
Andrew J. Hogan

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Amid ongoing debates concerning religious exemptions from the birth-control mandate of the U.S. Affordable Care Act and age restrictions for over-the-counter access to emergency contraceptives, historical accounts that broaden our perspective on the regulation and uptake of reproductive technologies are welcome resources. The two books reviewed here offer an excellent overview of the various points of fracture that have shaped the postwar social and political histories of contraceptive technologies. Together, they provide a rich understanding of how the issue of birth control became wrapped up in the larger, and increasingly militant, debate over abortion in America during the 1980s and '90s.

Heather Munro Prescott’s *The Morning After: A History of Emergency Contraception in the United States* (New Brunswick, NJ: Rutgers University Press, 2011. Pp. x+164. $22.95) traces the winding history of emergency contraception in the country since the 1960s. Many readers may be surprised to learn that, while some form of the “morning-after pill” has existed for almost fifty years, no pharmaceutical product marketed specifically for postcoital emergency contraception was available in U.S. drugstores until the late 1990s. Prescott does an excellent job of accounting for why this was the case, and what forces came together to finally push for the creation of such a product. In doing so, *The Morning After* represents an important contribution to other recent literature focusing on the active role of women as users and shapers of reproductive technologies.

The opening chapters of Prescott’s book examine the rise of a postcoital contraceptive option in the context of concerns over the sexual revolution and the growing prevalence of pregnancies conceived out of wedlock. The

Andrew J. Hogan recently completed a Ph.D. in the history and sociology of science at the University of Pennsylvania, working on the use of visual technologies, conventions, and nomenclatures in postwar genetic medicine. He is currently a lecturer in the Department of Engineering and Society at the University of Virginia.

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author notes both the paternalistic and benevolent aims of researchers who sought to develop a postcoital option for women. Emergency contraception was viewed as a technological solution for preventing unwanted pregnancies resulting from unprotected sex, the failure of other contraceptive options, and sexual assault. Given this focus on the prevention of unwanted pregnancies, and the fact that emergency contraceptives could only be obtained from a physician, Prescott argues that the morning-after pill fit into a *disease model* that aimed to “cure” unintentional pregnancies (p. 3).

Prescott describes how, in the 1970s, the use of synthetic estrogen (DES) as an emergency contraceptive became a focus of the ongoing feminist critique of the medical profession. Questions were raised about whether physicians had moved too quickly to begin prescribing DES. The resulting concern over the safety of the drug led many women’s health centers to cease offering DES for emergency contraception, but demand for a postcoital option persisted. Prescott traces the subsequent development of the Yuzpe method, which turned an alternative dosage of already available birth-control pills into an emergency contraceptive option. However, because this was a do-it-yourself method rather than a pharmaceutical product, most women and healthcare providers remained unaware of it for decades.

The second half of Prescott’s book examines the realignment of support and opposition in the morning-after-pill debate and the push for a marketable drug. Faced with increasing political opposition to abortion rights during the 1980s, more radical feminist groups began to recognize the importance of hormonal birth-control methods in protecting a woman’s right to reproductive choice. This led to a more unified call for an emergency contraceptive product that could replace the little-known Yuzpe method and be actively marketed to women and health-care providers. As the author describes, however, even after uncharacteristic prodding by the FDA, no major pharmaceutical company was interested in marketing a product specifically for emergency contraception for fear of lawsuits and anti-abortion backlash.

In her final chapter, Prescott examines the issue of over-the-counter access to the morning-after pill. Despite the active approval of FDA committees, the George W. Bush administration continued to block nonprescription access. Prescott uses the push for over-the-counter availability for emergency contraceptives as an example of how women’s activism overcame the disease model of unwanted pregnancy. By taking the need for a prescription out of the picture, she argues, another aspect of reproduction became a matter of female choice rather than medical oversight. Prescott’s disease model of unwanted pregnancy is a useful concept to which she regularly returns throughout this book; however, its origin remains unclear. Did Prescott’s actors use the terms *disease* and *cure* (often placed in quotes by the author) in their discussions of unwanted pregnancies and how to prevent them, or is this her own construction? A better explanation of
these terms and their use would have helped the reader to better understand either Prescott’s analytical model or the assumptions and goals of her actors.

