User Representations and Diaphragm Use in
The Netherlands

Thesis submitted for Masters Degree
by
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Chapter 1.
Introduction

Purpose of the Study

The aim of this paper is to study user representations of women using the diaphragm\(^1\) in the Netherlands. The paper will specifically focus on, firstly, whether there is a "typical" user of the diaphragm, secondly if there is a typical user what are the characteristics of this typical user and finally what are the factors that lead a certain type of user to chose the diaphragm.

I particularly choose to study the diaphragm because one often finds conflicting perspectives of users, providers and women's health advocates on the diaphragm concerning its safety, efficacy and use. I will elaborate on these differing views in a later section. Studying diaphragm use in the Netherlands is particularly interesting because its use has decreased considerably in the last ten years (Vennix 1990). Further, family planning services in the Netherlands have gained a world-wide reputation for good quality care and efficiency, as indicated by high acceptance of modern contraceptives (Schaafsma & Hardon 1997). Thus it would be useful to analyse what factors have led to the diaphragm being a less acceptable choice over the years and also to see who constitutes the minority of women who continue to use the method. The subject, therefore, provides a platform to study the inter-relationships between a contraceptive technology, its users, providers and the socio-cultural context.

To facilitate the analysis of diaphragm use in the Netherlands and understand user and provider perspectives I shall at points compare its use with that of the oral pill, which is the most commonly used method in the Netherlands and is used by over 90 percent of contraceptive users. Also, many of the people I spoke to about the diaphragm often contrasted it to the pill.

User Representations of Women Using the Diaphragm

In this paper I use the term 'user representations' to describe the kind of images that exist about women using the diaphragm. These representations may exist amongst the users themselves, the providers of contraceptives and in scientific and feminist discourses. The representations can be

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\(^1\) The diaphragm, referred to as the *pessarium* in Dutch, is a barrier contraceptive method for women. It is made of latex or silicone and is dome shaped with a metal spring around the rim. It is inserted into the vagina before sexual intercourse and works by covering the mouth of the cervix, thus preventing the sperm from entering the uterus.
concerning characteristics such as socio-economic or educational backgrounds, the way diaphragm users view their body, the way they perceive risks of pregnancy and side effects or their personality traits. User representations might project users as active decision makers or as clients dependent upon the advise of the provider. In the study I attempt to investigate these representations obtained through interviews and existing literature and then compare these representations with the characteristics of the diaphragm users who I have interviewed to see whether there is such a thing as a typical user of the diaphragm and if so why.

Such a study of user representations is particularly interesting and useful because it is only since the 1980s that studies have started to focus on one specific contraceptive method and the characteristics of its users (Sciortino & Hardon 1994). However, few studies have looked into how these user representations evolve and in turn influence who uses a particular contraceptive method and this study therefore proposes to do so.

Medical discourse often puts forth an image of the “typical” diaphragm user as someone who is conscientious about her health and motivated to use this method which is considered less convenient than the more modern methods. Further, user representations of diaphragm acceptors mainly point to their being middle class, university educated women and/or women who are not very sexually active and do not need continuous contraceptive protection (McEwan 1978). McEwan’s (1978) study in England, states that diaphragm users tend to be older, married, starting their first baby later and having smaller families on an average than acceptors of other methods. According to the study, diaphragm users were less likely to have had an induced abortion and more likely to have a baby at a later age. They are less likely to have pursued an active sexual relationship at as early an age as other contraceptive users.

An interesting study Vessy et al (1976) showed the rather puzzling association that diaphragm users are less likely to be referred to hospital with an accidental injury than users of the pill or IUD.

Kay found that pill takers smoked more cigarettes than his control group (1974). McEwan (1978) states that the reason diaphragm users are less likely to have an induced abortion and to have had their first baby later may be because “they are careful people and less likely to take a
chance and use any contraceptive method". On the other hand women with a history of induced abortion or pregnancies at a comparatively young age may be persuaded by clinic staff to use an IUD rather than a diaphragm because an IUD is less amenable to failures by the user’s omission.

A study among 280 diaphragm users in the Netherlands found that diaphragms are most used by well educated women. Reluctance to use oral pills was a predominant motivation for choosing a diaphragm (Coopmans 1988).

Some studies also point to certain personality characteristics which determine diaphragm use. Kelly (1979) found that attitudes about using specific contraceptives were related to heterosexual and auto-erotic feelings. Positive attitudes about methods involving genital manipulation (e.g. the diaphragm and the condom) were correlated with more positive feelings about masturbation and greater expressed comfort with touching one’s genitals. Positive parental attitudes and more sexual experience were also related to positive attitudes about these methods.

Along with the medical discourse on the diaphragm there is also at the international level literature brought out by women’s health advocates on the advantages of the diaphragm. Most of this literature puts forward the view that the diaphragm is not only beneficial because it has no side effects but it is also a means for women to control their fertility on their own without being too dependent upon doctors. One line of discourse also argues that since pregnancy is a natural process, hormonal and other invasive contraception which cause side-effects should not be used and that the diaphragm provides a safer alternative to them (Hartmann 1987). This study will, therefore, also observe whether the respondents in this study contemplate about issues of control and the naturalness in the way the contraceptive works and whether this view differentiates diaphragm users from other contraceptive users.

A study conducted by Ravindran and Rao (1996) among women of low income and low educational backgrounds who are effectively using the diaphragm, provides a useful basis for comparison with studies done in the West on diaphragm users since many of them, as shown above, suggest that diaphragm users tend to be university educated women from middle-class backgrounds. This study found that some of the reasons given for choosing to use the diaphragm included infrequency of sexual intercourse and not needing constant contraceptive protection, limi-
ted contraceptive options and good service delivery in the case of diaphragms. This study will on similar lines argue that factors besides the users socio-economic and educational backgrounds can greatly influence the choice of contraceptives.

Factors Influencing User Representations
Numerous studies have been done on the social and attitudinal determinants of contraceptive choice and the decision-making processes involved in choosing a contraceptive. Determinants which are often studied are perceived risk of pregnancy and perceived costs of using the method in terms of efficacy and possible side effects. Also factors such as financial costs, convenience in using the method, its availability and partner attitude have been put forward as determinants of contraceptive choice (Conselli, 1986; Jaccard et al, 1996).

Literature focusing specifically on determinants of diaphragm use also point to similar factors. This study will analyse whether such factors not only influence the use of a method, in this case the diaphragm, but also whether they also lead to a certain kind of user to adopt the method.

As part of this study I will attempt to analyse factors that might lead to a certain type of woman to opt for the diaphragm. To facilitate a better understanding of the range of issues involved in influencing who uses the diaphragm (or who is expected to use what method), I will broadly classify these factors into four groups - user factors, method factors, service factors and contextual factors. However, it is important to note that these factors are inter-related and issues may overlap making it difficult at times to draw clear distinctions between them.

User factors include the user's social and economic background, age, belief system, personality traits, relationships and past contraceptive experience amongst others. The second set of factors are method related such as its mode of use, duration of effectiveness, side-effects etc. These may be characteristics of the diaphragm that certain users and providers may find attractive. As McEwan (1978) states, it is always difficult to decide whether particular characteristics of behaviour are determined by the features of a given contraceptive method, or by the appeal of that method to a certain type of personality.
Service factors that may influence the use of the diaphragm include factors such as the provider’s attitude towards the diaphragm, availability of information about it and the accessibility of the method itself. Madeleine Akrich (1992) argues that innovators of technologies "inscribe" their hypotheses about users in the technologies they develop and thus the technology contains a script about the kind of user it is meant for and the way it should be delivered. I would like to argue that providers of contraceptive technologies too "inscribe" a hypothesis of potential users. In the case of Norplant\(^2\), it is provider dependent for the user who is forgetful and the pill is for women who can remember to take the pill everyday. Thus the provider may advise a woman to use a certain contraceptive according to how the user is viewed. For example if the user seems older and responsible they may be advised the diaphragm and if she is young she may be asked to use the pill. Therefore, the characteristics of the contraceptive that providers advise may be reflective of the way the user is viewed by the provider. Further, user representations within the medical discourse may influence the way counselling for diaphragm is done or the kind of users that the diaphragm is recommended to.

As mentioned earlier, the influence of provider motivation and service quality on contraceptive choice is an area which has not been studied much in the past. It is particularly important to do so when studying a method such as the diaphragm since it requires the provider to teach the user how to use and keep the diaphragm.

Woolgar (1991) takes the idea of user representations a step further and introduces the concept of user configurations where configuring includes defining the identity of putative users of a technology, and setting constraints upon their likely future actions. As part of the study I will attempt to analyse whether users of the diaphragm have such behaviour codes enforced on them and briefly compare these configurations with those of other contraceptive users.

A third category of factors influencing who uses the diaphragm are external factors in terms of the socio-cultural context in the Netherlands concerning attitudes towards contraception, sexuality, children etc.

\(^2\) The Norplant is a hormonal implant for women, consisting of six silicone rods that are inserted surgically under the skin, in the upper arm. It is effective for five years after which it has to be removed.
This last set of factors - the external factors are particularly important because they usually act in a subtle way and are often overlooked by users, providers and those conducting research on the issue. Wajcman (1991) while discussing the history of contraception states that birth control became commonly used only in the nineteenth century not so much because of the introduction of effective technology but more so because of society's changing attitude towards sex, children and the status of women. She thus argues that birth control has always been a matter of social and political acceptability rather than of medicine and technology. On the same lines, in this paper I would like to state that the use of the diaphragm (and pill) are greatly influenced by the social and political culture in the Netherlands. In the concluding section of this paper I will elaborate on this point in more detail.

