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"It Can Actually Make You Infertile": Reproductive Bodylore and Vernacular Knowledge about Contraception

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Storytelling is central to human culture. Stories help us to explore the world and our experiences and position within it. From the fairy tales told in childhood to the contemporary legends shared in adolescence and adulthood, these narratives help us to explore anxieties and risks in an uncertain world. Folk narratives have many different functions. For example, they aid us in making sense of the world and in reaching collective agreements about ways for living, as well as shaping and defining our own individual value systems. Folk narrative is a rich area for study, and folklorists have studied them in popular culture and the mass media (e.g., Dégh 1994), and to a lesser extent in health (e.g., Goldstein 2000, Blank and Kitta 2015), which is the focus of this paper.

So much of what we learn about the body is learned socially, as informal knowledge passed on in conversations between family and friends (Newton 2016). This is particularly pronounced in sexual and reproductive health (Whatley and Henken 2000). Sensitive subjects, such as contraception, menstruation, and pregnancy, are surrounded by popular beliefs and vernacular knowledge (Newton 2016). Folkloristic research can provide new insights into sensitive subjects, such as reproductive and sexual health (Whatley and Henken 2000; Newton 2016), with folklorists recognizing the impact folkloric research can have in health and education (Hufford 1998, Whatley and Henken 2000, Blank and Kitta 2015, Kitta 2019). Folklore methodologies have a long history of prioritizing the individual as expert in their own lives, and exploring an individual's unique repertoire, experience, and vernacular knowledge. Health researchers also are beginning to value storytelling as a means of uncovering richer understandings of health experience (Andrews et al. 2020, Hoggart et al. 2023).

In parallel with the above, some recognition has been made in reproductive and sexual health research that lay knowledge and folklore can influence contraceptive choice (Kuiper et al. 1997, Clark et al. 2006, Asker et al. 2006, Glasier et al. 2008, Linton et al. 2023). Social networks also have a role in information sharing and informing contraceptive choices (Glasier et al. 2008; Williamson et al. 2009; Yee and Simon 2010; Anderson et al. 2014; Okpo et al. 2014; Pratt et al.2014; Levy et al. 2015; Hoopes et al. 2016; Gomez and Freihart 2017; Greenberg et al. 2017;

Kakaiya et al. 2017). In a recent qualitative evidence synthesis, Linton et al. (2023) identify vernacular knowledge and storytelling as still key barriers to accessing Long-Acting Reversible Contraceptives (LARC), with many patients relying on social networks for information, leading to misunderstandings.

The study of vernacular knowledge can, therefore, tell us much about everyday understandings of health, and the study of folklore and vernacular knowledge can provide fresh insights into both individual and group attitudes towards, as well as experiences of, the reproductive body. At present, the contemporary folklore of contraception has not received enough scholarly attention (Whatley and Henken 2000, Tully 2018) and, although there is growing interest in bodylore (Young 1994, Milligan 2018a, Milligan 2018b, Tully 2018), linkages between research and practice are sparse.

In this paper, I discuss an interdisciplinary project which explores contemporary lore and understandings of the reproductive body. I explore folk narratives and legends that are shared as part of conversations about contraception. In the United Kingdom, contraception is available free of charge through the NHS (National Health Service) and is usually accessed through general practice and specialist sexual health clinics, with some methods also available in high street pharmacies. However, research suggests that women's contraceptive beliefs, attitudes, concerns, and knowledge are not fully understood (Mann *et al.* 2018), and unintended pregnancy remains a public health concern and focus for policy (DSE 2022).

I begin by describing the project structure, before sharing some top-level findings. I conclude with a brief discussion about the usefulness of folklore for health research and beyond.

The Reproductive Bodylore Project

The interdisciplinary project that produced the data for this paper, *Reproductive Bodylore: The Role of Vernacular Knowledge in Women's Contraceptive Decision-Making*, is an example of how applied health and folklore research can enrich each other. Funded by the United Kingdom Arts and Humanities Research Council (AHRC) between 2020 and 2023, it was led by the Open University in collaboration with the Folklore Society and Public Health England (PHE). At the core of the project was a drive to improve understandings about vernacular contraceptive knowledge and to make suggestions about practical applications to support women's contraceptive choices. While I refer to women throughout this paper, and all participants in the study identified as ciswomen, not all people who require contraception for personal pregnancy prevention identify as such.

