

Contraception in Aotearoa: Shaped by and Shaping Family, Morality, Religion, Science, and  
Women's Reproductive Rights

By

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## ABSTRACT

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Throughout the history of contraception in Aotearoa, the position of women as contraceptive users has been shaped by society and legislation. At the beginning of the twentieth century, due to the racial fears of the time, legislators banned contraceptive use from the feared mortality of white New Zealanders. The eugenic and racial logics that drove the original prevention of access to contraceptives were also influential in the establishment of organisations like the New Zealand Family Planning Association that was able to work towards establishing birth control clinics. Family and religious morality played a major role in how people responded to contraceptive use. In 1954, they were mobilised in the Mazengarb Inquiry, condemning parents who did not fit into the narrow roles expected of them by the Inquiry members. They appeared again throughout the 1977 Royal Commission into Contraception, Sterilisation and Abortion. Family and religious morality not only shaped these investigations, but also the ways individuals responded to different aspects of contraception and the surrounding conversation. The personal morality of individual Members of Parliament shaped their position in the debate of the 1977 Contraception, Sterilisation and Abortion Bill and with how doctors and other medical professionals responded. This culminated in decision-makers and individuals in the public sphere imposing their own morality to justify conflating abortion and contraception, which resulted in doctors and other medical professionals controlling access to contraception. In Aotearoa, women's ability to access contraception and contraceptive information, controlled and restricted by these political, legal, and moralistic forces as exemplified and focused by these key events, has shaped their position as contraceptive users.

## INTRODUCTION

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Six years after the Pill was introduced in New Zealand in 1961, 20% of women of reproductive age were users, compared to approximately 8% of women in the United States and 3% of British women.

(Brookes et al., 2013)

According to Brookes et al. there were two key reasons for the speed and ease of uptake of the Oral Contraceptive Pill (the Pill) in Aotearoa. First, was that pharmaceutical companies were well-established in Aotearoa and were able to easily market the Pill to medical professionals. The second was that women already went to the doctor frequently, due to the subsidised health care available, which was particularly encouraged for women of reproductive age. Women in Aotearoa were active participants in the uptake of the Pill because of the widespread medicalisation of women's bodies (Brookes et al., 2013) even prior to the arrival of the Pill. This medicalisation is evident throughout the changes to contraception and fertility control policy and legislation and influenced the role women played in this "phenomenal usage" of the Pill. The numbers quoted above suggest that women who chose to use the Pill en masse were encouraged to do so by institutions, however, this was not the case. Women's acceptance of hormonal contraception in Aotearoa is in fact indicative of a history of women and contraception in Aotearoa that is a complex entanglement of medicine, policy, social infrastructure, and feminist activists working for women's reproductive rights.

In Aotearoa, women's reproductive lives have been shaped by many events and forces. Studying women's access to contraception allows a glimpse into some of the ways this has happened. In 1977, in the aftermath of the Report of the Royal Commission of Inquiry

investigating Contraception, Sterilisation and Abortion (CSA) (1977), Jill Ranstead writing for *Broadsheet: New Zealand's Feminist Magazine*, described the New Zealand political system as one in which the State was developing regulation of fertility control. Abortion issues also came to dominate discussions around women's reproductive rights, polarising the conversations, and resulting in downplaying other areas of fertility control that were a part of the Royal Commission's investigation. Contraception and sterilisation allow women to control their fertility without having public opinion condemning their choices. In 1977, women were fighting for the right to obtain an abortion, however, concerns around power and who was in the position to make choices regarding women's reproductive health also applied to both contraception and sterilisation. Ranstead saw a number of different groups and institutions that were "in ascendancy" (Ranstead, 1977). In her writing, she referred to groups that would work to "preserve the very foundations of society itself" (Ranstead, 1977) such as Members of Parliament (MPs), the Royal Commission, churches, and the medical profession. In this thesis, I illustrate how each of these groups have shaped women as contraceptive subjects, by advancing public conversation and policy through particular ideas of the family, moral conduct, and of the ideal New Zealand.

From the 1960s to present day, contraception, and access to it, have been crucial to understanding the various forces involved in shaping women's everyday existence in Aotearoa. Most recently, in 2017, the Pill was made available over-the-counter from the pharmacist which, in theory, increased access. In March 2020, the Abortion Legislation Act reformed abortion laws and abortion was decriminalised. However, as I show in this thesis, the

introduction of the Pill in 1961 was made possible by the prior state, social, and cultural struggles in Aotearoa that were influential to the evolution of contraceptive access.

New Zealand is a settler colonial state. In 1840, Aotearoa became the British colony, New Zealand, with the signing of Te Tiriti o Waitangi. With the arrival of European settlers, Māori populations were decimated, falling by up to 30% from 1769 (the arrival of James Cook) to 1840 from introduced diseases (Lange, 2011). Some scholars have written about how by the end of the nineteenth century, subsidised health care was developed specifically to work with Māori communities (Lange, 2011). However, there were also those who argue that the “neglect and apathy of the government was conspicuous” and that this was used to justify beliefs that Māori were a dying race (Le Grice, 2014). Despite the conflicting perspectives, the Māori population started increasing by the beginning of the twentieth century. There were many who believed that this increase was due to the acceptance of western medicine and argued that the healing work of tohunga<sup>1</sup> was harmful to the health of Māori communities, resulting in the Tohunga Suppression Act 1907 (Lange, 2011). This colonial practice of suppressing Māori culture continued with the State encouraging white New Zealanders to continue procreating and increasing the population.

Because of New Zealand’s status as a British colony, our medical system has been developed based on that of Britain. At the beginning of the twentieth century, there was no universal health care. In 1905, the first St Helens maternity hospital opened, the first state-run maternity hospital in the world, and provided care for wives of working men (Neill, 1961; Tennant, 1993).

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<sup>1</sup> “Skilled person, chosen expert, priest... leader in a particular field because of signs indicating talent for a particular vocation” (Le Grice, 2014)



Affordable care, rather than free. In 1939, the Social Security Act of 1938 instituted free hospital care – paid for by the government. It would have incorporated free general practitioner’s services, however, General Practitioners objected to not being able to keep their “fee-for-service” system (Belgrave, 2011). This resulted in creating a dual health care system where there was the fully funded public system and visits to the general practitioner were subsidised by the government, although, they were still able to bill patients for additional services rendered (Belgrave, 2011). General practitioners have remained primary health providers, allowing them to exist as the gatekeepers to medical information in Aotearoa.

When I began this research, I was expecting this relationship between contraception and women’s reproductive rights to be simple, i.e., men in positions of power using their religious beliefs and own personal conservative position to prevent and control women’s access to reproductive healthcare. However, the more time I spent in the archives and the deeper I delved into the data, the more complex relationship between women, contraception, and control of women’s bodies has revealed itself. Instead of men attacking women’s reproductive rights, it has instead come to light that it is a more complex push and pull between different groups and individuals, including men and women, on either side of the argument. All of this is shaped by and also shapes the gendered and radicalised inequities, which have become embedded in social institutions like government, medicine, and religion in New Zealand, especially when it comes to women’s reproductive rights.

## RESEARCH QUESTION AND THESIS

History shapes the present day; however, the contemporary moment also allows for a particular lens through which we can view and understand our histories. This research is interested in asking how social, political, religious, and gendered institutions have shaped women's relationships to contraception in twentieth century Aotearoa? Drawing on extensive archival research, media and policy analysis, and in-depth literature analysis, in this research I show that women and their relationship with contraception has been shaped by family and religious morality at a societal level, political decision-makers at a policy level and by individuals who, in public spaces, mobilised science as a way to control women's access to fertility control. Throughout this thesis, I outline the complex struggles for reproductive rights women have undertaken in face of stringent opposition from powerful institutions – be it from science and medicine or religious and political leaders. This research shows how the women of Aotearoa fought to establish themselves as contraceptive users and how they worked strategically to change the attitudes and practices, that in turn condemned them.

## METHODS

In order to appropriately approach this topic of the development and history of contraception in Aotearoa, I focused on archival research. There are a few different options for archives, depending on the direction of the research. Archives New Zealand would have allowed me to focus on the official, governmental records. However, I chose to explore the Alexander Turnbull Collection in the National Library of New Zealand, which allowed me to explore a wider range of content, including personal documents of those involved in

contraceptive conversations, letters to and from MPs, and the records of the New Zealand Family Planning Association (NZFPA). By using this broader variety of archival sources, I was able to gain an understanding of the public opinions relating to the events discussed in this thesis. I have also explored several different online newspaper archives, which also allowed me to draw on a wider range of perspectives, events, and time periods.

The Alexander Turnbull collection is a physical archive in Wellington that holds personal papers, together with records and published and unpublished papers from a number of organisations and groups. Some collections I accessed include those of activist groups, such as the Women's Electoral Lobby. I also read correspondence to and from, individuals who were involved in activist groups, including Marilyn Pryor (a founding member of the Society for the Protection of the Unborn Child) and politicians who were involved in either drafting and implementing the Contraception, Sterilisation and Abortion (CSA) Act of 1977 (including Frank Rogers, Leslie Gandar and Mary Batchelor – a mix of both National and Labour members). I also read documents, correspondence, and newspaper clippings from a number of societies and associations, including the NZFPA and New Zealand Society of Sexual Health.

I also included online databases containing archived newspaper and magazine articles from a range of countries. This included Papers Past, Newztext, ProQuest ANZ Newsstand, ProQuest News & Newspapers, EBSCOhost, Gale Primary Sources, which are all online databases. When searching these databases, I used the terms “emergency contraception”, “emergency contraceptive pill”, “morning after pill”, “contraception” and “abortion”. I used “abortion” as a search term because much of the debate surrounding contraception overlaps with the abortion debate, and because abortion and contraception tend to be conflated in public discourse.

Papers Past and Newztext both hold only articles published in Aotearoa. Papers Past holds newspaper articles up to the end of January 1950, which has allowed me to understand the way that contraceptives were viewed in the early twentieth century and how these views changed over this time. Newztext holds both newspaper and magazine articles from the beginning of 1980 to present day. The gap between these two databases was bridged by the collections of newspaper articles held in the NZFPA collection, allowing access to the conversations in the media surrounding contraceptives in more recent years. Some of the newspapers commonly appearing in these searches include: *The New Zealand Herald*, *Scoop*, *The Press*, *The Waikato Times*, and *The Dominion*.

ProQuest ANZ Newsstand and EBSCOhost have allowed access to both Aotearoa and Australian newspaper and magazine articles. ProQuest News & Newspapers and Gale Primary sources provide more international information, particularly from the United States and Britain, which allowed me to develop my understanding of how Aotearoa stood internationally regarding contraceptive rights.

Thematic content analysis, informed by the literature review, allowed me to sort the data by common themes that arise throughout the texts. Some themes that emerged early in my research included attitudes towards Family Planning, the positions of family and religion within the contraception debates, the power struggles between women and conservative society, and the position abortion has within conversations surrounding contraception. Exploring these different themes allowed me to understand the way Aotearoa, and the women in Aotearoa, have been thought about and discussed specifically regarding contraception. This thematic

analysis guided my access to the different perspectives that were involved in the conversations and contributed to making decisions about women's reproductive autonomy.

From the Alexander Turnbull Collection, I analysed a combination of published and unpublished work, containing both written and visual content. When working with the written content I took notes on the general themes of each piece, as well as some of the more specific content, such as the mentions of the different types of contraception, how the attitudes surrounding contraception were raised and some of the different societal views that were held at the time. For both the written and visual content I took photographs, allowing me to look back over some of the more specific wording in the written content and view the relevant visual content again. The content from the Papers Past, Newztext, ProQuest ANZ Newsstand, ProQuest News & Newspapers, EBSCOhost, Gale Primary Sources databases was all read. All the reading and revisiting allowed me to explore and sort the themes of my data.

## LITERATURE REVIEW

Conversations surrounding contraceptives and women's rights, are researched, and written in several different fields. However, the primary field that I am engaging with is Feminist Science and Technology Studies (Feminist STS). Feminist STS offers an interdisciplinary perspective of how the different power relationships, critiques of, and different actors involved in and surrounding contraceptives shape the way these technologies circulate within and beyond women's bodies. I also engage with literature which touches on religion as logic, most of which comes from Anthropology, STS and History.

## Feminist Science and Technology Studies

A key debate that established Science and Technology Studies as an academic discipline was how science and technology were embedded with politics and had agency in their own right (Jasanoff & Kim, 2009; Kennedy et al., 2003; Loader & Mercea, 2011; Takeshita, 2012; Timmermans & Berg, 2003; Winner, 1980). Feminist STS scholarship took those defining debates on the subjective nature of science, technology, and medicine to analyse the gendered power relationships that shaped women's lives (Haraway & Wolfe, 2016; Harding, 2000). In the 1990s, these influential ideas started to impact on the way feminists studied medical interventions for and on women's bodies – contraception being one of the first medical technologies directed solely towards female bodies. Some key sites of analysis were: a) the power relationships at play in doctor/patient interactions around contraception and the medicalisation of women's health (Bordo, 1993; A. E. Clarke & Montini, 1993; Finkler, 2001; Munro Prescott, 2011; van Kammen & Oudshoorn, 2002; van Wichelen, 2014; Wynn & Foster, 2012; Wynn & Trussell, 2006); b) how gender roles influence allocations of risk and responsibility surrounding contraception (Marks, 2001; Munro Prescott, 2011; Sawicki, 1991; van Kammen & Oudshoorn, 2002; Wynn & Trussell, 2006); and c) the coproduction of contraceptive technology and reproductive subjects (Bartky, 1990; Bordo, 1993; A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Sawicki, 1991; Sheoran, 2015; Takeshita, 2012; Trussell, 2012; van Kammen & Oudshoorn, 2002; Wajcman, 2007, 2010; Wynn & Foster, 2012; Wynn & Trussell, 2006).

Issues around access and control of access are often discussed in terms of control exercised over women's bodies (Bartky, 1990; Bordo, 1993; A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Sawicki, 1991; Takeshita, 2012; Trussell, 2012; van Kammen & Oudshoorn, 2002; Wynn & Foster, 2012; Wynn & Trussell, 2006). Clarke and Montini (1993) and Wynn and Trussell (2006) discuss the different ways actors involved in developing contraceptive policy, particularly doctors, gatekeep the access to contraceptive methods, and in doing so reinforce their positions of control over the contraceptive user. Munro Prescott (2011) presents the history of Emergency Contraception in the United States as "one of the nation's best kept secrets" where pharmaceutical companies and medical professionals used their positions as gatekeepers to prevent knowledge of this contentious contraceptive method spreading and bringing with it controversy (Munro Prescott, 2011). Munro Prescott (2011), along with Marks (2001), also argues that by shaping societal understanding of contraceptives, medical professionals work to obtain society's conditional acceptance of contraception. Takeshita (2012) discusses how the IUD was co-configured by the user, the contraceptive researcher, and the State, in particular how the State and contraceptive research configured the IUD to as a method to control the population.

In the 1960's through 1980's There were feminists and feminist scholars in the second-wave feminism movement, who considered emerging contraceptives and reproductive technologies to be new ways for society to control women (Bordo, 1993; Sawicki, 1991; Wajcman, 2007, 2010). This was because these technologies were based on patriarchal male values. These accounts portrayed women as "victims of technological change" (Wajcman, 2010) and did not acknowledge women's agency or the way gender and technology shaped each other (Wajcman,

2007, 2010). In practice, governments, religion, feminist groups, scientists and calls for population control all contributed to shaping both practical and symbolic elements of contraception (A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Takeshita, 2012; Wajcman, 2007, 2010; Wynn & Foster, 2012; Wynn & Trussell, 2006). The development of contraception was often justified by attempting to control the undesired population. Studies have shown how government and policy groups were those making decisions regarding contraception, often using ideas and positions from religious, feminist and scientist groups to inform their decisions (A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Takeshita, 2012; Wajcman, 2007, 2010; Wynn & Foster, 2012; Wynn & Trussell, 2006). The population control rhetoric was often used as a tool by many of those involved in these decision-making and control processes. It has been used as a way to justify State and medical interventions into who should be allowed to reproduce and who should not, while also being used as a way to resist state power (Marks, 2001; Munro Prescott, 2011; Takeshita, 2012; Wynn & Trussell, 2006).

Women have been placed in a position by society where a woman is always potentially pregnant because she has the capacity to be (Hubbard, 2001). This is a highly problematic way for women to be viewed because it allows women's actions and roles to be limited. This idea is also present in contraceptive decision making. Women are the ones who have the capacity to get pregnant and as such they are the ones who must take the responsibility to use contraceptives, along with any health risks associated with them, or else risk becoming pregnant (Marks, 2001; Munro Prescott, 2011; Sawicki, 1991; van Kammen & Oudshoorn, 2002; Wynn & Trussell, 2006). Despite a woman's capacity to become pregnant, male biological



material is also needed. Therefore, while fertility control has been framed as a women's issue, it is not exclusively so. The risks associated with long term use of hormonal contraceptives have become a part of many women's lives (Grigg-Spall, 2013; Skovlund et al., 2016). However, the same risks for men associated with male hormonal contraceptives have historically prevented them from being approved by the United States Federal Drug Administration (van Kammen & Oudshoorn, 2002).

In these global feminist STS debates, Aotearoa is not widely featured. Instead, research here is often focused on the social history that has influenced the small snapshots of the contraceptive history of Aotearoa (Brookes, 1981; Brookes et al., 2013; Smyth, 2000). This research sits within the field of feminist STS; however, it also draws on the social history aspects of the research completed in Aotearoa, both of which have influenced the research for this thesis. The chapter structure, outlined in the summary below, reflects some of the key themes that have emerged from the data in relation to these key debates in feminist STS.

## THESIS STRUCTURE

Following this introduction, Chapter One, titled *Contraceptives in Aotearoa, 1901-1990*, maps the history of contraceptive methods and legislation in Aotearoa throughout the twentieth century. This historical mapping explores from the beginning of the twentieth century up to the Royal Commission into CSA in 1977. It sets out how colonial, eugenic, and population control arguments were used to control contraceptives and other fertility control methods. These were early examples of how women's agency was controlled and, in many ways, shaped the contemporary contraceptive conversations. From that history, I then move on

to the development of the Pill and the Emergency Contraceptive Pill (the ECP) because this allows for a more detailed understanding of how oral hormonal contraceptives circulated – shaping and shaped by women’s lives and desires here in Aotearoa.

Chapter Two then outlines how family, morality and religion have been mobilised within contraceptive debates and legislation to maintain the conservative position of those who drove legislation. The examination of the arguments around adolescents’ access to contraceptives, gender roles in both parenting and contraceptive use and the position of religion in the New Zealand family illustrates the way that family and religious moralities have been mobilised by individuals and institutions to shape contraceptive use and acceptance. In this chapter, I focus on the arguments that have evolved throughout the twentieth century. However, the central components of these arguments – namely concerns about the degradation of family, the rising immorality of the nation and people failing to understand the worth of religious and moral sanctions – have remained remarkably consistent throughout.