The Dutch Scenario

Contraceptive Use:

In 1882, a couple of years after the diaphragm was invented in the United States, Aletta Jacobs, the first female physician in the Netherlands, started providing contraceptive services using the diaphragm (Rolong 1987). Before its introduction more natural methods were applied such as coitus interruptus and periodic abstinence. The belief that the fecundation took place during menstruation led, however, to incorrect calculations. Condoms made from animal skins were also available but they were not comfortable. Therefore, the introduction of the diaphragm was welcomed by many women at that time.

The diaphragm remained a popular contraceptive choice over the next three quarters of a century. However, it became less popular after the introduction of the pill in the 1960s, and other contraceptive technologies like the Intra Uterine Device (IUD) and hormonal injectables and implants in later years.

When the pill was introduced in the late 60s, feminist groups and women in Europe and North America, trying to be freed from a passive sexual role and the traditional mother role with in nuclear families enthusiastically welcomed this new contraceptive method. However, in the 70s after initially welcoming it as a technology that benefited women's emancipation, women's health advocates became concerned about its safety. The identification of long term (cancer) effects caused by estrogen DES, used by thousands of women to prevent miscarriage during pregnancy,
was one of the main causes for increased suspicion towards hormonal products (Brandts et al 1990). At the end of the 70s these concerns led to a pill panic (Ketting 1981) which resulted in many pill users turning to other contraceptive methods.

Fertility surveys done in 1977 and 1982 reveal a remarkable decline in preference for the pill among married contraceptive users (18-37 years of age) in the early 80s due to the pill panic. The percentage of married, contraception using women choosing the pill was 64 percent in 1977, while in 1982 only 26 percent of them choose the pill. An increasing number of older women and men chose sterilisation after completing their family. A proportion of women who had not completed their family shifted to the IUD and (not reflected in most official statistics) to the diaphragm (Coopman 1988).

During this time, feminist groups pointed out that modern contraceptives made women more dependent upon medical professionals for control of their reproductive functions. Within these circles, the diaphragm was promoted as a method without side effects and one that women could use without interference from the medical professionals (Terwiel 1986).

The pill was not the only contraceptive to come under scrutiny. In the early 80s, concerns were also raised by women's health advocates about the negative effects of the IUD, causing pelvic inflammatory disease, following the decision of one of the manufacturers to withdraw its IUD, the Dalkon Shield from the US market. Dutch women, supported by the Dutch Consumers Organisation, Consumentenbond, filed suits and received damage awards. In the Netherlands, IUDs are no longer recommended for women without children because of the risk of infertility related to pelvic inflammatory disease caused by these devices (Sciortino & Hardon 1994).

By the late 1980s the effect of the pill panic had diminished. The study by Delft and Ketting (1992) shows a gradual increase in total pill use among women of reproductive age in the 1980s, with 36.5 percent of women using the pill in 1989. Contraceptive pill use is remarkably high among adolescents and women below the age of 30 (around 50 percent). The most commonly used type of pill is the sub-50 pill, which has fewer side effects than the older generation of 50 plus pills that were used before and during the pill panic. A total of 63 percent of pill users use the sub 50 pill. The increase in pill popularity does not mean that pill users are entirely satisfied. An interesting
study by Vennix (1990) shows that a relatively high percentage (28 percent) of pill users suffer adverse affects. Pill users, according to Vennix, often feel ambivalent about the pill, but do not see any alternative contraceptive that could serve their needs. Physicians according to his study, tend to automatically prescribe the pill, and give little information on other methods. Moreover, women above the age of 30 are still prescribed higher dose pills.

Contraceptive Delivery:
The key figure in the Dutch system's provision of selected contraceptive methods is the general practitioner. According to the literature, the central role of the general practitioner accounts for the effectiveness of fertility control in the Netherlands. It makes contraception an integral part of the health service, easily accessible and prevents medicalisation of the process (Sciortino & Hardon 1994). The general practitioner's central role in contraceptive provision is majorly responsible for the widespread popularity of the pill in the Netherlands. This is due to the fact that for most of these physicians, the pill is the only method they can prescribe. Natural methods and condoms do not require a medical prescription and the IUD and sterilisation need specialised knowledge which the physician often does not possess. Till as recently as 1994, general practitioners did not learn about the diaphragm as part of their study. Many of them do not know how to take measurements for its fitting and have to refer clients to women health centres or other contraceptive services (Delft & Ketting 1992:6).

According to the National Association of General Practitioners, there are 4,800 general practitioner practices in the country of which approximately 650 run an incorporated pharmacy as well. Most clinics are staffed by one or two doctors. Most of the country's general practitioners are male, only 18 percent of those currently registered are female.

In addition to the family physicians, Rutgers clinics (Rutgershuizen) are involved in the provision of contraceptives, although on a smaller scale. These bureaus are spread throughout the country and are part of the Rutgers Foundation, a national organisation partly subsidised by the government which offers assistance for all kinds of questions and problems related to contraception, sexuality and relationships. Although the services are not free of charge, it remains a preferred alternative for women desiring anonymity. In the last few years the Rutgers Stichting has been undergoing structural changes and they no longer receive large
amounts of funds from the government. The number of their clinics have decreased from forty eight in the country to only eight.

Since general practitioners deal with all kinds of problems and questions regarding illness and health, family planning services are only a small part of the family doctors tasks. More than half the doctors interviewed in a study done by Schaafsma and Hardon (1997) said that they carry out ten or fewer family planning consultations each month, with a maximum of forty consultations a month. In contrast the Rutgers clinics are specialised in sexual health and providing family planning services is a major task and staff interviewed in the same study stated that the clinics carry out 120-400 family planning consultations per month. However, it is important to note that the general practitioner practices account for 90 percent of the contraceptive practices and Rutgers Foundation for only 10 percent of the services.

During the early 1970s, the government decided that the costs for medical contraceptives such as the pill, IUD and the diaphragm, if they were prescribed by a general practitioner, would be reimbursed by the public health insurance funds. Later sterilisation and hormonal injections were also added to this list. Only contraceptives available without medical prescription, including those got from the Rutgers clinics and methods such as the condom, were not included (Delft & Ketting 1992). In the case of spermicide too, though it is to be used with the diaphragm, its costs are not covered by the insurance. It is interesting to note that despite the condoms important role in controlling the AIDS epidemic, no changes have been made in this financing policy. Among the methods not allowed in the Dutch market and therefore not provided, is Norplant. The women's condom is also available but is not as yet widely distributed (Sciortino & Hardon 1994).

However, one finds that despite the large spectrum of available contraceptives, certain "reliable methods" which are also often referred to as "modern methods" are mainly propagated. These include the pill, IUD, hormonal injections and sterilisation.

The condom is promoted as a complementary measure to prevent AIDS, but not as a substitute for reliable contraceptives. In the information material of the Rutgers Stitching, the instruction to use both the pill and the condom is explained as follows: "For healthy young women

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3 In the Netherlands it is advised that the diaphragm be used also with spermicide.
the pill is the best choice: the best method to be sure not to get pregnant. Nowadays it is, however wise to use the condom in addition to the pill when you make love to somebody you do not know so well or when you make love to more than one person. In this way you reduce the risk of getting an STD or AIDS" (Rutgers Stitching quoted in Sciortino & Hardon 1997).

The preference that some women's health groups have for the diaphragm is not shared by most contraceptive providers. Instead they view this method as unreliable in view of the fact that many women do not check it correctly and do not always know how to use spermicide products (Sciortino & Hardon 1997)

While most doctors usually stock pills, injectables and morning after pills and few doctors keep IUDs also, very few doctors stock diaphragms. Nor do these doctors have fitting rings to measure the required size of the diaphragm and they do not usually advise their clients to use the diaphragm. Clients usually asking for the diaphragm are usually referred to the Rutgers Foundation (Coopman 1988).

At the Rutgers clinic the cost for fitting a diaphragm is around US$40, this includes the cost of the method and consultation fee. A study conducted in the Netherlands shows that 100 percent of the doctors in the Rutgers clinics compared to 23 percent general practitioners, had advised or prescribed the diaphragm to a client in the last three months.

There are various reasons given for the relatively low popularity of the diaphragm. These include the fact that it can be cumbersome and inconvenient to use since it has to be inserted before sexual intercourse (Hirschfeld; 1983). As mentioned earlier, the pill is viewed as the most effective method and the diaphragm is not compared favourably with it. Studies on the efficacy of the diaphragm show that efficacy rates vary from approximately 83% to 96%. However, in the case of the diaphragm, it is important to point out that efficacy greatly depends on the provider and user motivations and ability to learn to use it (Trussell et al 1993). Further, the provider has to spend time initially teaching the user how to use it. If the diaphragm is not properly used there can be a high user failure rate compared to hormonal methods. However, one of the major advantages of the diaphragm is that it has no side-effects
it is therefore considered a relatively safe method compared to other methods.

