptable age for contraceptive provision to be 15 years. This, in her opinion, creates a dilemma between the dictates of the government and those of parents that she must negotiate during contraceptive counselling. In this regard, the side-lining of the prospective contraceptive user in decision-making is not considered necessary. Instead, moral politics about the legal

[12] Sr Vathiswa is incorrect, as contraception "may be provided to a child on request from the child and without the consent of the parent or caregiver of the child if: the child is at least 12 years of age and proper medical advice is given to the child" (Department of Health, 2019, p. 44).

implications of providing contraceptives to (by law) non-consenting subjects is rendered at issue.

However, the healthcare provider resolves this dilemma or tension through the use of a risk discourse by which she calculates characteristics and acts performed by the adolescent woman, e.g., being physically mature and not coming home at night, that point to sexual initiation and an inherent "threat" of pregnancy. This counters or vetoes Sr Vathiswa's tentativeness about the ethics involved in providing contraceptives to a subject who is not considered either willing/unwilling but somewhat below the age of consent as she cites providing injectable contraceptives to the young adolescent woman. This is acceptable "Because if she falls pregnant, she will have a baby, and it will sit here in the womb". Therefore, even though young women are rendered "fledgling" and not yet adults, Sr Vathiswa emplots herself as responsible or liable in the event of unintended pregnancy if she resists contraceptive provision. Hence, she is obliged to provide contraception to an unwilling contraceptive user and thereby deny her agency.

Another instance of ambivalence about unconsented contraceptive provision during contraceptive counselling is illustrated by extract 7.31 below. Investment in contraceptive use by contraceptive users, achieved through shared decision-making, was deemed a necessary precedent for consistent use or to avoid early discontinuation of contraceptive use.

Extract 6.31

> **Sr Beja**: So, I asked her, "*Mama,* do you live with this child? Because if you don't live with her, let's say she stays in boarding school, she will only take the injection now that she has come with you". Let's say it's around December, like now, and she is back home. "When she goes back to school in January, she won't go get another one because you made her do something she didn't consider and doesn't want". She kept saying, "Sister, please, please inject this child". But I ended up injecting her. *[Village, PHC, X]*

Like the healthcare providers' accounts in the previous micro-narratives, drawing on an adolescence-as-transition and a risk discourse, the mother in extract 6.31 is construed as imploring the medical practitioners to administer injectable contraceptive use to her adolescent daughter. Mobilising a choice discourse, which emphasises the individual's right to choose and freedom (Nordgren, 2010), Sr Beja *appears* to be countering this one-sided decision. In so doing, the healthcare provider informs the female guardian that the young woman's willingness to use contraceptives is a necessary precedent for continued use, as coerced uptake results in early discontinuation.

The utterance, “When she goes back to school in January, she won’t go get another one because you made her do something she didn’t consider and doesn’t want”, demonstrates the limits of coercion. Beyond the mother-daughter relationship, the young woman’s agency determines decision-making. Correspondingly, Sr Beja refers to contraceptive uptake as something to be “considered” and “wanted” by the patient for ongoing compliance or adherence. In this case, the adolescent woman is implicitly emplotted as resisting uptake. Sr Beja’s question, “Mama, do you live with this child?” signals the use of an adolescence-as-transition pivoting from the previously mobilised choice-centred talk. Here, she implies that coerced, one-sided contraceptive decisions or the use of sovereign power is acceptable but only effective when the young woman resides with the parent due to the increased opportunity for surveillance. Healthcare providers are, by implication, framed as sometimes more concerned about continuity or having a compliant contraceptive user rather than agentic contraceptive users. This is demonstrated by how Sr Beja, in the same way as Sr Vathiswa in the previous excerpt, ultimately offers the requested measure. This acquiescence is framed as the product of the mother’s constructed pleas, seen in the utterance, “Sister, please, please inject this child”. The use of “please” twice and the use of the referent “this child” suggests that the mother is appealing to Sr Vathiswa’s understanding of an implicit risk discourse that marks young women’s “maturation” into adulthood. Therefore, while contraceptive counselling is constituted as directed by the parent, the healthcare provider overlooks the young woman’s limited agency due to her understanding of the emplotments of the health user as vulnerable.

3.2 “It's about a conversation with the individual"

Most healthcare providers talked about contraceptive counselling as a consultative process that seeks to meet the needs of the contraceptive user. As such, decisions were expected to emanate from the user rather than be recommendations by a healthcare provider who steers conversations towards certain options or objects to women’s decision to use certain options. However, the ability to maintain the assertion that all contraceptives are available to all who desire them was contradicted by some healthcare providers. The extracts below are representative of healthcare providers’ constructions of patient-centred care.

Extract 6.32

> **Sr Thami:** We inform them of all their options, and they decide for themselves. Then, we inform them thoroughly how each and every one of them works. If they find that the one they chose is giving them issues, they have the right to change it and start with a new one and then see how that one treats them. They do not have to stick to one method when it does not work for them. *[City, PHC, X]*

In the above excerpt, Sr Thami reports on the significance of explicating all contraceptive technologies alongside their mechanisms of action and ultimately expecting a decision to be enacted by the contraceptive-seeking woman. This talk mobilises a choice discourse as all options are discussed to invite the best fit for the health user. In addition, she normalises "wrong" choices through a rights discourse, which entitles contraceptive users to the revision of options which produce unwanted embodied and situational experiences. This way, offering the full spectrum allows for narrowing down to the best fit through trial and error.

Beyond availing the full range of contraceptive options, Dr Henning, in the extract below, speaks to the importance of allowing health users to tailor the conversation towards their needs.

Extract 6.33

> **Dr Henning:** Well, I think it's about, I don't think I have a specific criterion, but there is specific, I mean, it's about a conversation with the individual. So, what are their priorities? What's their lifestyle like? What they, uhm, what is their previous experience? Do they have any contraindications to the oestrogen in oral contraceptives? I mean, it's fascinating for other people. It's about, uhm, their perceptions are much swayed by people or friends they might have chatted to. *[Town, PP, E]*

Dr Henning advocates for personalised conversations rather than one-size-fits-all approaches to contraceptive counselling. Hence, a "criterion" does not inform the process; the individual person does. Drawing on a medical discourse, she further medicalises the relevance of personalised counselling by citing possible contraindications. At the end of the extract, she questions the inputs of both the healthcare provider and the contraceptive-seeker within the contraceptive counselling encounter as sometimes irrelevant as peers influence the decisions enacted. The talk, in the above extracts (6.32 and 6.33), affords Sr Thami and Dr Henning emplotments as open to health users' choices and decisions while emplotting the health users as rights bearers.

Some contraceptive technology requests, e.g., injectable contraceptives, were more associated with public healthcare facilities than private healthcare facilities. Yet, healthcare providers reflected on their ability to provide these technologies to their health users. See below:

Extract 6.34

> **Dr Henning**: And obviously, we would discuss the injection and can offer the injection, although most people in practice (.) It is available free of charge in the state sector; [people] tend to go for that, the injectable, at the state clinics. Uhh, the *Implanon* we would offer and insert here [at private practice] and also intrauterine devices and intrauterine systems in the form of *Cuyena* and *Mirena*. *[Town, PP, E]*

Extract 6.35

> **Dr Jason**: We've got quite a few [people who seek injectable contraceptives], hey. A lot more obviously oral but a lot more than you would expect coming in for injectables, you know. I've got quite a few people on injectable because we have got sisters that are practising, and they don't even have to come in to see us [doctors] /okay/ so they can come for the injections with our nursing staff at our practice. And some of them maybe come from the government before and now are on medical aid and stuff, and they have had no problems with it [injectable contraceptives]. *[City, PP, E]*

Dr Henning construes health users who seek the option of injectable contraceptives in the private sector as scarce when she says, "And obviously we would discuss the injection and can offer the injection although most people in practice… It is available free of charge in the state sector tend to go for that the injectable at the state clinics". She, therefore, suggests the rarity of requests for injectable contraceptives in private healthcare, although a general openness to discussing the contraceptive measure is implied. A choice discourse underlies the talk where a market of options is availed to the consumer. Dr Henning's construction of the injectable contraceptive as futile to mention in the discussion of the full range of contraceptive technologies suggests constrained choice and general exclusion of injectable contraceptives in private health care. In the utterance, Dr Henning is emplotted as mostly sensitive to the needs of her context, while contraceptive users are emplotted as recurrently choosing specific options.

In Dr Jason's micro-narrative, more women are construed as taking up oral contraceptives than LARC measures such as injectable contraceptives in private healthcare. He later complicates this by saying, "But a lot more than you would expect coming in for injectables, you know". This surprising fact, "More than you would expect", requires some explanation. One explanation provided is that nurses assume the role of the injectable contraceptive provider at Dr Jason's practice, thus not necessitating interactions with the doctor, contrarily to other LARC measures, such as the *Implanon* and IUD, that demand expert skills. In addition, the use of injectable contraceptives is construed as emanating from public health facilities but carried forward into private healthcare. Implicit in this utterance is that injectable contraceptive-using women rarely start using them from information counselling received in the private health sector; they usually emanate elsewhere. This is suggestive of constrained choice as the healthcare provider implicitly distances himself from the option of injectable contraceptives. The talk emplots all contraceptive users as catered for while Dr Jason self-emplots as sensitive to his context and open to contraceptive users' choices.

3.3 "They are comfortable on injectable contraceptives"

In negotiating options-based contraceptive counselling, some healthcare providers were caught in contradictory talks about providing choices and promoting injectable contraception. As such, they would start their micro-narratives centring patient choices and decisions but would end up foregrounding injectables. This is evidenced in the narratives below:

Extract 6.36

> **Sr Nombulelo:** We recommend all of them because they're all important, but our people really like injectable contraceptives. For instance, the *Implanon*, in my experience, they have it inserted, and within two months, the person comes back and says it gives them a headache, you see since the *Implanon* is still new. There are few in the clinic who are on it. They don't like it much, it's injectable contraceptives [that they do like]. Few also opt for oral contraceptives, you see? They are comfortable on injectables. *[City, PH, X]*

Extract 6.37

> **Brother Zukisani:** We do give, we give them options. We give them injectable contraceptives, pills and the implant, and then we tell them the benefits. Like if you use the injection, you will have to come back in three-months on the *petogen* and on *nur-isterate* once in two-months. The… the pills require a daily dose, so we don't recommend them for small children. We tell them about the benefits, and if you don't want to get pregnant, the condom is another contraceptive measure. *[Town, PHC, X]*

In excerpt 6.36, Sr Nombulelo grants equal importance to all contraceptive measures when she says, "They are all important", thereby implying counselling that is non-directive and open to the needs of the contraceptive user. A choice discourse is drawn upon where healthcare providers responsibilise themselves for informing their clients of the full spectrum of contraceptives. However, Sr Nombulelo also refers to the unprecedented use of injectable contraceptives, which leads to the account on early removals of the *Implanon,* where she suggests that while healthcare providers uphold informed choice, contraceptive users are only open to using a limited range of birth control technologies. This is entrenched by the conclusion around injectable contraceptives as a superior alternative in terms of continuity and uptake inherent in the assertion, "They really like the injectables" and "They are comfortable with injectable contraceptives". Though implicit, the futility of counselling about the subdermal implant as an option is embedded in this utterance: "In my experience, they put it on, and within two months, they take it off again". Early removal seen in the first two months of use is covertly framed as upholding the dominance of injectable contraceptives in the context of the non-directive and options-based counselling offered. This talk emplots Sr Nombulelo as non-directive and providing neutral support, whereas the contraceptive users are closed-off to choice and purely open to familiar methods.

Unlike Sr Nombulelo, who constructs options-based counselling as essential but also references what she construes as the realistic contraceptive uptake trends shown at her health facility as relevant, Brother Zukisani disallows specific options for certain subjects at his facility. He begins his storytelling with a choice discourse where a range of contraceptive technologies is offered to willing users. In listing the various contraceptive technologies' benefits, injectable contraceptive time-frames are the only ones mentioned, albeit the implant can circumvent pregnancy for longer. He thereby shows an implicit bias towards injectable contraceptives. Hence, he depicts oral contraceptives as too user-dependent and thus unviable for young contraceptive users. In addition, his use of the referent "children" signals the operations of the adolescence-as-transition discourse, where commitment to oral contraceptives is framed as "too difficult" for young contraceptive users who are emplotted as too "immature" to comply with their regimen consistently. Yet, injectable contraceptives are differentially framed as suitable for all health users, including young women. This talk emplots him as the "gatekeeper of 'bad' choices" and indicates directional contraceptive counselling practices.

Sr Carol also reports on the construction of oral contraceptives as unsuited for use by certain women in the extract below. Postpartum women are excluded from oral contraceptive usage rather than young women when compared to the previous narrative.

Extract 6.38

> **Sr Carol:** We do look at your reliability in all the types of things, and what type of person you are, like are you a very active, like a busy person? Like for the pregnant, not pregnant, for the postnatal moms that have just delivered; what happens from past experiences is that they usually forget, because the babies are so small, the babies are, it's hectic in the beginning […] So they tend to forget the pill, and then they become pregnant soon after. So mainly, we'll promote, not promote, but we'll tell them that the injectable is a bit better than the tablets. So, then, we'll always opt for the injectable one. *[Town, PHC, E]*

In the above extract, consistent contraceptive use is understood as contingent upon one's lifestyle. Women considered too "busy" are expected to be less "reliable". In line with this, postpartum women are rendered as preoccupied with tending to their babies and, as a result, often default on oral contraceptive use. As such, compared to the options-based counselling or the attempt towards this seen in the previous extracts, Sr Carol's talk assumes a directional form of counselling. Her use of the utterances, "We'll tell them that the injectable is a bit better than the tablets" and "So mainly, we'll promote, not promote, but we'll tell them", affirm the

touting and steering used to determine decision-making. Here, healthcare providers occasionally avoid merely advising but enact decisions on women's behalf. This emplots Sr Carol as the decision-maker and postpartum women as sexual beings but also passive recipients of decisions made by their healthcare providers.

In the extracts that follow, Sr Avela and Dr Lynn explain how, though patient-centred care is a priority in their counselling practices, they operate within a system that is influenced by experience postpartum, women's relationships and the communities in which they are nested:

Extract 6.39

> **Sr Avela:** We have *nur-isterate* and *petogen,* right? The one also known as *depo* (.) Those who use *petogen* usually come asking for it because that is what they were given when they gave birth at the hospital, and it will last them a long time before they have to come to the clinic again. They do not like coming to the clinic to come wait in line just for an injection. You understand? So that is the reason that they put forward. Then, the ones who use the *nur-isterate* are usually the school children. They really like the *nur-isterate*. But before we administer contraceptives to anyone, we explain all the different contraceptives. Then, it is always the person's choice which one they want. Before making their decision, we always inform them properly of all the options; then, it's the person's choice to make. But they come with the preconceived notion that they will start off with the *nur-isterate*. *[Village, PHC, X]*

Extract 6.40

> **Dr Lynn:** I mean, our patients all use DMPA (*depo-provera*). I think it's historical. I think people use what their grannies used. They use what their mothers used, so they know that's what people use. So, patients, particularly we will see postnatal patients, and they will say, we will say to them, "What would you like to use?" And their first answer will always be injectables. It will never be anything else. We have to really counsel and try quite hard to motivate patients to try and use something we would consider to be better. Although I know that LARC, including injectables when I think about LARC, I don't think about injectables because I know that in a year, 50% have stopped using it. So, I, for me it's only long-acting for three months, and then after that, it's not long-acting anymore /yes/ so I try to discourage patients from only thinking about injectables. Not that I discourage them from using injectables, but from only thinking about injectables. *[City, PH, E]*

In extract 6.39, Sr Avela describes contraceptive uptake as configured in society or other institutions rather than through interactions with healthcare providers at clinics. For example, postpartum women access clinics to continue with methods chosen at hospitals. In reinforcing this statement, *depo provera* is seen as convenient in limiting healthcare centre visits for postpartum women who supposedly lack the time for frequent clinic visits. In contrast, *nur-isterate* is simply cited as a method young women "like". While this talk indicates constrained choice, Sr Avela refigures this constraint by drawing on a choice discourse where she encourages health users to select desired contraceptive technologies from various options. This

options-based counselling is, however, presented as manifesting the same configurations in use, e.g., young women gravitating towards *nur-isterate* rather than exploring other options.

In extract 6.40, Dr Lynn construes information counselling that results in women opting for LARC measures other than injectable contraceptives as requiring more than the usual effort. She attributes this skewed preference towards *depo provera* to shared knowledge within kinship ties when she says, "I think it's historical. I think people use what their grannies used. They use what their mothers used, so they know that's what people use". Therefore, women's decisions revolve around their mothers' and grandmothers' decisions. As such, during postnatal contraceptive counselling, when allowed to choose from various contraceptives, women are said to consistently opt for *depo provera*, which Dr Lynn covertly problematises. To do this, firstly, she problematises the long-acting nature of injectable contraceptives and whether it warrants them being termed a form of LARC. Secondly, she references inconsistent contraceptive use as another deterrent for her in her counselling practice. Lastly, she problematises and challenges health users for limiting their own range of birth control technologies to injectable contraceptives, albeit she avoids denying them the option of injectable contraceptives within counselling, thus pointing to the operation of a choice discourse. Both Sr Avela and Dr Lynn are emplotted as non-directive or open to LARC users' choices in the above extracts but restricted by their patients' choices, while LARC users are emplotted as closed-off to choices and sticking with the familiar.

4. Conclusion

This chapter explores healthcare providers' constructions of contraceptive users' decisions to use LARC and the emplotments these constructions avail and restrict. The analysis of the first part, stories of seeking contraception, shows that healthcare providers reported on engagements not only with the contraceptive users' wants but also with partner and parental influence in women's decision-making. As such, not all contraceptive users who seek LARC technologies do so freely. Planning parenthood and "my body, my choice" discourses were used to narrate the secrecy within which women met their own reproductive intentions to space, limit or avoid childbearing under circumstances in which their partners' intentions threatened their ability to use contraception openly. What is increasingly apparent within the analysis is LARC users' defensive use of contraception, and the collusive, supportive role healthcare providers rendered themselves as providing, which emplotted them as allies to health users. Yet, this supportive and rights-based talk had its limits within parent-child relationships as healthcare providers failed to remain consistent when defending young women. It was multiparous women who

could be defended while young, public health-using women were steered towards the coerced and sometimes unconsented provision of LARC technologies.