Chapter Three looks at the way two key decision-making groups – MPs and medical professionals – used their personal morality and positions within society to control the contraceptive conversation and available contraceptive technology. Through the exploration of the Hansard debates surrounding the CSA Bill, the MPs attitudes toward contraception is evidenced, raising the question of whether those who were involved in the development and passage of the Bill were the ones whom it was intended to serve. Doctors have control over access to contraceptives and contraceptive information. Their response to perceived threats related to contraception show how they were afraid of losing their position as gatekeepers to contraception within Aotearoa.

Chapter Four examines the boundary between contraception and abortion, resulting in contraception being viewed as if it were abortion. Analysing the language used by the political institutions, the Royal Commission into CSA and Parliament who were involved in the creation of legislation, shows the way they have conflated the two methods of fertility control. The keyways that this occurred was through the manipulation of the scientific terminology used throughout the Report of the Royal Commission and legislation, and how the Royal Commission deliberately used emotive language to reinforce their own positions regarding the different methods of fertility control. The conflation of contraception and abortion continued into the public sphere where individuals used arguments based on their personal beliefs relating to the morality of fertility control to attempt to change public opinion to their beliefs. This chapter shows the societal criticisms women were faced with regarding their personal use of contraceptives and the way women as contraceptive users were positioned within these arguments.

The conclusion of this thesis briefly discusses the events discussed in each of the preceding chapters and the Feminist STS themes that have been central to this research. I suggest that the societal norms that lead to the incredible uptake of the Pill described above were actually means of controlling women's agency and their relationship with contraception.

## NOTES AND TERMINOLOGY

As a Pākehā, cis-gendered woman, there are certain aspects of Aotearoa history and gender issues that I am not in a position to discuss in depth. When discussing the colonial history of New Zealand, I have attempted to draw primarily on Māori scholars. In this thesis, I have used

both the terms 'Aotearoa' and 'New Zealand'. My preference would be to use Aotearoa throughout this thesis. However, because this thesis is an historical analysis, there are times and groups where it would be inappropriate for me to use Aotearoa. An example of this is within the discussions of the works and debates of the New Zealand Government which is based in colonial practice.

As gender is a central component of this thesis, I use the terms 'women', 'female', 'men' and 'male' throughout. I am using these terms referring to the genders assigned at birth and the biological features of these two sexes. Due to the nature of the archival content, I am unable to ensure that I am discussing everyone using their preferred pronoun, instead I am using as much information as I can obtain to infer their gender assigned at birth and using the singular 'they' if I am unable to do so.

This thesis is exploring means of fertility control available to women. Because of the nature of this work, I am focusing on medically recognised methods of preventing pregnancy. There are a number of ways fertility can be controlled that also act in other ways. For example, condoms act as a prophylactic, preventing the spread of sexually transmitted infections, however, I am focusing on their use to prevent pregnancy, and, therefore, as contraceptive measures.

## CONCLUDING COMMENTS

This thesis engages with primary archival research to help us understand how women as contraceptive users has emerged through time. Throughout the past century in Aotearoa, there were several societal shifts, each impacted the acceptance and use of contraceptives. By

analysing these shifts and the events that either occurred as a result of them, or to curb them, this thesis shows the impact that each of these shifts had on women and their position as users of contraceptives. The social history of contraception in Aotearoa has been explored in the past. However, by critiquing the positions of those involved in the contraceptive debates, through a Feminist STS lens, I have been able to critically examine how the historical constructs discussed in this social history has shaped women's position as contraceptive users in Aotearoa.

This thesis provides a unique historical perspective regarding contraception. The phenomenal uptake of the Pill described at the beginning of this introduction shows that Aotearoa was in a unique position regarding contraception, especially in comparison to Britain and the United States – where the Pill was developed. By offering an understanding as to why Aotearoa was so different, we can see that the development of the medical system and related medical groups were some of the key reasons why this was possible. Moving on to events following the introduction of the Pill shows that while attitudes and access changed, the historical impact of medicalisation of women and contraception, as well as the Eugenic logics that drove legislation for the first half of the twentieth century remained.

In this thesis I contribute to Feminist Science and Technology Studies body of work regarding contraception and offer the historical analysis of the position of Aotearoa in the twentieth century.

# 1 CHAPTER 1: CONTRACEPTIVES IN AOTEAROA, 1901-1990

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To understand the pivotal role contraception had in shaping societal and familial relations in Aotearoa, unpacking the history of the introduction of contraceptives is vital. These aspects have all worked together to create the societal understanding we have of contraception today. In this chapter, I map out the history of contraceptive methods and the legislative changes that accompanied them. By exploring the eugenic and racial fears that drove early contraception policy in New Zealand, this chapter also explores the ways attitudes changed throughout the twentieth century. From the Sale of Preventatives Prohibition Act in 1901 to the Contraception, Sterilisation and Abortion (CSA) Amendment Act 1990, arguments over who should be allowed to access and use contraceptives and under what conditions, have shifted. The history of the development of oral hormonal contraceptive methods – the Pill and the ECP – are discussed in detail because of their central position in this thesis.

While I highlight the trajectory of access to and denials of contraception in Aotearoa, I draw on archival research from the NZFPA collections, collections from individual MPs, newspaper articles from the PapersPast collection, and the reports of the Mazengarb Inquiry and the Royal Commission on CSA.

The theoretical framework that I engage with in this chapter includes the medicalisation of bodies and the control that gives to medical professionals (Bartky, 1990; A. E. Clarke & Montini, 1993; Finkler, 2001; Sawicki, 1991; Wynn & Trussell, 2006); how eugenics and population control were at the centre of contraceptive arguments globally, particularly around the development of new contraceptive technologies (Marks, 2001; Munro Prescott, 2011;

Takeshita, 2012; Wynn & Trussell, 2006); and how policy makers and medical professionals were attempting to control women's agency as reproductive beings (Takeshita, 2012; Wynn & Trussell, 2006). By engaging with this Feminist STS literature, the work done in this chapter allows me to work towards answering my research question by giving context to the events and themes discussed in later chapters, allowing modern critique to be applied.

## 1.1 EARLY USE OF CONTRACEPTION

Contraceptive technology exists in an interesting societal position between moral decision making, population control and wanting what is best for women (Brookes et al., 2013; Smyth, 2000; Sparrow, 1999). Throughout the twentieth century, in Aotearoa, nationwide contraceptive policy has been examined a number of times, each resulting in a change to contraceptive legislation. Support of contraception in Aotearoa has changed over time, from a policy level rejection to an accepted part of life. These changes largely followed international trends.

During the nineteenth and early twentieth centuries, there was a resistance within national government and local policy, to provide access to contraception (Smyth, 2000). However, on an individual level, women found and used contraceptive methods. Some of these methods were devices and medicines that came from the pharmacy, others were word of mouth knowledge, passed down through the centuries. In the early twentieth century, techniques and devices that

can be medically recognised as contraception, included withdrawal<sup>2</sup>, douching<sup>3</sup> and condoms (Brookes et al., 2013; Smyth, 2000). There were also a number of herbal remedies that were used by women attempting to control their fertility (Koblitz, 2014)<sup>4</sup>.

One of the earliest forms of birth control was the condom, also known as sheaths. They were one of the only contraceptives available that also acted to prevent the spread of venereal diseases. Condoms, in one form or another, have been used for centuries and made from materials ranging from linen to animal intestines. Condom manufacturing has changed over the years. They are now made from latex, following the development and mass production of artificial rubber. Condoms before the 1960s were thick, poor quality and unreliable (Brookes et al., 2013). However, by 1977, the Report of the Royal Commission of Inquiry into CSA rated the effectiveness of condoms to be between 90 and 99.5%, although, this was dependent on them being used properly. They also noted that the effectiveness of condoms increased with the use of a spermicidal gel (Royal Commission on Contraception, Sterilisation and Abortion, 1977). Despite how useful and widely used condoms became during the early twentieth Century, there was a stigma around them. This stigma was because of condom distribution to soldiers during the wars and the association with prostitution (Brookes, 1981), “venereal disease and illicit sex” (Brookes et al., 2013) and moral codes underpinned by the idea that they were “not something

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<sup>2</sup> Withdrawal, also known as *coitus interruptus*, is where the man withdraws himself from the woman before he ejaculates. This method relies on the man’s cooperation and good sense of timing.

<sup>3</sup> Douching is where the woman washes out her vagina after sex with either water or a douching fluid, which eventually came to contain spermicidal components (Koblitz, 2014). Douching can also be quite harmful, often causing thrush or other infections. This would happen because douching can alter vaginal pH and can kill some of the protective microorganisms that exist there (Brookes et al., 2013; Marks, 2001; Munro Prescott, 2011; Smyth, 2000).

<sup>4</sup> For this thesis I am focusing on medically recognised contraceptive methods, so these alternative herbal remedies are not further discussed.



married people would use” (Brookes et al., 2013). This attitude also existed amongst groups who supported birth control (Brookes, 1981; Smyth, 2000) and continued through the rest of the twentieth century. Although, once the Pill was introduced in 1961, this stigma became less of a concern for married couples (Brookes et al., 2013). I outline below the different policy and law changes that impacted the way contraceptives were able to be used, and the ways that women who did use contraceptives were viewed by those responsible for making policy decisions about women’s reproductive lives.

## 1.2 POPULATION ANXIETY AND EUGENICS LOGICS

In New Zealand, the first piece of legislation for managing contraception was the Sale of Preventatives Prohibition Bill 1901. The Bill was introduced by Premier Richard Seddon to prevent the sale of “any contrivance or thing for the purpose or with the intention of hindering or preventing conception,” (The Sale of Preventatives Prohibition Act, 1901) unless a prescription was obtained from a medical practitioner. At the time, the items that were prohibited contraceptives were medicines and condoms. These were most commonly sold by pharmacists (Brookes, 1981; Brookes et al., 2013; Smyth, 2000). However, this Bill was not successful in preventing the sale of contraceptives, with the Wellington Pharmaceutical Association stating: “[...] that in the opinion of this Association the Sale of Preventatives Bill is an interference with the rights of the public” (Telegraph Parliamentary Reporter, 1901; Telegraph Staff Author, 1901). The introduction of the Sale of Preventatives Prohibition Act 1901 was both a way to attempt to regulate women’s access to contraceptives and also to make contraception a medical issue. These contraceptives were non hormonal and often

prophylactic. The medicalisation of contraceptives allowed doctors to gatekeep access to contraception. The medicalisation of women's bodies has been happening for hundreds of years, particularly as pregnancy and birth moved to being medical processes as part of the global aims to reduce maternal mortality or to 'develop' society through biomedicalization (A. E. Clarke et al., 2010). The medicalisation of pregnancy and birth allowed control of women's bodies to be given to the male doctors, the medicalisation of controlling conception – i.e. contraception – then appears in some registers as another way to control their bodies (Bartky, 1990; A. E. Clarke & Montini, 1993; Finkler, 2001; Sawicki, 1991; Wynn & Trussell, 2006). Through the medicalisation and regulation of access the Sale of Preventatives Prohibition Act 1901 was able to control and manage the way women accessed and used contraceptives throughout the beginning of the twentieth century – as a way to also manage the social lives of women.

In spite of this legislation, there were those who could see uses for contraceptives beyond birth control. The Protestant Churches of Christchurch were some of those who put forward their position stating that contraceptives were immoral but had their medical uses. They suggested restrictions, including making contraception obtainable only from qualified pharmacists – who would be required to keep a register of sales, placing an age restriction on sales, and making all contraceptive advertisements illegal (N.Z. Times, 1900).

When the Sale of Preventatives Prohibition Bill 1901 was introduced, other British Colonies had seen their birth rates decline following contraceptive use. New Zealand was the smallest and newest of these colonies and policy makers were worried that a declining population was in the immediate future, especially as "immigration had declined as a reliable or even desired

source of population” (Smyth, 2000). As a newly established commonwealth nation, still under the influence of the British crown, the policy makers were worried that a declining birth rate caused by contraceptive use would lead to under-population of the newly established colony<sup>5</sup>. The more established colonies already had an established European settler population and were less worried about a declining population than New Zealand was. Because of this fear of under population, throughout the first half of the twentieth century, women in New Zealand were faced with the ‘populate or perish’ rhetoric<sup>6</sup> (Cronin, 1977; Smyth, 2000). However, even with the declining immigration rates, New Zealand’s population continued to increase until the mid-1930s (Smyth, 2000), thus making clear that the fears of a decline in a particular kind of population were unfounded. Yet, these anxieties served two strategic goals. In the first instance, they allowed the state and its concomitant medical institutions justifications to continue to interfere in women’s reproductive lives; and secondly, allowed for a particular racial logic to circulate as legitimate concerns for a new nation (Le Grice, 2014; Smyth, 2000).

Those who were making policy and legal decisions in 1901 regarding contraception and women’s reproductive choices were largely middle class men and members of the Liberal Party (New Zealand Government, 1900). These men were not the ones who were risking their health with every pregnancy, nor were they the ones who were struggling financially to feed their families (Finlay, 1977). Men remained the decision-makers in contraceptive and abortion legislation throughout the twentieth century. Although women were able to vote in 1901, they

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<sup>5</sup> The underpopulation that the Government were worried about was that of the European settler (Smyth, 2000).

<sup>6</sup> This rhetoric was used to encourage Pākehā women to reproduce and populate Aotearoa. This was based in the eugenic concept of positive eugenics, which encourages those of the ‘desired’ population to reproduce more than those of the ‘undesired’ population (Smyth, 2000).

were not able to stand for Parliament until 1919 (Ministry for Culture and Heritage, 2018).

There were only four women MPs to 116 men at the time of the CSA Act in 1977. This under representation has continued, with 46 women to 74 men voting on the Abortion Legislation Act 2020.

Once the 1901 legislation was passed pharmacists adapted by continuing to advertise or naming contraceptives for different purposes (Smyth, 2000). Some such names included “Dr Bonjean’s Female Pills” or “Rendell’s Wife’s Friend”, which were sold as female vitamins, containing known abortifacient ingredients, including quinine, and were often named after the pharmacist who created them (Smyth, 2000). However, ten years later, the 1910 Indecent Publications Act was passed. The 1910 Indecent Publications Act banned any material, published or not, that contained information on “organs of either sex, or to any complaint or infirmity arising from or relating to sexual intercourse, or to the prevention or removal of irregularities in menstruation, or to drugs, medicines, appliances, treatment, or methods for procuring abortion or miscarriage or preventing conception” (Indecent Publications Act, 1910). This Act was also meant to prevent the sales of contraceptives, as well as spreading information about them. However, it resulted in the same problem as the 1901 Sale of Preventatives Prohibition Bill with pharmacists working around the restrictions, at the behest of women who needed these methods to abort or prevent pregnancies.

However, these attitudes around criminalising or preventing access to contraceptives (or information about them) started to change with the First World War. Condoms were distributed throughout the Armed Forces in World War One and Two (Mazengarb et al., 1954) in an attempt to stop soldiers contracting and bringing home venereal diseases. The New

Zealand Armed Forces did not make condoms freely available to soldiers until 1917, following a campaign by Ettie Rout. Rout was the founder of the New Zealand Voluntary Sisterhood, volunteering as nurses in Army camps in the First World War. After arriving in Egypt and finding out how many soldiers had venereal disease, Rout developed prophylactic kits containing condoms and started writing to newspapers in New Zealand. She worked hard to raise awareness of venereal diseases and make them a medical problem, rather than a moral one. Her work in Egypt and her published letters led to her writing being banned from New Zealand newspapers. This censorship was made possible under the War Regulations Act 1914. Her work with condom education resulted in Rout becoming demonised by many. She has been variously remembered as the “guardian angel of the ANZACs” and “unforgettable heroine” to “the most wicked woman in Britain” (Tolerton, 1996). From 1901 Sale of Preventatives Prohibition Act to the 1914 War Regulations Act, it is clear that the New Zealand state and society repeatedly intervened to regulate and retain control of access to birth control information for fear that contraception would be used by Pākehā women, thereby decreasing the “white” populous.

### 1.2.1 Eugenics in New Zealand

The anxiety that shaped policies and acts in New Zealand were clearly articulations of a social anxiety, playing out at a policy level. Research has shown that the Pill, while a feminist emancipatory technology, was also entangled with a eugenics movement (Marks, 2001; Watkins, 1998). However, even before the Pill makes an appearance on the New Zealand (or global) social and political landscape, the eugenics movement also played a role in shaping new nations. Eugenics was a pseudo-scientific concept that justified racial fears that were prevalent in the twentieth century. It attempted to cleanse society of those who were considered

‘undesirable’ or ‘unfit’. There are two Eugenics tropes, positive and negative. Positive encouraged those of the ‘desired’ population to reproduce and negative prevented those from the ‘undesired’ population from reproducing (Smyth, 2000).

In early to mid-1900s New Zealand, eugenic policies became clearly visible primarily through the 1924 Committee of Inquiry into Mental Defectives and Sexual Offenders. The Committee’s final report suggested that to keep those who were ‘unfit’ from reproducing, marriage should be prohibited, people should be sterilised, or they should be committed to a mental asylum or another form of a segregated colony. There was no mention of using contraceptives as a means of preventing procreation (Smyth, 2000) nor did the Committee explicitly say that Māori were ‘unfit’ or ‘undesirable’. However, they did comment that New Zealand “should be not only a ‘white man’s country’, but as completely British as possible” (Committee of Inquiry into Mental Defectives and Sexual Offenders Report as cited in Smyth, 2000). Comments such as this showed the colonial position that was driving a lot of the eugenic thinking in New Zealand in the early twentieth century and the role, or lack thereof, contraception was imagined playing in the production of the white New Zealand population. Policies like this made evident the ways in which policy makers were able to control both access to contraception, and the way in which the public perceived contraception.

Following World War Two, Eugenic theory was disproven and came to be recognised as the highly problematic concept that it was. Nazi Germany used eugenics during the Holocaust to justify the imprisonment, torture, and murder of thousands of Jews and others who were considered ‘undesirable’ people. In spite of the horrors and war crimes that came out of these eugenic practices, and eugenic doctrines being discredited, the discriminatory basis of eugenics

remained. The prevalence of eugenic ideologies allowed these ideas to morph into what became known as neo-Malthusianism<sup>7</sup>, which, based on Malthusianism – the origin for the science of demography - advocated for contraception use as a means of controlling the size of the population (Macdonald, 2016; Marks, 2001; Rao, 2005; Roberts, 1997; Sheoran Appleton, 2019; Smyth, 2000; Takeshita, 2012; Watkins, 1998). This resulted in groups advocating for birth control and sterilisation as a means to prevent the growth of particular ‘undesirable’ populations.