Percentage of Providers who prescribed or advised clients on specific methods during the last three months (n=52)

<table>
<thead>
<tr>
<th>Method</th>
<th>General Practitioner</th>
<th>Rutgers clinics</th>
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<tr>
<td>pill</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>IUD</td>
<td>81</td>
<td>66</td>
</tr>
<tr>
<td>Male sterilisation</td>
<td>70</td>
<td>44</td>
</tr>
<tr>
<td>Condoms</td>
<td>60</td>
<td>55</td>
</tr>
<tr>
<td>Injectables</td>
<td>58</td>
<td>66</td>
</tr>
<tr>
<td>Female sterilisation</td>
<td>56</td>
<td>66</td>
</tr>
<tr>
<td>Morning after pills</td>
<td>35</td>
<td>88</td>
</tr>
<tr>
<td>Diaphragm</td>
<td>23</td>
<td>100</td>
</tr>
<tr>
<td>Abortion</td>
<td>21</td>
<td>77</td>
</tr>
<tr>
<td>Progestin-only pills</td>
<td>14</td>
<td>11</td>
</tr>
<tr>
<td>Spermicides</td>
<td>2</td>
<td>44</td>
</tr>
<tr>
<td>Natural methods</td>
<td>2</td>
<td>11</td>
</tr>
<tr>
<td>Number of respondents</td>
<td>43</td>
<td>9</td>
</tr>
</tbody>
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Source: General practitioner Interviews; E. Schaaafsma

Coopmans relates the limited use of the diaphragms to the unfamiliarity and lack of attention that this method receives from the medical profession (1988). Descriptive statistics suggest that the use of the diaphragm is diminishing. In 1980, approximately 10 percent of the consultations at the Rutgers Stitching were for the diaphragm and in 1989 four percent were for the diaphragms (Delft & Ketting 1992). This may be due to the fact that unwanted pregnancies occur relatively often, mainly due to incorrect use of the method (Hirschfeld 1983). The diaphragm was found to be used by only 0.2 percent of women between 20-40 years of age in 1988 (Vennix 1990). Compared to this 43 percent women were using hormonal pills and injectables, 5 percent the IUD, 7 percent condoms, 3 percent female sterilisation, 7 percent male sterilisation and 5 percent other methods (Delft 1991)
Chapter 2.
Research Methodology

Study Type
The study is an exploratory and descriptive study and mainly focuses on qualitative research amongst a small group of respondents to understand the characteristics and motivations of diaphragm users.

The study is comparative in terms that it studies perceptions about the diaphragm and its users amongst different groups - diaphragm users themselves, users of other methods and contraceptive providers.

Data Collection techniques
Primary and secondary data was collected over a period of eight weeks. The locations for the data collection were Amsterdam, Utrecht and Arnhem.

Primary data collection:
The methods used for primary data collection were:

1. In-depth interviews
A total of eighteen semi-structured interviews were conducted with the following groups:

a. Diaphragm users
   Number of interviews: nine
   Selection criteria: They should have used the diaphragm, with or without another contraceptive method, for a period of over two years since that would reflect some degree of satisfaction with the method.

b. Users of other contraceptive methods
   Number of interviews: five
   Selection criteria: That they be users of some other contraceptive method besides the diaphragm.

c. Contraceptive providers
   Number of interviews: four
   Selection criteria: In the case of the providers, two general practitioners were interviewed
and one doctor and one nurse who were doing fittings in two separate Rutgers Stitching were contacted. I approached one general practitioner staying in my residential area and another who was known to a friend. I did not inquire about their experience with the diaphragm before approaching them for interviews. The providers at the Rutgers clinic were approached through people I knew and I did specify that I wanted to interview providers involved in diaphragm provision at their clinics.

I had initially planned to conduct interviews with a larger number of non-users. However, I seemed to have reached a saturation point very soon with experiences being quite similar especially among the pill users and I found myself consciously looking for women using other methods besides the pill.

The in-depth interviews were semi-structured to facilitate the respondents to introduce issues and concerns that were primary to them and help understand their specific contexts better. All interviews were tape recorded. Most interviews took place over a period of one to one and a half hours. All, except one, of the interviews of the contraceptive users were conducted in their homes. In the case of the providers two interviews were conducted in the clinics where they worked and two at their residences.

2. Participant observation
In one of the clinics on one morning during consultations to see the interaction between clients using the diaphragm and the providers

3. Visit as Client
One general practitioner and a Rutgers Stitching clinic were visited by a friend of the researcher as a client wanting to use the diaphragm, to know about the counselling and service provided. This also helped to triangulate the findings from the interviews with the contraceptive users and providers.
4. Visit to the diaphragm manufacturing Unit and Distribution Office

I visited the diaphragm production unit of the Centraal Meddelen Depot (CMD) in the Hague to find out about how they were made and distributed.

5. Visit to pharmacies

Two pharmacies in two different localities were visited to find out whether they had diaphragms available and whether they had people asking for them.

Secondary data collection:

Secondary data was collected from existing literature in social science and medical journals. A thorough search was done on Social file Articles and book on contraceptive use and attitudes in general, and the diaphragm and its use in the Netherlands specifically were looked at. A number of libraries in Amsterdam were visited including university libraries, the Royal Tropical Institute Library, Women's Archives and the Medical College Library. The library at NISSO, Utrecht, particularly proved useful for literature on contraceptive use in Netherlands. Publicity brochures and information material on the diaphragm and other contraceptive methods in Rutgers clinics were also looked at. Feminist literature on contraception and the diaphragm was also analysed. Material that was in Dutch was translated by friends.

Sampling techniques

The respondents were contacted through two methods -
- Clients of a Rutgers Stitching clinic
- The snowball method.

Both the methods were used together so that one could reach a wider sample of contraceptive users. The interviews were conducted in Amsterdam, Arnhem and Utrecht.

It is possible that despite using these two different methods to reach out to a diversity of respondents, I may have not been very successful in doing so. The Rutgers clinic may have a certain clientele and the snowball sampling may have also introduced me to women with

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4 I actually visited the Unit prior to the time I started my fieldwork. However, some interesting information emerged from this visit that I would like to include in the study.
similar characteristics. However, despite these possible sampling biases, the findings of the study reveal some important issues in the use and delivery of the diaphragm.

**Practicalities of conducting field research in the Netherlands**

Being a foreigner, the experience of conducting research in the Netherlands added an interesting dimension to the fieldwork. Finding respondents and fixing interviews was a lot more complicated than I had expected. Initially I had planned to conduct the fieldwork only in Amsterdam and interview clients coming to one of the Rutgers clinic and also use the snowball technique along side with people I knew. However, going through the official procedure and getting permission to interview clients at the Rutgers clinic needed more time and the clinic was concerned about respecting the privacy of their clients.

I finally did get to interview some of the clients at a Rutgers clinic in Arhnem, but it was done at a more informal level. Letters were sent to eight diaphragm users explaining the study and asking if they would be interested to come on a particular day when I was visiting. Interestingly, six responded and said that they were willing to be interviewed and four of them came to the clinic on that particular day despite the fact that three of them were working women. A couple of women who I interviewed even asked if I wanted to interview their friends who were using the diaphragm. This raises the question whether all clients actually feel the need for privacy and anonymity that clinics extend to them. Some of them may in fact, as this experience shows, want to share their experiences. However, it is true on the other hand that their willingness to talk about their experience with the diaphragm may be reflective of the kind of women diaphragm users are. I will go into more detail on this point in the analysis section.

With the snowball technique, I realised that most of the people I knew were at the university or women's groups and the people they got me in touch with were also often highly educated women and aware women and I had to make a conscious effort to move beyond that group.

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5 The keywords that were used included contraception, *anticonceptie*, diaphragm, *pessarium*, barrier methods, the Netherlands, user representations, user configurations.
I also found that some of the people I got in touch with were only willing to give me appointments a week or two later and since I had only six weeks to conduct the research this was a disadvantage.

I had been expecting some of the respondents to say that they would like the interview to be conducted in Dutch and I had arranged for someone to do the interpretations during such interviews. However, surprisingly not a single respondent said that they would prefer the interview in Dutch and though some respondents had to stop and think of the words during the interviews, most were able to express themselves very well in English. This could also be a reflection of a bias in my sampling technique whereby I reached a select group of women.

Another possible bias in this study was that before going into the field I had already constructed an image of the real user and the user representations put forward by the providers. I had to be careful not to let this imagery influence the way the research is conducted and the final findings of the study.
Chapter 3.
Findings

I will now present the data and findings of the study. To do so, I will first profile each of the three groups with whom interviews were conducted and then report about the outcomes of the vistas to the pharmacies, general practitioner, the Rutgers clinic and the diaphragm manufacturing unit. In the next chapter I will then analysis of the some important issues that emerge from the study.

Profiles of Users

Out of the nine diaphragm users interviewed, only two were using the diaphragm alone. Four were presently using condoms because they were in new or short term relationships where they had felt the need for protecting themselves against sexually transmitted diseases. Two of them said that though they were no longer at risk (both partners having been tested) they had now got used to the condom and continued using them. Among the other three respondents, two used the diaphragm and condoms alternately, and one used both the methods together (she called it her interpretation of the double Dutch method!). These three users stated that using the condoms and diaphragm was a way of sharing responsibility for contraception. They also found it easier to use the condoms in certain circumstances for example while travelling or when they had spontaneous sex and the diaphragm was not handy. (See appendix 1 for a detailed profile).