Healthcare providers also drew on a male reproductive pardoning discourse to construct women's decisions to avoid contraceptive duty as equivalent to choosing pregnancy, as men are not recognised as contraceptive users. As such, the role accorded to male sexual partners was minimal, thus conveying the sense that they were "lacking concern, knowledge, and responsibility in terms of reproduction" (Saunders, 2018, p. 188). Hence, they often were excluded as legitimate decision-makers about contraception beyond the male condom. Thus, many young women were obligated to subjugate themselves to become docile bodies or disciplined contraceptive-using subjects through self-surveillance and other disciplinary mechanisms. While awareness of males' invisibility was reported, parents' visibility was recurrently cited as hinging on LARC users' decision-making within consultations.

A different alliance was formed in three-way counselling sessions that included female guardians. These alliances forged with guardians/parents in pushing for contraceptive uptake were premised upon young women's "failure" to exclude boys from social circles or upon menarche and in case of rape. As such, healthcare providers reported on coerced users who sought contraceptives under duress, following these directives from their female guardians through adolescence-as-transition and risk discourses. Therefore, stories of seeking contraception also demonstrate that not all participants who do so are willing contraceptive users.

In stories elicited about provision, healthcare providers framed contraceptive counselling with third parties, particularly the mother, as not an easy alliance as they presented tensions needing resolution during the consultation. Should they provide the requested LARC measure, and if not, on what grounds? While most healthcare providers were acquiescent to the externally mandated directive to offer LARC, they validated their decisions by drawing on the adolescence-as-transition discourse in conjunction with a risk discourse to frame themselves as complicit in the event of pregnancy based on their denial of access to contraception. Within this was an implicit assumption that young women were unattuned or unaware of their own "risk". As such, the "elevation of the consumer to the status of master" (Nordgren, 2010, p. 112) was amiss within the consultation as the consumer became female guardians even though the service was for the young woman whose choices were relegated to the side. As such, the decision to administer the requested LARC technology became a shared decision between the

healthcare provider and parents, with the adolescent women as spectators to the contraceptive counselling and ultimate provision of the contraceptive technology. These young women's consent was thus not obtained. Instead, parental consent was obtained.

Many healthcare providers formulated accounts of prioritising patient-centred care within contraceptive counselling. As such, choice discourse and rights discourses were used to construct the necessity of provision being a consultative process where enacted decisions were the product of health users' responses to various contraceptives offered rather than healthcare providers' recommendations. Individualised experiences were identified as supporting this process. Contradictions about full method choice were also evident as, for example, healthcare providers elicited accounts of the overconsumption of injectable contraceptives, although they, through choice discourse, attempted to open up choices. Health users were emplotted as obstinately choosing injectable contraceptives. However, if they were "too young" or in the postpartum period, they were almost obligated by healthcare providers to choose injectable contraceptives. This affirms the assertion that patient-centred care is increasingly identified as a "moving target" (Hayer, 2022, p. 2) when it relates to groups considered "at risk", even though decisions are meant to belong to the health user. The support or maybe guidance healthcare providers are meant to give is overextended; as such, the counselling can assume a directive nature rather than being options-based and ultimately meeting the needs of the health user.

Chapter 7: Information counselling and decision-making

1. Introduction

In the previous chapters, I explored healthcare users' and healthcare providers' micro-narratives on the prescription and use of LARC. This chapter presents an overview of data from contraceptive users that relates to the discursive construction of the contraceptive information counselling session, and the emplotments availed and restricted by the talk. I speak to the ways health users negotiate decision-making within contraceptive consultations. In addition, I explore the resultant power struggles between the medical practitioners and contraceptive users using three overarching narratives, *viz.,* information and decision-making was expert-led, information and decision-making was patient-led, and the information and decision-making was collaborative.

2. Information and decision-making was expert-led

This section explores talk about contraceptive encounters in which healthcare providers were deeply involved in decision-making to the degree that contraceptive users themselves assumed secondary roles or even abdicated their part in decisions reached within contraceptive counselling sessions. Their own knowledge featured as deficient; thus, medical knowledge took precedence. While the health users could remove themselves from decision-making, decisions sometimes were dressed as pre-packaged and, when presented in this way, health users were unknowingly obligated to accept the health provider-made decisions.

A medical expert discourse is used recurrently by participants in this section to indicate how healthcare providers "secure authority" (Morison et al., 2022, p. 236) in interactions. In so doing, prescriptions were set up in static ways and as "truths", and so were the decisions expected to emanate from such formulations. For example, information sharing could be deceptive, thus conscripting health users towards LARC use while concealing the source of these mandates as not the medical experts' own biases and judgements but belonging to the Department of Health. Healthcare providers also sometimes found no value in offering thorough, in-depth information about side effects tied to using some LARC technologies. In later sections, information sharing is also manipulated to remove many LARC technologies from the realm of choice as healthcare providers regulated and managed the reproductive destinies of health users. Contraceptive counselling as a space that marks patients as parous,

unreliable, young, poor and thus not deserving of agency can be gradually noted. Here, we see how according to Foucault (1976), perceptions of medicine differ in history, and so does the treatment of the medical-seeking subject in the present as the forces applied by healthcare providers upon health users tightened and loosened depending on the subject. "The fundamental perceptual codes that were applied to patients' bodies, the field of objects to which observation addressed itself, the surfaces and depths traversed by the doctor's gaze, the whole system of orientation of this gaze … varied" (Foucault, 1976, p. 54). As such, the medical experts' inconsistencies and silences evident in health users' narratives challenge medical knowledge's claim to be bound in truth but nevertheless demand authority and pacify health users, as will be seen in the section below:

2.1 "I was (not) told"

Some postpartum and post-abortion LARC-using women reflected on the lack of voluntarism towards contraceptive uptake, with healthcare providers spearheading the process and decision-making. Within this, the enactment of a decision by the contraceptive user became befuddled as participants took for granted that this was supposed to be an expert-directed or expert-led process that precluded their consent. In addition, enacted choices were often limited to the provision of injectable contraceptives. Extracts 7.1 and 7.2 below are evidence of this:

Extract 7.1

> **Nandipha**: They never asked; they just injected us. They injected us and then told us to go to the clinic after three months to get another injection. *[Village, PBH, X]*

Extract 7.2

> **Zonke**: They didn't give me a choice /ja/ they were like, "We don't want to see you here [abortion clinic] again, so go there and get the injection". They even decide on it while sitting there. Another will ask which needle did you inject her with? She'll respond, "We injected her with *petogen*. She will be back after three months or something" /mhh/ So it's not like you have a choice. *[City, PBH, X/E]*

The expert-led nature of the encounter is contained in the use of the utterances, "They never asked", "they […] told us", and "They didn't give me a choice". This way, silence and manipulation prelude decision-making and centre the contraceptive counselling session around provision for Nandipha and a group of other women in excerpt 7.1. In the interactions, the contributions of contraceptive users were, according to the participants, disregarded. As such, healthcare providers dominated decision-making by avoiding asking contraceptive users about their preferences but merely administering injectable contraceptives to circumvent the possibility of a repeat pregnancy. In addition, contraceptive users are instructed or issued a directive to access the health facility after three months for continued use of the expert-

determined contraceptive measure. An unreliable patient discourse undergirds the micro-narratives as the capability to avoid repeat pregnancies reliably is implicitly questioned and forcibly regulated through unconsented LARC provision, and subsequently, decisions around non(use) are elided from the women's realm of choice. This talk emplots Nandipha and Zonke as passive, non-agentic subjects while healthcare providers are emplotted as fulfilling governmental mandates. Such talk affirms the assertion that "doctors do not consider that women can be trusted to make the 'right' or 'rational' decisions over contraception, and this perception informs and recasts the power relationship between women users and health providers" (Lowe, 2005, p. 363).

Some participants reported on the brevity and quality of contraceptive counselling sessions, associating limited and poor interactions with an absence of care. For example, in the excerpt below, Viwe reports on experiences encountered accessing injectable contraceptives and eventually deciding to discontinue use:

Extract 7.3

> **Viwe**: With the injection, it was horrible, I think that's one of the reasons why I stopped using it, Yanela. The injection, like those nurses would pull a straight face and just want to **pshhh** [makes sounds] the needle into your bum, and that's that, get out. [Raises voice] "**NEXT!**" /YN *laughs*/ Like it was so horrible. There was no sympathy, the advice, they were just doing what they were doing. *[City, PVH, X/E]*

One word is reportedly uttered during the encounter, "next!". There was reportedly minimal communication during the eight or twelve weekly administration appointments, thus suggesting no contraceptive counselling, just contraceptive provision. In further describing the interactions, Viwe says, "those nurses would pull a straight face and just want to **pshhh** [makes sounds] the needle into your bum, and that's that, get out". The use of the referent "those nurses" works to other healthcare providers as insensitive and unengaged, thus incapable of caring about clients' well-being given the oversubscribed nature of the clinics. Hence, they, reportedly, with a "straight face", almost violently inject a needle into one's buttocks and dismiss the patient without any consideration of their emotions, preferences and embodied experiences. This talk suggests that contraceptive users can be seen as mere numbers rather than human beings, where fertility reduction through the provision of contraceptives among compliant contraceptive users who avoid defaulting on specified repeat-injection dates is tacitly deemed the only important aspect of healthcare providers' mandates. Viwe sums up the micro-narrative by saying, "It was so horrible. There was no sympathy, the advice, they were just

doing what they were doing". Viwe takes up a medical expert discourse (Foucault, 1976), which activates and verbalises the healthcare provider through the medical gaze while pacifying and even hurting the healthcare user. Yet, the healthcare provider's oblivion to this is evidence of how "the doctor's gaze is directed initially not towards that concrete body, that visible whole, that positive plenitude that faces him—the patient—but towards intervals in nature, lacunae, distances, in which there appear, like negatives, 'the signs that differentiate one disease from another, the true from the false, the legitimate from the bastard, the malign from the benign'" (Foucault, 1976, p. 8). While Foucault (1976) refers to the abstraction of the patient during the localisation of disease in the text, the same mechanics can be seen in fertility regulation. In reaching a wide number of contraceptive users, the healthcare provider detaches and objectifies individual health users to abolish fertility but at the expense of quality care. As such, medical knowledge takes ownership of the interaction.

This narrative emplots healthcare providers as lacking empathy and not tending to the patient's needs, while contraceptive users are emplotted as needing empathy and advice. As a result, loss of bodily integrity can be experienced; hence, Viwe says, "I think that's one of the reasons why I stopped using it". Discontinued use is thus also caused by interactions that are starved of bi-directional engagements and care.

While the use of silence or lack of communication within expert-led encounters is seen in the above extracts, in the extracts below, other participants recited stories of medical experts overselling certain contraception, closing down options and limiting information sharing around contraceptives. That is, healthcare providers were construed as saying a lot (over-selling) or saying little (closing down certain options) by Hlengiwe and Zonke in order to direct decision-making:

Extract 7.4

> **Hlengiwe**: This loop, I mean the doctor that inserted it [IUD] in me, sold it as good, you see. But did not tell me about how it works, so I put it on and did not have any problems. Then I found out when I went for my check-up they gave us more information about it. When we were being told about it, they told us that while on the loop, you can fall pregnant… While on the loop what can happen is that while you're menstruating the loop can move from its place. Let's say you and your boyfriend did what you did, and it hasn't returned to its place; I mean, that's one of the things I wish they... It would have been better if they told you before. Before inserting because I would have never, I would have used my injection because I see being on this loop as a risk, and they said you must use a condom on this loop. *[City, PBH, X]*

Extract 7.5

> **Zonke**: Look, when you are going to terminate, everyone who is there to terminate sits in the same room. People who are there for contraception do what they are there for and leave; they

> don't even queue with you. How about while they are wasting time and doing nothing there by the table, one person talks to us and says, "Look, we realise it's a mistake and you don't want… and we wouldn't want you to be here maybe next year or in two years' time if that's not part of your plan. Why don't you consider family planning and then place them… *[City, PBH, X]*

In extract 7.4, Hlengiwe describes her doctor as minimising the side effects of IUD use. She frames more information about side effects as possibly having been a precedent to her refusing the IUD and opting instead for injectable contraceptives, with which she cites a pleasant history. This disjuncture in the information offered by one doctor and omitted by another points to the instrumental nature of the depth of information sharing. The talk suggests that medical experts use information in various ways to ensure uptake. This includes making trade-offs between full disclosure and avoiding or minimising side effects. In avoiding full disclosure and using reassuring language about the prescribed measure, more contraceptive users willingly use these contraceptive technologies. However, when provided with more information, these decisions can be regretful for health users like Hlengiwe in extract 8.5. An uninformed choice discourse underlies this talk and feeds into the medical expert discourse as it disregards consumer choice and satisfaction by regulating the information shared. While the contraceptive user can be the decision-maker within the talk, healthcare providers set information sharing in ways that ensure certain choices are made over others that could suit the contraceptive user better. The participant is emplotted as an uninformed IUD user in the talk, while the healthcare provider is emplotted as deceptive.

In extract 7.5, Zonke emphasises the need for a thorough contraceptive consultation post-abortion, thus rendering the time presently attributed to contraceptive counselling insufficient. In the text, contraceptive counselling, and ultimately LARC uptake, is construed as a valuable solution for circumventing the "risk" of repeat unintended pregnancies that can assist women in avoiding abortions, which she construes as a wrongful act or a "mistake". Zonke thus frames healthcare providers as the gateway to contraceptive compliance by asserting that "while they are wasting time and doing nothing there by the table, one person talks to us". However, according to Zonke, these providers opt for time-wasting at the expense of educating contraceptive users about the range of available contraceptive measures. Therefore, drawing on an uninformed choice discourse, an assumption is made about healthcare providers as either choosing not to engage or not dialoguing enough with the women when they could. As a result, this becomes a lost opportunity for informed consent around uptake for the participant. This

way, healthcare providers are emplotted as failing to support women and women as denied information, which can result in regretful decisions.

Hlengiwe and Zonke draw on an expert-led narrative but point to potential problems with it – overselling a contraceptive or inefficiency. The solution they propose is not more agency on their own part but better expert-led practices – the correct information and better efficiency.

2.2 "It's a standard procedure after birth"

In this micro-narrative, participants narrate how LARC measures were not always administered with their consent, especially postpartum. Instead, these decisions towards uptake were described as framed by healthcare providers as stringent Department of Health policies. As such, use was understood as non-negotiable. This suggests that, as seen in the previous chapter, healthcare providers also coerced women to take up contraceptives in the same way as some female guardians were reported as doing.

Extract 7.6

> **Thandiwe**: I was injected with the two-month injection, *nur-isterate*. It starts at the hospital after you've given birth, and then you continue with it when your month arrives consistently after every two months. *[City, PBH, X]*

Extract 7.7

> **Yamkela**: After we had given birth, we were taken to post-delivery wards. Then, we were asked what we were going to inject. The three years one or the... I said I was scared of the three-year one cause I don't even know what it looks like. I said, "I'm sorry, nurse. I don't want the three-year one". I said, "No, I want the one I am used to, *petogen*". I was then injected with *petogen* before I left. *[Village, PBH, X]*

Extract 7.8

> **Zimkitha**: Uhm, I think it's standard procedure for the Department of Health. Everyone after giving birth is given contraceptives; it's not a choice *ja.*
> **YN**: Please tell me the story. What happened?
> **Zimkitha**: You give birth, and then they tell you that okay this is what we're gonna do because after you've had a child, we, as the Department of Health think it's best that you have at least a space of two years to three years before you can have another child again. So, they inject you and then after that, it's up to you if want to go back or not; they don't [can't] force you. *[Town, PBH, X]*

In the above extracts, healthcare providers are represented as tailoring and structuring the conversation towards contraceptive uptake. This is achieved by depicting postpartum periods as risky, and so women are forced to limit this risk. As such, this period spent at the hospital marked contraceptive debut for some participants and continuation for others. The utterances, "It starts at the hospital", "We were asked what we were going to inject", and "Everyone after giving birth is given contraceptives; it's not a choice" points to ways in which healthcare

providers normalise contraceptive use within medical institutions for postpartum women despite policies against such coercion and deception. What constitutes the talk as expert-directed decision-making is how uptake is negotiated through a question that already assumes use, e.g., "What are you going to inject?" or a deceptive statement around the government expecting contraceptive usage, thus limiting opportunities for refusal. As such, minimal input is required from the clients who are emplotted as "at risk", optionless and adhering to government regulations within these encounters, while healthcare providers are emplotted as the authority and reducing fertility in postpartum women.

Thandiwe and Yamkela, in extracts 7.6 and 7.7, both link their contraceptive uptake with brief encounters with healthcare providers where they are either given a contraceptive or asked about their contraceptive technology of choice. Implicit within the talk is an unreliable patient discourse that renders patients as deceptive or untruthful, unrealistic, or refusing to confess to their "risk" of repeat pregnancy. Therefore, allowing non-use of LARC technologies reinforces this risk. Hence, healthcare providers direct both participants to use measures they did not seek. In addition, in pre-packaging the decision as externally mandated by the government, they implicitly push against health users' claims of agency. This talk emplots the contraceptive users as non-agentic and the healthcare providers as in control.

Zimkitha also constructs the postpartum injection she received as procedural, thereby nullifying choice. To further support this, a deferral of responsibility about the coercive nature of the consultation is evidenced by the healthcare providers' reported implicit framing of the expert-directed decision and subsequently reduced choice as a component of a top-down mandate from the Department of Health rather than their own biases about birth spacing. Within the text, the option of non-use is delegitimised. Yet, towards the end, self-determination within expert-directed decision-making is reclaimed. Although injectable contraceptive use is normalised and not to be resisted ("not a choice"), ongoing use is rendered as dependent on the subject as "they don't [can't] force you". This suggests that beyond the hospital setting, decision-making rests upon the individual. Therefore, the veil between choice and coercion becomes thin, here, because, beyond the consultation room, the sovereign power that produces compliant contraceptive-using subjects through coercion can be tacitly resisted. Health users are thus emplotted as temporarily non-agentic while healthcare providers feature as temporarily in control.