The project addressed the broad question: How does vernacular knowledge influence women's contraceptive choices and mediate their experiences of reproductive control? In addressing this question, it had three aims: to explore and document the greatest possible range of vernacular knowledge about the reproductive body and contraception; to offer an interpretation of this data, analyzing and theorizing how vernacular knowledge about contraception is transmitted between friendship and kinship groups, and how it may influence attitudes, behaviour, and experience; and to engage with policy and practice, enhance practitioner understandings about women's vernacular knowledge of the reproductive body, and make appropriate suggestions for improving services.

The project comprised three distinct work packages. Work Package 1 (WP1) was a qualitative secondary analysis (QSA) of interview data from five different UK research studies on women's contraceptive use and experiences of reproductive control undertaken between 2010 and 2016. This data included projects on the contraceptive implant, menstruation and hormonal contraception, fertility knowledge, intrauterine contraception, unintended pregnancy, and abortion.[1] We used the QSA to develop our interview topic guide for Work Package 2 (WP2), which involved participatory research with eighteen volunteer researchers who conducted qualitative interviews with friends and family members. This then informed Work Package 3 (WP3), *Bodylore: The Role of Shared Stories in Making Contraceptive Choice*s, a public engagement exhibition held at the Truman Brewery in London in October 2023. It used the quotes and candid insights collected by our volunteer researchers to encourage fresh dialogue about making contraceptive choices. Visitors were invited to read, listen, and contribute their own stories.

As an area of study, bodylore highlights the body's role in "communication, social meaning, identity, and social interactions in everyday life" (Milligan 2018a: 2). If the body is read and experienced as a social and cultural text, then bodylore can tell us much about experiences, knowledge, understanding, and belief pertaining to all that is central to reproductive bodies. Nowhere are social interactions more poignant than in the forming of partnerships and sexual relationships, and people have probably always sought to separate sex for pleasure from sex for procreation, using different methods, from herbal preparations to prophylactic devices. The Reproductive Bodylore project draws together applied health research with feminist folkloristics: "Feminist folklore is a distinct methodology that centers women's voices and experiences, while at the same time [it] investigates structural inequalities, power and oppression, stereotypes and the cultural coding of gender" (Milligan 2018b: 11).

This paper frames contraceptive narratives, and folklore more generally, in terms of "vernacular knowledge" (Valk and Bowman 2022). "Vernacular" refers to the everyday informal culture of social networks, in this case, of actual and potential contraceptive users, and including the communication, and where relevant, adaptation of contraceptive and reproductive knowledge. I take a broad definition of "knowledge" to include "awareness" (i.e., "knowledge of something"). Thus "knowledge" is not conceptualized as only something believed or factual: "multiple beliefs, doctrines and frames of interpretation co-exist. Personal experience is always assessed within the context of former experiences, shared interpretative frameworks and traditional 'belief narratives'" (Valk 2022: 16).

Vernacular knowledge is the unofficial, informal, and everyday culture of a group. Women seeking contraceptive advice frequently use female friendship and kinship networks as a way of obtaining knowledge about specific methods. Some studies suggest that women are more likely to rely on advice from friends and family members than from medical practitioners (Anderson *et al*. 2014) or other informal sources such as social media (Schneider-Kamp and Takhar 2023). In researching folkloric narratives about contraception and the reproductive body, we wanted to explore how they were articulated by women when speaking about their contraceptive and reproductive choices. We did not search for or collect specific narratives, but rather studied them *in situ*, as they were reported by our participants. Often references were incidental and woven through longer narrative accounts.