Reasons for opting for the diaphragm:

The disadvantages of other methods:

Each diaphragm user gave a number of reasons for using the diaphragm. Interestingly, the unsuitability of other contraceptive methods was often mentioned as a reason for choosing the diaphragm, though at the same time some users stated that they would anyway not like to take hormonal contraceptives. The IUD was not an option for most because it is mainly recommended for women who had children and also most respondents feared an increase in the risk of infection from IUD use. Two diaphragm users stated that the did not like the idea of anything inserted in the uterus. Five of the women said that they and their partners did not like the condoms and preferred not to use it because it interrupted having sex. Two stated that
they did not trust the condoms either because they tore or one tended to use them (or not use them) at the last minute and increase the risk of pregnancy. Similar reasons were given amongst the non users who were not using these methods.

All except one of the diaphragm users had first used the pill when they had started with contraceptive use. Six of the nine users stated that they had side-effects while using the pill; these mainly included headaches, heavy and painful breasts, being irritable and a feeling of not being well. One of them stated that:

"I did not like to take hormones, it caused physical problems ...such as pain in the breasts and heaviness. My periods also felt different. I have heavy periods myself and I do not want to have light periods. Its not me - its like I am not a women".

One of the respondents pointed out that while she had stopped using the pill due to these side effects, most women may have continued. Most of the diaphragm users did not report severe side-effects of using the pill:

"I did not physically like the pill. I knew friends who had much heavier side effects. So from the medical point of view I was certainly not in the category of people not suited to the pill."

Thus the majority of diaphragm users had tried other methods, particularly the pill and condoms, and not found them suitable before they opted for the diaphragm:

"I basically felt that amongst the things that you could do it was the less worse one because it was more an anti pill thing than a pro diaphragm thing."

"It was more the negative things about others. Earlier I was using the temperature method and was really nervous about getting pregnant. So I
said that I do not want to use the spiral or pill and that only leaves the diaphragm. So it was that I do not want that, do not want that and only that is left!"

The advantages of the diaphragm:

While it is difficult to talk about the advantages of the diaphragm without comparing it to the disadvantages of other methods, which are mentioned above, a wide range of positive attributes of the diaphragm were mentioned by users. Six users said that they liked the diaphragm because it was more natural. Most of them stated that the diaphragm suited their way of looking at their bodies and health. Three said that it fitted with their way of living. Five of the users mentioned that they either did not like to take medicines or that medicines did not suit them and they therefore liked the diaphragm’s mode of working better than other methods. The following are some of the statements made by these women on the subject:

"I started using the diaphragm because it fitted with the way I was living. I was concerned about the environment and was vegetarian trying a certain way of living and the pill would not have fitted in that pattern of living. I did not want to swallow hormones. I did not want to do something with my body."

"Over the years I have become much more conscious of the bodily integrity of one’s body - so I would not play around with it...I have been against piercing my ears...and am also clear about not smoking and then I find other solutions to these. Maybe I am a kind of person who likes to find solutions to problems and say that there are different solutions and then be enthusiastic about it and say look at me I found a solution."

"With my being in sports it was important for me to stay in good health and shape - and that may have also influenced my decision to use the diaphragm".

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"I was always busy with being healthy and living healthy so I had a kind of clearness and commitment to the diaphragm."

Interestingly, three of the respondents mentioned being influenced by feminist readings and influence concerning the way ones body and contraception should be looked at. All three of these women were in their late 30s and though I did not bring up the issue of feminism, they spoke about how their choice of the diaphragm was influenced by feminist understanding of the body.

"My using the diaphragm was also influenced by the time...there was the feminist movement which said that you had to take care of your body and the pill was not suitable...I was not a majority, not all my friends were using the diaphragm, but at least one third were."

One of the users explained that the diaphragm was suitable because it fitted with the she viewed sex and pregnancy

"...I did not want to be always ready to have sexual contact. Also I did not want to not talk about having a child or not. When I take the pill its like being sterilised and not being able to have a child. Its not anymore a subject, a thing that you talk about...(with the diaphragm)...I like the idea or the fact that I am busy with it. I do not like the pill because its not visible. Its something we do not have to talk about once we get it home. With the diaphragm you have to use it each time...you have to decide with your partner whether you are going to use it now - you have to talk about it."

Some of the users stated that they liked the idea of using the diaphragm and taking responsibility for contraception because it gave them a sense of control compared to using the condom:

"...My taking responsibility also gives me control."

"Rationally, I think its important that the man take responsibility as well. I would rather like a kind of equal responsibility. But I find it very
difficult because its something concerning my body...its I who gets pregnant."

"I always wanted to have my relationships, not only contraception in control...It was not that I felt it was my responsibility and not theirs and that I wanted to take the responsibility, but more that I was not sure whether they felt responsible and were willing to take the responsibility."

The term control was used at very different levels as the respondents statement shows:

"Its more control over something which is related to safety. You do not have to do something which could be harmful to your body. Also you are in control over prevention of pregnancy and also the way in which one can do this. And also control in terms that I use it."

Another user who started using the diaphragm at an early age (17 years) states that:

"In the case of condoms - I felt it was like a man thing. For me to be walking around with a condom in my pocket did not suit my self image...Whereas walking around with a diaphragm in my pocket was more feminine and compatible with my self image."

Effectiveness of the diaphragm:

Interestingly, compared to the non users, diaphragm users did not quote figures about the effectiveness of the diaphragm compared to the pill. None of the users themselves stated that they believed that the diaphragm was less effective and that they were compromising efficacy for safety, though a few expressed that they were compromising convenience for safety. Three users stated that the diaphragm was effective if it was used properly:

"I feel that if you use the diaphragm properly it is effective and research has shown that. At certain points I did get a little angry...they should not
say that its not effective but that its ineffective when not used properly. If you do not use the pill or condom properly it is also not effective."

Four of the users got pregnant and underwent abortions during their periods of diaphragm use. It is important to note that none of them discontinued the use of the diaphragm. While three of these women said that it was a case of user failure rather than method failure, one said that she had been fitted with the wrong size of diaphragm by her general practitioner since he had not fitted a diaphragm for over 15 years.

The fact that four of the diaphragm users got pregnant and went in for abortions contradicts what some of the providers said about diaphragm users being women who are ambivalent about whether they wish to have children. None of the women went ahead with their pregnancies. One women commented that:

"I feel that one should not be pushed to use one method - that’s the pill. Because it makes everyone think its the way not to have a child. You have to look at what really fits you. I am taking the little risk of having a child this way...People who really do not want a child are using the pill...I feel when I say this I am saying that the diaphragm is less to trust than the pill. But that’s not so. I do not think so. Maybe I say this because of the ideas of people around me which is that the pill is the way for people not to get pregnant. I do not think that I am someone who would drink so much and have sex that I would forget to use the diaphragm or that I would not use it for some other reason. And maybe that is the risk of the diaphragm - it says about the woman- not the diaphragm."

Response of others to diaphragm users:

Four of the diaphragm users stated that they had got negative responses from people, including contraceptive providers, when they had stated that they were using or wanted to use the diaphragm.
One of the users approached her general practitioner for the diaphragm and he said "What? I have not prescribed one in 15 years, you are very old fashioned for wanting one". He prescribed a very small size and she had difficulty inserting it and removing. At one point she to go back to him at one point to ask him to take it out. Then she got pregnant and had to have an abortion. Then she was asked to go to a hospital to a gynaecologist who also did not know how to fit the diaphragm and finally she came to the Rutgers Stitching. In another case when the woman went for an abortion the doctor at the clinic asked her why she used the diaphragm and said that it was not a safe method.

In some instances friends of diaphragm users expressed curiosity and wanted to know more about it. One respondent said:

"...I feel that when I read information about contraception, I often miss information on the diaphragm. My friends say - what's that the diaphragm? that's something old fashioned or does not exist. So I think there should be more information about it".

Importantly, many respondents (more so among non diaphragm users) felt that they knew very few people who used the diaphragm. One of the major reasons given by respondents for choosing the pill during the initial years of their sexual life was that everyone was using the pill. This factor - of knowing people who use the method- can be a major influence in choosing contraception. Two of the respondents while explaining why she choose the pill when she first started using contraception said that:

"All my friends were using the pills".

"It was something to tell your friends that you were using the pill but it was not something to say that - I am using the diaphragm".

Attitudes towards ones own body:
Most diaphragm users emphasised the importance of being comfortable with one’s body to be able to use a method like the diaphragm. However, four users said that using the diaphragm could in turn make one comfortable with one’s body:
"I think that its a very valid point when people say that the use of the diaphragm can be empowering because you have to learn some basic things about your body and that can be helpful in general to take care of your body."

"For young women ..its a good way of getting to know and taking responsibility of your body. With the pill you do not see and think about it."

"You do really have to feel at ease with your body to be able to use the diaphragm"

"I have changed the way I see my body over the years. In the beginning when I came here (Rutgers clinic) I would really wash my hands a lot of times because I was not used to it. But now I am also 10 years older..."

"I think other people feel that its a fuss to use it (the diaphragm)...I think for most people the pill is cleaner and easier to use - you just swallow it. You do not have to do anything with your body, you do not touch your body anywhere. But I think that it is nice to see it as natural to touch your body"

One of the users had brought out a sheet on which she had recorded her menstrual cycle and contraceptive use since the time she started her menstruation till her late 20s. She said that: "I was so enthusiastic about my periods that I wanted to register them". In my opinion this reflected a rather positive towards one's body.