Thandiwe and Zimkitha in extracts 7.6 and 7.8 reflect on method choice being exclusively limited to injectable contraceptives. In extract 7.7, Yamkela does not deny uptake but denies the unfamiliar LARC technology (the three-year, *Implanon*) selecting injectable contraceptives in its place. Choice of measure, in this way, becomes optional while uptake remains mandatory. However, not all participants emplotted themselves as agentic and thus able to resist, particular LARC technologies. Examples of expert-directed counselling narratives, in public health, that frame contraception as an incontestable necessity and injectable contraceptives as the only contraceptive measures rendered suitable for postpartum women are evidenced below:

Extract 7.9

> **Siyasanga**: No like, how am I going to explain this? Because like I thought after giving birth a person has to get that injection, so that's why I did not say no. I was given a date for the next one, and then after going, I would get another date just like that so that I continue with it.

Extract 7.10

> **Sandisiwe**: It's the nurses, they told me that a person that has just given birth uses the injection for contraception and I didn't know much about the injection, so I agreed.

Siyasanga and Sandisiwe report on decision-making capabilities around contraceptive uptake postpartum resting purely with the nurses as, for the most part, the women constructed themselves as unaware of their right/ability to resist the unilateral decision. The participants take up the uninformed choice discourse where full disclosure about contraception is not a priority for the healthcare providers, instead contraceptive uptake is prioritised, and such talk emplots them as unknowing and healthcare providers as concealing information. Both participants also assume a reflexive approach by which Siyasanga provides a reason for "why I did not say no" and Sandisiwe says, "I didn't know". The interview space, therefore, causes trouble as participants bear witness to the power dynamics that produced directive and coercive contraceptive counselling sessions. In addition, contraceptive provision as potentially disempowering is visibilised by this power differential; "the view of users as uniformly underprivileged, undereducated, and excessively fertile women, or targets of population control" (Takeshita, 2004, p. 74) is implied by the one-dimensional decision-making that coerces use through deception to safeguard against repeat pregnancies in public health facilities.

More overt instances of expert-driven decision-making narratives and the normalisation of injectable contraceptives underlie the extracts below:

Extract 7.11

> **Qaqamba**: The *petogen* right? As I was being discharged from the hospital on the day after giving birth, they said that *petogen* is mostly for people who have children. They injected me with it, and then I just never stopped using it. I started birth control with it and just continued with it. *[City, PBH, X]*

Extract 7.12

> **Lindelwa**: I never chose *depo [provera]*. They said *depo* [*provera*] is used by people with children. People with children shouldn't use *nur-isterate*. *[City, PBH, X]*

In the above, choices around contraceptive use, particularly injectable contraceptive use are depicted as static or determined by parity. In these cases, a dichotomy of nulliparous versus parous women is created thus emplotting Qaqamba and Lindelwa as restricted access to other contraceptives and directed towards *depo provera* by healthcare providers based on parity rather than choice. The differences between *nur-isterate* and *depo provera* are often arbitrary as both contraceptives have comparable efficacy but are different in their long-acting nature. Parous women were cast as more appropriate users of *depo provera* while nulliparous women were *nur-isterate* users. This demarcation has to do, according to Martin and Kraus (2013), with inconclusive evidence about *depo provera's* promotion of lactation over other hormonal contraceptive alternatives. Both participants acquiesce to the directive towards *depo provera* use and further associate it with a firm boundary that cannot be transgressed in terms of choice of contraceptive measures, thus limiting access to other forms of LARC. The workings of an uninformed choice discourse are evident in the above extracts through which contraceptive users are stratified as legible or ineligible for certain choices and thus not deserving information about methods they are disqualified from using. This denial of certain contraceptives to certain women or interference with agency is coined as "downward coercion" by Senderowicz (2019, p. 3).

The binary created that allows and disallows contraceptive technologies based on parity extended to abortions. For example, Thozama offers an account of how the nulliparous versus parous dichotomy extends to terminations of pregnancies.

Extract 7.13

> **Thozama**: If you get pregnant, it doesn't matter if you miscarry; you have to use the three-month one. So, at that time, I was still a child, and I was using the two-month one, so after the abortion, I used the... they put me on the three-month one. *[City, PBH, X]*

Like many of the participants who mobilised the uninformed choice discourse to relay using

certain contraceptives while nulliparous, Thozama reports on being on the *nur-isterate* injection first. Drawing on an expert-directed decision-making narrative, she is later switched to *depo provera* due to the history of conception, even though she terminated the pregnancy. The method switch to *depo provera* for most women often occurs postpartum before women are discharged from the hospital*,* as mentioned above. However, given her medical history, she is steered towards *depo provera,* even though she emplots herself as a child and is thus still suited to use *nur-isterate*. Healthcare providers' understanding of what this method-switch implies – pregnancy – is construed as having induced shame and embarrassment; this can be seen in the extract below:

Extract 7.14

> **Thozama**: And believe me, being a teenager in high school and injecting the three-month one is so embarrassing. *[City, PBH, X]*

Thozama is unable to successfully method-switch back to *nur-isterate* even though she is also nulliparous as she never gave birth. The shame Thozama feels is related to the general social disapproval of "teenage pregnancy" and abortion. The method shift "outs" her as having been pregnant and having had an abortion. An uninformed choice discourse is here also drawn on to depict the rigidity of contraceptive choices in contraceptive counselling to certain users that closes off other contraceptive technologies and information sharing. This emplots adolescent, nulliparous women who use *nur-isterate* as performing their sexuality and reproduction better than parous young, adolescent women who use *petogen*/*depo provera*.

2.3 "They don't beg if you are a child and you have a child"

Overt coercive provision of contraception was evident in young women's micro-narratives. Here, the option to refuse contraceptives was framed as unavailable. This is illustrated by the text below:

Extract 7.15

> **Kuhle:** Obviously, when you are being discharged from the hospital, they do inject you. In fact, they don't tell you and don't beg you, especially if you are a child and you have a child. They don't beg you; they don't ask you if you want it or not. *[Town, PBH, X]*

Correspondingly with other participants, Kuhle reports on receiving injectable contraceptives as procedural; this is implied by her use of "obviously" at the beginning of the extract. She adds, "They don't tell you and don't beg you", which signifies the entitlement healthcare providers can approach young women's bodies qualified by expert-patient power dynamics.

By repeating the phrase "they don't beg you", a sovereign form of power is invoked where women's own decision-making is cast as irrelevant if it resists LARC uptake. Yet, Kuhle does not find an issue with the violent nature of the interaction due to the problematic adolescence-as-transition discourse that constructs reproduction during adolescence as mistimed and inappropriate, thus requiring regulation (Macleod et al., 2020). This is further reinforced when she says, "especially if you are a child and you have a child", which constructs a hierarchy in terms of women's ability to refuse contraceptive provision, with young adolescents being given the least amount of opportunity to evade contraception postpartum. This utterance also "underwrites the idea that motherhood is a class privilege, properly reserved only for women with enough money to give their children 'all the advantages,' a deeply antidemocratic idea" (Ross & Solinger, 2017, p. 5). Kuhle repeats this statement at the end of the excerpt "They don't beg you, they don't ask you if you want it or not", thereby reinforcing the notion that choice is reserved for a particular kind of woman as once child bearers are emplotted as "fledgling" or the boundaries of "good womanhood" are transgressed, rights are revoked.

Kuhle later uses age differently to refigure the above account of reduced agency. Here, she asserts that the consequences of unintended pregnancy are different for older women vis-à-vis adolescent women. Extract 7.16 below is evidence of this:

Extract 7.16

> **Kuhle**: When you are a child, when you are an older child, shame. If right now I fell pregnant /mhh/ they would ask me. But when you are a child, they don't beg you. They expect that you will have another pregnancy, /okay/ so they try to avoid you falling pregnant again. *[Town, PBH, X]*

Kuhle describes a hypothetical situation that details the potential for a shift in power relations. Reflecting on then (during her adolescent years) and now (during adulthood), she indicates, "If right now I fell pregnant /mhh/ they would ask me. But when you are a child, they don't beg you". While patients do exert agency in consultations (Lorentzen, 2008), many participants spoke about being denied this agency in adulthood; thus, the juxtaposition of then and now does little to guarantee women agency in expert-patient relationships. In addition, within the utterance, adolescence is construed as a period of enforced docility, with young women's reproductive experiences being shaped by others. Nullifying the opportunity for patient-led decision-making based on age presupposes appropriate or inappropriate reproductive subjects and emplots medical experts as gatekeepers of reproduction.

2.4 "What are you going to inject?"

This micro-narrative centres around the contraceptive users who constructed accounts of minimal conversations in consultations on contraceptives they took up, thus framing their decisions as largely steered by the healthcare providers. In addition, the variety of available methods was not shared with the women, pointing to constrained choice. Instead, decision-making was directed and limited to two different forms of injectable contraceptives rather than producing fully informed contraceptive-using subjects – an essential outcome of the information counselling session (Higgins, 2014; National Contraceptive Clinical Guidelines, 2019). This can be seen in the excerpts below in which birth control options are restricted to injectable contraceptive provision:

Extract 7.17

> **Buhle**: I don't want to lie; the nurses arrived pushing those things they drive around [medical trolley]. I don't know what they are, and they have things inside. They asked, "Which injection do you want"? They didn't ask me if I would like to get an injection or not. Then I told them that I wanted the *petogen* and the other one [another patient] wanted the one-month [two-month] one. I don't know what it is called. We were injected with it and given the dates for us to come back to the clinic. *[Village, PBH, X]*

The contraceptive counselling session for Buhle and another patient in the post-delivery ward was presented as, too, part of the delivery process and thus not optional. Informed consent is a valuable component of contraceptive counselling (National Contraceptive Clinical Guidelines, 2019). Yet, women's agency is obfuscated through constructing LARC provision as a procedure, thus hiding provider force. In asking, "Which injection do you want?", a limited choice is offered – not whether, but which contraceptive is desired. Thus, choice must be enacted despite their possible desire to refuse contraceptives. This way, choice devolves to deciding on a desirable method between two injectable contraceptives (*nur-isterate & depo provera*) even though quality contraceptive counselling is expected to be inclusive of the full range of contraceptives as well as the right to refuse uptake, which emplots the health users as docile bodies and the healthcare providers as gatekeepers of choice.

This absence of options-based counselling is indicative of how expert-driven decision-making stands in opposition to the notion "that women are not passive recipients of medical care and medicalization, but active participants in medical power relations as they attempt to achieve particular health states and configurations of gendered embodiment" (Lorentzen, 2008, p. 52). To further entrench the differential power relations between medical experts and contraceptive users, medical apparatuses are invoked at the beginning of extract 7.17. The presence of the

trolley with contraceptive equipment during the consultation points to the effects of institutional power in information sharing, which creates an inability to resist the imposition of contraceptives for many patients. Key in the exercise of this power are dividing practices that demarcate the healthcare provider as an expert and the contraceptive user as the patient, which, for some patients, refuses them the status of collaborators in consultations.

Similarly, Qaqamba, in the extract below, reports on directive counselling practises that worked to obscure choice of usage and method beyond injectable contraceptives within contraceptive counselling despite the availability of a wide range of contraceptive methods and refusal.

Extract 7.18

> **Qaqamba**: No, shame, I don't wanna lie. There was no conversation no there is no conversation. They just ask you what you want. "What are you going to inject? The *petogen*?" They inject you, and then you leave. *[Town, PBH, X]*

Qaqamba in the above shows how healthcare providers are construed as enquiring about the preferred measure of contraception, using the narrow reference "What are you going to inject?" Thus, expert-directed information presents injectable contraceptives as the only choice, as these LARC methods form the backdrop upon which choices and decisions are enacted. In so doing, healthcare providers tacitly framed provision as compulsory and decision-making as superfluous, thereby emplotting health users as non-agentic.

2.5 It wasn't a personalised conversation

Some participants bemoaned a one-size-fits-all approach. However, what was common was the desire for contraceptive users' voices to either steer or collaborate in the decision-making rather than be excluded. For example, Khanya renders the information counselling she received problematic, further stating that she sought information counselling that could be custom-tailored to suit her lifestyle – "a personalised conversation". However, the healthcare provider is constructed as having failed to provide this:

Extract 7.19

> **Khanya**: Very like, they gave me really like a thing that I know maybe they've rehearsed from a thing. Like they went to a workshop. It was not very much a thing of, "What type of person are you?" It wasn't a personalised conversation. It was very much a professional, tick-a-box PowerPoint presentation of what this thing is. If you can't do this, do that; if you can't do this, do that, blah blah. *[Town, PBH, X/E]*

Khanya constructs the information counselling she received as "rehearsed". She describes it as rote learned from a workshop and regurgitated in the counselling session. This description

serves as her portrayal of the healthcare provider's inability to relate to her lived experiences. This suggests that the medical discourse that excludes women's personal experiences is considered alienating (Downey et al., 2017). This point is further reinforced when she says, "It was very much a professional, tick-a-box, PowerPoint presentation of what this thing is. If you can't do this, do that; if you can't do this, do that, blah blah" at the end of the excerpt. The health user prefers a patient-led discussion. Yet, the traditional, expert-directed interaction, which places the healthcare provider at the centre of the conversation while the LARC user assumes a peripheral role, is invoked.

The above talk emplots the participant as a "knower" and "expert" of her circumstance, with this information rendered potentially useful to the conversation since it could offer the healthcare provider context about the best contraceptive fit for her. Khanya, thus, prefers an equal partnership in decision-making. This is evidenced by her utterance, "What type of person are you?" and the summation "It wasn't a personalised conversation". The healthcare provider is therefore emplotted as ignorant of the "expert" information that Khanya brings into the information counselling session. Downey et al. (2017) point out that "when epidemiological data and method effectiveness are the primary evidence [for LARC method choice], many women's needs are neglected, resulting in a 'one-size-fits-all technological solution' to an issue that is highly personal, contextual, and evolves over time" (p. 540). This, therefore, suggests that a deviation from generic information sharing in garnering contraceptive users' choices and preferences is necessary.

Chwayita, in the extract below, reports on the lack of support as healthcare providers were to journey elsewhere at the onset of her contraceptive counselling session. This left little time for a thorough conversation about the available LARC technologies.

Extract 7.20

> **Chwayita**: The injection I like went after school with a friend of mine, and then the sisters were in a hurry to leave, so they were just like, "Read this; I will just give you the shot and then go". So, I never really got, uhm, any counselling, or this is what... I think that's what made me panic when I suddenly got all these changes, and then I didn't know what was happening, so I just stopped. *[City, PBH, X/E]*

Expert-directed decision-making is also invoked within the narrative. Little to no bidirectional information exchange is allowed within the interaction, thereby making the contraceptive uptake an uninformed choice. Indeed, an abdication of information provision within the counselling is evident as Chwayita is expected to read the information after she receives the

injection. Hence, she continues to say, “So I never really got uhm any counselling, or this is what... I think that’s what made me panic when I suddenly got all these changes”. This talk demonstrates the workings of an uninformed choice discourse where uptake remains the top priority in healthcare/user interactions. Information sharing is discounted as either secondary or unnecessary despite contraceptive users needing the interaction to be the site of information sharing and not the fringes. Chwayita continues to problematise this, given her inability to understand and cope with the side effects she experienced while using injectable contraceptives, which induced panic. She, thus, emplots the healthcare as “unsupportive” and herself as “unsupported” and “unknowing”. This denial of a full comprehensive consultation can be experienced as neglect.

The provision of in-depth information to contraceptive users during contraceptive counselling with elaborate explanations of the merits and shortcomings of using particular contraceptive measures also had the potential for slipping into expert-directive counselling practices that uphold traditional expert-patient power dynamics. This can be seen in Abosede’s micro-narrative below:

Extract 7.21

> **Abosede**: Well, based on the doctor’s advice there in [South America] where I had… He told me that this will fit because when he wanted to, when he started a lecture on contraception he told me all the various options, he didn’t just talk about the IUD. He told me all the various options, telling me the side effects, and the pros and cons of each one of them. After the lecture, he now said, this one, because he is my gynae. I don’t know what made him, but he said, based on my structure and everything concerning me, that this will best fit with me. *[Town, PVH, X]*

Despite its options-based and pedagogical nature, the counselling offered above can also be expert-directed. This is demonstrated by Abosede’s reconstruction of the informed opinion offered by the medical practitioner when she says, “he told me that this will fit” and “said, this one, because he is my gynae I don’t know what made him, but he said based on my structure, everything concerning me that this will best fit with me”. The healthcare provider in the narrative is emplotted as a “knower” and “expert”, while Abosede emplots herself as a compliant contraceptive user since she accepts the recommended IUD. Implicit in this informative counselling session is Abosede’s inability to resist the use of the contraceptive measure prescribed and construed as the best fit for her based on her “structure” and “everything”. Consequently, this suggests that informative, options-based counselling can also be expert-directed, particularly among compliant contraceptive users who deem healthcare providers’ advice as scientific and, thus, irrefutable.

3. "Information and decision-making was patient-led"

Some participants problematised healthcare providers who allowed them more agency than they were willing to assume, marking the emergence of a patient-led decision-making narrative. Within these narratives, as the analysis will show, patients either sought to make more active decisions or were left to decide by healthcare providers. For example, patient-led decision-making is problematised in the extracts that follow as some participants reported not being fully informed by health providers about the contraceptive measures deemed appropriate for them in contraceptive counselling drawing on the nulliparous versus parous dichotomy when allowed the choice of *depo provera* albeit nulliparous or *nur-isterate* while multiparous. That is, the contraceptive users overtly and covertly report on the desire to be guided about good or bad decisions by healthcare providers.