Some of these neo-Malthusian groups advocating birth control as a population control, were able to get footholds in New Zealand. Members were spreading their positions and beliefs around the world. Doctors traveling to England would often come back with ideas of using contraceptives to help “economic conditions, Eugenics, & social problems generally” (Wallace, 1936). This came from a 1936 letter from Dr Victor H. Wallace to Mrs E. Freeman – one of the founding members of the Sex, Hygiene and Birth Regulation (SH&BR) Society. Wallace had established a “Birth Control Clinic in one of the poorest districts of Melbourne” following a trip to England where he became “generally interested in Contraception” (Wallace, 1936). “Every woman who is given instruction in contraception at our Clinic has some physical disability... had I adhered to my original plan many more women would have attended, as advice would have been given to women just because of poverty” (Wallace, 1936). These attitudes were typical of the time and show how these eugenic ideas manifested themselves through the establishment

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<sup>7</sup>Neo-Malthusianism is based on the teachings of Malthus, a clergyman who theorised that worlds population would outgrow the Earths resources and as such the size of the population would need to be controlled. Neo-Malthusianism advocated for the use of the developing contraceptive technologies to control population sizes (Rao, 2005; Sheoran Appleton, 2019).

of birth control clinics, targeting those with physical disabilities and in poorer communities. By mobilising contraception for the specific purpose of addressing “social problems generally”, medical professionals were reinforcing eugenic doctrine and the idea that only certain types of women should be allowed to control their fertility (Marks, 2001; Takeshita, 2012). These ideas prevented women from having freedom to access contraception and allowed doctors to enforce these ideas by only allowing women who fit into their idea of the ideal contraceptive user, which would be a poor, unhealthy, non-white women who believed that she was a burden on society, to use contraception.

In 1936, a group with the same eugenic beliefs as Wallace, the Eugenics and Racial Improvement Society, lobbied the Minister of Health, Peter Fraser, to establish a birth control clinic in New Zealand. However, the newly-elected Labour Government had decided that birth control was not supported enough within local communities and decided to follow “the Australian Labour movement whose vigorous growth owed much to a Catholic workforce” and the Government “quietly dropped all references to birth control and sex education” (Dobbie, 1984). This suggested that New Zealand would not get birth control clinics soon.

This rejection came as the numbers of women dying from septic abortions were rising, and the New Zealand population was starting to decrease. By preventing the opening of birth control clinics, the New Zealand Government was trying to prevent the population from decreasing any further. However, this also offered no alternative fertility control method for women aborting pregnancies.



Groups aside from the Eugenics and Racial Improvement Society were also advocating for birth control clinics. A number were doing so because, following the Great Depression, families found that they were unable to afford large families. These groups were made up of people with different political backgrounds including feminists, socialists, and communists. This need to limit family size, along with the lack of contraceptive information and availability, resulted in the number of illegal backstreet abortions and women dying from septic abortions increasing throughout the 1930s (Committee of the McMillan Inquiry, 1937; Smyth, 2000). Feminist STS scholars, writing on population control, critique the power relationships of those who advocated for population control (A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Takeshita, 2012; Wajcman, 2007, 2010; Wynn & Foster, 2012; Wynn & Trussell, 2006). Takeshita (2012) critiques how the western patriarchal system using population control arguments to regulate non-white, non-middle-class citizens.

### 1.3 NEW ZEALAND FAMILY PLANNING ASSOCIATION

In 1935, New Zealand's SH&BR Society had their first meeting. This meeting, convened by Elsie Locke, a well-known social activist and communist, largely comprised of married women who wanted to control their own fertility and help others do the same. The objectives of the SH&BR society were "To educate and enlighten the people of New Zealand of the need for birth-control and sex education, and to promote the provision of facilities for scientific contraception, so that married people may space or limit their families, and so mitigate the evils of ill-health and poverty" (The Sex, Hygiene and Birth Regulation Society, 1935), as outlined in the pamphlet handed out at this first meeting. The individual members of the

SH&BR used their positions within communities, as well as their own friendships, to gather information about what types of contraception were being used by married women. They were later able to present this research to the 1936 McMillan Inquiry<sup>8</sup> (Dobbie, 1984; Smyth, 2000).

The McMillan Inquiry helped legitimise the SH&BR Society. This happened because the Committee of Inquiry allowed the SH&BR Society to present information on birth control, giving them a platform to spread their message. However, the Society's attempt to get the Inquiry to support establishing birth control clinics did not work. Dr Thomas Corkill, one of the Inquiry Committee members, said that "When I [he] thinks of birth control I [he] think of the dwindling population of New Zealand which is very serious. It would be much better if we could find out why birth control is necessary and try to see whether that problem could be solved" (Submissions/Evidence presented to 1937 Committee of Inquiry into the Various Aspects of the Problem of Abortion in New Zealand (McMillan Inquiry), National Archives, cited in Smyth 2000). The McMillan Inquiry, in spite of being tasked with investigating abortions, was largely concerned with New Zealand's population. The eugenics logics underpinning policy were never far away in New Zealand. Instead of investigating the reasons for women obtaining abortions, they focused on blaming women for putting the Country's population at risk. The SH&BR Society were working to decrease abortions to prevent women from dying from septic abortions and were hoping to do so through increased sex education. However, the McMillan Inquiry was more concerned with women wanting to have fewer children and its implications for the Nation. The SH&BR Society were using their position to fight for women's survival and

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<sup>8</sup> A national investigation into the rising number of deaths from septic abortions.

the McMillan Inquiry were fighting for what they perceived to be national survival. Women's agency was the target of both groups, one supporting and one reshaping it into what they wanted it to be. The McMillan Inquiry, as policy makers, used their position of power to enforce their perspective on the issue (Wynn & Trussell, 2006), that women were damaging New Zealand by limiting their family size. This ultimately was an attack on women's agency and their freedom to control their fertility.

The report produced by the McMillan Inquiry spoke about the role of the state in maintaining the population, appealing "to the womanhood of New Zealand, in so far as selfish and unworthy motives have entered into our family life, to consider the grave physical and moral dangers, not to speak of the dangers of race suicide which are involved" (Committee of the McMillan Inquiry, 1937). This sent the country into a panic and blame for the declining population fell on women. "Until we bring women back to that old fundamental Eastern idea that motherhood is their mission, barrenness their disgrace, until we do that, or unless we do that, we can be prepared to write RIP over the short-lived race at present known as New Zealanders" (Dr Doris Gordon's evidence presented to 1937 Committee of Inquiry into the Various Aspects of the Problem of Abortion in New Zealand (McMillan Inquiry), National Archives, cited in Smyth, 2000). In its report, the Inquiry said that one of the ways to reduce the number of abortions would be to restrict the information given about birth control to medical channels. This meant that before the SH&BR society could establish a birth control clinic, they had to employ enough doctors to ensure that every patient was able to be seen and advised by doctors. This meant that the fledgling society had to put their goal of a birth control clinic on hold for a number of years.

As I have shown above, the McMillan Inquiry were invested in decreasing the number of abortions, not for the protection of women, but for the protection of the population of New Zealand as imagined by them – as a white nation. The concerns around the “dwindling population” and the “short lived race” of New Zealanders, shows how the McMillan Inquiry mobilised the fears around the preservation of the white New Zealander that the 1924 Committee of Inquiry into Mental Defectives and Sexual Offenders Report had first voiced in policy. This is a key example of how racial fears drove policy to prevent the desired white New Zealand woman from gaining access to contraception, while encouraging them to reproduce – to populate the country.

Because of the national awareness of birth control, abortion, and the deaths associated with the illegal abortions that was raised by the McMillan Inquiry, the SH&BR Society also became known by the wider public. They wrote newspaper articles and were often approached by women who were wanting to find out about birth control. The Sex, Hygiene and Birth Regulation Society decided to change their name in 1938, after being misprinted as the Sex, Hygiene and Girth Regulation Society. In order to change their name, they became an associated member of the British Family Planning Association, becoming the New Zealand Family Planning Association (Smyth, 2000).

In the 1930s, contraception and contraceptive information were still subject to the Indecent Publications Act 1910 and the Sale of Preventatives Prohibition Bill 1901. A new method of contraception that largely worked around these legislations, allowing women to start taking control of their own fertility and limit their family size, started to rise in popularity, called Natural Family Planning. The NZFPA were able to promote Natural Family Planning at the newly

established birth control clinic, as it provided a way for women to determine when they were likely to be fertile and avoid sex at that time. There are a number of different types of Natural Family Planning, including the so-called rhythm<sup>9</sup>, ovulation<sup>10</sup>, and temperature<sup>11</sup> methods (Blackwell et al., 2018; Fehring & Schneider, 2014; Royal Commission on Contraception, Sterilisation and Abortion, 1977).

While the establishment of the NZFPA birth control clinic was a progressive move, medical practitioners' lack of knowledge of contraception and available contraceptive technologies impacted the contraceptive choices that women were making. This changed in the late 1940s as the diaphragm became available. The diaphragm is a rubber cap that fits over the cervix, preventing sperm from entering the uterus. These became a reusable alternative for couples who chose not to or could not use condoms, especially with the stigma surrounding condoms. It also provided women autonomy, where they were able to make decisions on how and when to use protection and prevention from pregnancies, independent of their male partners. However, at the introduction of this technology medical practitioners were needed to fit the diaphragms and explain how to insert them. This became a problem, with a large number of medical practitioners, who were at that time, almost universally male, untrained, and unwilling to discuss contraceptive methods, while those who were willing and had knowledge of contraception were often unequipped and untrained in fitting diaphragms. The uncomfortable

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<sup>9</sup> Tracking when a woman is ovulating based on when her period is (Blackwell et al., 2018; Fehring & Schneider, 2014; Royal Commission on Contraception, Sterilisation and Abortion, 1977).

<sup>10</sup> Using the mucus secreted from a woman's vagina to determine when she is ovulating (Blackwell et al., 2018; Fehring & Schneider, 2014; Royal Commission on Contraception, Sterilisation and Abortion, 1977).

<sup>11</sup> Using slight changes in a woman's temperature to determine when she is ovulating (Royal Commission on Contraception, Sterilisation and Abortion, 1977).

nature of discussing this with their doctors often led to women to purchasing their own diaphragms, but not being able to use them properly fitted. Diaphragms became known as an unreliable contraceptive method (Brookes et al., 2013). When used alongside a spermicidal cream, they become a lot more effective, however they still needed to be correctly fitted (Watkins, 1998). In spite of this, the 1977 Royal Commission into CSA claimed, diaphragms were the most recommended form of contraception before the Pill was created (Royal Commission on Contraception, Sterilisation and Abortion, 1977).

The reason that general practitioners were often not able to give sufficient information regarding contraceptive options can be traced back to their training. Contraception had historically been relegated to the margins of medicine, thus was education and training around it. Dr Roger Ridley-Smith, who had been a medical student at Otago University in the late 1950s recalled that he had only received a single lecture on contraception, which was only a brief overview of the contraceptives on the market and being told that “nothing worked particularly satisfactorily” (Brookes et al., 2013). It was similar for Dr Margaret Sparrow in her time as a medical student in 1962, the same time as the Pill was introduced to the Country. She recalled that the lecture hall was full and “not just with medical students”, with the entire campus knowing about the lone lecture (Brookes et al., 2013; Smyth, 2000). This showed not only the interest that many university students had in contraceptive information, but also how much of an exception discussions, awareness and education around contraception were.

Women’s increasing demand for knowledge of contraception and the failure of medical practitioners to provide it, led to the NZFPA releasing their first sex education pamphlet in 1943 (Smyth, 2000). The NZFPA were able to work around the Indecent Publications Act of 1910.

Contraception was beginning to become more accepted, and more couples were starting to use the contraceptive methods available to them. The NZFPA's first birth control clinic finally opened in 1953 in Remuera, Auckland (Brookes et al., 2013; Smyth, 2000). This was a big win for the NZFPA and women around the country.

Within a year of the NZFPA opening their first birth control clinic came the Mazengarb Inquiry. In 1954, this committee was established to investigate "revelations of sexual immorality in the area of Lower Hutt" (Royal Commission on Contraception, Sterilisation and Abortion, 1977). The report of the committee found "a strong public demand that contraceptives should not be allowed to get into the hands of children and adolescents. Whatever views may be held concerning the use of contraceptives by older people (married or unmarried) no responsible father or mother could countenance their possession by their young sons and daughters" (Mazengarb et al., 1954). The Mazengarb Committee's perspective on contraceptives showed how attitudes towards contraception had evolved from the beginning of the century. However, this also raised the issue of who should be allowed access to contraception.

#### 1.4 ADAPTING POLICY

The Mazengarb Inquiry was a political response to around 100 charges of "indecent assaults on females" and "carnally knowing girls under 16" against 59 male youths following the arrest of the "Milk Bar Gang" following a tip by a teenage girl on the 20 July 1954 (Guy, 2009; Mazengarb et al., 1954). The Inquiry was launched on the 27 July 1954 and published their report on 20<sup>th</sup> September 1954. Copies were distributed to every household in the country. The

report attributed the “moral degradation” (Mazengarb et al., 1954) of young New Zealanders to slack censorship laws, state housing, working mothers leading to parental neglect, the lack of respect for religious values, and the introduction of contraceptives and sex education (Mazengarb et al., 1954). In order to address these causes of moral degradation the Police Offences Amendment Act of 1954 was put before Parliament on the 27<sup>th</sup> of September, passing on the 1<sup>st</sup> of October. The Police Offences Amendment Act 1954 made it illegal to give or sell contraceptives or contraceptive information to anyone under 16 years old. Anybody found doing so could be charged and fined or imprisoned. Any under 16s could also be charged and fined if they were found to have contraceptives (Royal Commission on Contraception, Sterilisation and Abortion, 1977). No allowance was made for medical practitioners, the NZFPA, or parents to provide information or devices should the child find themselves in need of contraception.<sup>12</sup> The timing of the Mazengarb Inquiry suggests that there was a concern around the activities of the NZFPA, as well as women’s visible presence on issues around contraception and female body autonomy.

The Police Offences Amendment Act 1954 prevented young people from using the newly established birth control clinics. Despite this set back, NZFPA clinics continued to be established around the country. NZFPA became a nationwide provider of contraception and sex education for those over 16. However, until 1972, the NZFPA remained unfunded by the Government. By funding the NZFPA, the New Zealand Government acknowledged the need for contraceptive information and that general practitioners were not always able to provide it (Brookes et al.,

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<sup>12</sup> The Mazengarb Inquiry is discussed in more detail in Chapter 2



2013; Smyth, 2000). The Mazengarb Inquiry and the following Police Offences Amendment Act 1954 continued the argument of who should be allowed access to contraceptives. Originally it was surrounding the race and physical fitness of parents but by this stage it moved on to age. The evolving image of the typical contraceptive user allowed the policy makers and political institutions to create narratives and structures to shape the contraceptive user into who they wanted it to be – married couples.

In the 1960s, two new forms of contraception were made available in Aotearoa, the Intra-Uterine Device (IUD) and the Pill (Brookes et al., 2013). The IUD became a popular method of contraception in the 1960's (Brookes et al., 2013; Royal Commission on Contraception, Sterilisation and Abortion, 1977; Smyth, 2000). The type of IUD that was most common was the Copper IUD which would be inserted into a woman's uterus using an introducer which, when removed, allows the IUD to spring back into shape, stopping it from coming out. The IUD requires a doctor to insert it. This brings with it some of the same issues as faced diaphragm use earlier. However, the major difference between the two was that the diaphragm requires an instructional process, whereas the IUD only needs to be inserted once. Furthermore, the 20 years that passed between the introduction of the two methods saw significant development in the patient-doctor relationship, improved contraceptive knowledge, as well as the introduction of different places that women could go to for contraceptive advice.

The Pill was introduced in Aotearoa in 1961, following the Federal Drug Administration's approval in the United States of America (the US) in 1960. The Pill had other therapeutic uses,

and brought with it other therapeutic hormonal medications, including Diethylstilbesterol, which eventually came to be used as a postcoital hormonal contraceptive.<sup>13</sup>

The 1977 Royal Commission into CSA stated that “the working of the IUD is still not fully understood. Because of this, doubts were expressed to us as to whether the IUD may achieve its anti-fertility action by causing detachment of the implanted blastula (abortion)” (Royal Commission on Contraception, Sterilisation and Abortion, 1977), although they later state that it “appears to exert its main contraceptive action on the uterus itself by inhibiting the process of implantation” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). For the IUD to be accepted as a form of contraception and not abortion, the Royal Commission had to accept and define pregnancy as beginning at the point of implantation, rather than at fertilisation.<sup>14</sup>

The next legislative change regarding contraceptives came following the Royal Commission of Inquiry into CSA, which began in 1975. The Royal Commission was established to review the abortion laws, following an unlawful police raid on an abortion clinic, which was attempting to prove that they were performing illegal abortions (Royal Commission on Contraception, Sterilisation and Abortion, 1977; Smyth, 2000). Prior to the Royal Commission, abortions were available for women who were referred to abortion clinics by doctors who believed that the pregnancy was a risk to the health of the pregnant woman.

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<sup>13</sup> The Pill and postcoital hormonal contraceptives are further discussed later in this chapter.

<sup>14</sup> This will be discussed in further detail in Chapter 4

It took two years for the Royal Commission to complete their investigation, which required multiple renewals of their Warrant of Inquiry, but its report largely ignored contraception. The little coverage there was focused on outlining the contraceptive laws with which New Zealand was operating and the contraceptive methods available, and the Commission made their preference for Natural Family Planning very obvious (Milne, 1977). The most significant recommendation made regarding contraception was to allow medical practitioners, parents and agents of the NZFPA to pass on contraceptive information and methods to people under 16 and that, if there was not already one, an NZFPA clinic should be established in each District Health Board (Brookes et al., 2013; Milne, 1977; Royal Commission on Contraception, Sterilisation and Abortion, 1977; Smyth, 2000).

Allowing medical practitioners to distribute contraceptive information to under 16-year-olds started to open up the conversation surrounding contraception. However, as previously explained, many general practitioners knew very little about contraceptive methods (Brookes et al., 2013; Smyth, 2000). This changed over subsequent years as the nationwide acceptance and usage of contraception increased. By allowing medical practitioners to distribute contraceptive information, this again allowed for the medicalisation of contraceptive users. In 1901 with the Sale of Preventatives Prohibition Act, medical control was placed over women's access to contraceptives. Here with allowing those under 16 to access contraception only through medical practitioners or parents – even though there was an increase in access – allowed medical practitioners to again become gatekeepers of contraceptive information, controlling that which under 16s had access.