Where they got their diaphragms:
As stated earlier all except one of the diaphragm users first used the pill when they began using contraception. Their ages when they first started contraception varied from 16 to 20 years. The ages at which they first started using the diaphragm varied from 17 years to 27 with
six out of the nine starting to use it before they were 25 years. While all except two got their pills from the Rutgers clinic all the others got their pills from a general practitioner.

When they started using the diaphragm, all users except one (who later also went to Rutgers because her doctor gave her the wrong size of the diaphragm) got the diaphragms from the Rutgers clinic and go back for follow-up visits and to get new diaphragms. Only one user asked her general practitioner to renew her prescription for the diaphragm since she already knew her diaphragm size.

"I went to Rutgers...because I knew that they were specialised in sexuality and contraception. I did not want to go to my GP because he has to talk about your food, headache, about the child and also the diaphragm. I knew that doctors do not know about alternatives to the pill."

However, it is important to note that while all users got their diaphragms fitted at Rutgers clinics, none of them stated that it was their visits to the clinic or the counselling there that made them opt for the diaphragm. All nine women when the came to the Rutgers Stitching had already decided on the diaphragm or were keen to use it but needed some information before they made a final decision.

The main source of information and motivation to use the diaphragm came from knowing someone who had used it and was happy with it. Two of the users had older sisters who were using the diaphragm and who suggested to them to use it. In one of these cases the mother had been a diaphragm user too. In another instance the diaphragm had been suggested by a sister-in-law who was a general practitioner and in one by the sister of the boyfriend. Only one user out of the nine had gone for a diaphragm to the clinic not knowing anyone else who used a diaphragm in all other cases the women knew someone using a diaphragm.

Four of the users said that they liked to read about contraception and other health related subjects. Two said that they bought books and searched in the library when they wanted certain information. Two of the respondents had professions related to women's health research and they said that they came across material on contraception during their work.
Relationships and partner support in diaphragm use:
While five of the women had used diaphragm in both long term and short relationships, four had used it in long term relationships. Some of the women stated that they would find it easier to use a method such as the diaphragm in long term relationships than short term since in the latter they may have to explain its use and may not have partner support. However, this feeling was more amongst the women in long term relationships and those who were in short term relationships did not express any disadvantages in using it in such relationships.

In three the partners expressed initial wariness and concern about the effectiveness of the diaphragm. However, they accepted it later and were supportive of their partners using it. Five of the users stated that their partners had come with them for the diaphragm fittings and had also learnt how to insert it.

“I did not have any problems inserting the diaphragm before intercourse - that maybe because my partner and I had fun when we inserted it.”

“...When we are in a mood to have sex, he (partner) takes the d and puts spermicide and gives it to me. Its always he and not me. So we do it together and have a feeling that we are both responsible for it. Afterwards it is I who cleans it and puts it in”.

Four of the users emphasised that it was their own attitude that made the difference -

"Well - I said that it was not a bother and it was accepted when I stopped the foreplay to put the diaphragm. And I would also make fun of it- so I did not make it out to be a problem”.

Most women said that their partners were happy when they did not have to take the responsibility for contraception. The respondents stated that in most cases the partners and at times the respondents too did not like to use condoms.
When asked if there is a typical user of the diaphragm:

Most of the diaphragm users did not have strong views about which women could or could not use the diaphragm. As one stated:

"I do not think that the diaphragm is only suited to a certain kind of user. Most women could use it easily. I think it's even less difficult to use than the pill and specially those pills that one has to take at a particular hour in a day."

Two of the diaphragm users stated that one had to stick by certain rules to use the diaphragm and that one had to be responsible:

"Also you have to be a very exact person, because when you love someone and have sex it is not easy - you have to choose the moment and you have to think about it and talk about it."

In a similar the two of respondents felt that since young people who were just starting their sexual lives tended to experiment and be less responsible, the diaphragm may not be the best choice for them. However, both felt that in case young women wished to use it, it should be an option and they should be told about it.

Enthusiasm of diaphragm users:

One of the interesting things that I came noticed during my interviews with the diaphragm users was that they were very "enthusiastic" (a word that two of them used) about the diaphragm and seemed to want to talk about it to others including me. Many of them spontaneously volunteered information about talking their friends about the diaphragm and even taking them to the Rutgers clinic for more information and diaphragm fittings. There was also a keenness to introduce me to other people they knew who were using a diaphragm. I was curious about it because in my interviews with other contraceptive users I had not heard that kind of an enthusiasm.
"...I keep promoting it to everybody. I really do feel that way about it. I find it strange that other people do not use it since I am so satisfied with it - the way it works and the way you use it. I am surprised."

"I always tell my girlfriends to use it (the diaphragm) - I told them Ah! I found a good method...its so nice. Its soft on your body and does no harm. I am still happy with it though I am not using it now. I happy talking about it. It was only because of HIV and different partners that I was not feeling good."

"I have showed the diaphragm to many neighbours and friends, its very interesting for them...Its like being a teenager who uses something new and wants to show it to girlfriends and say its interesting..."

A couple of the respondents tried to explain their enthusiasm with the diaphragm:

"I feel enthusiastic because I feel happy to have found a way out of a tendency to put one on something very effective but hormonal. Maybe I felt that I was saying you see there can be an alternative - that it can be different. You are fully in control of it and then you have to put in more effort in convincing first yourself and then others about it. So maybe therefore one is enthusiastic. Maybe not so many people use it so you have a sort of self defence."

Difficulties of using the diaphragm:

Interestingly while most non users and providers mentioned inserting it and interrupting sex as the major disadvantage about the diaphragm, most users felt that was not as much a problem as was to remember to remove the diaphragm after 6 to 8 hours. However, two of the diaphragm users did mention that during the initial stages of using the diaphragm they had been unsure of the exact placement of the diaphragm and they took time learning the technique.
Another the concern expressed about the diaphragm was of using it in new places - during vacations and camping trips and while living or travelling abroad in developing countries. The users at such times had worried about water and cleanliness and privacy to insert and remove the diaphragm. Also in this context, three users mentioned the importance of good backup abortion services available in the Netherlands which was important for them in their decision to use the diaphragm in the Netherlands.

Profiles of Non Users of the diaphragm

Among the five non users who were interviewed, one woman had used the diaphragm for six months and had then stopped because she did not like the fact that she had to interrupt sexual activity to insert the diaphragm. She is now using the IUD since the last 10 years. Amongst the other four non users, none had ever used the diaphragm. While two were using the pill, the other two used condoms. One of these condom users had previously used the foam (nonoxynol) and the sponge and it proved interesting to compare these barrier methods with the diaphragm. (See appendix 2 for a more detailed profile of the users).

Two of the non users are unable to use the pill due to severe side effects - in one case menstruation stopped and in the other there was severe nausea and sickness. Another non user consciously choose not to use the pill because of feminist consciousness and was using condoms. She was previously using the foam and sponge and some of her reactions to the pill were similar to those of diaphragm users:

"I am infertile while using the pill is because I am not ovulating. With the foam and sponge I am still ovulating and my uterus still has a lining made every month and is not hostile to having children".

However, though she was using barrier methods where the technique of use is similar to that of the diaphragm she had clear views of why she would not wish to use the diaphragm:

"I guess that the barrier methods that I use just feel more modern than the diaphragm. Maybe the fact that Nonoxynol kills sperms and not my eggs - some kind of sub conscious power feminism aspect to it. Maybe
the fact that you can use it with a condom which is easily accessible at a drug store and is not expensive. With the diaphragm its the way it looks...like a deflated balloon. I also have the feeling like they are from my mothers generation - that its what older women used. The idea that one has to be fitted for it is also a funny idea...walking up to my doctor and saying measure me up doc - when at the same time I could just go out and buy condoms. Also the condoms are disposable and one does not have to take care of them and the foam too you can buy of the shelf."

This respondent also stated that she had difficulties in getting the nonoxynol and sponge in the Netherlands and she used to get them from Canada, where she is originally from. Their not being easily available here is also a reflection of the fact that female barrier methods in general are not promoted and that the major emphasis is on the pills and condoms in the Netherlands.

Reasons for not using the diaphragm among the other non users also included similar reasons. Some said that they were old fashioned and kind of silly, that one had to be fitted for it, one did not know any one who uses it and the fact that they looked so big.

One of the respondents who uses a combination of condoms and the calendar methods and who is unable to use the pill because of strong side effects stated that:

"With the diaphragm no one talks about it. You do not get any information about it and one does not know any one who uses it. Also I think its not as safe as for example the pills. If I were to have a relationship and was using the diaphragm I would worry that its not safe. I am also not considering any other method because one has to use the condom anyway for STDs and AIDS. By not using any other method I force myself to use condoms."

"I have read somewhere that the effectiveness of the pill is 99 percent while that of the diaphragm is 94 percent. That's drastically less. For me
that's too much risk. So if I would use it I would probably use it in the same way as condoms. I would not do it (have sex) when I am having my fertile period because I would worry - I am a worrier."

Some of the other responses for not considering the diaphragm for themselves included:

"I know very little about the diaphragm. I think most people I know use the pills or condoms. I never heard of someone using it so its never been an option for me. I think its difficult to use. They talk about condoms and pills on the television - they say if you do not know someone use the condom and that with the pill there is the least chance of getting pregnant. So there are not so many people talking about the diaphragm."