A patient autonomy discourse is at the root of the detachment in some healthcare providers' responses to patient requests (Aasen & Dahl, 2019). Calls have been made for patients to participate in their own care to transform paternalistic care models within doctor/patient interactions that devalue health users' input. Part of embracing this call requires managing one's own well-being by aiming towards being the "expert patient ideal" (Johnson, 2014, p. 332) where "[m]aternal subjects, as expert patients, are expected to adopt a highly reflexive, intentional and carefully researched orientation to the consumer market catering to pregnancy" (Johnson, 2014, p. 331). Patients are thus not only the objects of care but also direct this care towards objectives that suit their preferences and their lives, drawing on past experiences and their own research, which indicates their increasing position of power. My body, my choice, is a related discourse that advocates for bodily control among its subjects but also inadvertently personalises the consequences of that control (Person & Wetterberg, 2004). Therefore, while the objective is often to share power within medical interactions, some overcorrections can be seen in the extracts below:

Extract 7.22

> **Khazimla**: She didn't say that the three-month one… We tend to choose the three-month one because we get irritated by queueing at the clinic. She didn't say that the three-month one is for people who have given birth and whatever, so I never knew. I [later] heard from my sister and other people. So, I thought I clearly went into the wrong door. *[City, PBH, X]*

Extract 7.23

> **Zodwa**: Err, the first time, I didn't know, so I used the three-month one, and then when I came back, they said, my friends said the three-month one is wrong. I must use the two-month one because the three-month one is for people who have just given birth. Then I

went back there and said I wanted the two-month one, then I continued using it. *[Village, PBH, X]*

Khazimla, in extract 7.22, explains how, when presented with both types of injectable contraceptives and further informed that *nur-isterate* lasts for eight weeks while *depo provera* lasts twelve weeks, she opted for *depo provera* to avoid frequent clinic visits. However, she doubted her chosen method after discovering existing societal constructions about the appropriateness of *depo provera* for nulliparous women. As a result, based on this notion, she expresses a desire for expert-directed decisions to avoid making choices deemed biologically incorrect. Thus, these patient-led decisions are redressed at subsequent clinic appointments. Patient autonomy discourses thus do not always allow health users to make what they deem as "normal" decisions as the scope for choice is widened.

Zodwa relays a similar account, basing this wrong choice on a knowledge gap – one that her peers later fill. Both Khazimla and Zodwa emplot themselves as "novices" and their peers who have experience with contraceptive measures as the "knowers" or "experts". In turn, healthcare providers are emplotted as deferring to participants. While both participants depict their decisions as enacted without sufficient information about social norms, the patient autonomy discourse allows the re-enactment and revision of no longer adequate decisions.

As seen above, peer information was construed as influential in shaping decision-making about contraceptive use, and so was conducting one's research. Siphosethu, in extract 7.24, relays an account in which uncertainty about the appropriate contraceptives to use emerges.

Extract 7.24

> **Siphosethu**: Some say the one that you are using is not right; you must use another one. Then, when you do your own research, the one they made you take is for people who maybe already have children. Then, you become unsure if they know what they are doing. *[Town, PBH, X]*

In the above extract, Siphosethu questions the appropriateness of the contraceptive technology she is using, suggesting a level of mistrust about the competence of the healthcare providers based on the nulliparous versus parous woman dichotomy. This is apparent when she says, "Then, you become unsure if they know what they are doing". Siphosethu draws on community knowledge to gather information about the most suitable injectable contraceptive, thereby emplotting herself as an active and knowledge-seeking contraceptive user and detached healthcare providers as incompetent. The excerpt is thus indicative of how other support

structures can influence decisions.

Other participants sought more individual decision-making and thus were less passive during the contraceptive counselling encounter. Instead, they were active, conducted their research and centred the contraceptive counselling around their own personal preferences, making the encounter patient-led. See below:

Extract 7.25

> **Colleen**: Uhm, I didn't really discuss that with her purely because I had already made up my mind when I went there. She didn't try and dissuade me from it, and I think it's a pretty common thing to have done, [so] she was happy. I said to her I've come to have the *Mirena* put in. We didn't discuss anything about it. I had no prior health issues; maybe that's why we didn't; I didn't discuss it with her. I already knew that I wanted to have it done. *[City, PVH, E]*

Extract 7.26

> **Julie**: So uhm, why I mentioned the UK thing earlier is because I got my implant from the UK because I am on the provident system there /okay/ and I had first heard about the implant when I was probably like 16 or 17 [years old], my cousin from the UK had one. I don't know if it was in South Africa then. If it was, it wasn't very well known /okay/. So, when I was visiting my dad on holiday, I decided to go to the clinic, and I asked for one essentially. *[Town, PVH, E]*

Colleen describes her encounters with healthcare providers as instructive and not consultative. As such, she does not rely on medical experts for information as in the broader text; she reports on having conducted her research on IUD usage, configuring the counselling session as patient-led. Her use of utterances such as "I didn't really discuss that with her" and "I had already made up my mind when I went there" support this and emplot her as an agentic contraceptive user who could not be steered into an alternative contraceptive measure by her healthcare provider and an expert patient ideal given her active role in managing her own fertility. Nevertheless, she also constructs her healthcare provider as "happy" with her decision, which counterpoises her initial agency and suggests collaborative decisions where the approval of medical experts in women's decision-making about contraceptives can be deemed important. This need for support is balanced by the assertion, "I had no prior health issues; maybe that's why we didn't". In so doing, her medical history and embodied knowledge validate her place in decision-making during contraceptive counselling. However, the full agency is reclaimed at the end of the extract when the participant self-corrects from "we didn't" to "I didn't", thus shifting from a collaborative decision to an individual or patient-led decision.

Julie, in extract 7.26, also speaks to a patient-led decision-making narrative. Here, her decisions are informed by her cousin's chosen LARC technology rather than the healthcare providers'

preferences. While she asks for one, the decision is made by her outside of the clinical space and not renegotiated, directed, or denied by the healthcare provider. In addition, discussions about other forms of contraception are closed down. This emplots her as agentic and the provider supportive of the enacted decision. The impact of the patient in optimising their own well-being within the encounter and the muting of the healthcare provider as not necessarily needed within the decision indicates the use of the patient autonomy discourse by Colleen and Julie.

In the excerpt below, the repercussions of not abiding by an expert-led decision can be seen where the participant problematises her healthcare provider's response to her patient-led decision to remove her IUD following three months of use:

Extract 7.27

> **Thobeka**: *Yho,* I wasn't embarrassed, but I was shocked by how angry that nurse got. So what if I get pregnant? It's almost as if I am going to say, "Here, please take care of this baby". Wow, that woman got very angry. I understand that they want the best for us, but…*[City, PBH, X]*

In reflecting on the encounter, Thobeka draws on a "my body, my choice" discourse, which specifies women's entitlement to freedom and choice over their bodies without the permeating influence of a third party (Wigginton et al., 2016), to express shock about the healthcare provider's irate response to her patient-led decision. Inherent in the narrative is the recognition that Thobeka should have the agency to decide whether to use or discontinue contraception. However, the healthcare provider attempts to maintain compliance through anger. This anger configures the relationship in traditional expert-client ways. However, Thobeka's resistance to expert-directed decision-making allows her the choice to remove her IUD. This suggests women's desire for agency and decision support from healthcare providers (Dehlendorf et al., 2017).

In the extract below, Alejandri also demonstrates how patient-led decisions can disrupt expert-led ones. She narrates a story about self-removing an IUD due to side effects upon noticing healthcare providers' delay tactics and resistance to its removal.

Extract 7.28

> **Alejandri**: After my period, I had my period, and then I was just, I actually wanted to go to the woman's clinic, and then they booked me, and then they had my dates wrong and excuses whatever, and I was over it. So, you know when you always have to wait for something, and then you get over it, it felt like that […] I felt that, so I just like pulled it. When I couldn't pull it any more, I took my tweezers and I pulled it out. *[Town, PBH, E]*

This reflection on poor access to contraceptive services ("wrong dates and excuses") presents as a counter-narrative to IUD removal being healthcare provider-reliant. Alejandri removes her own IUD using tweezers to regain bodily autonomy. In so doing, she draws on a patient autonomy discourse to avoid circumscribing health users' ability to act as only relating to accessing medical knowledge. Instead, in removing her own IUD, for Alejandri, the agency goes beyond information sharing and includes performing procedures on oneself when healthcare providers refuse to share power. She, therefore, resists expert-led decision-making ("I was over it"), thus reclaiming her agency.

Thobeka and Alejandri's enactment of the decision to remove LARC technologies in the face of resistance shown by healthcare providers emplots them as agentic. In contrast, the healthcare providers are implicitly emplotted as unsupportive of decisions to remove LARC.

4. "Information and decision-making was collaborative"

More equitable roles within contraceptive counselling than those cited above can be found in collaborative decision-making micro-narratives. The significant aspect of this decision-making micro-narrative is that the pitfalls of the patient-led and expert-directed decision-making narratives are avoided through collaborative decision-making. Medical practitioners in collaborative contraceptive counselling sessions assumed passive and supportive emplotments. Their prime responsibility became the provision of usable knowledge that the contraceptive user must consider concerning the enacted decision, whereas the contraceptive users were the decision-makers. In addition, some participants emphasised the information-sharing aspect and some the emotional support provided. For example, in the excerpt below, information sharing is construed as valuable:

Extract 7.29

> **Nomawabo**: With the gynaecologist, uhm, it was very informative. At least I also had some knowledge from Google, so that okay… I have come with my own information, but it's nice to hear it from someone else. So, the information was fine, you know, because people tell you that listen, there are no contraceptives that are 100% effective. So, there is always that room [for error], so you keep that at the back of your mind that it's not gonna prevent pregnancy 100%. And that was the main thing for me; I didn't want to fall pregnant. So, my decision was based on that mainly. Uhm, the information I received I really appreciated. It was information I needed, so *ja*. *[Town, PVH, X/E]*

Nomawabo reports on experiencing the information counselling session with her gynaecologist as informative, thus implying traditional, expert-directed information giving. An implicit medical discourse operates within extract 7.29, where the role of the expert in inciting and

explaining various contraceptive technologies is not compromised. However, at the same time, she constructs a clear account of having conducted her own research about the contraceptive method she desired, thereby making a linkage with a patient autonomy discourse where she is an active participant in managing her reproductive intentions. A patient-led decision-making narrative is thus introduced. She consolidates both information sets obtained to enact her decision within the consultation. More importantly, her research is not used to shut off communication with the healthcare provider by emplotting herself as the "expert". Instead, she self-emplots as an active, agentic, knowledge-seeking yet supported contraceptive user with the medical expert emplotted as supportive. Unlike many other participants, the conversation is bidirectional, implying a collaborative discussion as the underlying principle behind decision-making. Hence, she sums up the narrative by saying, "The information I received I really appreciated. It was information I needed", which suggests a common basis for the knowledge offered by the medical expert and that which she gathered herself within the consultation.

The possibilities and feasibility of in-depth information sharing in sometimes overcrowded healthcare facilities did not, in some instances, preclude collaborative decision-making. While many participants reported accepting the choices enacted by healthcare providers on their behalf, suggesting a lack of awareness of their right to engage further about the contraceptive measures in question and their mechanisms of action, others were satisfied with the limited information exchange and subsequent brevity of the interaction. This is because they entered the information counselling meeting knowing what contraceptive measure would best suit their needs. Thus, a brief discussion was construed as ideal for them.

Extract 7.30

> **Ndivhuwo**: *Ja,* it was fine because I didn't want like a long explanation. When you go to the clinic, you just want them to help you with what you want and then leave and not like get 30 minutes of counselling like, "This is that, and this is that". So, it was short and quick, and I think they provided all the necessary information that anyone can use. *[Town, PBH, E]*

Ndivhuwo constructs the counselling encounter as "fine" and further expresses a preference for this form of "short and quick" contraceptive counselling session with "all the necessary information that anyone can use" instead of a "long explanation". To facilitate this, the participant plays the authority role by issuing directives that will limit the duration of her visit. In addition, she accesses the health facility already knowing her desired contraceptive choice. By doing this, she tacitly constructs elaborate information provision about unwanted contraceptive measures or informed choice as a waste of time. A medical expert discourse that

allows for information sharing to feature within the talk and a patient autonomy discourse that streamlines options towards contraceptive users' needs undergird excerpt 7.30. Ndivhuwo assumes a busy contraceptive user emplotment while the healthcare providers are emplotted as receptive to her needs and effective in offering brief counselling that “anyone can use”.

Some participants mobilised psychological discourses to construct accounts of care in describing the contraceptive encounters they received or those they desired to receive when negotiating their contraceptive choices during information counselling. Psychological discourses specify ideas, images and beliefs used to understand and perform the self, which demarcate between well-being and unhealthy behaviour through reflexive practices facilitated by the counsellor. Clients are, through talk, counselled away from what is considered maladaptive behaviour towards the direction of well-being (Mavuso, 2017; Parker, 1998).

In the extract below, Sinoxolo construes the contraceptive counselling she received as emotionally supportive and further emplots the healthcare providers as sensitive to her emotional needs when describing the uptake of the IUD:

Extract 7.31

> **Sinoxolo**: What I needed were contraceptives, and they gave me that /yes/. They gave me support, and they even told me if I am not feeling right, like emotionally, I must go to them /ok/. They even said to me, “When you come back [from university], Sino, just come. Come just so we can chat and see how things are going”. They are very nice people. *[Town, PBH, X]*

Sinoxolo’s reference to the expression of care and ongoing support when method-switching from injectable contraceptives to an IUD is implicitly construed as healthcare providers exceeding expectations about contraceptive provision. Her assertion, “What I needed were contraceptives”, demonstrates this, after which she cites practices considered procedural as evidence for emotional support. By implication, the healthcare provider is construed as responsive to the client's physical and emotional needs. Collaborative decision-making is implied as dual roles are laid out.

The contraceptive seeker’s role extends further than the consultation room. In addition to choosing the contraceptives, she is to survey the body for side effects within the constructed expression of care and inform healthcare providers of any emergent oddities. To encourage vigilance and the reporting of side effects among contraceptive users, there is an implied shared responsibility where Sinoxolo monitors the body. At the same time, the healthcare providers confirm the “normality” or “abnormality” of the manifested physical symptoms. Sinoxolo’s

embodied experience of the contraceptive measure is valued, while healthcare providers' expertise, knowledge and care offered on an ongoing basis point to how teamwork is given precedence in collaborative decision-making narratives. This talk emplots Sinoxolo as supported and the healthcare providers as supportive.

Zimkitha constructs an account akin to Sinoxolo's in extract 7.32 below, following her fear about the possibility of repeat pregnancy. To placate her, the healthcare provider is construed as offering, in addition to a contraceptive measure, psychological support:

Extract 7.32

> **Zimkitha**: There was a point where like, I got a scare. I was thinking maybe I'm pregnant, and then I went to the clinic to find out if it was the case, and they were like. "No, you're not". Then, the nurse who was helping me sat me down and talked about the different options of contraception. That's when I decided, okay, I don't want to feel like this ever again, so let me try it out. So, I chose the IUD because she told me that she thinks it's the best because you can take it out anytime and that you can still go on your period while on it, and that it doesn't have many side effects. *[Town, PBH, X]*

Compared to Sinoxolo's account, the talk of psychological care is more implicit in this micro-narrative but evident when Zimkitha frames the pregnancy as a "scare", leading to being "sat down" by the healthcare provider and counselled about the full range of contraceptive measures. Related to this response is the planning parenthood discourse, which renders pregnancy consequential and thus the decision and its timing as something to be thoroughly reflected upon by the subject (Wigginton et al., 2016). The healthcare providers' ability to rule out the presence of pregnancy, induce relief and provide reassurance to Zimkitha while sympathising with her fears of the "risk" of pregnancy emplots the nurse as supportive and Zimkitha as supported. Decision-making is portrayed as collaborative, with the healthcare provider saying what she "thinks" and Zimkitha deciding.

Many participants constructed the information counselling they received as informative insofar as "the incitement for the individual to develop a usable knowledge of the body" (Hayter, 2006, p. 33) was inherent within the talk. Guidance about bodily changes to expect and monitor using medical and risk discourses after taking contraceptive responsibility occasioned the production of narratives that deem the consultations useful and evidence of support for contraceptive users. For example, Bronwyn and Lunathi illustrate this in the excerpts below:

Extract 7.33

> **Bronwyn**: *Sjoe,* that was about seven years ago, so Doctor (inaudible 04:55) would have just explained everything and where it [IUD] gets put in and how long it will last and that it's a

fraction of the oestrogen, is it oestrogen or one of the hormones that the pill would have released. So, there is very little… She explained that to me and just a few experiences that I might feel putting it in and taking it out and that kind of stuff. But I really didn't have any pain afterwards. A lot of women experience heavy bleeding and severe pain, wanting to pass out, which I didn't have. I went shopping afterwards and took *Panado*. *[City, PVH, E]*

Extract 7.34

> **Lunathi**: So very easy like I did it here at [place] and uhm, I think also being an older student gives me more confidence, and you know, you know I was like, "Lady, may I please have a contraceptive" uhm, and she's like, "Have you been on it?" "No, it's my first time. Can you take me through it?". She was like, "Okay, okay*, ja"* I was like, "No, two months one, needle needle, done done" She gave me a card on when to return and then took me through the risks if, like I am bleeding crazy the side effects I must come. I was okay. *[Town, PVH, X/E]*

In preparing Bronwyn for uptake, the healthcare provider in extract 7.33 provides medical knowledge on the mechanisms of action of the IUD, which Bronwyn normalises by relating it to oral contraceptives. This functions to familiarise her method-switch to the novel contraceptive technology. The healthcare provider further prepares her for discomfort induced by inserting or removing IUDs alongside side effects. However, she frames her experience as lacking risk or adverse side effects. To do this, she cites worst-case scenarios women have reported, such as "heavy bleeding and severe pain", with other women relaying stories about "wanting to pass out". She then juxtaposes these accounts with her own, which she construes as relatively easy. As a result, she "went shopping afterwards and took *Panado*". This talk emplots her as a health-consuming, "free subject who can "have it all" (Saunders, 2018, p. 9), who not only partners in the decision-making, her agency is maintained. The healthcare provider is, in turn, emplotted as supportive.

Similarly, Lunathi, in extract 7.34, renders the contraceptive counselling she received as "easy". Drawing on an age discourse, she emplots herself as mature and assertive, thus able to confidently request information and the desired LARC measure without being directed or steered towards other methods. As a first-time contraceptive user, she draws on a collaborative decision-making narrative to tell a story about directly asking the healthcare provider to impart her knowledge about injectable contraceptive use. Thus, the healthcare provider is emplotted as playing a supplementary role in the decision-making, which is a vital component of the consultation. Implicit in Lunathi's narrative is her freedom to choose and resistance to being cajoled into using other contraceptive measures as she sought the information counselling session, knowing what contraceptive technology she desired.