The starting point, then, for the Bodylore project was the re-examination of a mass of qualitive data, accumulated over the course of six years. The quote below, from WP1, is a good example of someone wanting to know the experiential, embodied experience of others, and the consideration of these viewpoints in decision-making:

> [Speaking to others] that's the only way you can gauge, because you think, GPs [family medical doctors] are only going to tell you the good stuff, it's almost like salespeople, they're only going to tell you the, you know, they're going to try and make you try it. Whereas friends and that are just going to give you what they feel is an honest experience. They're trying to offer advice, so you do want to take that, you know, consideration. You know that not everyone's the same and it could be different for you. So, you think about that, but it would have a big impact I think on whether you want to do it [try a contraceptive] or not if all your friends are going, "Oh no, it's horrible." (woman aged 36)

A New Look at Old Data

As a starting point, we undertook a folkloric reading across the datasets in WP1 to explore narrative constructions and folkloric customs and practices. Narratives often had traits of contemporary legends, even though these tended to be short fragments:

> I've heard of like a friend of a friend who had really bad endometriosis and she basically contracted out her coil in the toilets of a nightclub, and I just don't want that (woman aged 27).

> … there's scary stories going around that, "If you have a termination, you know they cancel your insides and stop people like us from having children because there's too much population—it's over populated" (woman aged 23).

The story happening to "friend of a friend" is a recognized structure and, in common with other legend narratives, the action occurs in a liminal or subversive place (Brunvand 1983), of which a nightclub is a well-known example and motif (Bennett 2005). The participant describes the contraceptive device being "contracted out" which is suggestive of the contractions experienced during childbirth. This narrative imagery is similar to the motif of a well-known legend where a baby is born with a contraceptive coil (IUD) held in its hand or embedded somewhere on its body. In the second quote about termination of pregnancy, the narrative serves as a warning tale about the consequences of rejecting motherhood, encompassing a moral panic about young female sexuality and unintended pregnancy. It also touches on reproductive governance and that "they" (the doctors) perform a sterilisation alongside the abortion because the patient is not deemed a suitable future mother due to her sexual indiscretions. Amounting to eugenics, this is presented and justified as a method of population control. The narrative concluding with a loss of fertility is significant and "fertility fears" is a strong theme and repeated motif among study participants:

> ...the implant and the coil affects your fertility for the amount of time that you have it in your body […] I think if you use contraception for such a long period of time, years and years and years, it could affect your fertility but you just have to use it in the right way really. (woman aged 19)

This quote alludes to using contraception in the "right way"—inferring responsible use. Like the termination narrative above, it suggests that sexual practices must be both responsible and moral. Using contraception for extended periods and having sex for pleasure rather than procreation comes at a price. This was echoed by other participants:

> I feel kind of strange that there's something [a contraceptive coil/IUD] inside of [your uterus] for five years and I'd be worried about infections or – it's just a long time for something to be inside you controlling your pregnancy really and I'd just be really worried about the future if there'd be any problems with getting pregnant in the future when you had it taken out. (woman aged 22)

The quotation below further illuminates this unease with the idea of having a device inside the body, which was seen as unnatural and involving a high level of medical intervention, pain, and even gynaecological violence, when the device is "dragged out" during a "horrible procedure":

> Well, first of all how do they get [a coil/IUD] in you, do they have to cut you open, or does it sort of go up, or, and does it sort of, can you feel it when its inside you, if you're on your period does it sort of like, I don't know, make the cramps even worse, do you have to change it regularly, and if so how do you do that, do you have to go through this horrible procedure having it dragged out of you or something? (woman aged 21)

Other common narrative motifs, such as the rule-of-three, featured in participant accounts of acceptable contraceptive use. The quotation below demonstrates a concern about emergency hormonal contraception (EHC) also known as "the morning after pill":

> I think they tell you not to take [EHC] after three times because I think … I don't know where I got told this but someone said that it can actually make you infertile because if you take it more it's obviously killing whatever is inside and then that will stop you getting pregnant (woman aged 20).

Again, the narrative concludes with a concern about future fertility relating to perceived irresponsible use. The participant has linked something she has heard about a limit on the number of times you can take EHC with a reason for this. Again, there is an element of violence, in "killing whatever is inside."