Chikako Takeshita’s *The Global Biopolitics of the IUD: How Science Constructs Contraceptive Users and Women’s Bodies* (Cambridge, MA: MIT Press, 2011. Pp. xiii+238. $32) also examines the technological approaches to preventing unwanted pregnancies, but it expands its focus beyond the United States to offer a broader perspective on contraception in the context of global population control. Takeshita takes a more explicitly STS approach in her study of the IUD, focusing on the interactions of heterogeneous actors, markets, and interests. Each of her chapters begins in the 1960s and considers how the original intentions for the IUD—rooted in population control—have been subject to “diffraction” (a metaphor borrowed from Donna Haraway) during the intervening years, allowing the IUD to be rebranded for use among wealthier populations.

The first two chapters of *The Global Biopolitics of the IUD* contrast the aims and expectations of IUD use in the United States and the global South. Takeshita demonstrates that the technology was initially developed in the 1960s, with a focus on providing “birth control for a nation” (p. 33) rather than for individual users. This focus on facilitating state control over populations, in particular those thought to have “dangerously” high fertility rates, is compared to the construction of this technology for use in the United States by “safe” populations of monogamous mothers. As part of this comparison, Takeshita describes the level of scrutiny that women in the United States have been subjected to by physicians in order to be deemed an appropriate IUD user. While in the global South, IUDs were inserted with little concern for their potential harm to individual bodies, in the United States, physicians and developers were anxious about the lawsuits from wealthier users that might ensue following infections or other complications.

Chapter 4 examines the alignment of pro-choice feminists and IUD developers in response to religious and right-wing rejection of the IUD as a potential abortifacient. As part of this, Takeshita recounts debates over the contraceptive mechanism of IUDs: whether this technology only prevents fertilization, or if it may also stop uterine implantation after conception. Like Prescott, she describes how the rise of the anti-abortion movement during the 1980s led to the alignment of previously contentious groups in favor of more options, including medically regulated technologies, that would improve reproductive choices for women.

In her final chapter, Takeshita examines the rebranding of the hormone-releasing Mirena IUD from a technology of state control over reproduction in the global South to a lifestyle technology in the United States. This chapter highlights the challenges that this IUD technology, which reduces menstrual bleeding, but often makes it more erratic, faced in cultures where menstruation plays an important role in women’s social lives.
In the United States, on the other hand, reduced menstruation was sold as a beneficial side effect of this newly available IUD.

The focus of this book is primarily on the developers, providers, promoters, and opponents of IUDs. Takeshita describes many women as passive, or unwitting, users or rejecters of this technology, rather than active participants in its construction. In doing so, she gives little agency to women who have chosen to reject a particular reproductive technology in favor of other options. For instance, Takeshita suggests that specific groups of women do not use certain IUDs either because they have been “written off” by developers as “less modern” (p. 149) or because they have been misled by anti-choice physicians about the IUD’s potential to prevent uterine implantation post-conception. Historians of technology might alternatively interpret these women as making autonomous and culturally informed decisions to pursue a different reproductive option. The ability to reject an IUD may instead suggest that women have been empowered by the existence of other contraceptive options—and fully informed consent—rather than subjugated by developers and providers motivated by social and financial interests.

Historians of technology will appreciate the important contribution that these books make to existing scholarship on the producers, users, and mediators of contraceptives. Studies examining medical technologies offer a valuable opportunity to explore the role of state actors, regulators, and corporations in both promoting and slowing uptake. Prescott’s study offers a unique look at how the FDA has acted not only as a gatekeeper for new medical technologies, but also as an advocate in making them more available. Similarly, both books demonstrate the significant role that corporations may play in actually preventing the availability of a product that state regulators would like to see marketed. Indeed, these contributions both do an excellent job of further complicating our sometimes overly dichotomous producer–consumer model for analyzing the marketing and uptake of new technologies.