"I think one is already influenced by the information one gets because people tend to already be a bit negative about it, like with the IUD also...people would say (about the diaphragm) that its a fuss or that its messy - getting it in. Even though you may not really think about it, but because people say so, you also say its a fuss."

Issue of control:

When asked whether the issue of control influenced their decision and use of contraception, one of the respondents replied that she did not feel that female methods like the diaphragm gave more control than male methods like the condom:

"In a steady relationship...there can be sharing of responsibility, but with loose relationships it is more your responsibility. Then I do not expect any responsibility from the other side because they will not take it mostly. If I want them to use the condom and they do not - then nothing happens. So I do not feel out of control. I have control over having unsafe sex. Therefore its difficult to say that one has more control with the pills and diaphragm than the condoms..."

One non user mentioned that she would not like to go to a doctor for a diaphragm fitting.
Where they got their contraception from:

All the respondents had used the pill as the first contraceptive method (two used the rhythm method initially for a short period). On being asked why they used the pill many said that their friends were using it and that it seemed easy to use. In most cases they went to their general practitioner and asked for it. In 2 cases the general practitioner had suggested it to them.

Only one user stated that her general practitioner had told her about the diaphragm and said that if she wanted one she should go to the Rutgers clinic. In another case the respondent had gone for a morning after pill to the Rutgers clinic and was told about the diaphragm along with other methods.

Four respondents mentioned that initially the risk of sexually transmitted diseases was not a concern for them during their initial years of contraceptive use and that over the years they were more into using the condom in new relationships to reduce the risk.

Three respondents from the group of non users stated that they got a lot of information of contraception from girls magazines like the VIVA\(^6\) besides information from friends. These were among the women who were less than 35 years. Interestingly, none of the diaphragm users mentioned these magazines as their sources of information. The initial information often came from sex education classes in school though not all remembered the diaphragm being stated.

Three of the non users had never been to Rutgers clinics. The other two had been to the clinic for after morning pills and some other information.

Provider Profiles

Four contraceptive providers were interviewed. All four of them were women. Two women were general practitioners, one was a doctor at the Rutgers clinic and one was a nurse at another Rutgers clinic.

\(^6\) I looked through some of the recent issues of this magazine and did not find anything on the diaphragm. There were articles on the pill and condoms also on a new temperature method of contraception.
One of the general practitioners who was interviewed had her own practice since the last six years. She completed her specialisation of general practice ten years ago. She had never prescribed or fitted a diaphragm. She said that she told the women about all the methods including the diaphragm and that while 90 percent of the clients wanted the pill, the other 10 percent wanted the IUD or condoms. She said that on the rare occasion that somebody inquired about the diaphragm, she sent them to the Rutgers clinic. She has a clientele consisting of women from many different countries and cultures and some of them have difficulty communicating.

The other general practitioner had completed her training last year and is presently working in a health care centre for homeless people. Most of the clients in the clinic are not insured and the clinic provides free medical help. The respondent has been mainly doing gynaecology associated work at the clinic and she related the interesting experience where the clinic had got a supply of free diaphragms and that 2.5% to 3% of the contraceptive clients are using the diaphragm. This is a higher percentage than the national percentage of users which is 0.2%). The general practitioner stated that this was because they only charged dfl. 5 for the consultation and the diaphragm and it therefore worked out to be an inexpensive option for these women, who do not have much money.

The third provider who was interviewed was a doctor who had many years experience in the Rutgers clinics. The clinic that she was working in had over a 100 clients a week for contraceptive services and of these approximately 2 percent were for the diaphragm. I had the opportunity of meeting some of the diaphragm clients in this particular clinic and they were very positive about the counselling and consultation there. Some of them had been clients of this clinic for over 8-10 years.

The forth provider was a nurse at another Rutgers clinic in a different city. Here too there are on an average a 100 contraceptive clients a week who come to the clinic. Approximately five clients a week come for diaphragm related things like checking the fitting or getting a new diaphragm.
Attitudes towards the diaphragm:

All four of the providers had positive attitudes towards the diaphragm.

"I know many patients who have a problem with the pills and the hormonal changes it causes. They have weight gain, pimples, mood changes and they can get depressed...the diaphragm does not have a big influence on the body - and its not difficult to use."

"What people like about the diaphragm is that they are their own boss they use it when they need it. There is this idea about Dutch women having sex constantly that's projected in the media but its not true...so its your own choice. Its 96 percent safe so hardly ever do they become pregnant. Even then its patient failure and not user failure. They always come back to use it after they have a baby - that's very positive."

"I feel that they (diaphragm users) do not see the diaphragm so much as a medical instrument but more like something they comb their hair with. With people who have an IUD they see it as something that they cannot control - that the doctor has to check and see if its okay or still there. I see a big difference."

One of the general practitioners who were interviewed mentioned that since September 1994 part of the three month training for general practitioners included training on the insertion of the IUD and the diaphragm and also trained to do deliveries. She herself had undergone this training. She felt that the diaphragm was a good method for many women and that this training would lead to more women being able to use the method:

"I do think the training will make a difference and there may be less people using the pill and more the diaphragm and the IUD because you do not have to take the diaphragm everyday and it does not change your hormonal balance. You can use it when you need it. If you give good information on how to use it and clean it - its a good method. In my opinion it gives people more control and when you take a pill everyday
your are not really in control over your body. Also with the contraindications of the pill like high blood pressure, vascular problems, cerebral problems, liver disease and specially older smoking women and the discussions about whether it causes cancer - people may opt for it if it becomes easier to get from their general practitioner."

Is there a typical user of the diaphragm:
Three of the providers involved in diaphragm delivery, stated that when advising or providing diaphragms they did see whether the woman was according to them capable of using the diaphragm

"I think one has to look at the potential user who is coming to use one of these three methods. With the diaphragm you have to be very handy and strict and motivated. With the IUD you have to always remember that it gives a higher risk of infection. At our centre we often encourage the women to use pills and condoms because they are....."

While on one hand the providers saw themselves as playing a decisive role in deciding who uses the diaphragm at the same time they pointed out to clear user characteristics amongst users who wished to use it. They described them as people who were making independent decisions and were conscious women. One can interpret this either in terms of a contradiction, since both the user and the provider are seen in very decisive roles, or look at it as a situation where providers reinforce their ideas of who is likely to use the diaphragm on the contraceptive clients they interact with:

"I think the typical woman who would use the diaphragm are women who are not so young. It is not a thing for an 18 year old because of the fact that they are just experiencing sexual awakening. So I think that young girls should go on the pill and that is also IPPF's idea".

"Most of these women (diaphragm users) have used the pill for many years and are tired of the pill. Some of them are around 30 years old and they do not really choose to have baby, but if they have one its
okay...Also women who are very ambivalent about wanting children - they want them, they do not want them - or their partners do not want them. These women do not want to use the pill because it's a kind of definite thing - you cannot get pregnant”.

As mentioned earlier most diaphragm users did not fit in with this description since they had not used the pill for long in most cases and were clear that they did not wish to have children, and this is reflected in the fact that four of them underwent abortions when they got pregnant.

“I think that the group of diaphragm users is a very selective group. But that’s also because we did not promote it. The pills are so easy so the general feeling is why not take the pill... The diaphragm users are a group of women who are very much aware of the consequences and are interested in their own health, their body and the function of their body. And they made a decision that they made by themselves. They have been reading about it (the diaphragm. When you take a pill its not so much of a decision because its the easiest way.”

“These are very conscious ladies who choose for conscious living...they grounded women I must say with very high educational levels. Women who think about their lives and their bodies. Also the alternative kind of women - we call them the grey socks in Holland because they wore socks and sandals in the 60s. They were anti-whatever and also anti the pill and they used the diaphragms. That’s the type of women who usually use the pill - educated, alternative views and 28-30yrs. The other type of women who use it are older women who smoke or who cannot take the pill for physical reasons.”

“Usually women who use the diaphragm when they come here have already read about it and they ask for it.”
One of the general practitioners also pointed out the prescribing and fitting diaphragms can take a lot more time and energy on the part of the provider and they might not prescribe it much for those reasons:

"Most general practitioners find it easy to prescribe the pill. They prescribe it to 99 percent of the time, 0.9 the IUD and the diaphragm less than one percent. Its easy for them because it does not cost time. Most women already know about it since they hear it from their friends and mothers...with the diaphragm they have to explain it and teach the woman how to use it. You (the GP) has to ask afterwards how its going and you have to support the woman."

"I always ask them why (they want to use the diaphragm)....I warn them that it is very sexually related. I am always very keen on their motivation because otherwise I am not going to go through the whole thing of fitting and explaining it."

One of the practitioners felt that there would be a difference in the services provided by male and female doctors:

"I think women doctors are more aware of the advantages of methods like the diaphragm and are more willing to support their patients and help them choose and to work with it...it needs more energy, time and support to the patient and I think women are more willing to do that - so she can understand her patients better..."

I am unable to comment on this since I did not meet any male providers. However amongst the users of the diaphragm only who stated that they would prefer men doctors.