While the contraceptive users in extracts 7.33 and 7.34 above are conscripted by the medical gaze and made patients who must comply, obey and follow a particular regimen, a patient autonomy discourse is also invoked within the text as the users are not enforced or subdued to be and remain contraceptive users. Instead, medical hierarchies are restricted as healthcare providers share power with their clients. The use of this patient autonomy discourse is also present in extracts 7.35, 7.36 and 7.37.

Many participants valued transparency and openness throughout the information counselling session, and medical experts who negotiated and renegotiated consent through information sharing reinforced contraceptive users' ability to choose or decide. The extracts below evidence this:

Extract 7.35

> **Emma**: My mom was like, "You need to do all the tests. Get your cervix, Pap smear and all the… and then also you can get the IUD". So, we [healthcare providers and I] did everything, and we went through all the pros and cons, and she gave me like a pamphlet as well, and she was like… She explained it to me uhm and then uhm, I could ask her questions like, "How long... What must I…" like, "What are the side effects? Are they going to be...? Is this going to involve…" and she will explain, and as she was doing it, she would explain what she was doing as well. *[Town, PVH, E]*

Extract 7.36

> **Gladys**: Eer, because I got the loop inserted at a clinic in [place], there is a nurse there that is… How can I put this? She's in love with her job. She explains to you. She doesn't do anything without talking to you and giving you options so that you choose. She educates you a lot. I think she is Sister [name]. So, she talks to you. She has a discussion, and I made the decision because I was informed. I never felt I didn't know what it was going to do. Even with the implant, she explained everything because I had it inserted there, she explained everything to me. So, I think at [place] their family planning side they can educate a client better than when you go see a private doctor. At a private doctor, if you don't ask questions most of the time, you don't get the information there, so… *[City, PBH, X]*

Emma suggests that she decided to use the IUD in conversation with her mother. She talks positively of the healthcare provider weighing the pros and cons, using pamphlets and open communication, and her willingness to explain the insertion of the IUD while conducting the procedure. Such pedagogical information enlightens the contraceptive user about what to expect during the insertion and use of the IUD. Her conversation is portrayed as bi-directional, with Emma posing various questions. The traditional expert-client dynamic does not fit this interaction as Emma enacts her decision towards the IUD before the consultation and has questions answered to her satisfaction. In addition, in being transparent about the costs and benefits of uptake, the decision is expected to be patient-led. The micro-narrative emplots

Emma as informed and agentic.

A similar account about the informative nature of contraceptive counselling, in which health providers are emplotted as "experts" or "knowers" by contraceptive users, can also be seen in Gladys' narrative in extract 7.36. In narrating about options-based counselling and pedagogy in contraceptive counselling sessions, Gladys cites a particular clinic with a healthcare worker framed as "in love with her job". Being in love with one's job is conflated with the ability to engage contraceptive users through a conversation about their needs and preferences and thus "not doing anything without explaining it to you first". A collaborative decision-making narrative emerges from the talk with the healthcare provider as supportive and the contraceptive user as informed and supported.

Inherent within the talk is also a private/public facility healthcare provider comparison in which the public health facility's family planning service provision is construed as efficient due to its staff's willingness to educate or inform the patient about the contraceptive measures they are taking up. In contrast, medical practitioners in private health facilities are construed as providing insufficient knowledge or withholding information about contraceptives from patients and thus only offering this information if the patients ask questions. The tenets of patient-led decision-making are fleshed out within the extract with extreme cases (argued to be prevalent in private health facilities), where medical experts expect the consultations to be steered by the contraceptive user being problematised by the participant.

Informed contraceptive users often elicited narratives that drew heavily on choice. Therefore, the more information the women received, the more they construed their contraceptive uptake as a personal choice. This can be seen in Balisa's narrative below:

Extract 7.37

> **Balisa**: No, it was my choice. You are told, I was asked if I would like this thing rather than that, you see? Just like they also have the loop, so they put them all in front of you, but I was never told about the loop. I was told about the *Implanon*. I just recently found out now, and I'd rather not put it there /*both laugh*/ I don't want anything that is going to be uncomfortable uhm, so they explained to me that it is like any other injection. But it takes longer and also travels along the bloodstream. You will not have to frequent the clinic to get an injection. *[Town, PBH, X]*

Balisa's decision to use LARC measures, specifically the implant, stems from her use of short-term contraceptives. She reported struggling to maintain compliance with the pill, resulting in

several unintended pregnancies. Hence, the healthcare provider is construed as negotiating method-switching with Balisa in an informative, demonstrative and options-based contraceptive counselling session, which she accepts. Here, the nurse places the LARC measures (other than the IUD) in front of her and encourages her to choose the one she desires. Implicit within this is the self-imposed moral obligation to correct her indiscretions, evidenced by her noncompliance with short-term contraceptive use. Both parties contribute meaningfully to the decision as some measures are ruled out, thus suggesting that a collaborative decision-making narrative underpins talk.

To solicit LARC uptake, the healthcare provider compares the use of the implant with injectable contraceptives, thus promoting its acceptability and discussing its long-lasting nature as an added advantage. In the narrative, Balisa also states that the IUD was not available at the time yet does not construe this as a constrained choice as she would “rather not put it there”, which occasions shared laughter between us. She adds, "I don’t want anything that is going to be uncomfortable”, Berndt and Bell's (2024) notion of embodied aversion can help us understand women’s orientation away from vaginally inserted contraceptive technologies, associating them with a sense of harm rather than as aiding birth control. Balisa associates the IUD with discomfort or pain. These individual preferences contribute to the collaborative decision enacted at the end of the consultation and, further, emplot her as agentic.

5. Conclusion

Three decision-making micro-narratives were drawn upon: the “Information and decision-making was expert-directed decision-making micro-narrative”, the “Information and decision-making was patient-led”, and the “Information and decision-making was collaborative” micro-narrative. The “Information and decision-making was expert-led” micro-narrative maintains paternalistic models of interacting with health users amid calls “for the shifting of traditional patient-provider power relations by, for instance, tasking providers with making space for interactive information sharing and deliberation, limiting inappropriate influence over decision-making processes, and being aware of their agenda (of pregnancy prevention) or role in creating barriers” (Morison et al., 2022, p. 242). The findings show that through the medical expert, unreliable patient, adolescence-as-transition and the uninformed contraceptive user discourse, health experts continued to dominate encounters. LARC users were thus emplotted as passive and unknowing, while health experts were emplotted as experts and knowers.

The “Information and decision-making was patient-led” micro-narrative was indicative of patients increasingly taking charge of their reproductive destinations with regard to contraceptive counselling. As such, contrary to the information and decision-making being expert-led” micro-narrative, minimal input is given by healthcare providers, although this detachment was not always desired, thus bringing about emplotments of health users as unsupported by medical experts. Patients who wanted to play a more active role within their own contraceptive care mobilised the patient autonomy and the my body, my choice discourse to steer conversations towards their desired contraceptive technologies. They, thus, foreclosed information sharing about other contraceptive technologies and even disrupted med

Partcipants were drawn to the “information and decision-making was collaborative” micro-narrative the least. Here, both parties were knowledgeable and thus invited to the decision-making. A medical expert discourse in conjunction with a patient autonomy discourse was used to depict health users’ interactions as bidirectional while still centring the healthcare provider as offering medical knowledge within the encounter but through narrative emplotments as supportive and passive, medical experts did not feature as dominating the health user. As such, participants also used the patient autonomy discourse to narrate having conducted their own research as to supplement the medical advice healthcare providers might offer thus self-emplotting as active and knowledge seeking contraceptive users. In addition, a psychological discourse was used to depict interactions with healthcare providers as not only addressing the questions the health user might have but also providing care for their mental wellbeing. An age discourse was also used to render health users as assertive enough to steer their reproductive needs and healthcare providers as receptive to these needs.

Chapter 8: Concluding discussion

1. Introduction

In the present chapter, I review the findings in chapters six, seven, and eight in relation to the research questions undergirding the study and existing literature on contraceptive use. To do this, I begin with a summary of the way participants within the two datasets (interviews with contraceptive users and healthcare providers) deployed discourses in constructing decision-making about contraceptive use. This summary is followed by a discussion of each finding, comparing and contrasting it to the existing literature on contraceptive use. I end the chapter with a conclusion section and a discussion of the implications of my research and of future studies.

With the study, I sought to offer an in-depth understanding of contraceptive users' and healthcare providers' constructions of decision-making regarding contraception. The main research question was: What micro-narratives and discourses do healthcare providers and women who use, have used, or considered using LARC draw on in constructing decision-making when being prescribed, advised, or seeking to use LARC? The sub-questions explored how contraceptive users and healthcare providers are differentially emplotted in narratives based on culturally available constructions of the decision to use, continue using, or discontinue using LARC. In addition, the power relations inherent in the micro-narratives and discourses, how they influence agency in decision-making, and how these micro-narratives and discourses drawn upon maintain or constrain coloniality and reproductive justice were explored.

I deployed a poststructural, postcolonial feminist lens in conjunction with a reproductive justice framework to locate the micro-narratives and discourses contraceptive users and healthcare providers used to construct decision-making around contraceptive prescription and use. I also used Barker's (2017) notion of the figuration of plots within narratives to explore emplotments offered and negated by the talk. Macleod et al.'s (2020) work on coloniality, where signifiers are problematised for their reifications of exclusion, is also drawn upon. As such, I illustrate how the signifier "fertility control", when a reproductive justice approach does not underpin it, carries within it colonial mentalities that create a linkage between individual and social development with implications for agency.

2.1 Convergences and divergences in both datasets

In this section, I compare and contrast the discourses deployed by healthcare users and healthcare providers at *mimesis*$_1$ (narrative possibility, which includes discourse) and the potentials for emplotment at *mimesis*$_2$ these discourses contained. At *mimesis*$_3$, the refigurations that resulted from the invocation of particular conflicting discourses are also discussed. To do this, I begin with the convergences within both sampled datasets, and I follow this presentation with those discourses unique to health users and healthcare providers, respectively. The sampled contraceptive users and healthcare providers drew on similar discourses around contraception, *viz.,* choice, self-responsibilisation, male reproductive pardoning, planning parenthood, pronatalism, and adolescence-as-transition in conjunction with a risk, a male sexual drive, and a traditional femininity discourse.

Contraceptive users used choice discourses to depict decisions made in enabling environments within healthcare provider/health user relationships. Here, the full range of contraceptive technologies was availed, and all decision-making was left to the health users who self-disciplined and self-policed themselves to regulate pregnancy through LARC technologies. This way, external influence from decision-making was obviated. These contraceptive users thus emplotted themselves as agentic consumers and emplotted healthcare providers as neutral within these conversations. However, choice discourses were also drawn upon by contraceptive users to express self-determination even when choices were streamlined by medical experts towards certain technologies instead of availing market options. This denial of agency went unnoticed as these health users also self-emplotted as agentic while emplotting the biased healthcare providers as providing neutral, options-based counselling or non-directive support. This signals constrained agency.

Healthcare providers used the choice discourse to detach from health users' contraceptive decisions, thus inviting and normalising all choices made by the contraceptive user as sensible and empowering. Emplotments of health users as rights bearers and of themselves as providing neutral support to contraceptive-seeking subjects were taken up. Nonetheless, other healthcare providers drawing on this choice discourse described most choices as unwelcomed by their health users who resisted all attempts by the medical experts to introduce LARC technologies other than injectable contraceptives. The "freely chosen" familiar contraceptive technologies were understood as heavily influenced by culture and structure rather than borne out of the immediate interaction unfolding between the health user and healthcare provider. Medical

experts, thus, emplotted contraceptive users as closed off to choices while emplotting themselves as providing options-based and neutral support to their consumers.

Despite the curated image of a detached healthcare provider, some healthcare providers failed to maintain this choice discourse. A rupture became evident in their accounts as they introduced method bias and hegemony in their attempt to provide option-based talk but also circumvent "bad" or "wrong" choices among "risky" subjects. As such, healthcare providers veered away from a choice discourse and, through the adolescence-as-transition and risk discourse, denied young and postpartum contraceptive users preferred contraceptive technologies. Certain choices, thus, became obligatory, limiting users' entitlement to choose given assumptions of specific ages and interbirth spaces as unideal for a healthy pregnancy. This way, health users were made docile subjects as healthcare providers emplotted themselves as decision-makers or gatekeepers to "bad" decisions enacted by young contraceptive users, emplotted as children and immature, and by postpartum contraceptive users, emplotted as busy, unreliable, and as passive recipients of healthcare provider decisions.

Demonstrating the feminisation of contraceptive responsibility whereby pregnancy featured as an intrinsically feminine threat, several health users drew on a self-responsibilisation discourse to signal having weighed up circumstances within their lives and further used those reflections to optimise their reproductive outcomes by seeking out "healthier" ways of being. A case in point was the seeking out of birth control technologies to regulate pregnancies or repeat pregnancies. This intervention, and by consequence, the responsibility for pregnancy, was personalised by women in sexual relationships. Healthcare providers were emplotted as providing options while health users emplotted themselves as agentic, responsible, and enacting options.

Not all health users used the self-responsibilisation discourse without difficulty. Some participants optimised their behaviour by self-disciplining and self-policing themselves towards contraceptive use in constraining environments, as their male sexual partners had differing reproductive preferences from these LARC-using female sexual partners who had intentions to avoid or defer childbearing. As such, conflicting reproductive desires produced contraceptive users who self-emplotted as having to overcome resistance from their sexual partners, emplotted as desiring parenthood and thus resisting LARC use.

Similarly, health users were also denied the enactment of decisions to use birth control (expressed through a self-responsibilisation discourse) by healthcare providers when they were

already pregnant. Individual decisions to take up or resume contraceptive use were thus dependent on the absence of pregnancy. As such, healthcare providers were emplotted as resisting requests for contraception by already pregnant health users emplotted as late in seeking contraception. Operating within the choice, self-responsibilisation, and the planning parenthood discourse was disciplinary power that incites its subjects towards accessing a healthcare facility, seeking a LARC technology, and complying with its requirements without force. In addition, contraceptive users are to understand this vigilant use of birth control as a self-determined, self-chosen, or self-made decision rather than imposed or coerced.

Healthcare providers also drew heavily on a responsibilisation discourse where contraceptive duty was framed as an individual issue women were held accountable for regulating. As a non-relational issue, men's role in fertility control was in submission and deference since they were depicted as unencumbered by the "risk" of pregnancy. In contrast, women had to assume the primary role in birth control use to uphold the couple's reproductive desires. As such, men were emplotted as irresponsible and women as responsible for contraceptive decisions. When healthcare providers attempted to resist the responsibilisation discourse and attribute equal responsibility to men and women, they later pivoted their accounts through a male reproductive pardoning discourse to depict men's inaction and non-involvement in contraceptive duty as understandable. Therefore, men were emplotted as sexually irresponsible by these health service providers, a shift from the previously availed responsible emplotment.

Through a planning parenthood discourse, many healthcare users indicated gaining mastery over pregnancy or childbearing by either avoiding, stopping, or deferring it to a later stage through LARC. This timing of reproduction, if desired, was portrayed as crucial for preserving women's industriousness or achieving other societally desirable goals, e.g., marriage or completing school. These health users took up emplotments as rational, responsible subjects while men were pardoned from contraceptive duty.

A dichotomy was created when the planning parenthood discourse was used alongside a pronatalist and a religious discourse. These discourses (planning parenthood and a pronatalist discourse, as well as a planning parenthood and a religious discourse) can be diametrically opposed due to the conflicting reproductive desires they produce. A pronatalist discourse valorises reproduction over childlessness, whereas a planning parenthood discourse prevents or delays childbearing until couples are "ready". Therefore, when health users emplotted male sexual partners as desiring parenthood and self-emplotted as secret contraceptive users due to

having “too many children”, being at risk of condom subterfuge or condom use refusals, they were freed from involuntary reproduction and could maintain their own reproductive desires despite their sexual partners’ preferences. However, while LARC technologies’ invisibility allowed women to actualise their reproductive intentions and remain child-free, inequitable gendered power relations still operated within the generated talk. These disparities in power “determine whose preferences are actualised” (Morison, 2011, p. 163). As such, the desire for parenthood in males was glorified, while direct resistances of parenthood in females were avoided. Nonetheless, women did not yield to this power; they pretended to give men’s reproductive desires weight by not challenging them, but also secretly used contraception and thus freed themselves from the “risk” of pregnancy.

A male reproductive pardoning discourse that mutually reinforces self-responsibilisation and planning parenthood discourses also emerged from the participants' talk. Within the male reproductive pardoning discourse is the normalisation of men as uninvolved and inactive in contraceptive responsibility, achieved through overstating women's involvement in the management of pregnancy while silent about men's roles. Health users thus self-emplotted as present in contraceptive decisions while men were absent. Healthcare providers also advanced the male reproductive pardoning discourse to exempt men from contraceptive duty. Within this, men were represented as sexual beings with interest purely in sexual intercourse and no concern for pregnancy. Therefore, pregnancy did not feature as an issue that affects or demands their user action. Hence, women were emplotted as rational beings and men as irrational and hypersexual.

Through medical discourses, many contraceptive users marked the uptake of birth control as not having a sexual genesis but a medicalised one. These contraceptive users took up oral contraceptives to correct hormonal imbalances that caused skin problems or irregular menstrual cycles. Contraceptive users were emplotted as sexually innocent or chaste by the talk. However, these health users later sexualised personal decisions towards contraceptive use, with the knowledge base around short-term contraceptives reportedly informing decisions for LARC uptake. Among healthcare providers, medical discourses served to justify both the “threat” of pregnancy and the denial of consent in LARC provision among young women. Herein, healthcare providers self-responsibilised for unintended pregnancy among adolescents and, thus, directives to “risk-proof” them by parents were legitimated. Such talk emplotted young women as “mature” or “fit to conceive” while emplotting healthcare providers as liable or responsible in the event of pregnancy.

Decisions to use contraception were also identified as not self-made by some LARC users. Practices such as having a boyfriend, menarche and being “out-there” were understood as underscoring sexual desire. These young people were, thus, through risk discourses, emplotted as fecund and thus at risk of pregnancy. These “adult-like” qualities were, however, also contradicted through an adolescence-as-transition discourse, which deemed the health users as “too young” and “too immature” to parent a child and to enact decisions about contraceptive use, while emplotting mothers as “knowers” and “experts”. Sovereign power fuelled these accounts by which the creation of contraceptive-using subjects was achieved through force and authority. Therefore, contraceptive users who refused, resisted or avoided contraceptive uptake were forced into subjecting their bodies to contraceptive technologies as the non-use of contraception as a valid option was challenged by parents.