Not all our folkloric reading of the data was concerned with narratives. Some observations related to actions and customs. For example, everyday ritual, such as remembering to take a contraceptive pill:

> Yeah I am quite forgetful but like I have—I got myself this like—it's really like old women, but like a little pill box,

> because I have to take tablets as well to stop water infections and so like if I'm putting them in there and then it makes me remember. (woman aged 19)

There were also accounts of status passage, the collective marking of transition points in social life whereby people move from one socially recognized status to another, and in the following quotation the participant describes getting (and removing) a contraceptive implant with friends: "We all got the implant together, three of us, and two of us took it out together" (woman aged 18).

This folkloric reading of existing data then informed the creation of a topic guide to explore emerging findings in the next work package. This explored informal talk about contraception: where and from whom information was sought, who it was discussed with, and what could be said.

Talking to Friends and Family

Work Package 2 was participatory and involved recruiting and training volunteer researchers to undertake interviews with their friends and family members. They undertook their interviews between March and June 2021), resulting in 47 transcripts with 52 participants in total (a small number of interviews were a group discussion with two or three participants).[2] Volunteer researchers were invited to have ongoing involvement throughout the project and attended a further analysis workshop where they helped us to refine our emerging themes, discussed below.

The first theme was *the contraceptive network*. When making decisions about contraception, participants spoke about needing to sift through and make sense of many different sources of knowledge. Different knowledge sources provided different functions. For example, something different was gained from reading medical information versus the more personal or experiential narrative accounts of friends and family or of internet message boards. Participants described sophisticated sifting in making sense of all the different types of information available to them. Experiential accounts were valued, within the context of broader sources of information. For example, they may seek facts and side-effects from medically-backed websites such as the NHS, but in seeking out embodied knowledge—a sense of what a contraceptive method may actually be like for them and their bodies—they looked to more informal sources of information including online message boards and the accounts of friends and family members:

> [Friends] don't have any medical credentials but it's also an experience that they've had, whereas even if you're seeing a female doctor, they may not have had the experience with that form of contraception. (woman aged 31)

Here the participant noted that lived experience is for her a valuable information source, with the caveat that friends' accounts lack medical underpinning. She also similarly acknowledged that embodied knowledge may be missing from a contraceptive consultation with a doctor. The following participant noted the subjective nature of experience but believed that speaking to someone with lived experience of a method is "always good":

> I value my friends' opinions. I guess everyone's going to have different experiences with different things but it's always good to get their feedback the experience with that form of contraception. (woman aged 35)

Another strong theme to emerge from the data was the importance of *narrative sharing*. In sharing contraceptive accounts, there was an acknowledgement that storytelling was part of the process. Participants noted that the stories they heard were more likely to fall on the extreme ends of a spectrum of experience, particularly negative experiences, which may serve as warning tales:

> I think you always heard the really positive or the really negative stories. (woman aged 41)

> Even though it might not happen very often, it still does happen, and I think if it happens to someone, they want to share that experience so it doesn't happen to anyone else. Whereas if the majority of the time people have a positive experience, they're less likely to share that because they're just happy they don't have any need to warn people. (woman aged 22)

When discussing contraceptive decision-making, participants noted that it was helpful to hear the stories and experiences of others, and that something additional was to be gained from these types of knowledge:

> …other people's stories are super powerful. Love hearing others, their stories and their friend's stories as well. (woman aged 30)

Negative stories could inform how open people were to trying new methods:

> I guess if I heard something positive from someone I would probably be more likely to try it but if I heard something

> negative I'd probably just rule that out without looking into it. (woman aged 35)

Some types of narratives were perhaps more overtly recognized by participants as what they might understand as folklore. For example, the following excerpt demonstrates "Coke-lore" in circulation. The teller does not necessarily believe the account, recalling it as "crazy":

> I think reading magazines when we were younger there was always something crazy on the problem page that you'd just think what. You know, like pouring Coca Cola down your vagina after sex or something crazy like that and you'd be like, eh? There'd always be something like that that you would hear as a method of contraception. (woman aged 40)

In addition, motifs such as the rule-of-three applied in the context of sexual indiscretions and infertility as punishment. "Fertility fears," which I discussed earlier, was a strong theme cross-cutting all three work packages:

> I remember hearing that at school, as in sex ed classes or something, when we were talking about the emergency contraception and the emergency pill […] I heard that you could only take it three times in your life otherwise you would not be able to have babies when you're an adult. So it was a specific number, it was oh three times only, then it's over, then you can't be pregnant at all. (woman aged 22)

Contraceptive narratives, therefore, serve a number of purposes. They are told for entertainment, as a means of exploring perceived risks and risky behaviour, as a way to test acceptability of contraceptive methods, to explore wider societal discourses and moral panics (Cohen 2002) about female sexuality, and also to seek embodied knowledge about different contraceptives.