The CSA Act of 1977 is the basis of the current contraceptive laws in Aotearoa. However, in 1990, the CSA Amendment Act was passed, removing all age restrictions around the sale and dissemination of contraceptives and contraceptive information ('Changes to Contraceptive Law Welcomed', 1990; 'Sex Advice Now Legal for People under 16', 1990). This change was largely supported within the community due to the rising numbers of teenage pregnancies and abortion, but there was still a public backlash against changing the law (Act Now Please, 1990; Armstrong, 1990; Burgess, 1990). Those who were against this amendment were largely arguing that the change would lead to loosening morals, increasing abortions and illegitimacy (Armstrong, 1990; Burgess, 1990), and causing the degradation of family and the parent-child relationship (Act Now Please, 1990; Burgess, 1990)<sup>15</sup>.

Throughout the twentieth century, policy and regulations surrounding contraception had evolved, going from a complete ban in 1901, to having no restrictions on access to contraception and contraceptive information in 1990. Nationwide inquiries investigating different aspects of contraception and abortion use arguments based around age, race, and the New Zealand population to create legislation controlling who has access to contraception. The changing attitudes that often led to the inquiries, also came along with evolving contraceptive technologies. The most influential of which was the introduction of the Pill.

Controlling the type of population by encouraging the nation's racial fears was a justification for preventing access to contraception to certain groups of people. However, as I have shown above, those advocating for access to contraceptives were also able to use racial fears to push

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<sup>15</sup> The discussions around family, morals and religion will be examined in Chapter 2

for the use of contraception for particular groups. These narratives were working in conflict with one another, even though they were arguing for the same thing. This shows the discriminatory and often contradictory nature of contraceptive discussions throughout the early twentieth century.

The medicalisation of women occurred with the gatekeeping position that medical practitioners were placed in with the Sale of Preventatives Prohibition Act of 1901. Although married couples using contraceptives became accepted toward the middle of the twentieth century, the arguments over who should be able to access contraception continued, moving from race and physical and mental fitness, to age, resulting in the medicalisation and control of under 16s' bodies as contraceptive users.

Contraceptive policy in Aotearoa has changed following nationwide inquiries examining immorality or illegal actions. These legislative changes were driven by arguments around age, race, and population. While the contraceptive legislation was changing, the contraceptive technology that was being introduced and used was also changing. The development of new contraceptive technologies reflected the changing attitudes towards contraception, along with the changing need for contraception and new technologies.

## 1.5 ORAL HORMONAL CONTRACEPTIVE HISTORY

### 1.5.1 Oral Contraceptive Pill

The acceptance of contraceptive technologies in Aotearoa largely mimics those of larger countries. The acceptance of contraceptive technologies internationally led to the development

of hormonal medications and contraceptives. Research into hormonal contraceptives culminated in the creation of the Pill.

Prior to the creation of the Pill, the available contraceptive options were not very effective. This was largely the result of research into contraceptives being illegal in most countries (Marks, 2001). In the United States, contraceptive research was illegal, however, with significant financial backing, researchers were able to work around this to develop the Pill.

The researchers involved in the development of the Pill – particularly the male, American researchers, John Rock and Gregory Pincus - are often praised for risking their careers and freedom by undertaking this work.

Of all the great works that men have undertaken for women, [the pill] must surely rank amongst the noblest. The work was instigated at a time when financial reward was very slight and the risks considerable. It was done in the teeth of social disapproval and in the teeth of great apathy on the part of the medical profession at large. The first men who devised those things at such risk to themselves must one day be named and honoured by all women as the “instigators of the revolution”.

(Biezanek, 1965, quoted in Marks, 2001).

Dr Anne Biezanek, a British, Catholic doctor, was very public in her disagreement with the Catholic church’s stand on contraception. The Catholic Church was, and still is, publicly against the use of artificial measures of preventing pregnancy, whereas Biezanek supported and encouraged the use of artificial contraceptives, in spite of her Catholic roots. Biezanek’s views on the men who developed the Pill were common. They reflect the idea that women were passive recipients of the technology designed by men, and that the potential women consumers were the only ones benefiting from the development of the Pill, ignoring male

partners (A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; VanSickle-Ward & Wallsten, 2020). This narrative has also not sufficiently acknowledged the involvement of women in this research (Marks, 2001; VanSickle-Ward & Wallsten, 2020; Watkins, 1998).

The development of the Pill was started and funded by women. One of the most influential was Margaret Sanger, whose own mother's health had suffered after having a large number of children. Sanger believed that:

Science must make woman the owner, the mistress of herself. Science, the only possible saviour of mankind, must put it in the power of woman to decide for herself whether she will or will not become a mother.

(Quoted in Marks, 2001)

Originally, Sanger had tried to train as a doctor but was not allowed to enrol in medical school due to the sexual discrimination within education at the time. This led her to training as a nurse, marrying soon after. Sanger expressed the need for a pill that would control whether a woman was able to get pregnant and found an ally in Katherine Dexter McCormick, a wealthy feminist (Marks, 2001). She married into a very wealthy family, however, following her husband's diagnosis of schizophrenia, she was able to gain control of her husband's estate. With her husband spending the rest of his days in a mental hospital, McCormick turned to advancing women's rights (Marks, 2001; VanSickle-Ward & Wallsten, 2020; Watkins, 1998).

Through mutual friends at the Planned Parenthood Federation of America, McCormick and Sanger met Gregory Pincus, a biologist who had a background in fertility research. At this meeting, Sanger convinced Pincus that he should turn his work to contraception and McCormick offered the funds to complete the research. Gregory Pincus worked with Dr John

Rock, a Catholic Obstetrician and Gynaecologist, on the development of the Pill. Pincus himself later acknowledged that he had “invented the pill at the request of a woman” (Marks, 2001).

Once the knowledge of the creation of the Pill spread, a number of women, mostly from America, wrote to the researchers asking to be a part of any trial they might run (Marks, 2001; Munro Prescott, 2011; Watkins, 1998). However, by this time, human trials were mostly completed. Very few human trials were ultimately run. Most trials were held in Puerto Rico and Haiti, smaller countries with less restrictions surrounding contraceptives and contraceptive research. Trials in Puerto Rico were done on a number of populations ranging from medical students who were told that if they did not participate their grades would be affected (Watkins, 1998) to officials encouraging women to have fewer children because of overpopulation (Watkins, 1998). The trials in Haiti were also run through governmental officials attempting to curb overpopulation (Watkins, 1998). There were also trials held in the United States, however, these used the vulnerable population of a Massachusetts Psychiatric Hospital.

Historians writing on this encourage readers to see how these trials and research followed the standards of the 1950s (Marks, 2001; Watkins, 1998). The research responsible for developing the Pill occurred while current research ethics guidelines were being formed. This was before the Tuskegee Syphilis Study was uncovered and the Declaration of Helsinki was written but after the Nuremberg Code was created following the Holocaust. The Nuremberg Code (1947) said that “the voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice”. This places this research within a time where it had been acknowledged that research on people required the person’s full knowledge



of what was happening and their permission. However, the attitudes of the researchers and doctors running these studies had not caught up with these requirements. The resulting research was often done without explaining all the risks to the people involved and by using the most available group, who were not always in a position to question the researchers or walk away from the study. There are a number of cases that show these attitudes, including the Aotearoa Cartwright Inquiry.

Following these trials, the Pill was soon approved by the US Federal Drug Administration and available for prescription in America in 1960 (Watkins, 1998). With the usage of contraception becoming largely accepted in 1950s America, the Pill was welcomed (Marks, 2001; Watkins, 1998). While the Pill was initially more accepted and used in English-speaking countries, by the end of the decade its popularity had spread throughout Europe (Marks, 2001). When the Pill was introduced in Aotearoa in 1961, there was a rapid uptake (Brookes et al., 2013). The usage of the Pill was described as “phenomenal” (‘Pill Slashes Birthrate’, 1965) and the National Government became worried about the population of New Zealand not growing, echoing the sentiments and concerns around contraception from the early twentieth century.

As increasing numbers of women came to use the Pill, side effects also became apparent. Almost immediately, the Pill was linked to blood clots and, within the next few years, questions arose whether the Pill was linked to cancer. While the risks of blood clots forming could be lowered by dispensing a Pill with a lower dose of oestrogen, the question of whether the increased amount of oestrogen would increase the likelihood of cancer remained unresolved for years (Marks, 2001; Watkins, 1998). This contributed to the diminishing popularity of the Pill in the 1970s, and to criticism of the researchers.

The researchers involved in the development of the Pill have been criticised for the clinical trials they did run, taking issue with the subjects of the trials and the limited number of clinical trials (Marks, 2001). The use of women in psychiatric hospitals and in countries with less access to health care in the Pill trials has been criticised by feminist authors as these groups are less able to give informed consent. Feminist authors also argued that women were being used as “unwitting guinea pigs” (Marks, 2001) because there were so few human trials done to determine the effectiveness and safety of the Pill. Historians have challenged this idea by both shedding light on the women who were involved in the process of developing the Pill, and also by changing the narrative of women’s passivity (Marks, 2001; Watkins, 1998). Marks (2001) also addressed the women who were involved with the clinical trials, claiming that sociocultural factors did not affect the choice of trial subjects. However, as previously discussed, the lingering American anti-contraceptive research laws, convenience for the researchers and government attitudes towards overpopulation all played a role in how decisions about where to hold trials were made.

The changes in attitudes to sexual freedom that came through the 1960’s and 1970’s, also known as the sexual revolution, have been credited directly to the introduction of the Pill (Brookes et al., 2013; Munro Prescott, 2011; Watkins, 1998) and, more recently, that its introduction allowed women to start thinking about their lives as more than as mothers and wives. This also allowed the separation of sex from reproduction, bringing the discussion around reproduction into the sphere of ‘choice’ and ‘rights’ (Brookes et al., 2013). However, this discussion of reproductive choice and right highlights issues regarding unwanted pregnancies including both how to prevent them and how to end them.

### 1.5.2 Emergency Oral Hormonal Contraception

One of the ways that was discussed to prevent unwanted pregnancies was some form of postcoital emergency contraception. One of the first forms of recognised postcoital contraception was menstrual extraction. Menstrual extraction involved inducing a period by suctioning the uterus. This method was used to induce periods, not specifically for contraception. However, it became viewed as a “very early termination of pregnancy” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). This was because it was often used for inducing periods that were up to 14 days late, suggesting that there is a chance that the woman is already pregnant. The contents of the uterus that could be suctioned out include the lining of the uterus and any present developing embryo that at that stage would be a small bundle of cells.

This technique falls into the grey area between abortion or contraception, largely because it was often performed without first testing for pregnancy. The 1977 Report of the Royal Commission of Inquiry into CSA states that there was no evidence suggesting that menstrual extraction was practised in Aotearoa (Royal Commission on Contraception, Sterilisation and Abortion, 1977). However, the Royal Commission clearly felt as though it was an important method to discuss under the “Commonly existing forms of contraceptive techniques” section. By including menstrual extraction as one of the “Commonly existing forms”, they contradicted themselves, first, when they described it as a form of termination rather than contraception, and second when they said that it was not practised in Aotearoa. Also there was more space devoted to menstrual extraction than was given to diaphragms and condoms (Royal Commission on Contraception, Sterilisation and Abortion, 1977). By doing this, the Royal

Commission has allowed menstrual extraction to be seen with more relevance than some other, less controversial contraceptive techniques.

Another early form of emergency oral hormonal contraceptive was synthetic oestrogen in the form of the medication Diethylstilbesterol (DES). DES was originally developed in the 1940s and used to help prevent miscarriage, premature labour, and other pregnancy complications, and eventually came to be used as emergency contraception. For emergency contraception, the first dose of DES had to be taken within the first 72 hours following unprotected intercourse, then a dose taken for each of the following five days. DES became labelled as a postcoital contraceptive in the United States in 1975 (Schmidt, 1975; 'What They Don't Tell You', n.d.). Although we cannot be sure when DES was first used in as a postcoital contraceptive in Aotearoa, it was still the emergency contraception available in 1977, when the Royal Commission produced their report. This was in spite of it becoming apparent that DES is carcinogenic, found to "cause cancer [usually cervical, ovarian or breast] in 25% of the female offspring" ('What They Don't Tell You', n.d.) of women who took it during pregnancy. In spite of this, the 1977 Royal Commission labelled the side effects as "more unpleasant than dangerous" (Royal Commission on Contraception, Sterilisation and Abortion, 1977). In Aotearoa, it was well known that DES caused "severe side effects such as nausea and vomiting" ('What They Don't Tell You', n.d.) but many women were willing to risk if it meant preventing pregnancy. However, with this new knowledge of the carcinogenic risk, women and doctors, both in Aotearoa and the rest of the world, avoided DES and prescriptions fell (Munro Prescott, 2011).

With women not wanting to use DES, there was a need for a new type of emergency contraception. A Canadian student health doctor, Dr Albert Yuzpe, decided to address this. He

knew that doctors in Hong Kong had been using the synthetic progestogen, Levonorgestrel (LNG) as an emergency contraceptive and had found that the LNG use had fewer side effects than use of oestrogen-based compounds. Yuzpe decided to start a trial investigating the use of a combined hormonal contraceptive pill as a form of postcoital birth control. The combined hormonal contraceptive pill has both synthetic oestrogens and progestogens and is the most effective form of the Pill. Yuzpe's investigation, across 1972 and 1973 used patients from the student health centre where he worked. University students were considered a community at risk for having unwanted pregnancies (Brookes et al., 2013; Munro Prescott, 2011). In this trial, Yuzpe found that four doses of the Pill containing a combination of oestrogen and Levonorgestrel (LNG), with the first two taken within 72 hours of having sex and the other two 12 hours later, was as effective as the DES form of the ECP with fewer severe side effects and fewer doses. This use became known as the Yuzpe regimen (Munro Prescott, 2011; Task Force on Postovulatory Methods of Fertility Regulation, 1998).

The Yuzpe regimen was first published in 1977 (Sparrow, 1979). In Aotearoa, it was known of but was not widely used until the 1980s prescribing doctors' trust of the effectiveness and safety of the regimen grew. The regimen was used across the world. However, in Canada and the United States, the Yuzpe regimen remained relatively unknown. In order to have the Pill repackaged and remarketed as an ECP, drug companies would have had to reapply to the FDA and go through the full trial process to prove the drug safe for intended use. Because the drug companies were unwilling to go through this process, very few medical practitioners in these two countries were aware of this new form of ECP, even within Planned Parenthood, because as a federally funded medical institution they cannot supply medication for a purpose that is

not FDA-approved. It was only in 1994, when an executive from Planned Parenthood spoke on a televised broadcast, that many in the United States became aware that there was an alternative version of an ECP to DES (Munro Prescott, 2011). At the same time, in Aotearoa, the NZFPA and Contraceptive Choice<sup>16</sup> were pushing to increase public knowledge of emergency contraception, the opportunity to do so arising from the CSA Amendment Act 1990 lifting restrictions surrounding age and contraceptive information (Barnes, 1990; 'Morning After Pill Effective Alternative', 1990).

The current form of the ECP used in Aotearoa contains only LNG, which was part of the Yuzpe Regimen. However, in the 1990s, the World Health Organisation (WHO) ran a global study comparing LNG and the Yuzpe Regimen. This study found that LNG is just as effective as the Yuzpe Regimen, but with fewer side effects and doses. This study resulted in LNG becoming the global standard ECP (Task Force on Postovulatory Methods of Fertility Regulation, 1998). Along with the LNG, Copper IUDs can also be used as a form of postcoital emergency contraception. For the Copper IUD to be used as an emergency contraceptive, it must be inserted within the first 72 hours after sex and be planned to be used as a long-term contraceptive (Munro Prescott, 2011; 'Popular Misconceptions Surrounding Emergency Contraception', 1991; Smyth, 2000).

## 1.6 CONCLUDING COMMENTS

This thesis is a feminist historical mapping of the landscape of the society of Aotearoa, which allowed for the large uptake of the Pill in the 1960s. Each of the events described in this chapter

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<sup>16</sup> Another contraceptive information group.

show the struggle between different groups for women's bodily autonomy. The medicalisation of women and contraception in Aotearoa was one of the most influential ways in which contraception was controlled. However, it was the policies and legislation, driven by eugenics and population control, that were most influential on women's agency and relationship with contraception throughout the twentieth century. The next chapter explores how family and religious morality were mobilised, within the events I have discussed, in order to shape women's relationship with contraception.

## 2 CHAPTER 2: FAMILY, MORALITY AND RELIGION

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In the previous chapter, I outlined events that occurred throughout the twentieth century that contributed to the position of contraception in Aotearoa. This chapter explores the way family, morality and Christianity have influenced those involved in these events. The Western family unit has been shaped by the Christian faith, bringing with it what many call family morals, resulting in family, morality and Christianity becoming intertwined. When analysing archival data, I found this trio drove most arguments within historical contraceptive conversations. The primary data I am drawing on in this chapter include the NZFPA archives, online newspaper databases PapersPast and Newztext, and the reports of the Mazengarb Inquiry and Royal Commission investigating CSA.

Throughout this chapter I draw on Feminist STS literature engaging with the way society is adapting to protect the nuclear family (van Wichelen, 2014, 2016), along with the way motherhood is shaped within western society (Hubbard, 2001; Wajcman, 2001). The gender roles associated with contraception are also explored (van Kammen & Oudshoorn, 2002; Wynn & Trussell, 2006), as are power relationships surrounding contraceptive education and how this has impacted adolescents as contraceptive users (Munro Prescott, 2011; van Wichelen, 2014; Wynn & Trussell, 2006).



## 2.1 THE SETTLER COLONIST FAMILY

Prior to the arrival of European Colonists, and the beginning of the decimation of the Māori culture, the Māori family unit was a communal whanau where the whole community would work together to raise children (Le Grice, 2014). However, the introduction of the European family, urban centres and societal expectations started to change this. Māori communities were forced to change the way they existed. Legislation was put in place to stop Māori cultural practices and drive iwi and hapū apart. This resulted in the 'typical' New Zealand family becoming based on the classic British unit of father, mother, and children. However, this unit differs from the British unit because it would often be larger, with lots of children, reflective of life in European colonies. Families were encouraged to be bigger and have more children out of a perceived need to populate the new land with the desired people and, because at the beginning it was mostly rural farm work, out of a need to help the family and budding society survive (Le Grice, 2014; Pool et al., 2007; Smyth, 2000).