Risk and adolescence-as-transition discourses, together, also eroded user agency in healthcare providers' accounts. As such, parents coerced young people to seek contraception based on behaviours they understood as pointing to sexual desire and, consequently, the "threat" of pregnancy. Healthcare providers were self-emplotted as experts and arbiters in relation to health users who were emplotted as unaware of their own risk. Surveillance was understood as an essential component of contraceptive seeking and provision. Healthcare providers deemed this close monitoring as necessary for continued use of contraception as discontinuation was likely among users coerced into a LARC regimen. In addition, confessionary practices supported notions of a risky subject. Young women were thus required to confess and not resist imposed contraceptive technologies. This way, resistances emplotted young women as liars and denying their own “risk” of pregnancy while healthcare providers were emplotted as “knowers” and “experts”.

Drawing on a traditional femininity and male sexual drive discourse, some young women were identified as having transgressed the thresholds of “good womanhood”; they were now beyond the domestic and contained space they are expected to practice their femininity. They were depicted as “out-there”, presupposing a subject who has eroded their ability to refuse the externally enacted decisions. Hence, as an intervention on individual conduct, female guardians enforced contraceptive uptake, thus emplotting the young women as at “risk” of predation, which the young women resisted by taking up chaste emplotments. In denying the sexualisation of their relations with male peers, they also challenged their vulnerability, thus introducing some ambiguity to male sexuality as not always seeking to dominate traditional femininity.

More importantly, prefacing boy-girl interactions on birth control pointed to how sexuality is regulated and not denied by parents.

2.2 Divergences in the two datasets

Some discourses were unique to health users, while others were only available to healthcare providers. For example, a my body, my choice discourse, *homo economicus*, the conjugalisation of parenthood, psychological, traditional young femininity, female sexual desire, and a have/hold discourse were used by LARC users. Medical experts used a stranger danger discourse.

Drawing on the planning parenthood discourse in conjunction with the my body my choice discourse, contraceptive users claimed decisions around contraceptive uptake as self-made, identifying pregnancy as an embodied responsibility they had a right to avoid. Self-determination was personalised due to the tangible consequences of sexual behaviours for women. This was in relation to males who reportedly showed no signs or concern for pregnancy. Therefore, health users secretly took up LARC technologies to reliably avoid pregnancy, emplotting themselves as secret contraceptive users in relation to men, emplotted as lax.

To express discordance between studying and parenthood or singlehood and parenthood, *Homo economicus* and the conjugalisation of parenthood discourse were drawn upon by LARC users. *Homo economicus* values the alignment of paid labour with childbearing and construes their misalignment as a plan to “fail” at parenthood, one that must be policed. Similarly, subjects who had not attained marriage were subject to the same policing around the appropriateness of their timing of reproduction through the conjugalisation of parenthood discourse. *Homo economicus* and the conjugalisation of parenthood as two discourses that reinforce the planning parenthood discourse function to establish the rationality of enacted decisions. As such, health users were emplotted as unready for parenthood while schooling or unmarried.

When the planning parenthood discourse was used alongside a psychological discourse, LARC users reflected on personal distress they linked to the possibilities of an unintended pregnancy. As such, the decision to, upon reviewing lifestyle choices, become a contraceptive-using subject to avoid pregnancy, repeat pregnancies, or repeat abortions was enacted to affect psychological functioning—emplotments of health users as "at ease" responsible subjects were thus availed by the talk.

Through a traditional young femininity performance discourse, LARC users reinforced secret contraceptive use in parent-child relationships. However, participants who used this discourse did not fit the traditional femininity discourse that denies the expression of sexual desire as they expressed it, albeit within fringes, where their parents could not detect its presence. It is the need to constrain this expression of sexual desire, even in instances where parents supported and encouraged contraceptive uptake within these relationships, that is noteworthy. These health users were emplotted as overtly chaste and secretly agentic as enabled by LARC. In relation to this, some mothers were emplotted as sexually restrictive or not confidantes on sexual matters.

The female sexual desire discourse, which endows females with the capacity to desire, seek and access sexual pleasure, was advanced to demonstrate how LARC technologies allow spontaneity and are not prone to be forgotten in moments of passion within stable relationships. Contraceptive users were thus emplotted as "sex ready" and not susceptible to pregnancy when sexual intercourse was urgent.

A have/hold discourse operating alongside a risk discourse speak against the discontinuation of contraception within uncommitted relationships. However, a female sexual desire discourse, reinforced by LARC technologies' reliability in circumventing pregnancy, allowed participants to take pleasure in their sexual relationships in the absence of commitment. This emplotted contraceptive users as agentic and free from a have/hold discourse.

Healthcare providers used a stranger danger discourse to root contraceptive provision mandated by parents in fears of sexual violence. LARC users were thus emplotted as physically mature yet "at risk" subjects, with strange and familiar men emplotted as "posing as a risk".

3. Micro-narratives on decision-making in contraceptive counselling

Three decision-making narratives were drawn upon by health users, namely, the expert-directed decision-making narrative, the patient-led decision-making narrative and the collaborative decision-making narrative.

Many health users elicited stories that cohere around the expert-directed decision-making narrative, which maintained unequal power relations in healthcare provider/LARC user interactions. Here, the bi-directional exchange of information was inhibited as medical experts not only dominated the conversations but also weighed options and further enacted decisions on behalf of the patients. Therefore, LARC users' options were often pre-packaged as their

own embodied knowledge featured as deficient in relation to the medical gaze the medical experts invoked. Emplotments of medical experts as knowers and fulfilling governmental mandates achieved through mobilising a medical expert discourse in relation to passive, non-agentic health users reinforced healthcare providers' places at the centre of contraceptive counselling conversations. At the same time, little to no input was expected of health users.

An unreliable patient discourse, adolescence-as-transition and an uninformed choice discourse also reinforced these dynamics. The unreliable patient discourse legitimated imposed contraceptive uptake by questioning health users' ability to make decisions about their own bodies, while the adolescence-as-transition discourse denied young contraceptive users maturity in this ability. The uninformed choice discourse signified the use of falsehoods, withholding of information and deception to set up contraceptive uptake in particular ways. These discourses point to how trusting health users in decision-making was implicitly equated with entrenching their risk of pregnancy. As such, LARC users' roles in decision-making were expected to be peripheral and remained so as medical experts either kept mum, oversold LARC technologies to influence uptake deceptively or offered one-size-fits-all counselling to individual problems. Health users were emplotted as unknowing and passive within these interactions.

The patient-led decision-making narrative was also used recurrently by some LARC users. The micro-narrative overcorrects the expert-led decision-making micro-narrative by allowing the LARC user the opportunity to dominate the conversation. Health users used this agency to, through questioning, tailor and structure the conversation towards their desired contraceptive measures and, at times, foreclosed information-sharing on other contraceptive technologies. In turn, the healthcare providers were construed as responsive to the requests made by LARC users. A patient autonomy discourse and a my body, my choice discourse introduced the notion of health users as managers of their own well-being. However, choices made by healthcare users were not always celebrated as they were, at times, identified as "wrong" choices compared to choices made by their peer groups. As such, while health users self-emplotted as agentic, they also took up emplotments as novices and knowledge-seeking in interactions. In turn, they emplotted the detached healthcare provider as incompetent or unsupportive. Nonetheless, for the most part, minimal input from the healthcare providers was required, and decision-making was consequently left to the client within the patient-led decision-making narrative as health users relied on their own knowledge and information in enacting choices, which disrupts traditional expert-led decision-making.

The “Information and decision-making was collaborative” micro-narrative was used by health users the least. Within this narrative, medical experts and health users assumed more equitable roles in counselling as they were depicted as partners in decision-making within this configuration of provider-patient relationships. As such, drawing on a medical expert and a psychological discourse, healthcare providers’ expertise, offered through information sharing, provision of the chosen regimen, and emotional care, were considered essential. However, a patient autonomy discourse and an age discourse were also used to express the receptivity with which the healthcare providers approached patients’ needs. As such, healthcare providers were emplotted as supportive and receptive while health users were emplotted as active, supported, and assertive. Decisions were, therefore, considered shared rather than as belonging to the medical expert or the LARC user, as seen in the expert-led and patient-led decision-making micro-narratives. The pitfalls of the patient-led and expert-led decision-making micro-narratives are thus avoided by the collaborative or shared decisions made within these encounters.

4. Acts of resistance for and against contraceptive responsibility

Decisions to use LARC, whether self-determined or enforced, recurrently pointed to how health users and healthcare providers feminised birth control uptake. The female body was deemed fecund and thus "at risk", in "danger", or under the "threat" of conception in their accounts. Therefore, a requirement and even pressure was implicitly and explicitly placed on females to stop, defer, or limit the possibility of pregnancy by becoming rational beings who regulate their well-being by dutifully consuming LARC technologies. In contrast, this requirement excused men as not contraceptive users or, at least, reliable contraceptive users. This is demonstrative of how reproductive matters are problematically privatised or considered domestic matters women must resolve in silos (Klausen, 2004). As a result, refusals to assume contraceptive duty by females had implications for women's ability to claim reproductive responsibility. However, acts of resistance for and against this feminised responsibility are evident throughout the data. These resistances occurred within intimate partnerships, parent-child relationships, and patient/provider relationships. While some resistances were overt, most were silent. I offer a discussion of these resistances below.

The data show that male sexual partners' desire for parenthood could be used to override female contraceptive users' reproductive desires to remain childless or delay parenthood. To do so, LARC users were required to discontinue the disciplined use of birth control technologies so as to allow pregnancy to occur. In the “I didn’t tell my partner” micro-narrative, some females

covertly resisted such requests regarding involuntary reproduction. An overt resistance against this dissuasion to become or remain a contraceptive-using subject is evident in how one health user, by threatening the relationship, challenged her sexual partner's refusal of her personal decision to undertake this contraceptive responsibility in the "It was my decision" micro-narrative.

Covert resistances within intimate partnerships were demonstrated by how some contraceptive users avoided involuntary reproduction (potentially achieved through condom sabotage and difficulties in negotiating condom use) through the clandestine use of LARC technologies in the "I didn't tell my partner" micro-narrative. This way, they were not vulnerable to their partners' reproductive desires. In addition, the secret use of LARC was also used by one participant to sustain male condom use to prevent STIs, with the use of LARC technologies reliably preventing pregnancy.

The pressure to disclose birth control use was nullified, silenced, and even made trivial by the invisible nature of LARC technologies among a migrant woman, married women, and women in stable relationships. These findings are consistent with studies by Hawkey et al. (2018), who reported on hidden hormonal contraceptive use among some migrant women. Similarly, Wood and Jewkes (2006) also reported on adolescents' secret use of contraception, as well as the concealment of clinic information to maintain this birth control use and, by implication, circumvent pregnancy.

These silent and overt resistances against the valorisation of childbearing accomplished through active, open, and secret LARC uptake affirm Ross and Solinger's (2017) assertion that:

> [W]omen have always been determined to make secret decisions, pursue bold options, share information and resources, depend on the support of sisters, friends, and strangers, and take the risks they needed to take to make the reproductive decisions they could make. Sometimes these efforts were successful, sometimes not (p. 11).

The authors reflect on the restrictive contexts under which women's decisions and choices have historically been made alongside the strategies of silence that have been expedient in achieving their reproductive destinies. Albeit subjugated, alone or with each other's assistance, contraceptive users have made decisions about their bodies outside of intimate partnerships (both successfully and unsuccessfully).

Healthcare providers also reported on health users' secret use of contraceptives as acts of resistance against gendered power relations in the "She hides contraceptives\clinic visits". They assisted women who set out to avoid or space pregnancies by providing LARC technologies. However, support through availing invisible contraceptive measures was sometimes not their only considerations; medical experts also avoided documenting this information on clinic cards to entrench the secrecy of this decision. Dehlendorf et al. (2014) have identified this as a harm reduction strategy where the provision "of 'hidden' or discreet methods of contraception, including IUDs (without strings), subdermal implants, or injections to help women ensure privacy and autonomy and avoid conception" (p.9) is encouraged for women who seek that support. Kok et al. (2020) also reported on this collusive relationship between healthcare providers and contraceptive users in Malawi.

These silent resistances by which contraceptive users are careful not to disrupt traditional femininity and its valorisation of "motherhood and nurturing the family" (Davis et al., 2018, p. 821) visibilise how patriarchy assumes ownership of women's fertility. Indeed, "women's bodies are seen to exist primarily to fulfil the requirements of social reproduction" (Unnithan, 2020, p. 178). When femininity becomes entangled with motherhood, in this way, "readiness" to parent in females renders pregnancy (now or in the future) a given or a non-choice. In contrast, the right to childlessness is taken for granted as not a desired option or unusual. Hence, LARC users' decisions to avoid pregnancy could, at times, only be effected clandestinely through invisible female-controlled LARC technologies. However, according to Sargent and Kotobi (2012), secret contraceptive use can create the "risk of conjugal conflict, verbal or physical abuse, and pressure from extended family because they [contraceptive users] did not fulfil expectations regarding fertility" (p. 51). Therefore, while secret contraceptive use can be empowering, this silence also threatens women's physical and psychological well-being. In addition, it also produces, maintains, and even entrenches women's powerlessness in overtly resisting motherhood in romantic partnerships.

Acts of resistance against intergenerational power dynamics were also demonstrated by young women's secret use of LARC in stories elicited within the "I didn't tell my mother" micro-narrative. Some young women who chose to be sexually explorative did so in constraining environments where female guardians rendered premarital sex as a wrongful act. As such, to avoid these sanctions, the trace of sexual exploration was hidden through the uptake of invisible contraceptive technologies. They, thus, challenged these restrictions on their sexuality by overtly performing traditional femininity that idealises chastity (Davis et al., 2018). Openly

using contraception was equated with the admission of sexual exploration and the risk of pregnancy when marriage and stable relationships later were deemed as suitable contexts for reproduction. Therefore, young people overtly performed abstinence while also using birth control to avoid extramarital procreation, single-parenting, or any other parenting in which women are "culturally expected to 'fail' at" (Lowe, 2016, p. 47). These findings resemble those found by Margherio (2019) in a study conducted in South Africa, where young women's agency to seek contraception consistently was constrained by the secret user emplotment, exacerbated by lack of parental communication about contraceptive debut. As a result, young women's ability to openly claim sexual subjectivities for themselves was constrained by societal restrictions about who appropriate subjects for sexual exploration are and are not. However, young women who were encouraged to use LARC technologies in the study still upheld the secret use of birth control methods.

Acts of resistance against contraceptive uptake in parent-child relationships also appear in the data. For example, since unconsented contraceptive use was used as a strategy for "risk-proofing" young adolescents, a non-contextual directive towards LARC use was given. It was non-contextual in the sense that a bidirectional discussion about the onset of menarche and young women's sexual desires was omitted. As such, agency in the face of menarche and "straying" from established constructions of "good" womanhood was threatened due to parents' over-interpretations of them (menarche and sexual exploration) as signals of "an unmet need for contraception". However, some young women in the "I was coerced by my mother/aunt" micro-narrative silently refused these directives by female-guardians by pretending to be reliable contraceptive users or discontinuing use upon discovering ruses used to initiate contraceptive use. Despite these resistances, contraceptives were reportedly re-administered to non-consenting women who avoided or discontinued use.

A paradox is evidenced in parental interventions. On the one hand, a passive female sexuality that must be guarded or protected from virile male sexuality was constructed. On the other hand, proactive contraceptive uptake premised on menarche, consorting with males, returning home late at night or maintaining friendships with older women create a mature subject with sexual desire who can be sexually explorative and must be "risk-proofed" through coerced LARC use. As such, forced contraceptive use contains contradictory logic and conflicting aims, for instance, "a desire to preserve the innocence of youth and a simultaneous expectation that they 'grow up'" (Gabriel, 2009, p. 48). This, I argue, functions to separate the body from the

person under the parental gaze. Therefore, the body might be sexually explorative, but the person remains "sexually innocent" so long as the markers of exploration, which include pregnancy, remain absent or hidden by contraceptive technologies. This way, a mature, sexually explorative body without the risk of pregnancy can co-exist with a secretly explorative subject who assumes idealised emplotments of "chastity" and "sexual innocence" for their female guardians. This suggests that forced LARC use maintained a traditional young femininity performance discourse, which necessitates the effacing and erasure of young female sexualities within intergenerational interactions.

Healthcare providers also forcefully provided contraception, which some health users attempted, and sometimes even managed, to resist. For example, one healthcare provider reported on health users who presented discontinued contraceptive use as their sexual partner's wishes when, in actuality, they desired pregnancy and childbearing in the "Men are not involved" micro-narrative. Another healthcare provider also reported on a health user living with disabilities who showed emotional distress and dissatisfaction with every health encounter to show dissatisfaction with uptake in the "Mothers fear risk brought on by violence" micro-narrative.

Some health users challenged medical experts' refusal to remove LARC technologies they were no longer satisfied with using. For example, in the "Information and decision-making was patient-led" micro-narrative, one LARC user was emphatic about her desire to remove an IUD even though the healthcare provider reportedly used anger to dissuade her. In addition, another IUD user self-removed the technology using tweezers at home when medical experts avoided and delayed its removal at a healthcare facility. While these inputs on decisions by healthcare providers can be understood as "well-intentioned appeals to help" (Brian et al., 2020, p. 313), they can also be seen as "a kind of moralisation of health, whereby individual subjects are compelled to self-fashion and maximise their well-being" (Brian et al., 2020, p. 314) by forcibly becoming and staying disciplined contraceptive users. When this maximisation of well-being is not individually-driven but coercive and considers non-use, discontinuation or refusal to accept externally mandated contraceptives as defiance, rebelliousness, and thus not a choice, individual rights are violated. The absence of acts of resistances in healthcare providers' accounts is indicative of medical experts' overcommitment to providing a LARC-only solution to all women's contraceptive needs. This commitment can offer LARC technologies to women who need and do not need them and it can also deny their removal as not in the health users' best interests.