Pollution and the body was another theme and a concern for participants. Sometimes there was a lack of distinction between embodied experiential knowledge and broader anxieties around fertility and future motherhood. As Valk writes, stories of lived experience are important: "The storyrealm can be conceptualised both as domain of imagination and as socio-physical reality—the tangible world of lived experience" (2022: 9). Participants recounted concerns about hormonal contraception or chemicals accumulating in the body and having negative effects on both the physical and the emotional bodies. There was, for example, a perception that once hormonal contraception is discontinued that it takes time for hormones to "clear" from the body:

> … having been on the pill for such a long time, when it came time to me to actively try to have a baby, I'd been on the pill for so long that is a concern because obviously you've got all those chemicals in your body and it can have an impact on fertility and certainly in my case it took me two years and five months to be able to conceive. (woman aged 47)

Here again, fertility fears were a strong subtheme, and the participant grounded her account in her personal lived experience.

Informal narratives can help people to address their concerns about risk, and about the unknown, in these cases future fertility. Fisher studied the sharing of contemporary legends among healthy volunteers in phase-one clinical trials, arguing that the sharing of such stories in a medical context did a number of different things, although not necessarily all at once: scaring the listener, manifesting distrust in medical practitioners, forming the basis of a shared community, and establishing a fictionalized gradient of risk (Fisher 2015: 129). This was similarly true for our participants, whose accounts also dealt with exploring risk. In which context it is worth noting that although contraceptives are medicines designed for use by healthy individuals, the "maternal mortality model" of risk assessment often used in contraceptive development, in which the risk of using contraception is outweighed by the even greater risk of unintended pregnancy and possible unsafe abortion, means that women bear an unequal proportion of the risk with regard to fertility control (van Kammen and Oudshoorn 2002). This leads into the final theme that emerged from WP2, *the contraceptive burden*.

Participants spoke about the unequal burden of contraception that is borne by women and their bodies. Although some participants acknowledged that the side-effects of contraception were not all negative, and that having control over bleeding patterns, for example, was a positive benefit, there was a shared sense that no contraceptive method came without consequences. In general, although contraception was discussed with partners, it was ultimately viewed as an individual decision, made within the context of the wider discourses. What came though quite strongly in our analysis was an anger and feeling of injustice at society, at medicine, and at individual partners; about the contraceptive burden still being borne by women and the lack of equitable contraceptive methods for male partners. However, this discourse was in tension with a reluctance to hand over responsibility to partners, should more male contraceptive options become available:

> So for me it means having control over my fertility and even though I do, I find that's it's hard because it is the woman's responsibility. I much prefer to be on it when I'm sleeping with people, rather than just using condoms, because I would rather

> have the control rather than leaving it up to them [male partners]. (woman aged 22)

The Bodylore Exhibition

As a piece of publicly-funded research, and also as a piece of participatory research, it was important for us to take the stories that emerged during the research back to the public, and to share the role these narratives play in decision-making. We also wanted to bring these usually private stories that women told each other into a public space, to see how people responded to them. The project culminated in a public engagement exhibition in London in October 2023. Working in collaboration with design consultants The Liminal Space, and with input from our volunteer researchers, we framed the exhibition around five different stations, representing different points in life where contraception might have different meanings. In the space of six days, approximately 1,360 people entered and explored the exhibition and feedback from visitors was overwhelmingly positive and indicated an appreciation for the space to read, listen, and contribute their own individual stories. Bringing these stories to the fore is one way of tackling reproductive stigma and opening up conversations around sensitive topics. Visitors commented: *Thank you for this exhibit it should be talked about more; We are really talking about it. Can relate to many of these stories. Thank you; It's sad there are no other spaces like this—women should be able to share their stories and not feel alone in this*. Visitors also shared their own stories with contraception, some of which echoed narratives from the wider project demonstrating them to be in circulation in real time:

> I had taken the next morning's pill [EHC] twice in my life, and until today I thought that I have one more chance to take it. I am glad I learned today here in this exhibition, that these three times only number is a myth. But still, only women taking pills is not right.