The Pharmacy Visits
The visits to the pharmacy proved to be a reflection of the fact that diaphragms are not used very much outside of Rutgers Stitching clinics. These clinics provide the clients with the
diaphragm and they do not have to go to the pharmacies, therefore it is only women getting their diaphragm fittings or prescriptions for a new one from GPs who get their diaphragms from the pharmacies. While one pharmacy was in a suburban area in Osdorp, the other was more in the city centre near the Museumplein.

At the first pharmacy in Osdorp the woman at the desk and her colleagues did know about the diaphragm but said that they were not sure if I could get one from there. When I asked if I could order for one they asked me to come back later and speak to someone else. When I went later that person was still not there. In the other pharmacy, the woman at the desk did not know what I meant by the diaphragm and she asked someone else who seemed to know about it and asked if I had a prescription for it. I explained my study and he said that they did not get much requests for the diaphragm and that if there was an order it was usually from a doctor and not from users. He was reluctant to say how often people asked for a diaphragm and he just said that it was not much.

Visit as a client to the clinics
I asked a Canadian friend of mine to visit a Rutgers clinic and a local GP for contraceptive advise. She introduced herself as someone who is in a steady relationship and wants to stop the use of the condom and choose an alternate methods and was specifically interested in knowing more about the diaphragm. She is about 30 years old and when she visited the Rutgers Stitching she was given detailed information about the different methods. While it was emphasised during the counselling that the pill was the most effective and easy method of contraception, when she said that she was keen on the diaphragm she was in no way discouraged.

My friend felt that the information she got once she stated her interest in the diaphragm was objective and supportive. She told the staff at the clinic that she would think about it and talk to her boyfriend and come back and they said that was okay. In the case of the general practitioner, when my friend visited the clinic, she was told that the GP, a woman, only provided the IUD and pills and that she should visit the Rutgers Stitching, the address of which she could get at the reception desk of the GP.
**Participant Observation**

The data collection technique of participant observation did not prove to be very useful. The clinic staff had fixed appointments for diaphragm users on the same day as my visit to facilitate my observing the consultation. However, the clients seemed a bit surprised at finding me sitting in the consultation room and I felt that they were discomfited. It was also a very busy day and due to two unexpected abortions all the appointments were running late and both the nurse and clients seemed a bit pressed for time. Further, since the dialogue between the provider and client took place in Dutch which I did not understand much of I thought it better not to continue with the participant observation.

**Visit to the Diaphragm Manufacturing Unit**

I visited the diaphragm production unit of the Centraal Middelen Depot (CMD) at the Hague. The CMD limited is an independent agency since 1988. Prior to this it was the commercial unit of the Dutch Association for Sexual Reform. Since the 1950s they have been manufacturing condoms and since the 60s they are also manufacturing the diaphragm and spermicides.

Production was as high as 30 to 40 thousand diaphragms per year in the seventies and eighties but significantly decreased in later years and now is only 5,000 per year. Out of this amount some are exported to Germany and Italy. Within the Netherlands the distribution of diaphragms is mainly through the Rutgers Stitching clinics and with the decrease of these clinics the demand for diaphragms has also decreased. Others who purchase the diaphragms are individual medical practitioners and pharmacies, the latter even purchase them one by one if only one client requires it. This makes it more expensive for the clients since they have to pay the postage costs also. Apparently pharmacists in the Netherlands do not stock diaphragms.

The CDM production Unit is the only place where diaphragms are made in the Netherlands. The diaphragms are made of latex and at the centre they are hand made by one person who has been making the diaphragms since the last thirty years. As the manager of the
CMD emphasised, since the diaphragm production was not such a profitable venture they were reluctant to train any new people how to make these diaphragms and were not sure they wanted to continue manufacturing diaphragms.
Chapter 4. Analysis

I shall now discuss some issues that emerge from the findings in the study and relate them to how user representations about diaphragm users evolve and how they in turn influence the delivery services and use of the diaphragm.

Method factors

Choosing the diaphragm: a negative choice

I was intrigued by the fact that the majority of diaphragm users stated that the choice of using the diaphragm was mainly because they did not like or wish to use the pill or other methods and that it was therefore a negative choice. I wondered if this kind of decision-making was something that was specific to the diaphragm.

"The methods of fertility regulation from which most couples choose represent a choice among unpleasant alternatives. The choice is not so much a positive discrimination but a negative one, in that methods not chosen are even more disliked than the method that is chosen. The contraceptive methods most people use are therefore the least unpleasant of an unpleasant set of alternatives. However, it is most important that the realistic summary is set against the other reality that consumers greatly prefer the available range of methods to no method at all' (Robert Snowden, 1985).

Joan Walsh (1997) also puts forward evidence that women make 'negative' choices about contraception - choosing the 'least worst' method at the outset and changing from one method to another to escape undesirable characteristics or effects.

"Perhaps it is unrealistic to expect women to be positively 'satisfied' with their contraceptive method given that on a day to day basis, contraceptive use is rarely life enhancing and is often problematic. At best, contraception prevents pregnancy when you want it to, and does no
harm - it is difficult to value an outcome which is a non-event, something which does not happen. When high contraceptive efficacy is taken for granted, measures of acceptability and satisfaction can only focus on other characteristics. Given that all currently available reversible contraceptive methods have characteristics that could be regarded as undesirable and which potentially make them unacceptable to women, it is perhaps hardly surprising that women's experiences of contraception and their subsequent choices are essentially negative". (Walsh 1997).

Though its true that one weighs the advantages and disadvantages of different methods, one rarely hears pill users (or users of other methods) say that they choose it because they did not like other contraceptives. The diaphragm users may have expressed themselves in this manner because the pill is so commonly used that one compares the method one uses more easily with it. Also, in the Netherlands where the pill is so popular, one probably has clear strong reasons for not using the pill and the users I interviewed were probably expressing that.

Issue of control:

The topic of contraceptive methods and the control they give to users was mentioned by many of the respondents spontaneously. While the need to be in control did not seem to be a major factor in choosing the diaphragm or other methods, the interviews revealed interesting differences in how women defined control in different contexts. Some of the diaphragm users talked about control in terms of their having control over their body and not letting it undergo changes which may be caused by hormones. Diaphragm users also expressed the need to take responsibility of contraception and thus have control over contraception and pregnancy in stronger terms than the non users. Two women from the non-diaphragm using group said that they did not feel that the choice of female or male contraception affected control because they could refuse to have sex if their partners did not use condoms. They therefore talked about control concerning their relationship and sex. Finally one of the non diaphragm users stated that having to depend upon the doctor to have the diaphragm fitted gave her less control over contraception.
The diaphragm being a natural way of contraception:

Almost all the users of the diaphragm used the word 'natural' while describing the way the diaphragm worked and why they liked the method. In this context it is interesting to look at Oudshoorn's account of the development of the pill where she states that Pincus, who developed them was directly confronted with this norm by, Searle, the pharmaceutical firm who put the pill on the market. Searle's director of biological research let Pincus know that he did not want to take part in the development of any compound that might interfere with the menstrual cycle. Later Pincus presented the effect of progestin on menstruation as a way of mimicking nature: women would still have their menstrual period. He stated that:

“In view of the ability of this compound to prevent menstrual bleeding as long as it is taken, a cycle of any desired length could presumably be produced. We had chosen our standard day 5 through day 24 regime in the expectation that a ‘normal’ cycle would occur (Pincus 1958 in Oudshoorn)

In this context it is useful to deliberate on firstly how there has always been an emphasis on the importance of making contraception as natural as possible for users and secondly how the term natural can be used in different contexts and for very different methods, the pill and the diaphragm, in this instance.

User Factors

Is there a typical user of the diaphragm?

As the tables show there were no clear differences between educational and occupational differences between the users and non-users of the diaphragm. It is possible that differences did not come up because of the small number of interviews conducted and because of possible selection basis.

However, there were certain characteristics present amongst the diaphragm users in terms of their being health conscious, and not wishing to take medicines unless they have to and being
vegetarian. Many of the diaphragm users had read a lot about the diaphragm and other methods, in some way they were very conscious strong women (as the providers also pointed out). While this is true, it is important to point out that in a context where the diaphragm is viewed negatively, there is a lack of information, and it is not easily available, it can only be (very) determined women who will be diaphragm users. This may point towards the fact that more than social, economic and educational backgrounds, it is the personality traits that make women opt for the diaphragm.

Are their different perceptions of risk - of pregnancy and side effects of contraception - amongst users and non users of the diaphragm?

While it is not possible to draw any conclusive answers from this study this is one of the questions that emerge out of the study. Are diaphragm users less worried about the efficacy of a method than pill users. The fact that four of the diaphragm users got pregnant and then had abortions indicates that they are clear about not wanting children. Therefore one of the probable reasons for their opting for the diaphragm when they are repeatedly hearing that the pill is the most effective is that they weigh the trade-offs between the risk of pregnancy and risk of side-effects differently.

Walsh (1994) assesses a study conducted in November 1995 by the contraceptive Education Service to research women’s contraceptive choices and their access to contraceptive information. The study of 744 women between the ages of 16-49 shows that when respondents were asked to list the most relevant negative and positive factors which influence their decision to use or not use a method they listed experience of side effects and worried about side effects before they listed the methods effectiveness in protecting pregnancy.