A number of changes within society are reflected in changes to the Pākehā family over the past century. The original settler era was defined by several characteristics, including how common early marriage was and couples started to have children soon after marriage. This, in turn, allowed time for the couple to have a large family. This was compounded by the types of contraception that were used. In this period, the only contraceptive measures that were available were withdrawal and very untrustworthy barrier methods, like the early forms of condoms (Pool et al., 2007). Pākehā families also had an extended family component, when the multigenerational extended family would often live close by, providing support as needed. This

differs from the precolonial Māori family unit because each Pākehā family would live individually, with the access to extended family support as needed, rather than the shared responsibilities within the Māori communities (Le Grice, 2014; Pool et al., 2007).

At the beginning of the twentieth century, families started to decrease in size and couples moved away from parents and extended family support to the quickly developing urban areas. Couples started to get married later and have children later, resulting in fewer children than previous generations. This also coincided with the Great Depression, when couples were unable to afford large families, the rising popularity of fertility control and abortion. The reduction in extended family support facilitated the rise of the nuclear family. Thus, forming the family of married mother and father, and children (Pool et al., 2007).

The next societal change that shaped the family in Aotearoa was the transition in mid-century away from the nuclear family to greater diversity including unmarried parents, single parent families and families split by divorce. This coincided with the development and introduction of the Pill and other improved methods of contraception. These new contraceptive methods also aided couples in delaying having children, decreasing the time that couples were able to have children, which in turn decreased the size of the family (Pool et al., 2007). This was followed by the current period, where family formation is at historically low levels, other areas of life such as work becoming more important to people than having children, together with the increase of same gender couples and developing reproductive technologies (Pool et al., 2007).

The maintenance of the nuclear family, in spite of the way family has evolved, has remained a priority for those in positions to protect. Reproductive technologies and legislation surrounding them have evolved in order to protect and maintain the nuclear family (van Wichelen, 2014, 2016). Van Wichelen (2014) and (2016) explores the way adoption medicine and international surrogacy have evolved to support and encourage family production through the use of these unconventional family forming practices. Those who are involved in the legal and medical aspects of these family forming practices often support them by arguing that those involved have the “right to family life” (van Wichelen, 2014, 2016). This shows that, although we are moving away from the traditional nuclear family, it is still central to Western Society and many believe that it requires protection. Above, I show how the family has evolved in Aotearoa, and how, even through societal changes, the nuclear family has become a central tenet of Aotearoa society.

### 2.1.1 Moral and Christian Influence

These societal shifts are not the only ways in which the family in New Zealand has changed over the years since colonists first arrived. Some of the major impacts include introducing the patriarchal gender hierarchy and pressuring Māori to “assimilate to Pākehā norms and values” (Le Grice, 2014). Also, colonists arriving in Aotearoa came attempting to “save the souls” of Māori with the introduction of Christianity (Le Grice, 2014; Pool et al., 2007; Smyth, 2000). Many of the first settlers were Missionaries, coming to spread Christianity, which included disciplining the “immoral” and “savage natures” of wāhine Māori<sup>17</sup> and attempting to make

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<sup>17</sup> Māori women.

“the Māori woman’s body to appear to be more Christian” (Le Grice, 2014). This patriarchal control of wāhine Māori bodies was just one way that Christian morals were introduced to Aotearoa. Another way that Christian morals made an impact in early settler and Māori communities was through the blessing of heterosexual marriages, however, that had the legal impact that the husband gained “property rights over women and children in the family” which was not tikanga Māori<sup>18</sup> (Le Grice, 2014).

All of the ways in which Christianity worked to subvert tikanga Māori resulted in the developing settler colonial New Zealand society becoming based on Christianity and Christian morals, particularly those surrounding family. In the 1950s, the Mazengarb Inquiry acknowledged this: “the structure of western society and our codes of behaviour have, in fact, been based upon the Christian faith” (Mazengarb et al., 1954). Christianity is the basis for our moral system, and the Royal Commission investigating CSA also acknowledged this by stating that “without religion there can be no morality and that without morality there can be no law...but it would be unrealistic to relate morality solely to religion or to regard religion as the only source of morality” (Royal Commission on Contraception, Sterilisation and Abortion, 1977).

Morals imparted by parents to their children are discussed as family morals. Family morals and family units have been considered under threat by numerous secular organisations and church groups. There are multiple groups, including the United Nations, that have pledged to protect the family unit as a basic structure of society (United Nations, 1948). A number of

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<sup>18</sup> “Correct procedure, custom, manner and practice, pertaining to Māori” (Le Grice, 2014)

groups were created in Aotearoa throughout the twentieth century in order to protect the morals of society and family. Some such groups are:

- Society for the Protection of the Unborn Child (SPUC)
- Society for the Promotion of Community Standards (SPCS)
- Family Rights Association (FRA)
- Concerned Parents Association (CPA)
- New Zealand Organisation on Moral Education (NZOME)
- Credo
- Coalition of Concerned Citizens (CCC)

Not all these groups are linked to religious groups. However, “the most significant underlying feature among all these groups is their discourse and use of the family as an important ideological principle” (Ryan, 1986). Each group focuses on family through their own particular lens. SPUC focuses on preventing abortion. FRA and CPA both focus specifically on the protection of family morals through the prevention of homosexual law reform, abortion, and sexual education. SPCS wanted to maintain the societal moral standards to prevent access to pornography, abortion, and sex education, along with the prevention of homosexual law reform. Credo and CCC both focused on monitoring societal morals through censorship of education and media (Ryan, 1986). Although each of these groups were working to protect societal and family morals in their own ways, each was focused on issues relating to sex and contraception.

There were also a number of Christian churches that were advocating for maintaining the societal morals from prior centuries. Some of the most prominent were the Catholic Church, Mormon Church, Jehovah Witness, and the Apostolic Church. Within the teachings of the Apostolic Church, a central tenet regarding the preservation of morals and values regarding sex was,

the social and moral health of the nation is intrinsically connected with the quality of its family life. Therefore the Church is committed to protecting and enriching the family unit. The ideals of chastity before marriage are upheld and divorce and remarriage in the Church is possible only in the event of the moral death (as defined by scripture) of the original marriage,

(Donovan, 1985).

Above, I show how Christianity has become the dominant influence on the way societal morals have been formed in New Zealand. Becoming this dominant influence has placed Christian morals in a position where they are able to shape morals going beyond societal, to family and personal morals. This position within personal morals has allowed groups to develop surrounding a common morality in order to enforce this moral position within a wider group of people. The thought process behind these groups is similar to the one used by the Colonial Christians when they were placing their own moral positions and requirements over wāhine Māori (Le Grice, 2014). This shows these ideas go beyond the actions of the colonial missionaries of the nineteenth century.

## 2.2 PARENT AND GENDER ROLES

Since contraception became a public conversation, family, morality, and religion have all been mobilised to play an important part in New Zealand's acceptance of different methods of

fertility control. At the beginning of the twentieth century, when contraception first became a topic of conversation and in the middle of the first form of the settler colonist family, women were confronted by the 'populate or perish' narrative (Cronin, 1977; Smyth, 2000) and any women who were not married were often labelled "superfluous women" (Rout, 1914). These narratives all incorporate the expectations that women would marry and have a family without delay. Using contraceptives would have meant that women would be working against family and the nation.

### 2.2.1 Eugenics and Family

With the beginning of the twentieth century, new social concepts came to New Zealand. One of these concepts, eugenics, helped form groups that are still active today. Two such groups are the Royal New Zealand Plunket Society (Plunket) and the NZFPA. The NZFPA, along with a number of its international counterparts, was able to use eugenics movements as a way of furthering their own agenda to start birth control clinics for women wanting to control their own fertility (Marks, 2001; Smyth, 2000). As discussed in the previous chapter, Eugenics wanted to establish birth control clinics. Although the NZFPA used the eugenics movements to further their own agenda, they were not founded on the principles of eugenics.

In contrast to the NZFPA, Plunket was established to uphold the founder's eugenic beliefs. In 1907, Plunket, formerly known as the Society for the Promotion of the Health of Women and Children, was established by Dr Frederic Truby King. Its original purpose was to act as a place for information for new parents who needed to know how to take care of their babies, having moved into urban centres, away from the extended family knowledge base. The information

that was passed onto these new parents was of Truby King's own design and involved a strict regimen of sleeping, feeding, and excreting. This regimen also encouraged parents to refrain from showing affection for their children.

Lady Victoria Plunket, wife of the New Zealand Governor of the time and mother of eight, became the patron of the Society for the Promotion of the Health of Women and Children. The Society then changed their name to the Plunket Society to honour her. By this time, Plunket had established clinics around the country, mostly in denser urban environments (Smyth, 2000). By keeping Plunket urban, many poorer and Māori communities who were living outside of these areas were excluded from access to the facilities (Smyth, 2000). Truby King's ideas were considered a great help to new parents and Plunket offered support for a lot of women around New Zealand, many women later choosing to become volunteers for Plunket (Brookes, 1993).

Because of the effect that Truby King had on the health of babies, he was given a platform to spread his eugenicist ideas regarding race and gender. In his first lecture in Dunedin in 1905 called "Race Preservation: Infant Mortality and It's Causes", Truby King blamed the high infant death toll on parents, particularly mothers who do not want to breastfeed and stated that the only way to save the race of white New Zealander from extinction was to decrease infant mortality (Truby King, 1905a, 1905b). This was a different way of approaching the population problem, instead of trying to increase birth rates, do more to stop infants from dying (Brookes, 1993).



Within a couple of years, Truby King had become well known across the entire country. In 1909, Truby King, along with Dr Frederick Batchelor, gave one of his most controversial lectures, the “Vitality of the Race”. In the “Vitality of the Race”, Truby King and Batchelor both put forward their views of women’s education, neither supporting education of girls beyond the age of 11 in anything more than the skills needed in homemaking (Batchelor and Truby King, 1909). Truby King believed that humans have a limited capacity and that “girls should not be encouraged to cram subjects that were unnecessary and foreign to their nature” (Batchelor and Truby King, 1909) and that by educating girls, it was expending energy that was needed for later childbearing and child rearing. This logic resulted in the idea that educating women was harmful to racial welfare, preventing them from increasing the birth rate and raising healthy children (Batchelor and Truby King Batchelor, 1909; A. Bennett, 1909; Brookes, 1993).

Plunket and Truby King changed the way children of New Zealand were raised and Truby King was awarded for his work, being knighted in 1925. During his life, and since, Truby King has largely avoided criticism of his eugenicist and sexist attitudes, instead being praised as a hero and visionary (Brookes, 1993). Following his death, Plunket quickly removed itself from these ideals, but acknowledged the role they played in their past, allowing them to remain a feature of the societal and family structures in Aotearoa.

In spite of both the NZFPA and Plunket’s eugenic beginnings, they have been and still are two of the most influential organisations in Aotearoa society and family. Both of these organisations advocated for different ideas that we now recognise as eugenics. These ideas were integral to how it was historically thought that the New Zealand family should operate.

Eugenics was a scientific concept that has since been disproven. However, in Aotearoa, it has had a lasting impact, both through the way these institutions have worked to shape family, and through the lasting impact on the way contraception is viewed, accepted, and discussed, especially regarding population control. Contraception has globally held this position and has been used as part of global eugenics and population control movements (Marks, 2001; Takeshita, 2012).

### 2.2.2 Mothers

Women and mothers have been the ones tasked with maintaining the settler colonial family morals. As societal morals have evolved, women, particularly mothers, have been criticised for allowing these changes to occur. This happened throughout the twentieth century, first regarding the increasing numbers of abortions, and then with the “increasing immorality in children” (Mazengarb et al., 1954).

In 1936, a Commission was launched by the first New Zealand Labour Government, investigating the increasing numbers of septic abortions. This Commission was headed by MP Dr D. G. McMillan –later known as the McMillan Inquiry. Dr McMillan, in his report stated that the previous National Government “would have to accept the responsibility for the alarming increase in the number of deaths from septic abortions [sic] during the depression years, as it had failed to guarantee the workers an economic wage” (Otago Daily Times Parliamentary Reporter, 1936). These criticisms of wages became a highly debated issue in Parliament, with National MPs arguing that the minimum wage decrease that came along with the Great Depression did not cause a rise in septic abortions, even arguing that there had not been any

increase in septic abortions in married women but not commenting on the deaths of women ('Industrial Laws. Amending Bill Debate in House', 1936; Otago Daily Times Parliamentary Reporter, 1936). This debate shows that there was finger pointing happening at the policy and national decision-making level, with little to no change happening to help the individual women who needed it or changing policies that might help to prevent women from being in the position where they felt the need to have an illegal abortion in the first place.

The debate amongst the politicians was focused on blaming other politicians. However, those presenting to the McMillan Inquiry, as well as the report itself, placed most of the blame on women and mothers. The report called women "selfish" for going through with abortions and allowing "unworthy motives" to enter family life (Committee of the McMillan Inquiry, 1937). In the presentations to the Committee of Inquiry, Dr Doris Gordon spoke about how it should be impressed on women that "motherhood is their mission, barrenness their disgrace" (Dr Doris Gordon's evidence presented 1937 Committee of Inquiry into the Various Aspects of the Problem of Abortion in New Zealand (McMillan Inquiry), National Archives, cited in Smyth, 2000)<sup>19</sup>.

Following the McMillan Inquiry, the next time women were officially criticised for not maintaining family morals was in the Report for the Mazengarb Inquiry. The Mazengarb Inquiry was investigating the rising immorality in adolescents. They blamed this on the loss of religion and family morals within family. One of the main reasons they gave for this was the absent mother. The Report placed absent mothers in three distinct groups. The first was the mother

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<sup>19</sup> These positions are presented more fully in Chapter 1.

who works, maybe to earn money to live, however, it could also be “because they prefer the company at an office, shop or factory to the routine of domestic duties” (Mazengarb et al., 1954). The second was the mothers “who extend their social, and even their public, activities beyond the hour at which they should be home to welcome their children” (Mazengarb et al., 1954). The third was the mothers “who give their children money to go to the pictures, while they themselves go to golf, or to a football match, or to pay a visit to friends” (Mazengarb et al., 1954). The Report acknowledges that “fathers are not free from blame” (Mazengarb et al., 1954) although, this acknowledgement lacks the same specificity. This shows the level of sexism in gender roles that was accepted at a national level, along with the different weighting put on motherhood compared to fatherhood.

Motherhood and family have been shaped by these family morals prominent in western societies. The positions of those in the McMillan and Mazengarb Inquiries would have enabled them to consider the changing society and how their reports may impact those who were subject to these changes. The McMillan Inquiry with families not being able to afford to continue to grow in size, and the Mazengarb Inquiry, with increasing numbers of single and divorced parents. Neither of these inquiries took into consideration the way their reports would impact individuals. Instead, the individual members imposed their own morality on the women who were either turning to abortion as a last resort, or on mothers who were working to feed their families.

### 2.2.2.1 Family

The Report of the Mazengarb Inquiry concluded that the cause of the rising “moral delinquency in children and adolescents” was the degradation of the nuclear family. The report does not define what moral delinquency is, however, in this case it is interchanged with sexual delinquency and sexual immorality. Some of the specific causes mentioned in this report are that,

during the past forty [since 1914] years new concepts have entered into society. These concepts resulted from the unsettlement following two world wars. The changes were the increased use of contraceptives, the broadening of the divorce laws, an increase in pre-marital relations, and the spread of new psychological ideas, (Mazengarb et al., 1954)

The Mazengarb report also placed responsibility with “tension in the household, separation of the parents, lack of training for parenthood, the absence of parental sense of responsibility or poor discipline all help to create an unsatisfactory home environment... This unsatisfactory environment or feeling of being unloved is productive of much delinquency”. Along with working mothers, the “decline in certain aspects of family life because of a failure to appreciate the worth of religious and moral sanctions” was also to blame (Mazengarb et al., 1954). The report also raises the position that “no responsible father or mother would countenance their [contraceptives] possession by their young sons and daughters” (Mazengarb et al., 1954). This shows that the Mazengarb Inquiry considered the western nuclear family to be the most important aspect of society, however, only as they saw it. The nuclear family has been viewed in a particular way – mother, father, and children, ever since the concept was created, however, it has been evolving (Aikman, 2019; Pool et al., 2007; van Wichelen, 2016). The

Mazengarb Inquiry condemned families that did not fit into the traditional mould that they were attempting to impose on all families in New Zealand.

The Mazengarb Report discussed extensively the lack of appreciation for religion and morality. They endorsed the practice of family religion because “a real religious atmosphere is a good safeguard against immorality” (Mazengarb et al., 1954). However, the Report condemned the attempt made by scientists of the early twentieth century to move away from the “religious standard” to “a code of morals entirely devoid of religious content” (Mazengarb et al., 1954). They recognised that the view of scientists was not the cause of the drift away from organised religion, but they believed that it accelerated this shift. However, the Mazengarb Committee blamed science and scientists for the “moral chaos” that was occurring at the time (Mazengarb et al., 1954).

The Mazengarb Inquiry views were still present two decades later when the Royal Commission into CSA took place, starting in 1975 and ending in 1977. The Royal Commission heard submissions from a number of individuals and groups that ranged from feminist groups to religious groups, to health organisations, to anti-abortion groups. Each of these groups played a role in the final report. The Royal Commission were led by these submissions to write on topics outside their terms of reference.

One such topic is the Aotearoa family about which the Commission said that the reason they commented outside of their terms of references was that:

A number of individuals and organisations who made submissions to us [the Commission] on contraception, sterilisation, and abortion stressed the importance of the place of the family in society. Undoubtedly the family has been the basic unit of

society. It has been the centre of religious, educational, and recreational activity. Its importance has been stressed in Judaeo-Christian teaching, although it is fair to say that its influences have transcended religious boundaries.

(Royal Commission on Contraception, Sterilisation and Abortion, 1977)

The Royal Commission quoted the United Nations Universal Declaration of Human Rights when discussing the importance of family to society. “The family is a natural and fundamental group unit of society and is entitled to protection by society and the State” (United Nations, 1948). This idea of the family group being given protection by the State has been used to explain and justify the legislative changes regarding anything that has been deemed a threat to the family. This ranges from alcohol to state housing to contraception (Mazengarb et al., 1954).

This makes the Western nuclear family the object of social concern, often driving political change. The state protection of this nuclear family continues through to today (van Wichelen, 2016). This shows that in spite of the change in what was morally condemned by society, the nuclear family has remained a component of society that political institutions, such as the Mazengarb Inquiry and the Royal Commission, were working to protect.

### 2.2.3 Gender Roles in Contraception

Women have always been the ones who are primarily responsible for their individual fertility control. Fertility control has taken many forms, however, most of them result in the prevention of ovulation or induction of periods (Koblitz, 2014). In more recent years, with the acceptance of contraceptive methods like condoms, men have become more involved in the use of contraceptive methods, although women still remain the primary users of contraceptives

(Koblitz, 2014) and men have continued to still place responsibility with women (Snabely, 1990).