Conclusion

In this paper, I have presented data from the Reproductive Bodylore project and explored some of the layers of complexity within the data. Research into vernacular contraceptive narratives can tell us as much about societal anxieties about female sexuality as it can about contraceptive choice. For example, one key theme which cut across the datasets is "fertility fears" and the perception that a decline in fertility is a consequence of long-term or overuse of hormonal methods of contraception.

Participant concerns about future fertility highlight the importance of supporting education around fertility awareness in relation to pregnancy

planning and pregnancy avoidance. When seeking a new method of contraception, participants described sifting through information from a range of different sources, for example, NHS websites, personal experience accounts, media reports, and online message boards. Vernacular knowledge was just one component of information seeking. However, listening to the stories of others, together with personal experience, provided reassurance or discouragement in trying new contraceptive methods. A negative (or less often) positive experience of a friend or family member was a valuable consideration in personal decision-making. During our participatory research in WP2, interviewees spoke about contraceptive use as a trade-off between reproductive autonomy and the perceived effects on the emotional and physical body. Akin to David Hufford's work (1998: 305), quality of life and bodily autonomy were valued as outcomes as much as pregnancy prevention and sharing vernacular knowledge about contraception allowed people to integrate and make sense of contraceptive experiences in the wider context of their reproductive life story.

Looking to the future, we envisage new ways to engage clinicians with the study and these findings. One possibility for this is a further iteration of the public engagement exhibition to be installed where contraceptive decisions are realized—for example in clinic waiting rooms—to serve as a prompt for thought ahead of the contraceptive consultation. The essence of this is that vernacular narratives are a way in, a conversation starter. Moving forward from the notion that people just need more education, or to have their knowledge corrected with the right type of knowledge, we are advocating working with and around an individual's concerns—taking them seriously and understanding and respecting the knowledge and experience that underpins their decision-making. It is important to remember that lived experience of the body is not experienced in a vacuum and is also produced through discourse. In a way, this is what these informal knowledges attempt to do—to draw on and interpret bodily experiences, to articulate fears around how the living breathing body may be affected. To understand this in greater detail we need to explore how everyday understandings of health and the body are collectively created but interpreted individually. Our overall vision is for people to feel listened to and supported in contraceptive consultations and for their individual values and experiences accounted for.

The project also demonstrates a greater opportunity for legend scholars to think about the application of their work, for example, by further building on the momentum of a wave of interest in conspiracy theories and storytelling that emerged in response to the COVID-19 global pandemic (Shahsavari et al. 2020). Bringing together folklore and health in an applied context can be a rich and rewarding process for both areas, and an opportunity to generate new approaches to, and theories about, long-

standing real-world issues. Finally then, and more broadly, I shall end with a call to make greater links with practice and to think about the capacity of all that we study as folklorists to have lasting impact for the real world. Alongside talking to others and championing what a folklorist is and what they do (Kitta, McNeill and Blank, 2021), we should also be emphasizing the relevance of our work to other disciplines alongside being more explicit about why here? Why now? And why it is important?

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Notes

1. See: Newton, Dickson and Hoggart 2020; Hoggart et al 2018; Walker et al 2018; Newton and Hoggart 2015; Dickson, Hoggart and Newton 2014; Hoggart, Newton and Dickson 2013; Hoggart and Newton 2013.
2. Participants were all ciswomen, aged 19-47, ethnicity was reported as 28 white British, 9 white other, 12 women of colour and two for whom we do not know their ethnicity. Most did not report having a religion that they followed, but other religions represented were self-reported as Muslim, Christian, Church of England, Catholic, Buddhist and Pagan.

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