5. A postcolonial take on fertility control

In the theory chapter (chapter 3), I state that the data will reflect on itself for its perpetuation of coloniality in the present, where hegemony and asymmetry prosper, and examine the past as the potential architect. To do so, I use politics of signification to call to attention the power relations masked within the signifier “fertility control”.

The data revealed that fertility control among particular women was deemed compulsory. At the root of this discrimination was an implicit binding of women into categories as either educated or uneducated mothers, mature or immature mothers, financially liberated or socioeconomically disadvantaged mothers, employed or unemployed mothers, as well as married or single mothers. Such polemic classifications produced the policing of reproductive behaviours of women who fall in categories considered “less acceptable” and thus likely to “fail” at motherhood. The problematisation of teenage pregnancy discussed by Macleod et al. (2020) is evidenced by the ageist notions that pervasively disallowed young women the opportunity to refuse LARC in stories elicited by contraceptive users and medical experts within this study. As such, teen-age women were accompanied to clinics, or deception and surveillance were used to regulate and control their fertility. This exclusion from participating in decision-making is grounded in Macleod's (2003) notion of the threat of degeneration, where it is believed that “the less developed undermine the stability and morality of good society through abandoning schooling, perpetuating poverty, contributing to health costs, producing less-than-adequate children, and relying on welfare” (Macleod, 2003, p. 71). Young women thus represent the “less developed” with their pregnancy problematised as disadvantageous under all circumstances. Hence, they were denied the opportunity for meaningful participation in decision-making or coerced into contraceptive use. Apart from the signifier “adolescence”, with which work around its problematic nature has been done (Macleod et al., 2020), I argue that fertility control is a signifier that, too, is fraught with problematic and colonial connotations.

The politics around fertility control and coercion are not new; they have adapted to old and new circumstances. Indeed, Macleod et al. (2020b) assert that power tends to contain the capacity to find new circumstances. For example, Wanhalla (2007) speaks of eugenics as not only a project incited upon women but as a project that women were subjects as well as architects of through women's groups. As such, transformation can be seen where eugenics, by its exponents, intended fertility control for “race betterment” and “race improvement” to later

serve racist and classist imperatives in South Africa (Klausen, 2004)—for example, resolving the "poor white problem" through the restriction of white, poor women's fertility.

Built on the idea of whiteness as superior, the Race Welfare Society used birth control as a tool to uplift "poor white" communities. These poor women's reproduction was sanctioned through framings as deficient and a risk that impedes their own and their existing children's functioning. In contrast, the Mothers' Clinical Committee of Cape Town in the 1930s positioned itself as geared "to help poor women of all races to control their fertility and thereby secure greater success in raising their children under conditions of grinding poverty" (Klausen, 2004, p. 152).

The Mothers' Clinical Committee placated pushback from religious leaders against contraceptive use through the maternalist approach to contraceptive care it aligned itself with, where its consumption served the family and its quality of life rather than promoted premarital sex. In so doing, married women were identified as the committee's only service users to ease morality concerns among these religious leaders. However, constructions of the "poor whites" the Mothers' Clinical Committee served as unintelligent and lacking sexual control points to classism. In addition, these strides towards modernity and development were also entangled in racist inputs by funders like Marie Stopes with ambitions to use the South African facilities she funded (like the Mothers' Clinical Committee) as a "colonial resource" (Klausen, 2004, p. 82) for her "self-serving desire to be the world's foremost authority in birth control" (Klausen, 2004, p. 81). Fertility regulation, therefore, has been an object of manipulation by powerful institutions and figures throughout history with population control practices that "can quickly become coercion" (Brian et al., 2020, p. 313) rooted in "firmly pro-imperialist sentiments" (Klausen, 2004, p. 81) of sometimes problematic activists.

These classist and racist undertones within fertility control reveal its malleability. As such, women's reproductive desires are encouraged or prevented depending on who they are and the politics of the time. For example, in South Africa, the term mother of the nation was used to encourage procreation among White Afrikaans women, which was deemed noble and self-sacrificing in building an Afrikaaner nation (Van der Westhuizen, 2018). Comparably, births by Black, poor women were considered as deficient and a risk to "poor whites" who increasingly were living in close proximity to Black people in the 1930s (Klausen, 2004). In this study, the exact formulations of risk and deficiency vis-à-vis fertility control, seen in history, were also evident among young, postpartum, post-abortion women and women living

with disabilities. I home in on postpartum women and the denial of their agency by healthcare providers.

The "I was (not) told" micro-narrative highlights the medicalisation of short interpregnancy spaces whereby healthcare providers coerced contraceptive uptake to avoid repeat pregnancies. Consent is therefore not sought; instead, LARC provision is deceptively presented as mandatory or as the fourth stage of labour as young and poor women in the public health sector became targets for immediate postpartum LARC provision. Repeat pregnancies were thus implicitly medicalised as risky, harmful or a sign of degeneration. This way, postpartum mothers did not compare well to women with wider-spaced pregnancies in the capability to carry a pregnancy and mother a child. As such, a binary was created in which poor postpartum women's repeat pregnancies emerged as irresponsible behaviour and women with wider birth spaces as responsible. Even though postpartum women may have been fit to bear children during their pre-pregnancy phase, this ability is lost during the postnatal phase. Hence, they are stopped from conceiving another baby within this period.

However, an element of undecidability about postpartum women's capacity to produce fit offspring is contradicted by their existing healthy births and the body's readiness to conceive another child. Despite the subjects having carried and birthed healthy pregnancies, healthcare providers render postpartum women as "reproductively inadequate on an anatomical level (her pelvis or vagina are deficient…)" (Macleod, 1999, p.114). That is, they are less developed, less recovered or transitioning from pregnancy and hence the freedom to decide to use or not use contraception must be restricted towards encouragement or coercion to use LARC technologies. This is because "the medical or psychologised gaze provides the grids of visibility for the hidden, the interior, the unconscious, etc., simultaneously rendering these aspects audible as language is created to discuss their meanings or essences" (Macleod, 1999, p. 111). Informed by this medical gaze, health users cannot know their own vulnerability to risk, but medical experts do. When clinical assessments and examinations using "the rhetoric of risk and the practice of invoking fear by predicting negative outcomes" (Huschke, 2022, p. 339) identify the postpartum period as risky for pregnancy in this way, the risk (big or small, real, or constructed) must be managed by healthcare providers.

The case for child neglect also works in the same way. In classifying postpartum women's newly born babies as less developed and needing care. Decisions to have another birth or unintended pregnancies six months following the postpartum period feature as a transitional

stage and thus a risk to this care and a precedent of child neglect. In addition, because this subject is classed and raced, as it was only public health recipients, who are primarily Black and poor in South Africa, in the data who were subjected to coerced contraceptive uptake, in disguising LARC use as routine, compulsory or a governmental mandate, notions of reproduction as requiring the interprising neoliberal subject are shored up. Therefore, even though uncertainty about deformities and child neglect informs sanctions women are subjected to, concerns about public spending postpartum mothers are deemed as contributing to, feed the restriction of these repeat births. These births remain a supposed burden as the economic instabilities and social deprivation that are envisaged as the potential outcomes (even when deformities and neglect do not occur) informed by medicalisation and racialisation of these pregnancies sustain the restriction and policing of such births. Hence, pregnancy around postpartum women becomes "a social problem" not an individual problem— one needing remedying. Ultimately, postpartum women's reduction of agency, expressed through the revocation of authority over their bodies, is justified and normalised.

Herein lies the threat of degeneration that denies socially-disadvantaged, postpartum women non-use, discontinuation or refusal to accept contraception offered as governmental mandates by healthcare providers. This threat of degeneration amplifies the negative aspects of pregnancy and disallows the perpetuation of discourses of positive outcomes such as literature around siblings being less hierarchical relationships and offering a space of safety to discuss sexual subjectivities (Ndabula et al., 2020). Instead, individuals are made responsible for ensuring that the negative outcomes do not occur, by preventing pregnancy during periods of transition. Therefore, erecting this "imaginary wall" (Macleod, 2010, p. 61) where poor postpartum are treated as separate from other fertile women and a social problem. Notions of development and modernity cast poor postpartum women as a risk and irresponsible for not choosing LARC where an underlying message that "they cannot be trusted to manage their fertility" (Brian et al., 2020, p. 316) is communicated.

In addition to these class-based inequities was the ageist legitimation of coercive and punitive measures against young women to facilitate contraceptive uptake such as being asked to choose between two forms of injectable contraception (often being prescribed the longer-acting form, *depo provera*) instead of consent being sought or premised on the "child having a child" flawed argument, young women being given any form of injectable contraception. Macleod (2010) shows how this logic only functions by putting age to work as argue for deficiency, the same way the postpartum period is dubbed transitionary and thus deficient. For example, Macleod

(2010) asserts that all pregnancies and births around women under 18 years feature as a social problem when many women over 18 years also sometimes consider their births as unwanted. Yet, they are not recognised as a social problem. Moreover, the provision of LARC to non-consenting women living with disabilities as a basic precautionary measure against them being sexually violated all show that when fertility control is given political significance without caution, its violent effects seen in the past are survived by the present.

I, therefore, advocate for a reproductive justice approach to contraceptive uptake, one that is grounded in the unfolding social interaction, as well as the intersecting broader socio-cultural context that facilitates and constrains culturally symbolic ways of talking about fertility control. This way, I bring awareness to culturally symbolic forms of talk that (re)create aversive attitudes to the reproduction of certain women over others. Healthcare providers as bodies with the power to manage and regulate "risk" at all costs, when this sometimes includes coercive, alienating means is also brought to the fore by the approach. Alone, the signifier "fertility control" carries the potential to maintain regressive ideas that promote ageism, racism, classism and ableism. However, when underpinned by a reproductive justice framework, fertility control must attune to the unfolding interaction and use it to facilitate partnering equally in decisions made by healthcare users and healthcare providers to bring about shared decisions. It must also attune to historical class-based, gender-based, ableist and ageist issues and how they have been deployed to coerce women's reproduction towards certain destinations for the sake of regulating the population. A reproductive justice approach means undermining the (neo)colonialist mechanics of biopower and their historical governing of women's bodies that have been upheld in violent ways, even when well-intentioned, to threaten and reduce the agency of women considered risky.

6. Conclusion

The analysis has shown how colonial power structures continue to work in the present by discursively (re)creating hegemony that oppresses the dominated subject. The coloniality of knowledge, coloniality of power, coloniality of being as well as coloniality of gender remain ongoing and undermine women's rights. "These three systems of coloniality form, to use a Foucauldian term, a power-knowledge nexus that simultaneously enables and restricts particular ways of being" (Macleod et al. 2020, p. 294). The coloniality of knowledge in this study is instantiated by the superiority of medical knowledge over the embodied knowledge of health users advanced by medical experts to dismiss or shut off preferences they did not support. Unbalanced exchanges such as these operate by presenting medical knowledge as

factual and embodied knowledge as speculative and inaccurate, thereby creating the environment for the supersession of LARC users' reproductive preferences for the preferences of healthcare providers (Berndt & Bell, 2021). In addition, public health knowledge that foregrounds individual behaviour (e.g., taking LARCs) over social power relations and systemic inequities renders the cost and "risks" incurred by contraceptive users as their own doing rather than failure to provide reproductive healthcare by the government. Contraceptive users and non-users are thus singled out as problematic and hence the use of interventions that violate their rights.

The study also evidences the coloniality of power where the expert-led health encounter is steeped in (neo) colonialist understandings of how the poor, the disabled, the young and the Black body/person are and should be in the world—childless. Expert-led interactions may uphold and defend these health disparities by continuing to avoid adopting a health user orientation, especially among fertile beings considered as deficient, thus disrupting Eurocentric notions of "fit" reproducers. This, in the data, is evidenced by a recurrent "injectable contraceptive solution" to all public health users' contraceptive needs, which creates an injectable contraceptive hegemony. Within these medical encounters, young, post-abortion and postpartum health users assumed passive roles while *depo provera* and *nur-isterate* were the only accessible measures to their contraceptive desires. As a historically dominant contraceptive measure among poor, Black and Coloured women in South Africa, injectable contraceptives continue to be re-engineered into the present through endorsements by healthcare providers in contemporary practice, where agentic decision-making can be hindered in the name of development and modernity.

Coloniality of being denotes the dividing practices in which certain bodies are emplotted as risky and in need of management. Consequently, their reproductive wishes to pursue pregnancy feature as a problem the healthcare system cannot contend with and thus must solve rather than a right that must be realised. Strategies used to maintain this discrimination included overt and covert pressure and force by healthcare providers, e.g., outright refusing to remove LARC technologies, administering contraception to unwilling health users or the use of deception to target low-income women to use LARC technologies post-abortion and postpartum. In turn, health users also used overt and covert resistance to undermine or manage such emplotments. For example, young women pretended to use contraceptives mandated by their mothers to resist emplotments as "risky" albeit these secret refusals were sometimes discovered by parents. The resistance against the undermining of agency on the grounds of gender was also shown by

women's secret contraceptive uptake thus claiming their right to refuse or defer childbearing. Coloniality in these three forms recognises the deep cultural embeddedness of reproductive injustices restricted and maintained through micro-narratives, discourses and emplotments used to construct LARC use and its prescription that prevail despite legislative shifts towards liberal laws, making reproductive freedom a far cry.

The research has contributed to a transnational inquiry between New Zealand and South Africa exploring decisions to use LARC and the power dynamics in the prescription process. Our research collaborator has simultaneously conducted a similar study in Aotearoa/ New Zealand as a former British colony. Insights gained from this cross-national study will be aimed towards addressing social issues such as patriarchal coloniality, coercion and non-agentic decision-making vis-à-vis contraception and ultimately contribute to women's sexual and reproductive agency. As such, a policy brief based on the cross-national research will be developed and sent to all relevant health departments and health district offices. Additionally, de-colonial contraceptive counselling guidelines will be developed based on the analyses across the two contexts.

Future studies should explore parent-child communication regarding LARC uptake to understand in depth the ways it shapes the uptake, continuation and discontinuation of contraceptive technologies in the South African context. While exploring the family context, sibling influence also requires exploration since less intergenerational power dynamics as compared to parents have been identified (Ndabula et al., 2020). Studies in the future should also explore long term condom-use in males and involuntary pregnancies, where men become fathers while maintaining contraceptive responsibility within their relationships. Lastly, more research should explore contraceptive use among LGTBGQI communities.

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Appendix 1: Ethical Clearance

RHODES UNIVERSITY
Where leaders learn

Psychology Department
1 University Road, Grahamstown, 6139, South Africa
PO Box 94, Grahamstown, 6140, South Africa
T: +27 (0) 46 603 8500
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RESEARCH PROJECTS AND ETHICS REVIEW COMMITTEE

12 December 2017

Yanela Ndabula
Department of Psychology
RHODES UNIVERSITY
6140

Dear Yanela

ETHICAL CLEARANCE OF PROJECT PSY2017/63

This letter confirms your research proposal with the tracking number PSY2017/63 and title, 'Constructions of the long acting reversible contraceptive user', served at the Research Projects and Ethics Review Committee (RPERC) of the Psychology Department of Rhodes University on 18 October 2017. The project has been approved.

Please ensure that the RPERC is notified should any substantive change(s) be made, for whatever reason, during the research process. This includes changes in investigators.

Yours sincerely

Prof Saville Young
pp CHAIRPERSON: RPERC

Appendix 2: Eastern Cape Department of Health approval letter

Province of the
EASTERN CAPE
HEALTH

Enquiries: Zonwabele Merile Tel no: 083 378 1202

Email: Zonwabele.Merile@echealth.gov.za Fax no: 043 642 1409

Date: 26 JUNE 2018

RE: Constructions of the long acting reversible contraceptive user, (EC_201806_008)

Dear Ms Yanela Ndabula

The department would like to inform you that your application for the abovementioned research topic has been approved based on the following conditions:

1. During your study, you will follow the submitted amended protocol with ethical approval and can only deviate from it after having a written approval from the Department of Health in writing.

2. You are advised to ensure, observe and respect the rights and culture of your research participants and maintain confidentiality of their identities and shall remove or not collect any information which can be used to link the participants.

3. The Department of Health expects you to provide a progress on your study every 3 months (from date you received this letter) in writing.

4. At the end of your study, you will be expected to send a full written report with your findings and implementable recommendations to the Eastern Cape Health Research Committee secretariat. You may also be invited to the department to come and present your research findings with your implementable recommendations.

5. Your results on the Eastern Cape will not be presented anywhere unless you have shared them with the Department of Health as indicated above.

Your compliance in this regard will be highly appreciated.

SECRETARIAT: EASTERN CAPE HEALTH RESEARCH COMMITTEE

Appendix 3: Letter to health district managers

CRITICAL STUDIES IN REPRODUCTION
Tel: (046) 603 7329
RHODES UNIVERSITY
Grahamstown • 6140 • South Africa
SEXUALITIES AND RESEARCH PROGRAMME
e-mail: cssradmin@ru.ac.za:

XXXXXXXXX
XX XXXXXX XXXXX
XXXXXXXX
XXXX

15 October 2018

Dear [Insert name]

REQUEST FOR PERMISSION TO CONDUCT RESEARCH WITH HEALTH PRACTITIONERS AND PATIENTS WHO USE LONG ACTING REVERSIBLE CONTRACEPTIVES

My name is Yanela Ndabula, and I am a Doctor of Philosophy student at Rhodes University. I hereby seek your consent to approach the head of staff for primary healthcare clinics, postnatal clinics, termination of pregnancy clinics, health services clinics and hospitals in [town] to recruit health practitioners who administer long acting or permanent contraception (LARC) and patients who use LARC as participants for research. I wish to conduct research with women who use LARC and health service providers who prescribe and administer LARC.

This project is being conducted under the supervision of Prof. Catriona Macleod (c.macleod@ru.ac.za) and participation will be voluntary (please see attached the consent form, which will be given to all participants). Chosen participants will attend an interview session, at a time convenient to them, conducted by myself at a venue suitable to them. These interviews will be recorded and are expected to range between 15 and 30 minutes in length. The names of the clinics or centres will not appear in the thesis or reports and identifying particulars of participants will be anonymised.