Following the CSA Amendment Act 1990, which allowed the introduction of sex education, a number of individuals and groups expressed their concerns. Women For Life believed that sex education was the wrong way to prevent unwanted pregnancies. A letter to the Editor of the Auckland Star, suggested that the only way to prevent unwanted pregnancies was “if sex education was only taught to females. The younger the better” and “ladies can solve this problem [unwanted pregnancies] by being taught to say ‘no’. And by being prepared to say it far more often” (Snabely, 1990). The reason why boys should not be taught abstinence-based sex education was because “there are some things boys can never be taught” (Snabely, 1990).

In 1999, the University of Canterbury and the Christchurch School of Medicine launched a survey to investigate why only 3% of those who visited Family Planning Clinics were men. The survey showed that 60% of men had never used a Family Planning Clinic because “they did not believe they needed to go”, which “shows that there is an element of non-ownership of sexual issues on the part of men” (“Family Planning “a Woman’s Role””, 1999). The researchers involved in this survey suggested that the NZFPA should market themselves to men. Dr Christine Roke, Clinical Director of NZFPA, suggested that men did not come to Family Planning Clinics because they were seen as a “women’s organisation”. However, while men might not come for this reason, there were a number of women who come to the NZFPA for that exact reason (“Family Planning “a Woman’s Role””, 1999).



These attitudes held by men are indicative of the arguments occurring in Feminist STS literature surrounding gender and contraceptive decision-making. This literature looks at how women are expected to accept the risks associated with contraceptives and pregnancy, while men are not (van Kammen & Oudshoorn, 2002; Wynn & Trussell, 2006). One such example of these different attitudes was with hormonal contraceptives where the FDA have approved a number of different female hormonal contraceptives with all of the associated risks, however, they had not approved male hormonal contraceptives with the same risks because it was too dangerous (van Kammen & Oudshoorn, 2002). By placing the male hormonal contraceptives in the 'too dangerous' category, the attitudes around men not owning responsibility for "sexual issues", were being institutionally endorsed.

## 2.3 ADOLESCENTS AS CONTRACEPTIVE SUBJECTS

### 2.3.1 Mazengarb Inquiry

Children, teenagers, and family have been at the centre of debates in legislation surrounding contraception throughout the twentieth century. One of the most publicised cases was with the Mazengarb Inquiry in 1954. The Mazengarb Inquiry, originally known as The Special Committee on Moral Delinquency in Children and Adolescents, was established "to inquire into and to report upon conditions and influences that tend to undermine standards of sexual morality of children and adolescents in New Zealand, and the extent to which such conditions and influences are operative, and to make recommendations to the Government for positive action by both public and private agencies, or otherwise" (Mazengarb et al., 1954). In the report, the

Mazengarb Committee concluded that it was largely the degradation of the traditional family unit that was the cause of the rising sexual immorality (Mazengarb et al., 1954).

The original incident that triggered the Mazengarb Inquiry occurred in June 1954. A 15 year old girl from Lower Hutt contacted the Petone Police Station, saying that she had been part of the “Milk Bar Gang” which met “mostly for sex purposes” (Mazengarb et al., 1954). She called because she wanted out of the gang and was worried about the younger girls who were joining. With the information the girl gave the Police they were able to “obtain admissions and evidence of sexual misconduct by 65 children”, 17 of whom were girls (Mazengarb et al., 1954). This resulted in 107 charges being laid, all against boys because, at the time, any charges of indecent conduct were not able to be laid against girls. The Report said that this is because “the law has always been chivalrous to females”. Boys charged with any indecent conduct would face punishment ranging from probation to life in prison. Indecent conduct charges ranged from “indecent assault on female” to “carnal knowledge of girl under 10” to rape. One of the recommendations in the Report was to broaden the charges of indecent conduct to include girls as perpetrators, not just boys (Mazengarb et al., 1954). The Committee saying that “the law has always been chivalrous to females” is a very simplistic way to address this issue. This may have been correct regarding the “Milk Bar Gang” case. However, this statement ignores the extensive sexual discrimination within legal systems, especially regarding matters of indecent assaults and rapes.

The Committee of the Mazengarb Inquiry was made up of seven people. The Chairman was Dr Oswald Chettle Mazengarb, a Q.C. The members were Mrs Rhoda Bloodworth (Justice of the Peace in the Children’s Court), Mr James Leggat (Headmaster of Christchurch Boys High School),

Dr Gordon McLeod (Director of the Division of Child Hygiene, Department of Health), Mrs Lucy O'Brien (Vice-President of Women's Auxiliary of Inter-Church Council on Public Affairs and Arch-diocesan President of the Catholic Women's League), Reverend John Somerville (Chairman of the Inter-Church Council on Public Affairs), and Mr Francis Stace (President of New Zealand Junior Chamber of Commerce). Some of these committee members were appointed based on their experience working with children and adolescents. However, there were also those who were appointed based on their involvement with different Church based organisations.

Mazengarb was the son of a Baptist pastor and was described by some of the other members as a "puritan moralist" and "fundamentalist" (Barton, 2000). Mazengarb was also in a position where he had been appointed by the National Government who were facing an imminent general election. This caused Mazengarb to set a quick timetable for the investigation and he ended up writing a lot of the report himself (Barton, 2000).

The Mazengarb Report came at the beginning of the societal shift from the nuclear family with both mother and father to families with separated, divorced, single and unmarried parents. The Report helped create a stigma around families who did not fit into the traditional nuclear family mould. Most of the recommendations from the report were adopted into law and it became illegal for anybody under the age of 16 to have, provide, and use contraceptives.

Family in New Zealand continued, shaped by the position of the Mazengarb Committee. Contraceptives had now been reported to the entire country as something that was immoral and harmful to the Nation, reflecting arguments used over the 20 years prior, the "populate or perish" narrative (Cronin, 1977; Smyth, 2000). By preventing under 16s from having access to contraception, the policy makers and legislators following Mazengarb were acting as

gatekeepers, controlling the flow of contraceptives and contraceptive information, particularly between parents and their children.

### 2.3.2 Royal Commission into Contraception, Sterilisation and Abortion

The next time children and teenagers were at the centre of the debates surrounding contraception was with the Royal Commission into CSA in 1975. The Royal Commission investigating CSA, established in 1975, had 6 members. The Chairman was The Honourable Duncan McMullin, judge of the High Court. The members were Denese Henare – L.I.b., Maurice McGregor – B.A., Dip.Ed., Dip.Soc.Sci., Maurice Matich – M.B., Ch.B., Dip.Obst.R.C.O.G., M.N.Z.C.G.P., Barbara Thomson – B.A., M.Sc., and Dorothy Winstone – C.M.G., B.A. (Royal Commission on Contraception, Sterilisation and Abortion, 1977). In the warrants appointing the members, Henare was described as a barrister and solicitor, McGregor a medical social worker, and Matich a medical practitioner. However, Thomson and Winstone were both only described as being married women, ignoring their qualifications and the work they did outside of their marriages. Winstone received the award of Companion of St Michael and St George in the 1977 New Year's Honours and was later named a Dame for her service to the community. This again indicates the sexism relating to gender roles that was visible within the Report of the Mazengarb Inquiry was still prominent within Aotearoa society.

As with the Mazengarb Inquiry, a number of the members of the Commission were publicly linked to church-based organisations. McMullin served on a Judicial Commission of the Presbyterian Church of Aotearoa New Zealand, suggesting that he was a member of the Presbyterian Church (Presbyterian Church of Aotearoa New Zealand, 2003). McGregor started

his time as a social worker at Anglican Social Services, eventually becoming Director of Presbyterian Social Services (Nash, 2017). This shows that McGregor was involved with the Presbyterian Church, and that his work flourished within groups that shared the same core beliefs. Matich was Catholic ('Maurice Matich: Obituary', 2015). Thomson was married to a minister of the Presbyterian Church (Presbyterian Church of Aotearoa New Zealand, n.d.). In critiques of the Report of the Royal Commission, it has been discussed that the members of the Commission appeared to have biases surrounding abortion and certain types of contraception (Milne, 1977). It is likely that those coming from Christian communities were shaping large parts of the report.

Following the Report of the Royal Commission, the CSA Act of 1977 was drafted. The Act took up a number of recommendations from the Report of the Royal Commission. These recommendations included making contraceptives and contraceptive information only available to children under the age of 16 through doctors or educators involved in sexual education or biology; creating a panel system for approval of abortions; and that "courses in human development and relationships be provided in all schools" (Royal Commission on Contraception, Sterilisation and Abortion, 1977).

Article 3 of the CSA Act 1977 addressed giving contraceptive information to children under 16. In the first draft of the Bill, children under 16 could access contraceptive information without penalty from parents, medical practitioners, family planning representatives, registered pharmacists, at school through biology or human development and relationship courses, and any person who "does so to any pupils of a school with the prior approval of the principal or head teacher of that school" (Rogers, 1977). But the final Act only allowed for parents, medical

practitioners and family planning representatives (Contraception, Sterilisation and Abortion Act, 1977), removing all educational courses from the Act.

The public communications with MPs regarding the first draft of the CSA Act was largely against the introduction of the Human Development and Relationship courses and giving contraceptive information to “any pupils of a school” if the principal approved it. The wording of the Act did not place an age limit on how old children had to be before contraceptive information was distributed. This lack of clarification was a large point of objection for many people as it did not prevent primary schools from teaching these controversial courses.

People gave many reasons as to why they believed these courses should not be taught. These included, that parents should be the ones to teach their children about sex and human development, that the courses encouraged immorality amongst teenagers, and that the nuclear family would suffer if the courses were taught. In a letter to Minister of Education, Leslie Gandar, Mrs Joy Bennett of Masterton wrote about the damage that she felt the Human Development and Relationship courses would have, “I am totally opposed to sex education in schools... far greater need for teenagers to be taught about the traumatic hurts that occur when families break up, when adultery occurs, when an unmarried girl becomes pregnant and when a young man is taken to court for marriage proceedings.” (J. Bennett, 1977). Another woman, Jean Kirk of Timaru, wrote to Gandar about the “liberal politicians getting at us and our children with their un-Christian principles... If you decide now to educate them in at least 3 subjects in legalised fornication, prostitution, homosexuality etc. under the guise of Human Relationships, you will be responsible for the destruction of our society... our freedom of life in the family unit and in the community will be further eroded” (Kirk, 1977). These two letters are

examples of the strong attitudes of large sectors of Aotearoa society, illustrating the way a supposed threat to family was conflated with a threat to society. The threat was that the nuclear family was considered a key aspect connecting western society, and if it became degraded, then the societal connection disintegrated.

Advertisements were also placed in different national and regional newspapers, which people were encouraged to cut out and send to their MPs to voice their objections to the introduction of the Human Development and Relationship courses. These were not put together by advocacy groups, stating that “No specific organisation has been involved in the preparation and placement of this advertisement. Rather, an ad hoc group of individuals with a concern for the future well-being of children in New Zealand has actioned this advert and its placement has been made possible by the practical concern of many members of the public” (*Circular Letter to MPs Regarding Human Development and Relationship Courses, 1977*).

The Royal Commission made a number of recommendations regarding the content the Human Development and Relationship courses. It intended these courses to “aim at inculcating a sense of responsibility towards both the individual and the community, recognising the family as an essential feature of a stable community” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). They also recommended that any sex education should be integrated into the course as part of understanding the role of sex in a committed relationship (Royal Commission on Contraception, Sterilisation and Abortion, 1977). As part of the explanation as to why the Commission supported the introduction of these courses, they drew on some of the responses to similar propositions in other countries, such as a 1970 comment from the Roman Catholic Archbishop of Liverpool: “The education of children in sexual matters

is primarily the right and duty of parents. In not a few cases, however, parents through inability or neglect, fail to carry out their responsibilities in this field. In such cases, the school may have a positive duty to supply as far as possible, the deficiencies of the home. Such a task when prudently undertaken will not be opposed by those people who have accepted and fulfilled their responsibilities in these matters” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). This response to courses of sex education shows that, in spite of the fears of the public in Aotearoa, Catholic clergy viewed courses such as the Human Development and Relationships course not considered a threat to the family, instead as a way to protect it and to compensate for shortcomings that arise in these areas.

The Commission had originally intended the Human Development and Relationships courses to be about the importance of the nuclear family, with a small aspect of sex education. However, the ambiguity regarding age in the first draft of the CSA Bill, along with the lack of clarification of what would be taught in the courses, resulted in the public backlash.

Despite the public reaction to these proposed courses, this was not the first time that such a thing was suggested. In 1954, the Mazengarb Inquiry had concluded that “the school is not the proper place for fully instructing children about sex, although it may be convenient place in which mothers and daughters together, fathers and sons together, or parents together, may listen to addresses or see appropriate films” (Mazengarb et al., 1954). The Inquiry, therefore, recommended that the Department of Education work with nurses and teachers to develop ways to help give parents and children the safe space to have these conversations (Mazengarb et al., 1954). Following the report, no such efforts were made. After the removal of the Human Development and Relationship courses from the 1977 CSA Act, there were many who wrote to



MPs pointing out that there had already been “two Royal Commissions now agreeing that this area of human relations can be fairly and sensibly be handled by our teachers” (Richardson, 1977).

The positions of the Mazengarb Committee and the Royal Commission suggest that people were not necessarily objecting to having courses on Human Development and Relationships, instead objecting to the possible gatekeeping that could arise from teachers taking on this role. Any fears around gatekeeping were not fears for children, they were for parents. This would only prevent parents from being the primary source of information for their children, trained teachers would be.

### 2.3.3 Contraception, Sterilisation and Abortion Amendments 1990

The final time that children and teenagers were the subject of policy conversations surrounding contraception was with the CSA Amendment Act 1990. In 1990, which unsatisfactory areas of legislation were addressed by the Labour Government, particularly the Minister of Health, Helen Clark. In 1989, Clark originally promoted the CSA Amendment Act that intended to allow under 16s access to contraceptives and contraceptive information as well as lift restrictions around which doctors could authorise abortions. This would have changed the requirements from two certifying consultants who could be neither the operating doctor nor a woman’s general practitioner, to two medical practitioners, one of whom must be a specialist obstetrician or gynaecologist (Frings, 1989). The easing of abortion laws became a contentious issue within the media and MPs, with many opposing what became known as the “Abortion Amendment Bill” (‘Abortion Amendment Bill Criticised’, 1989; ‘Abortion Amendment Bill

Opposed by SPUC', 1990; Frings, 1989). However, there was a lack of conversation surrounding the amendment to the contraception laws. Catherine Morrison wrote in the Wairarapa News that she felt "that it is a pity that Helen Clark has clouded the issue somewhat by bringing what I [Morrison] believe[s] is the more emotive issue of abortion in under the same Bill as contraception for young people. The two are closely connected sure, young girls are becoming pregnant through ignorance of the facts and contraception, but the issue of abortion as such is far wider" (Morrison, 1989).

Ultimately, in 1990, before the Amendment Act was voted on, the Bill was split into two, separating the contraception and abortion law changes. Because of the topic, the original Amendment Act became a conscience vote. Clark said that the decision had been made to split the two "because there were urgent public health reasons for progress being made on the contraceptive advice provisions" ('Govt Politicising Abortion Debate Says Opposition', 1990). Public health issues that would be aided by the introduction of sex education were the rising teenage pregnancies, abortions, and HIV/AIDS cases. At the end of the 1980s, medicine was only just starting to understand HIV/AIDS. This meant that at the beginning of the 1990s, there was a push to educate people about condom use, to help prevent the spread. Preventing under 16s from being a part of the conversation limited the educational campaign's effectiveness.

The Labour caucus were supportive of splitting the amendments. Labour MP, Trevor De Cleene said that "it is vitally important to instruct those young kids in the schools as to how and what sex is about" ('Govt Politicising Abortion Debate Says Opposition', 1990). The splitting of the Bill faced criticism from the National Party Opposition, arguing that by splitting the bill Labour was politicising a conscience issue ('Govt Politicising Abortion Debate Says Opposition',

1990). The split bill resulted in the contraceptive amendments passing and abortion amendments failing, showing that the Labour Party understood that the MPs voting on the CSA Amendment Act were not comfortable with liberalising the abortion laws. Combining the two would have resulted in the contraceptive amendments also failing.

## 2.4 CONCLUDING COMMENTS

The conversations around contraception, family, morality, and Christianity throughout the twentieth century did not change. The family in New Zealand has evolved, from one of a more rural extended family to an urban family with any number of parents of any genders. With the twentieth century bringing new technological developments, the family was considered at risk by many groups who did not accept change and development as social progress. Arguments about family and contraception have taken place in a number of different ways, including parent and gender roles, and adolescents being contraceptive users. Parental and gender roles surrounding contraceptive use focus on the expectation of mothers to maintain the societal belief of family morals, resulting in women being the focus of blame as these morals change and evolve. Contraceptive use also has associated gender roles, where women have been expected to take responsibility around contraceptive use and failure.

The question of who should be able to use contraceptives changed from whether couples should be able to use contraceptives to if adolescents should be able to have access. Those involved in institutions, like the Mazengarb Inquiry, and in public conversations were drivers of these concerns. Although these arguments were grounded in concerns around family, they were particularly focused on parents' roles as contraceptive information providers together

with concern for the perceived degradation family and societal morals in Aotearoa. So, while contraception itself became more medicalised, discussion about its use and dissemination of knowledge, was frequently framed in a narrow group of social, moral, and even racial, discourse.

This chapter has shown how morality and religion was directly mobilised for the protection of family; however, morality has been mobilised far beyond this. Personal moralities can be mobilised more readily and subtly than the societal and institutional level family and religious moralities discussed in this chapter. Within conversations around contraception, personal moralities are responsible for the patriarchal gatekeeping acts by MPs and medical professionals, discussed in the next chapter, and for the manipulative use of science discussed in the final chapter.

### 3 CHAPTER 3: DECISION MAKERS

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Decision-makers have been central to the evolution of contraceptive history in Aotearoa. Some of the key decision-making groups were MPs and medical professionals. These two groups were central to both changes in contraceptive legislation and how the legislation was acted upon. By examining Hansard parliamentary debates, as well as a number of primary archival sources, from the NZFPA collections and from the collections of individual MPs, the impact these groups had on the changing legislation of New Zealand can be seen. This chapter discusses the conversations around these decision-makers, exploring the way they sit within the larger history of contraception.