Lori Heise states that many acceptability studies draw conclusions regarding the acceptability of a method without fully defining ‘to whom’ and ‘in what context’. The majority of research to date has failed to collect data on the contextual variables. While Heise lists contextual variables such as where the women is in her reproductive and sexual lifecourse, I would like to extend these variables to social attitudes towards sex, pregnancy and also deliver factors. In fact existing literature suggests that attitudes towards perceived method attributes are only marginally predictive of method choice and/or use. For example a study examining
women's attributes towards and use of various contraceptive methods in Los Angeles found that only 40 per cent of the variance in perceived desirability of each method could be explained by the methods attributes.

*Service factors*

As is evident from the interviews, service providers play an important role in deciding who can and should use the diaphragm. The fact that in the delivery of the diaphragm the provider stresses on the motivation and the fact that it interferes with sexual activity cannot be very conducive to encouraging more women to use the diaphragm. In the case of pills one does not stress motivation though it is required to be taken everyday. Many of the women I interviewed found it difficult to take the pill everyday - so its important to see what gets stressed by providers and whether it is truly representative of users experiences.

The clear descriptions of the "typical" users in the literature and the providers also prompts one to ask whether personality traits are simply reflective of people consciously asking for the diaphragm. It does not mean that they are the only ones who can use the diaphragm effectively. Moving away from these user representations may therefore help providers reach out to a larger number of potential users of the method.

*Social and Contextual Factors*

I would like to argue that while the above mentioned factors - method, user and service factors- are important in constructing and reinforcing user representations - they are all mainly a reflection of existing value systems in the society. Further, that concepts like control, safety, freedom, naturalness, risk, responsibility are also social constructs and can change over a period of time. In the present situation the diaphragm does not fit into many of the above mentioned constructions and requirements which are more present in the pill and therefore its popularity..

The strong emphasis on the need to prevent pregnancy by using pills is very much evident in literature and publicity material and many Dutch take pride about the high rates of
contraceptive use and low abortion rates. However, as Vennix's (1990) study showed there are many pill users in the country suffer side-effects with it but still use it. This is because the health services and media perpetuates it as the best method and more emphasis is given to the advantages of the pill such as high efficacy than to its side-effects. One of the diaphragm users stated:

"It has been investigated that while many women use the pill, they do believe that its not good for them....So there is a difference between knowing that its not good for you and feeling that its not good for you because if you feel its effect then there is an urgent need to change the contraception. If there is only an abstract notion of harm to health then its very different."

Wajeman (1991) states that one of the reasons doctors favour the pill despite its side effects because of the fact that it helps avoid ethical dilemmas of dealing with unwanted pregnancy and abortion. She also states while comparing the diaphragm and the pill, that the pill does not involve touching one's genitals, does not require male co-operation or even knowledge and it allows for 'spontaneous' sex. By comparison the diaphragms require some skill and to use it one has to admit to a man and oneself that one is planning to have sex.

The pills increased use may thus be seen as a reflection of the emphasis of sexual freedom and spontaneity in the Dutch culture - where people wish to keep the pleasure away from more serious concerns of not only pregnancy and abortion but also of communicating with ones sexual partner about sex, contraception and responsibility.

There are other contextual factors which may have affected diaphragm use over the years and led to its decreases popularity. The awareness of AIDS in the last decade may have led to people feeling the need for protecting themselves from HIV and using the condoms instead of other methods. Both the users and non users of the diaphragm in this study expressed their concern about the risk and need of protection from HIV AIDS. In both groups all the respondents said that they would use condoms in new relationships no matter what other form of contraception they were presently using.
Also, as Wajcman (1991) points out, it is also important not to underestimate the significance of the pills profitability. It is economical to produce and market and needs to be taken daily, thus generating vast profits for the pharmaceutical industry that supplies it. The diaphragm in relation is not very profitable since it last for many years. The fact that the CMD in the Hague are not keen to invest in the training of new personnel to make diaphragms and in the publicity of diaphragms is a clear indication of this.

During an interview with one of the providers I was told that change over the last in how sexuality and contraception is viewed may have contributed to the rise in the popularity of the pill (and in the decrease of use of the diaphragm). She stated that now there is a lot more acceptance and openness about the subject and many young women now go with their mothers to their family general practitioners for contraception who at least till a few years back were only trained to prescribe pills and.

The nearly half of the users diaphragm users identified with the feminist ideologies of the body and health may have been a motivation for them to use it ten years back. However, the connotation of the diaphragm with feminism (and in some ways of the users with feminism due to their use of the diaphragm) is more negative in the present time when there is a kind of backlash to the feminist movement. One of the diaphragm users said that:

"I think that the diaphragm was promoted by a small group of feminist women and people do not want to take it because they say Oh they are feminist and want to do everything different."
Chapter 5
Conclusions

I would like to conclude by saying that while it is true that there is a 'typical' user of the diaphragm, it is important to note that this 'typicalness' is not so much in their socio-economic backgrounds but more in their personality traits, attitudes towards their bodies and perceived risks of pregnancy and side-effects. Secondly, I would like to argue that the present group of diaphragm users are a minority of women who are in some ways acting differently from accepted value systems norms and the way they perceive their bodies and contraception differ from accepted patterns. However, at the same time I believe that because of clear user representations and classifications made by amongst providers and also literature these representations get reinforced. This results in the diaphragm being available to a very small selected group who fit in with the expected characteristics and women not fitting the description are not encouraged to use it though they actually may be equally capable of using it.

Further, since the use of the diaphragm is only seen to be limited to a small segment of the population, the service provision for the method and its publicity get limited. In these circumstances it is only a few determined women who end up using the diaphragm.

With the reduction in the number of Rutgers clinics in the country there is a serious need to consider the implications of these changes on the availability of the diaphragm. Due to the Rutgers Foundation not getting government funding, its clinics are becoming increasingly expensive and are now reaching out to higher educated, rich often older women. There focus is also changing from young contraceptive using women to older menopausal women who can afford the services (interview).

It is unlikely that there will be much changes with the introduction of training for general practitioners on diaphragm and IUD fittings. This is because of the fact that using the pill is such a culture in the Netherlands and it fits in with all the images of freedom and independence for women. Further, much easier for the general practitioners to prescribe in terms of money and time. Other efforts besides this have to be directed towards making the diaphragm more popular and accessible through the media and publicity brochures.
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Woolgar, S.
Appendix I - User Profile:

<table>
<thead>
<tr>
<th>Age</th>
<th>Education</th>
<th>Occupation</th>
<th>Relationship/s</th>
<th>Children</th>
<th>Duration of use</th>
<th>Method of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>32</td>
<td>Professional singer</td>
<td>married</td>
<td>none</td>
<td>10 years</td>
<td>alternates with condoms</td>
</tr>
<tr>
<td>2</td>
<td>39</td>
<td>Housewife</td>
<td>married</td>
<td>2</td>
<td>15 years</td>
<td>no other method except the diaphragm</td>
</tr>
<tr>
<td>3</td>
<td>41</td>
<td>physio-therapist</td>
<td>short-term</td>
<td>none</td>
<td>12 years</td>
<td>currently condoms &amp; IUD</td>
</tr>
<tr>
<td>4</td>
<td>31</td>
<td>playschool teacher</td>
<td>short-term</td>
<td>1</td>
<td>10 years</td>
<td>currently condoms</td>
</tr>
<tr>
<td>5</td>
<td>34</td>
<td>women's health advocate</td>
<td>short-term</td>
<td>none</td>
<td>6 years</td>
<td>with condoms</td>
</tr>
<tr>
<td>6</td>
<td>42</td>
<td>director of housing agency</td>
<td>long term</td>
<td>none</td>
<td>16 years</td>
<td>currently condoms</td>
</tr>
<tr>
<td>7</td>
<td>33</td>
<td>researcher at University</td>
<td>married</td>
<td>2</td>
<td>8 years</td>
<td>alternates with condoms</td>
</tr>
<tr>
<td>8</td>
<td>37</td>
<td>University - administration</td>
<td>long term</td>
<td>2</td>
<td></td>
<td>currently condoms</td>
</tr>
<tr>
<td>9</td>
<td>34</td>
<td>Housewife</td>
<td>married</td>
<td>1</td>
<td>6 years</td>
<td>no other method except the diaphragm</td>
</tr>
</tbody>
</table>

- The educational backgrounds have not been elaborated and only been categorised into university and non-university education since existing literature usually states that diaphragm users are often university educated women.

- In this case long term relations are those which are for over two years and short are those less than that.
### Appendix II - Non-users Profiles:

<table>
<thead>
<tr>
<th>Age</th>
<th>Education</th>
<th>Occupation</th>
<th>relationship</th>
<th>children</th>
<th>method of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>univ. Education</td>
<td>researcher</td>
<td>short-term</td>
<td>none</td>
<td>condoms / rhythm</td>
</tr>
<tr>
<td>2</td>
<td>univ. education</td>
<td>researcher</td>
<td>serial monogamist</td>
<td>none</td>
<td>nonoxynol/sponge, now condoms</td>
</tr>
<tr>
<td>3</td>
<td>non-univ.</td>
<td>actress</td>
<td>long term</td>
<td>none</td>
<td>pills, now condoms</td>
</tr>
<tr>
<td>4</td>
<td>non-univ</td>
<td>translator</td>
<td>long term</td>
<td>one</td>
<td>IUD with condoms</td>
</tr>
<tr>
<td>5</td>
<td>non-univ.</td>
<td>housewife</td>
<td>long term</td>
<td>one</td>
<td>pills</td>
</tr>
</tbody>
</table>