The Department of Health will benefit from this research by allowing women and health service providers to contribute to the creation of new knowledge. This knowledge can benefit society because the information gathered may be used to inform policy-making as well as initiatives aimed towards addressing social issues such as HIV and unintended pregnancy and ultimately contribute to women's advancement and health with regards to sexuality and reproduction. A policy brief based on the research will be developed and sent to all relevant health departments as well as the health district offices and will be presented to these departments at your invitation.

This research has been approved by the Department of Health and it also has ethical approval provided by the Psychology Department's Research Projects & Ethics Review Committee (RPERC) – see attached.

If you require any further information, please contact me on 083 738 3503 or yanelandabula@yahoo.com. Thank you for your time and consideration on this matter.

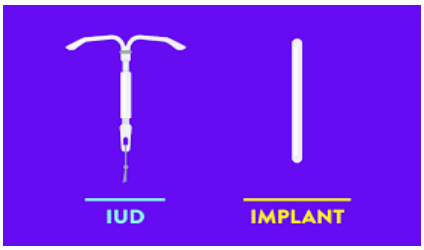
Yours sincerely,

Yanela Ndabula

Appendix 4: Recruitment advert

Are you on contraceptives?

Would you be willing to share your experiences of using the injection, implant or the intrauterine device with me?



If so, please take part in this study.

- My name is Yanela Ndabula and I am a Doctor of Philosophy student in the Psychology Department at Rhodes University. I would like to find out about your experiences of using the injection, implant or the intrauterine device as contraceptive measures.

- Participating is voluntary; your decision to participate or not will in no way affect the services you receive.
- If you would like more information about taking part, please call or send a please call me to Yanela Ndabula on 083 738 3503 or leave your number with the clinic nurses. We will reimburse you for travel and phone costs associated with the interviews.

This research has ethical approval as provided by the Rhodes University Ethics Standards Committee (date). Furthermore, permission to recruit participants has been obtained from the Department of Health. If you have any concerns about this recruitment message, please contact Prof Catriona Macleod on c.macleod@ru.ac.za

Appendix 5A: Participation consent form

AGREEMENT BETWEEN STUDENT RESEARCHER AND RESEARCH PARTICIPANT

I _____ (participant's name) agree to participate in the research project of Yanela Ndabula on prescription and use of long acting reversible contraceptives (injectable contraception, implant or intrauterine device). I understand that:

1. The researcher is a student conducting the research as part of the requirements for a Doctor of Philosophy degree at Rhodes University. The researcher may be contacted on 083 738 3503 or yanelandabula@yahoo.com. The research project has been approved by the relevant ethics committee(s), and is under the supervision of Prof Macleod in the Psychology Department at Rhodes University. Prof Macleod can be contacted on c.macleod@ru.ac.za or 046 603 7328.

2. The researcher is interested in health service providers' experiences of prescribing LARC and women's experiences of using LARC.

3. My participation will involve attending an interview session conducted by the researcher at a time and venue suitable to me. These interviews will be recorded and are expected to range between 30- 1 hour 15 minutes in length.

4. I may be asked to answer questions of a personal nature, but I can choose not to answer any questions about aspects of my life, which I am not willing to disclose.

5. I am invited to voice to the researcher any concerns I have about my participation in the study, or consequences I may experience as a result of my participation, and to have these addressed to my satisfaction. A counselling centre may be contacted for further support on_____.

6. I am free to withdraw from the study at any time.

7. The report on the project may contain information about my personal experiences, attitudes and behaviours, but that the report will be designed in such a way that it will not be likely to be identified by third parties and general readers.

8. The interview material may be used by researchers from the Critical Studies in Reproduction and Sexualities (CSSR) but identifying information will be removed before they can gain access to the interview material.

I want to receive a brief report of the results at the end of the study. Yes / No

If you wish to receive a report, we will send it to a postal address and SMS you to let you know when we have done so.

A trusted postal address (i.e. one where nobody will open the envelope before you) to which the report can be sent is:

_____

_____

Cell Number (to SMS confirmation that report has been sent): _____

Signed on (Date):

Participant: _____ Researcher: _____

Appendix 5B: isiXhosa Participation consent form

Dyunivesiti yase Rhodes

Icandelo lezolwazi ngengqondo

ISIVUMELANO PHAKATHI KOMPHANDI NOMTHATHI NXAXHEBA

Mna_____ndiyavuma ukuthatha inxaxheba kufundo phando luka Yanela Ndabula olujongene nokufumana ulwazi nzulu ngamava wabongi noogqirha abafaka i-implant ne IUD kwaye nezimvo zababhinqileyo abacwangcisa nge naliti, i-implant okanye i-loop. Ndiyaqonda ukuba:

1. Umphandi ngumfundi wase Rhodes University kwaye uphando lumalunga nezifundo zakhe zesigaba se Doctor of Philosophy kwaye angatsalelwa kukle nombolo (083) 738 3503 okanye abhalelwe ku yanelandabula@yahoo.com. Ophethe olu phando ngu Gqirha u Catriona Macleod okwa ngumhlohli kwicandelo lezolwazi ngengqondo kwi Dyunivesthi yase Rhodes angabhlelwa incwadi ku c.macleod@ru.ac.za okanye atsalelwe ku (046) 603 7328. Uphando olu luthunyelwe na kwi sigqeba esiphanda ngendlela uluntu oluziphatha ngayo iPsychology Department's Research Projects & Ethics Review Committee (RPERC) kwi Dyunivesiti yase Rhodes ukuze luphunyezwe.
2. Umphandi unqwenela ukufumana ulwazi nzulu ngamava wabongi ngemiba yocwangciso sapho namava wabantu ababhinqileyo abacwangisa nge implant okanye i-IUD.
3. Ukuba ufuna ukuthabatha inxaxheba njengomgqatswa kolu phando kufanelekile ukuba ungenele udliwano ndlebe kabini olu thatha phantse iyure ubude. Kolu dliwano ndlebe ndizakuthanda ukwazi ngamava onawo ngokukhula neendlela udade wakho okanye oodade bakho abakuchaphazele ngayo ekuthatheni iziqgibo ngezesondo, ukumitha nasekukhuliseni abantwana bakho. Ngemvume yakho udliwano ndlebe olo luyakushicilelwa kwaye luyakuthabatha ixesha elingange yure enimizuzu elishumi elinesithathu.
4. Usenokubuzwa imibuzo eyimfihlelo ngoko ke unegunya lokungazi phenduli izinto ezikwenza ungakhululeki.
5. Ukuba unemibuzo onayo nokungaqondi okuthile ngoluphando, ungaqhakamshelana nam ngokukhulekileyo ku yanelandabula@yahoo.com

okanye unditsalele ku (083) 738 3503. Kungenjalo ungaqhakamishelana nondiphetheyo uGqirha C. Macleod ku c.macleod@ru.ac.za okanye atsalelwe ku (046) 603 7328.

6. Inxaxheba yakho iyakuthathwa njengephuma kuwe entliziyweni futhi wamkelekile uba ungangavumi ukuthabatha inxaxheba. Akukho nto imbi ozakuchaphazeleka ngayo ngokwala kwakho. Ukwavumelekile uba ungarhoxa noba kunini kolu phando noba ubusele uqalile na.
7. Zonke iinkcukacha ezithe zafumaneka kolu phando ziyakugcinwa nje ngeziyimfihlo. Ukuqinisekisa ukuba iinkcukacha ezi zikhuselekile, ndim kuphela njengomphandi oyaba nelungelo lokukwazi ukufikelela kolushicilelo apho luzakube lufihlwe khona kwindawo ekhuselekileyo. Kwakhona akukho mntu uyakwazi ukuba olu phando belisenziwa nabani ngoba iinkcukacha ezinje ngamagama akho azizukuvezwa okanye zibandakanywe kumxholo woluphando.

Umhla:_____Umntu othatha inxaxheba:_____

Umphenyi:_____

Appendix 6: Tape recorder consent form

Rhodes University — Department of Psychology

USE OF TAPE RECORDINGS FOR RESEARCH PURPOSES
—
PERMISSION AND RELEASE FORM

Participant name & contacts (address, phone etc)	
Name of researcher & level of research (Honours/Masters/PhD)	Yanela Ndabula Doctor of Philosophy
Brief title of project	Constructions of the long acting reversible contraceptive (LARC) user.
Supervisor	Prof. Macleod

Declaration

(Please initial/tick blocks next to the relevant statements)

1.	***The nature of the research and the nature of my participation have been explained to me***	verbally	
		in writing	
2.	***I agree to be interviewed and to allow tape-recordings to be made of the interviews***	audiotape	
		videotape	
3.	***I agree to take part in and to allow tape-recordings to be made.***	audiotape	
		videotape	

4.	***The tape recordings may be transcribed***	without conditions	
		only by the researcher	
		by one or more nominated third parties:	

5.1 I have been informed by the researcher that the tape recordings will be erased once the study is complete and the report has been written.	
5.2 OR I give permission for the tape recordings to be retained after the study and for them to utilised for the following purposes and under the following conditions:	

Signatures

Signature of participant		***Date***
Witnessed by researcher		

Appendix 7A: Interview guide (Healthcare Provider)

Interview guide

My name is Yanela and I am a PhD student at Rhodes University interested in health service providers' experiences of prescribing and administering LARC. I think the voices of nurses in exploring contraceptive uptake are important considering their work at the ground level in trying to improve access to healthcare, in this case through providing contraceptive counselling.

1. Please start by telling me a bit about yourself? [Ask for: Age; occupation; ethnicity]
2. Please tell me a bit about the contraceptive services that you offer here.
3. Which contraceptive measure do you recommend the most? Why?
4. Which contraceptive measure do you recommend the least? Why?
5. Please tell me about the prescription of LARC (implant, IUD or injectable contraception).
    a. Which LARC do you recommend the most? Why?
    b. Which measure do women choose the most? Why?
6. What criteria are used to determine who is legible to use LARC?
    a. Whom do you encourage to use LARC?
    b. Whom do you discourage from using it?
    c. Who uses LARC the most in your experience?
7. What kinds of discussion do you have with women concerning LARCs?
8. What sorts of things do the women talk about when you discuss LARCs? [explore discussions about partners if not brought up]
9. Please describe some cases that were difficult that stand out for you in discussing LARCs with women.
10. Is there something else you want to tell me on this topic?
11. Do you have any questions to ask me?

Thank you for your participation. I really appreciate you sharing your experiences with me.

Appendix 7B: isiXhosa Health Provider interview guide

Isikhokelo sodliwano-ndlebe

Igama lam ndingu-Yanela ndenza izifundo ze-PhD kwidyunivesithi yase-Rhodes ndinomdla kumava onompilo/abongikazi abasebenza ngokunceda abantu basethyini nge-LARC. Ndicinga ukuba amazwi abongikazi ekuhloleni ukuthathwa kwezicwangciso abalulekile xa kuqwalaselwa umsebenzi wabo kwinqanaba eliphantsi bezama ukuphucula ukufikelela kwinkathalo yezempilo, malunga nokubonelela ngengcebiso neenkonzo zokusebenzisa izicwangciso.

1. *Ndicela uqale undixelele kancinci ngawe* [*Ucele: Iminyaka; umsebenzi; ubuhlanga*]
2. *Ndicela undixelele kancinci malunga neenkonzo zocwangciso ozinikelayo*)
3. *Sesiphi isicwangciso oye ukhuthaze sona kakhulu? Ngoba?*
4. *Sesiphi isicwangciso ongasikhuthazi kakhulu? Ngoba?*
5. *Ndicela undixelele ngokunikezelwa kwe-LARC* (*ifakwa engalweni, i-IUD okanye isitofu*)
    a) *Yeyiphi i-LARC oye uyikhuthaze kakhulu? Ngoba?*
    b) *Sesiphi isicwangciso esiye sikhethwe kakhulu ngabantu basetyhini? Ngoba?*

6. *Zeziphi iikhrayiteriya ezisetyenziselwa ukumisela ukuba ngubani ofenelekileyo ukusebenzisa i-LARC?*
    a) *Ngabantu abanjani oye ubakhuthaze ukuba babenzise i-LARC?*
    b) *Ngabantu abanjani oye ungabakhuthazi ukuba bayisebenzise?*
    c) *Kumava akho, ngabantu abanjani abasebenzisa i-LARC kakhulu?*
7. *Zingxoxo ezinjani eniye nibenazo nabantu basetyhini malunga ne-LARC?*
8. *Abantu basetyhini baye bathethe ngantoni xa ninengxoxo nge-LARCs?* [*phonononga iingxoxo malunga namaqabane ukuba azivezwanga*]
9. *Ndicela undichazele ngemeko ezinzima okanye imiceli-mngeni othe wahlangabezana nawo kwiingxoxo nabasetyhini nge-LARC*
10. *Ingaba ikhona enye into ofuna ukuyongeza kulomba?*
11. *Ingaba ikhona imibuzo ofuna ukundibuza yona?*

(Ndiyabulela ngokuthatha inxaxheba. Ndiyabulela kakhulu ngokuba uthe wabelana namava wakho nam).

Appendix 8A: Interview guide (Contraceptive user)

Interview guide (Contraceptive user)

My name is Yanela and I am a PhD student at Rhodes University interested in women's experiences of using LARC. Through this interview, I hope to create a space for the lived experiences and voices of women who use these contraceptives to be heard and thus contribute to the creation of new knowledge that can benefit society and ultimately add to women's advancement and health with regards to sexuality and reproduction. This is because the information gathered may be used to inform policy-making as well as initiatives aimed towards addressing social issues such as unintended pregnancy, contraceptive provision and HIV.

1. Please start by telling me a bit about yourself? [Ask for: Age; occupation; ethnicity]
2. Please give me a brief history about your use of contraception.
3. Please tell me about the contraceptive measure you are currently using (implant, IUD or injectable contraception). *If not LARC, then follow up why not/why stopped or choose another.*
    a. When did you start?
    b. What did you use and why?
    c. How did you come to know about it?
    d. How did you come to the decision to start using your current contraception?
    e. How long have you been using it?
    f. What do you like about it?
    g. What do you dislike about using it?
4. What discussions did you have with health services about contraception?
    a. What were those discussions like for you?
    b. Were you satisfied with the information you were given? Please explain.
    c. How did you feel about the interactions you had with health service providers?
    d. To what extent do you feel that your needs were considered in the prescription of contraception?
    e. To what extent do you feel that your beliefs were considered in the prescription of contraception?

    f. Did you feel like you had a say in the decision-making?
    g. Is there anything you would have liked them to have done differently?
5. With whom (other than the clinic/family planning) do you discuss your contraception use?
    a. What kinds of things do you discuss?
    b. What did they recommend?
6. Is there something else you want to tell me on this topic?

Thank you for taking part. I really appreciate you sharing your experiences with me.

Appendix 8B: isiXhosa Interview guide

Isikhokelo sodliwano-ndlebe

(Igama lam ndingu-Yanela ndenza izifundo ze-PhD kwidyunivesithi yase-Rhodes ndinomdla kumava abantu basetyhini okusebenzisa i-LARC. Ngolu dliwano-ndlebe, ndinethemba lokudala indawo yokuba amava aphilayo kunye namazwi abantu basethyini abasebenzisa ezi zithinteli/zicwangcis ukuba avakale kwaye ngaloo ndlela ndenze igalelo ekudaleni ulwazi olutsha olunokuthi luxhamle uluntu kwaye ekugqibeleni longeze kwinkqubela phambili yabasetyhini kunye nempilo ngokubhekiselele kwezesondo kunye nokuvelisa. Oku kungenxa yokuba ulwazi oluqokelelweyo lusenokusetyenziswa ukwaziswa kokwenziwa komgaqo-kqubo kwakunye namalinge ajolise ekusombululeni imiba yasekuhlaleni efana nokukhulelwa okungacetywanga, ulungiselelo locwangciso kunye ne-HIV.)

1. Ndicela uqale undixelele kancinci ngawe [Ucele: Iminyaka; umsebenzi; ubuhlanga]
2. Ndicela undinike imbali emfutshane malunga nokusebenzisa kwakho kwezicwangcisi.
3. Ndicela undixelele ngohlobo lwesicwangcisi osisebenzisayo sithetha nje (Le ifakwa engalweni, i-IUD okanye isitofu)
    a. Uqale nini?
    b. Usebenzise ntoni kwaye ngoba?
    c. Wazi njani ngayo?
    d. Ufikelele njani kwisigqibo sokusebenzisa esi sicwangciso?
    e. Sekulithuba elingakanani usisebenzisa?
    f. Yintoni oyithandayo ngaso?
    g. Yintoni onhayithandiyo ngaso?
4. Zeziphi ingxoxo oye wabanazo nowezempilo malunga nothintelo-kukhulelwa?
    a. Zazinjani ezo ngxoxo kuwe?
    b. Waneliseka lulwazi owalunikwayo? Ndicela ucacise.
    c. Waziva njani ngonxibelelwano obenalo nowezempilio?
    d. Uvakalelwe kangakanani ukuba iimfuno zakho ziye zaqwalaselwa xa unikwa eso sicwangciso?
    e. Uvakalelwe kangakanani ukuba iinkolelo zakho ziye zaqwalaselwa xa unikwa eso sicwangciso?
    f. Ingaba uye waziva ngathi unelizwi ekuthathweni kwezigqibo?

g. Ikhona into obunokuthanda ukuba bayenze ngokwahlukileyo?

5. Ngubani (ngaphandle kwekliniki/ucwangciso ntsapho) uncokole naye malunga nokusebenzisa izincwangciso?
    a. Nincokola ngezinto ezinje ngantoni?
    b. Bona baye bancome ntoni okanye esiphi isicwangciso?
6. Ingaba ikhona enye into ofuna ukuyongeza kulomba?

Ndiyabulela ngokuthatha inxaxheba. Ndiyabulela kakhulu ngokuba uthe wabelana namava wakho nam.

RHODES UNIVERSITY
Where leaders learn

I, _____, (name of translator) agree to maintain full confidentiality in regards to any and all audio recordings and documentation received from Yanela Ndabula related to her research study on the construction of long acting reversible contraceptives users.

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 Yanela Ndabula;

3. To store all study-related audio recordings and materials in a safe, secure location as long as they are in my possession;

4. To return all audio recordings and study-related documents to Yanela Ndabula 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 audio recordings and/or files to which I will have access.

Translator's name (printed)

Translator's signature

Date _____