The previous chapter explores the way religion and morals were mobilised to protect family and society. This chapter looks at how family, morality and religion were used to shape the CSA Act debates within Parliament in 1977. The CSA Act 1977 is the place to understand how these decision-makers, particularly MPs, were shaping women as contraceptive users because this piece of legislation remained the basis for Aotearoa contraceptive use and fertility control until the 2020 Abortion Legislation Act. This chapter also explores how medical professionals felt threatened by the changes introduced by the CSA Act 1977 and with the 1996 attempt to make the ECP over-the-counter. Finally, this chapter examines how those who conflated the different ends of the fertility control spectrum controlled and enforced their positions on women as contraceptive users.

The theoretical framework that I engage with in this chapter include; (a) the medicalisation of bodies and the control that gives to medical professionals (Bartky, 1990; A. E. Clarke &

Montini, 1993; Finkler, 2001; Sawicki, 1991; Wynn & Trussell, 2006), (b) how the control of contraception was used as a way to control women's agency (Bartky, 1990; Bordo, 1993; Sawicki, 1991; Takeshita, 2012; Wynn & Trussell, 2006), (c) the final framework I am working with in this chapter is how women were absent from these conversations around fertility control and how those who were present exploited this absence (A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Takeshita, 2012; Wynn & Trussell, 2006).

### 3.1 PARLIAMENT

In 1977, the National Government introduced the CSA Bill. This Bill contained the definitions of contraception and abortion that have been our legal definitions ever since. At the time of the CSA Bill, there were four women MPs, Mary Batchelor and Tini Whetu Marama Tirikatene-Sullivan in Labour, and Marilyn Waring and Colleen Dewe in National. This was compared to 116 male MPs.

On 13 December 1977, the CSA Bill was placed before MPs and put to a vote. The final day of Parliament in 1977 was 16 December and the original placement of the CSA Bill at the bottom of the Order Paper, making it last on their list of things to address possibly postponing until early 1978. This change in date meant several highly ranked members of the Labour Party were not present in Parliament for the vote. Bill Rowling, the Labour Party Leader, Jonathan Hunt, one of the longest serving Parliamentarians and Mary Batchelor, Labour's spokesperson on women's affairs were not present because they were in the United Kingdom on parliamentary business. These three, particularly Batchelor, were criticised by both the individuals and the media for not being present at the votes. Their absence was called "nothing short of a

catastrophe for the Labour movement and women's rights" (Cargill, 1977). Batchelor was known for wanting to liberalise abortion laws and had clashed with a number of the more conservative male MPs regarding her views.

Responding to a letter sent to Rowling, criticising the three MPs, Batchelor wrote that,

it is a personal insult to the women of this country to have legislation before the house in such a manner... it was taken to the top of the Order Paper without any prior warning... Before I left New Zealand, I was under the impression that the Bill would be the last on the order paper and that it would have plenty of time for debate. When I heard the rumour that it had been lifted to the top of the order paper, I immediately cancelled the rest of my overseas trip and came straight home. Unfortunately I was too late to vote on the issue,

(M. Batchelor, 1978).

Rowling also responded with similar sentiments, stating that "the conduct of the debate was disgracefully handled by the Leader of the House... Mrs Batchelor and Mr Hunt were absent from New Zealand on Parliamentary Business and greatly regretted that the affairs of the House were so managed as to prevent them from playing an active role in the final stages of passing the Bill through Parliament" (Rowling, 1978).

The CSA Bill was a conscience vote, meaning that people were able to vote in accordance with their own morals and beliefs. This resulted in criticism, with a number of people writing to MPs in both parties, claiming that "by allowing this Bill to be decided by a conscience vote you [MPs] are participating in an attack on parliamentary democracy and undermining our style of representative and responsible government" (Allen, 1977). However, this meant that the absence of these three particular MPs would not have made a difference for most of the more controversial clauses shaping the Bill (M. Batchelor, 1978; Rowling, 1978).

By allowing the vote of the CSA Bill to be a conscience vote, Parliament was allowing these elected officials to act for themselves, not for the people who elected them. Allen's letter (quoted above) questioned why the MPs should be allowed to use their own beliefs when they are voting to "remove our rights to do the same thing" (Allen, 1977). The MPs used their own position on religious and family morality to control women's access to means of fertility control, imposing their own moral position on the women of Aotearoa. This raised the issue, who should be able to use fertility control methods and who should get a say in this.

### 3.1.1 Starting the Process

On Tuesday 13 December, a number of votes were taken. The first vote was to grant urgency to the CSA Bill, fast tracking the debates and amendments. This passing prevented any of the MPs not present on 13 December from being involved in any of the debates and votes. The second was to allow the debates and voting on the CSA Bill to occur on 13 December. This had several supporters and opposition. The first argument against the CSA vote was from Robert Tizard, Deputy Leader of the Opposition (Labour). Tizard's argument was based on his belief that "the move to put the Bill to the top of the Order Paper was a stunt" (House of Representatives, 1977). He claimed the originally "the Bill stood at No. 23 on the proof Order Paper. Some people were told that the Order Paper had been changed, but that information was not generally available to members... The House has been told for some time that the Bill would remain at the bottom of the Order Paper... [because of this] the Opposition has about 12 members absent" (House of Representatives, 1977). Tizard thought the issue was too important "for the women and most of the men" (House of Representatives, 1977) to be introduced in such a way.



Aside from Tizard, a number of others spoke against the way the debate was moved. Two others of note, who opposed progressing the CSA Bill, were Dewe (National) and Tirikatene-Sullivan (Labour). Dewe spoke against progressing the bill because she believed that the Bill presented was being rushed and that the MPs needed more time to consider public opinion and to work on creating the best legislation that they could (House of Representatives, 1977).

Tirikatene-Sullivan's argument was,

Parliament is comprised of 95 percent of men. Of the 5 percent who are women, only two of us have had personal experience that enables us to empathise with women who, for entirely valid reasons, feel themselves unable to take a pregnancy through to full term. Yet in this House comprising 95 percent of males at this time of year and after a busy session, tired male members of Parliament are expected to make a decision that concerns the human anguish of women. I am concerned that the majority of the House has become separated from the human anguish on this issue. I am deeply concerned at the insensitivity of Parliament to various surveys of public and medical opinion,

(House of Representatives, 1977).

Tirikatene-Sullivan's stance was not well received by a number of male MPs.

William Robert Fenton, a National MP, responded to Tirikatene-Sullivan's presentation:

With due respect to the honourable member, I ask you to rule on whether the matters she is discussing are relevant and whether in supporting the motion [to not debate the bill at that time], she is giving us nothing more than statistics relating to the ratio of men to women in the House, and the anguish that people outside the House suffer. I do not think that it is germane to the question before the House,

(House of Representatives, 1977).

Fenton's address, allowed Tirikatene-Sullivan to respond:

That is the point to which I was directing my remarks, although the relevance would not be as clear to male members as it is to me. Parliament is not in a sufficiently clear-cut frame of mind to proceed tonight. Parliament is not competent to ignore the

public opinion polls, nor is Parliament competent to ignore the reaction of doctors to the issue... We will see then [at 2am, the time she suggested the debate would continue to] if male members of Parliament are really in a fit enough state to discuss something so relevant to thousands of New Zealand women who are not able to express their thoughts directly in the House. This measure is of deep concern to women, and it is a measure on which public opinion is clearly against Parliamentary opinion. Parliament will find itself in total disrepute if it presses on with the Bill at this stage of the session.

(House of Representatives, 1977)

Tirikatene-Sullivan's position raised questions about for whom this piece of legislation was acting. Tirikatene-Sullivan raising the "human anguish of women", (House of Representatives, 1977) only to have it shot down by Fenton, shows that those who were voting for and creating this legislation were more concerned with their own moral position than the effects the legislation would have on the women of Aotearoa. This dismissal and conduct is an example of how women's agency regarding their reproductive lives were controlled by male MPs (Bartky, 1990; Bordo, 1993; Sawicki, 1991; Takeshita, 2012).

Dewe's and Tirikatene-Sullivan's attempts to delay the Bill were discounted by Minister of Health, Frank Gill. In response to Dewe, Gill said "we have had the royal commission's report for some months now, and I do not know what the member for Lyttleton [Dewe] means when she says we have not had time to think" (House of Representatives, 1977). Responding to Tirikatene-Sullivan, he said "we are expected to back off from doing anything about it [the laws] because we have not had time or, as the member for Southern Maori [Tirikatene-Sullivan] said, because we are tired. Is it only when we are fresh that we know what our principles are?" (House of Representatives, 1977). Here Gill is saying, dismissively of the two women, that the morality and principles of the MPs are the only input needed for this vote.

Dewe and Tirikatene-Sullivan were attempting to draw the attention of the other MPs to the Publics opinion and raising the question of who should be able to make decisions for whom. Both were quickly dismissed by male MPs. All of this was indicative of the very problems of sexism and how the individual morality of the MPs should not be the driving force behind the Bill. Overall, the MPs voted to continue with the CSA Bill, 47 to 22 (House of Representatives, 1977).

All positions of MPs expressed above draw attention to the argument over who contraception legislation was for. Scholars writing on this often examine the different actors involved in decision-making and legislation (A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Takeshita, 2012; Wynn & Trussell, 2006). A common observation in these analyses is that women, as the users of contraceptive technology, are often absent from both the conversations driving changes and the decision-making groups who are involved in the changes (A. E. Clarke & Montini, 1993; Marks, 2001; Munro Prescott, 2011; Takeshita, 2012; Wynn & Trussell, 2006). This absence of women discussed in Feminist STS literature is explicitly shown in the debates outlined above.

### 3.1.2 Settling the Amendments

At 5:03 pm on 13 December 1977, the House started debating and voting on all of the amendments. There was little debated regarding contraception, with most amendments focused on the sterilisation and abortion aspects of the Bill. A number of amendments were considered contentious but the one that drew the most attention from both MPs and the public was what became known as the Birch Amendment.

The Birch amendment changed the group deciding on abortions from panels, as suggested by the Royal Commission, to certifying consultants. Certifying consultants were to be doctors who were neither the doctor of the woman requesting the abortion nor the doctor performing the abortion. One of these two doctors was expected to be an obstetrician and gynaecologist. This amendment was debated for over two hours. The final vote approving the certifying consultant system was 44 “Ayes” and 26 “Noes” (House of Representatives, 1977). Because of the urgency applied to the Bill, the voting continued through the night, finishing at 12:26 pm on Wednesday 14 December.

Throughout these 17 hours, the MPs made decisions on all the different amendments. At 3:45 am on the 14<sup>th</sup>, the clause which would have required counselling to be offered to women who were refused abortions, was removed from the Bill. Then at 6:41 am, George Gair (Minister of Energy Resources) attempted to add pregnancy resulting from rape to the clause listing the exclusions that allowed abortions. This was debated for almost an hour and Gair was ultimately unsuccessful.

Each of the amendments passed that restricted women’s reproductive rights were the result of certain MPs using their positions of power to control women. The different amendments allow for different methods of control including the medicalisation of women’s bodies, and the regulation of women’s bodies (Bartky, 1990; Bordo, 1993; Sawicki, 1991; Takeshita, 2012). The MPs creating this control of women’s access to fertility control is another way in which the family, societal and religious morality were mobilised to act on women in Aotearoa.

Marilyn Waring has since published a book on her time as an MP. In her book, Waring says that throughout the night of the 13<sup>th</sup>, 14 male MPs, including Robert Muldoon, appeared to have 'gone home' (Waring, 2019). Discussing Muldoon's absence, Waring points out that his "last recorded vote on a division was shortly before 2 am. His first recorded vote later on Wednesday morning was at 10.31 am. I [Waring] alerted the media, who asked him what he voted for and when. He couldn't remember" (Waring, 2019). The absence of a number of MPs through the night can also be seen in the Hansard Report outlining the debate results. Throughout the early morning debates there were fewer total votes than there were in the debates later in the morning (House of Representatives, 1977).

At the beginning of the night, Tirikatene-Sullivan said that the human anguish of women had been forgotten (House of Representatives, 1977). The actions of a small number of male MPs proved Tirikatene-Sullivan's point. By forgetting the individual women, actors, such as the MPs voting on the amendments, were preventing women from acting for their own reproductive health, instead only allowing them to be acted upon (A. E. Clarke & Montini, 1993; Takeshita, 2012; Wynn & Trussell, 2006).

### 3.1.3 Bringing Women Back into the Contraceptive Conversation

Martyn Finlay, member of the Labour Party of since 1943, wrote a document called "The Importance of SPAM", reflecting on how the Bill was handled. This document called out the Society for the Protection of the Unborn Child (SPUC) for their role in shaping the CSA Act and explained the need for an opposing group, the Society for the Protection of Anguished Mothers (SPAM). In his critique of SPUC, Finlay explained that SPUC was saying "We (adults) believe this

and that; you (all of you, men, women and children, and particularly women) must accept it and obey” (Finlay, 1977). He described this as “thought control at its ugliest and most repugnant... the antecedents of thought control are medieval – the Inquisition’s way of exorcising heresy and expiating findings of guilt” (Finlay, 1977). He drew attention to some of the objectives of SPUC. There were the more obvious, such as closing abortion clinics and restricting access to abortions, however, there were also those that are more subtle, such as restricting access to contraception, in particular, the IUD and the ECP because they were both thought to act after fertilisation.

Turning his attention to the CSA Act, Finlay attacked the way the Bill was passed,

They [women] – not men – are the ones affected [by the Act]; the ones to pay the price of our moral scruples. It is significant that all four of them in Parliament [women MPs] strenuously and angrily opposed the Bill. On the long night of 13 December that Parliament ceased to be a House of Representatives, and acted in spite of and in the face of repeated sampling of public opinion, and in contemptuous derision of the known views of the vast majority of women.

(Finlay, 1977).

Here Finlay was condemning the conscience vote allowing a male individual’s morality to control the legislation shaping women’s reproductive rights.

Harkening back to some of the decisions that were made in the amendment votes, Finlay said “in their professed and assumed interest for the child they [male MPs swayed by SPUC] have ruled against all relief for the mother – her health, well-being, mental serenity. All of these are expendable as long as the child can be dragged into the world, protesting or not, healthy or not, malformed or not, wanted or not, to starve or not” (Finlay, 1977). Here Finlay was referring to the removal of all counselling requirements for women who were denied an abortion.

Regarding the removal of the Gair amendment, Finlay said women who do go through pregnancy as the result of rape are “condemned to go through life clinging to the masculine illusion that some mysterious ‘mother love’ will somehow obliterate and replace her natural sense of disgust and shame” (Finlay, 1977).

Finlay highlighted the issues that Dewe and Tirikatene-Sullivan attempted to raise in the debates outlined above. Those who made decisions were not those who were living with them. Accentuating this point, Finlay wrote “why should we men deprive all women of the right of choice, and condemn those who lack such conviction to suffer for our dogma?” (Finlay, 1977).

Finlay expressed his dislike for the process that was manipulated to achieve the restrictive CSA Act. First with SPUC using MPs to restrict access to fertility control, then how the morality of individual MPs was given precedence over those of women. Finlay’s assessment supports my argument that those who were making legislative decisions regarding women’s use of fertility control were imposing their own principles, morality, and gender bias on women in Aotearoa.

## 3.2 MEDICINE

Another group of influential decision-maker in fertility control debates were medical professionals. They engaged at a number of levels, most commonly individual and profession wide. Profession-wide engagement was often focused on the position of the profession within Aotearoa. However, on an individual level, much like the MPs discussed above, engagement revolved around the personal morality of the doctors involved.

### 3.2.1 Doctors' Position Internationally

A number of doctors wrote about being unable to trust women to be responsible in their use of contraception, particularly hormonal contraceptives (Pidgen, 1991; Rowlands, 1982). An example, published in the British Medical Journal, was a British doctor, Sam Rowlands, who expressed concern at supplying the ECP in advance, rather than on an as needed basis. "Some doctors are now advocating that a special "first-aid" pack of pills should be issued to users of sheaths in case these break or as an 'insurance policy' to those not currently in need of contraception... there are still pitfalls in self-administered 'morning-after' treatment. Of greater concern is the possibility that women will use borrowed pills when frequently either the dosage or the preparation would be unsuitable. Totally unsupervised administration of hormones should not be encouraged or condoned" (Rowlands, 1982).

Rowlands's position was critiqued by another doctor J. Betts, who wrote "if we insist on a consultation before treatment is available it will usually be the less well educated who do not attend, for whom unwanted pregnancy is the biggest burden" (Betts, 1982). This is only one example of the positions of individual doctors in these debates.

Doctors, like Rowlands, who were attempting to prevent over-the-counter medications or changing how they are supplied, thereby supported the medicalisation of the women's bodies, allowing doctors to act as gatekeepers and controlling women's agency to control their own fertility. By gatekeeping contraceptive medications, that had been declared to be safe for over-the-counter use, doctors were supporting and reinforcing the power relationship between doctors and patients, which offers a mechanism of controlling women's reproductive lives



(Wynn & Trussell, 2006). Wynn and Trussell (2006) addressed how those reinforcing the doctor-patient relationship, in the US FDA hearings to make the ECP over-the-counter, were framing it as a relationship of “kindly concern for women’s well-being” (Wynn & Trussell, 2006), instead of the power relationship that it is.

In the CSA Act 1977 there is a conscience clause, allowing doctors to refuse to give prescriptions for contraceptives and refer women hoping for an abortion to certifying consultants if doing so went against their own personal morality. However, they were required to refer their patients to another doctor who would be willing to do so (Contraception, Sterilisation and Abortion Act 1977, 1977). In Aotearoa, we have this additional protection for women but, in other countries such as the United States, there is no such protection. In 2004, Caroline Bollinger wrote an article for the United States health magazine *Prevention*, in which she discussed the rising trend in doctors not prescribing the Pill and pharmacists not dispensing it. Bollinger described how the “‘hormonal birth control equals abortion’ view has quietly grown roots in the antiabortion underground” (Bollinger, 2004)<sup>20</sup>, through books written by antiabortion activists and lobbying groups. This movement has developed based on different areas of misconceptions surrounding the Pill, first, that the Pill is a form of chemical abortion, and second that “chemical contraceptives have the potential to harm an embryo” (Bollinger, 2004). This movement has become prevalent in the American Obstetrician/Gynaecologist (OB/GYN) community.

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<sup>20</sup> More is discussed on the clarification between contraception and abortion in Chapter 4

This movement has faced backlash from other members of the OB/GYN community. Some saying that they “have a hard time with people who market themselves as women’s health care physicians who won’t prescribe such a basic part of women’s health care... a growing trend among pharmacists and medical practitioners who consider it acceptable to impose their morality on women’s bodies... Imagine a pharmacist asking a customer whether his Viagra prescription is to enhance sexual performance in his marriage or in an extramarital affair” (Anne Drapkin Lyerly cited in Bollinger, 2004). Bollinger quotes the vice president of the American Association of Pro-Life Obstetricians and Gynecologists, “the post-fertilisation effect was purely speculation that became truth by repetition” (Joe DeCook cited in Bollinger, 2004). This “post-fertilisation effect” is the hypothetical effect that the Pill causes the “sloughing off a fertilized [sic] egg” (Bollinger, 2004) from the uterine lining.

Anne Drapkin Lyerly’s comment highlights the way the MPs’ morality was imposed on the women of Aotearoa with the CSA Bill process. The recurrence of this idea throughout this chapter shows the widespread influence individual morality, along with family and religious morality, had on decision-makers and the way these attitudes were imposed on women wanting to control their fertility.

### 3.2.2 Doctors’ Changing Role in Fertility Control

Although the medical profession was in a position of power as decision-makers, the General Practitioners Society was against several aspects of the CSA Bill, particularly the Birch Amendment, which put in place certifying consultants, because it threatened the professional remit of the medical profession. The certifying consultant system “removes decision making

powers from the family doctor, who knows the patient best, and from the operating doctor, who becomes a mere technician” (*Doctors Opinion on the Contraception, Sterilisation and Abortion Bill*, 1977). Further to this,

The General Practitioners’ Society has stated its opposition to the certifying consultants system in a letter sent to all doctors.

Among the points made are:

- (a) that the dignity and freedom of the medical profession will be subverted.
- (b) the certifying consultant may have to make a decision without seeing the patient.
- (c) doctors should not be required to make a legal decision on a law which has not been and may never be interpreted by a Court of Law.
- (d) the appointment of certifying consultants will undermine the professional and political cohesion of the profession.

(*Doctors Opinion on the Contraception, Sterilisation and Abortion Bill*, 1977).

Doctors were more concerned with the effect that the Act would have had on the medical profession, particularly the reputation of the profession, than they were for their female patients. The confusion surrounding abortion laws immediately following the introduction of the CSA Act created concerns about the positions of doctors within the new system. Prior to the introduction of the Act, the General Practitioners’ Society was concerned with the effect the Act would have on the reputation of the medical profession. However, following the period of confusion, the Act did not affect the overall reputation or position of general practitioners in Aotearoa, but rather it resulted in even greater medicalisation of fertility control. While the medical profession was worried about its professional standing, women, the primary subjects of the Bill, were facing more layers of control and loss of agency with respect to their own bodies and fertility.

### 3.2.3 The Emergency Contraceptive Pill Available Over-The-Counter

The introduction of the CSA Act was not the last time that a decision was made regarding fertility control where the medical profession was against changes because of the effect they might have on the profession. This happened again when the Ministry of Health attempted to make the ECP available over-the-counter in 1996. Although, in 1996, the Royal New Zealand College of General Practitioners (RNZCGP) appeared to be more concerned about pharmacists attending to the patients than anything else, “We [the RNZCGP] have concerns that in a pharmacy the patient may be disadvantaged” (College Chairman, Gregor Coster cited in Williams, 1996).

Following the RNZCGP’s concerns, several groups raised similar concerns regarding pharmacists controlling distribution of the ECP. However, most of this concern came out of doctors not being able control how women used the ECP. The pharmaceutical company, Schering, the manufacturer of PC4, the only medication packaged and marketed as the ECP, removed PC4 from the Aotearoa Market. Schering’s Managing Director, Paul Vleugels, said,

once young women know the ECP is available, they could use it outside the time frame and in larger doses... For us [Schering] the product is a service item, it has never been developed or promoted and it is not a commercial success. I sincerely believe the ministry should direct their energies into promoting contraception, rather than emergency contraception. I think that would be better for New Zealand women (Vleugels cited in Aggett, 1996).

The Schering Spokesperson, Lisa Sheffield, also spoke about Schering’s position. “Schering does not want emergency contraception taken outside of a medical consultation. We [Schering] are concerned at the possibility of the pills being used repeatedly and incorrectly, effectively

placing women on very high dose contraception... We believe this is a huge medicolegal risk to take on for a very small economic return” (Sheffield as quoted in Williams, 1996). In these two statements, Schering was displaying a lack of trust in women to be able to use the ECP correctly. With this first attempt to make the ECP over-the-counter, most objections originated with the concerns that it would harm the medical profession and that women could not be trusted with unsupervised use of medications. These arguments resulted in the 1996 move to make the ECP over-the-counter being unsuccessful.

The medical profession was maintaining the medicalisation of women’s bodies and reinforcing the power relationship between doctors and patients, by attempting to prevent pharmacists from being the first port of call when women wanted the ECP. Schering maintained their gatekeeping position by arguing that women were too irresponsible to be trusted with over-the-counter hormonal contraceptives. This was the same idea (discussed above) that Rowlands put forward. These ideas about the irresponsible women reinforced the doctor-patient power relationship, where the doctor could gatekeep and restrict information from women who they do not consider trustworthy (Takeshita, 2012; Wynn & Trussell, 2006).

Treating women as irresponsible regarding contraception, had been used to justify the medicalisation and gatekeeping of contraception. Takeshita (2012) discusses how the IUD has been used by both the state and medical professionals to control women’s agency to reproduce, because they could not be trusted to use other contraceptive methods effectively. Wynn and Trussell (2006) discussed how medical professionals presenting at the US FDA hearing on making the ECP over-the-counter, used similar arguments to Rowlands to justify maintaining control over women’s access to the ECP.

### 3.3 CONCLUDING COMMENTS

The events discussed in this chapter repeatedly reinforce several arguments. The first is that those who were in decision-making positions, such as doctors and MPs in 1977 with the CSA Bill were not those for whom the Bill was supposedly acting. Those who were in this decision-making position were able to impose their own morality on women, who were directly affected by the results of the Bill. Doctors used their own moralities to continually place themselves in gatekeeping positions, further controlling women's access to fertility control.

By increasing the medicalisation of fertility control methods following the introduction of the CSA Act, both MPs and doctors were increasing their control of women's access to these fertility control methods. This was supported by the medicalisation and gatekeeping of contraception and other methods of fertility control. Overall, these decision-making groups and individuals use their standing within Aotearoa society to impose their own moralities.

This chapter has outlined the way personal moralities of MPs and doctors impacted their actions as decision-makers within legislative debates regarding fertility control and contraceptive access. The coming chapter explores the way personal moralities drove how science was used. By choosing to promote particular aspects of science, which furthered an individual's personal morality, those involved in these arguments were shaping the way women who used contraception were seen by the rest of the country.

## 4 CHAPTER 4: BETWEEN CONTRACEPTION AND ABORTION

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In the previous chapters I have outlined the various historical, political, and personal pressures that shaped the landscape in Aotearoa, relating to the access to and denial of contraception. In this chapter, I want to shift the focus to explore how interest groups against the use of contraception used arguments often represented as being grounded in science to push particular ideologies as a way to attempt to control women's contraception use and reproductive lives. The archival data reveals that this dependence on science as a rational basis for control was a predominant theme through which people communicated their positions in the debates surrounding fertility control. Conflating abortion with contraception allowed those arguing against contraception to treat it with the same moral standing as abortion. The way people and institutions interacted with and viewed fertility control along with the arguments and issues, were common primary data. The primary data drawn on in this chapter include the Report of the Royal Commission into CSA, the NZFPA archives and online newspaper database, Newztext.

As I have shown in the previous chapters family, religion and morality have been mobilised to shape the way contraceptive and abortion laws in Aotearoa have evolved. These three aspects of our society have been used by decision-makers, both in legislation and medicine, to control women's access to fertility control.

This chapter addresses the way the control of contraception and abortion, by mobilising science, shaped women's relationships with doctors, including through the medicalisation of fertility control (Bartky, 1990; A. E. Clarke & Montini, 1993; Finkler, 2001; Sawicki, 1991; Wynn

& Trussell, 2006), together with how contraception and abortion were used to control women's position within society (Bartky, 1990; Bordo, 1993; Sawicki, 1991; Takeshita, 2012).

#### 4.1 FERTILITY CONTROL

Contraception and abortion exist at two ends of the fertility control spectrum. Abortion acts in one well recognised way, ending a pregnancy before it reaches full term. Contraception acts to prevent pregnancy. This can happen in any number of ways, but when a woman is using oral hormonal contraceptives, the most common is by preventing ovulation. Ovulation occurs when a woman's egg has matured and is released from the ovary. Without interference, this happens roughly once every 28 days if a woman is not using hormonal contraceptives. Occasionally, hormonal contraceptives fail, and an egg is released and can become fertilised. A fertilised egg is called a zygote; a single cell capable of dividing millions and millions of times, growing into an embryo, then a foetus, then a baby. Before this can happen, the zygote must develop into a blastocyst<sup>21</sup>. The blastocyst is then able to be implanted into the uterus, triggering a number of hormonal signals to tell the woman's body that she is pregnant (Lalitikumar et al., 2007; Royal Commission on Contraception, Sterilisation and Abortion, 1977).

Until implantation occurs, medicine and biology do not consider the woman to be pregnant (Lalitikumar et al., 2007; Royal Commission on Contraception, Sterilisation and Abortion, 1977). However, there are many who argue that the zygote's divisional potential makes a woman pregnant at fertilisation. This leaves a question over methods of preventing pregnancy that act

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<sup>21</sup> The blastocyst is a ball of cells that occupies the same physical space as the zygote. The outer wall of the ball is made up of cells, which develop into the amniotic sac. Inside the ball is an open space – called a blastocoele – which becomes the amniotic fluid, and an inner cell mass, which develops into the foetus.



in the window between fertilisation and implantation. Are they forms of contraception or are they methods of abortion?

## 4.2 POLICY POSITIONS AFFECTING CONTRACEPTION AND ABORTION

Within policy frameworks in Aotearoa, a line between contraception and abortion had to be drawn. The Royal Commission investigating CSA defined contraception as “the avoidance of conception”, an abortifacient as “a mechanical, chemical or pharmaceutical agent which causes abortion” and an abortion as “the expulsion of the embryo or fetus [sic] from the uterus before it has proceeded to term” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). Each fertility control method holds a position on this spectrum. Condoms, withdrawal, diaphragms, and natural family planning are firmly planted at the contraceptive end of the spectrum, with the way they work being very well known and understood. Surgery to remove a foetus is firmly planted at the abortion end. However, there are a few methods of fertility control that hold contentious positions on this spectrum.

The Copper IUD makes the uterus uninhabitable for fertilised eggs, preventing them from implanting and continuing to develop. This is largely accepted as a form of contraception. Hormonal contraceptives are often placed in between because their mechanisms are not obvious, or their mechanisms of action are disputed. The Pill acts by preventing ovulation, thickening cervical mucus to prevent sperm from reaching any eggs that come to be released. If those mechanisms fail and an egg is fertilised, the Pill also has an effect on the uterine lining to prevent it from implanting (Bollinger, 2004). The ECP, which in its current form of Levonorgestrel (LNG), when taken after unprotected sex, prevents ovulation and decreases the

likelihood that a woman would then get pregnant. These three methods of fertility control are not completely accepted as a form of contraception with some still arguing that each is still a form of abortion.

Historically, other methods held a disputed place on this spectrum. One such method was menstrual extraction, where the contents of the uterus were suctioned out. This was often used to keep periods regular but done without testing for pregnancy. This meant that a woman could have been pregnant before the extraction. However, without testing it could not be proven that she was aborting a pregnancy.

Going back as far as the twelfth century, possibly earlier, women have used forms of emergency contraception, exploiting the area between abortion and contraception using what became known as emmenagogues (Koblitz, 2014). Emmenagogues are substances, often herbal, which are taken by women to induce a late period, without knowing if she is pregnant, producing the same effects as menstrual extraction (Koblitz, 2014). There have been recent developments in contraceptive technology made in more recent years which have been placed on the spectrum of fertility control, including RU486, which is the market name for mifepristone, which when developed could only be used up to eight weeks after unprotected sex. Some call it a new form of the ECP and a contraceptive, others an abortion pill (A. E. Clarke & Montini, 1993). Now, mifepristone can be safely used as a medical abortion through the second trimester and is used in Aotearoa for this purpose.

The work of Ann Hibner Koblitz explores this position between contraception and abortion. Koblitz argues that there must be an intermediate method of controlling fertility – existing

between the two – which she postulates could be a post-conceptive method, using arguments of the contraceptive researcher, Etienne-Emile Baulieu, creator of RU 486. Baulieu had been criticised for creating an “abortion pill”, but he preferred it to be called an “un-pregnancy pill”. This “un-pregnancy pill” acts a “contragestive... Contragestion works a middle range, countering gestation before implantation or in pregnancy’s earliest stages” (Baulieu cited in Koblitz, 2014).

Methods of fertility control firmly planted at the contraceptive end of the spectrum have little to no control or regulations surrounding them. However, these more contentious methods have more medicalised control placed over them. The IUD requires insertion by a doctor, the Pill and the ECP required prescription by a doctor<sup>22</sup>, and mifepristone requires dispensation by an abortion provider. The different levels of control doctors have over the various methods reflects how close to abortion the contraceptive method sits.

#### 4.2.1 The 1977 Royal Commission

Within the Royal Commission Report (1977), the distinction between contraception and abortion became muddled. The different commission members’ own perspectives of fertility control methods on this spectrum, was likely responsible for this. When discussing contraceptive methods such as the IUD, the ECP and menstrual extraction, the Royal Commission said that they would have been excluded from contraception based on the Report’s original definition of contraception and as such their legality would have been questioned. However, the Commission then widened the scope of its definition, allowing the

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<sup>22</sup> Now they can also be obtained from a pharmacist but the pharmacist, another medical professional must observe strict criteria before dispensing.

inclusion of the IUD and ECP as contraception (Royal Commission on Contraception, Sterilisation and Abortion, 1977). By changing the definition of what contraception is, the Royal Commission contradicted themselves throughout their report, confusing and conflating contraception and abortion.

In order to justify this re-classification, the Commission attempted to define when human life begins, using the “biological point of view”, where there is no suggestion “that human life begins at anytime other than at conception”<sup>23</sup> (Royal Commission on Contraception, Sterilisation and Abortion, 1977). However, in spite of this, the Report later said that “the fetus [sic] has a status from implantation which entitles it to preservation and protection” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). Conceding this foetal status, allowed the inclusion of the IUD and the ECP as contraceptive methods, although, menstrual extraction remained an abortion. Having been created to explore legislation surrounding CSA, the Commission’s recommendations were to liberalise contraception legislation, but create more restrictive abortion legislation.

The Royal Commission not placing these methods securely as contraceptives allows for individuals involved in contraceptive decision-making, such as the MPs and medical professionals discussed in previous chapters, to take individual license on how much control they have around decisions regarding these methods. This has occurred internationally where individuals used ambiguous classification of fertility control methods to justify placing stricter control over them (A. E. Clarke & Montini, 1993; Wynn & Trussell, 2006).

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<sup>23</sup> The Royal Commission did not define conception.

The State's desire to control how contraception is viewed indirectly impacts women's lives. Wynn and Trussell (2006), when studying the FDA hearing into making the ECP over-the-counter, show the role the State played in supporting the medicalisation of a drug that has an "ambiguous ontological status as a contraceptive" (Wynn & Trussell, 2006). Clarke and Montini (1993), shows how easily a new fertility control method – RU486 in this case – can be co-constructed into any number of roles by different actors including State, medical, and feminist organisations (A. E. Clarke & Montini, 1993).

#### *4.2.1.1 The Position of Abortion Laws*

When addressing abortion laws, the Royal Commission dedicated an entire chapter to "The Status of the Unborn Child". When they originally discussed why they chose to use the term 'unborn child', the Commission acknowledged that they could just as easily use the scientific terms 'embryo' or 'foetus'. They chose to use 'unborn child' because they deemed it to be "appropriate to the embryo or fetus [sic] from the time of implantation to the time of birth" (Royal Commission on Contraception, Sterilisation and Abortion, 1977). They state that those who would prefer 'embryo' or 'foetus', "read into the use of the expression 'unborn child' an implication of status" (Royal Commission on Contraception, Sterilisation and Abortion, 1977). The term 'unborn child' was used by a number of anti-abortion groups, such as Society for the Protection of the Unborn Child (SPUC), to humanise the foetus (Ryan, 1986). In spite of the implications, the Royal Commission continued to use the term, concluding that, "the unborn child, as one of the weakest, the most vulnerable, and most defenceless forms of humanity, should receive protection" (Royal Commission on Contraception, Sterilisation and Abortion,

1977). This statement has since been used with reference to the Royal Commission by anti-abortion groups to justify preventing the liberalisation of Aotearoa abortion laws (Orr, 2000).

The Royal Commission was aiming to ‘maintain’ moderate abortion laws. To do so, they stressed that “the unborn child has some status, but that the pregnant woman has rights, which may at times take precedence over the unborn child” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). By clarifying that the pregnant women “*may at times*” take precedence over the ‘unborn child’, the Commission were detracting from the pregnant woman’s rights. ‘May’ is defined as “expressing permission” (Oxford Dictionary, 2001), which in legal work “need not be exercised. The exercise of the power, permission, benefit, etc is discretionary” (*Statutory Interpretation*, 2021). By saying that there are possible circumstances ‘at times’, there are already limitations on the rights of the pregnant woman, however, by adding ‘may’ the Commission was able to build ambiguity into subsequent legislation.

Later in the Report, the Commission discussed the woman’s “Right to Control Her Fertility”.

Once it is recognised that the unborn child has a status, the rights of the pregnant woman cannot be regarded as absolute, because any rights she then has must be measured against the existence of the fetus [sic]. Any legal code must give weight to that consideration.

We therefore conclude that while a woman has a right to control her fertility, she cannot, once she is pregnant, any longer assert that right as an absolute right and it must be considered against the status of the unborn child.

(Royal Commission on Contraception, Sterilisation and Abortion, 1977)

This shows the Commission’s view of abortion. There is no allowance or acknowledgement of circumstances when the pregnant woman is the priority over the ‘unborn child’, only that a woman’s reproductive autonomy is lost at an unknowable point of time, which, according to

the Royal Commission, is at implantation when the foetus is still a microscopic ball of cells, and thereby accrues a human being's status (C. Young, 2000). Here we can see how science was relegated to a secondary position behind the morality of the Royal Commission.

Women's reproductive autonomy has been a subject of many Feminist STS debates with some of them centred around the acceptance of fertility control measures, others the opposite. Sawicki (1991) discussed these two opposing views, writing that: "Both feminists and anti-feminists resisted the legalization [sic] of birth control... they tended to conflate control over the biological process of motherhood with control over motherhood itself" (Sawicki, 1991). In these arguments, it is the agency that birth control places with women, either the rejection of patriarchal control, or the acceptance of the choice of when one gets pregnant (Bordo, 1993; Sawicki, 1991). The Commission, in recommending that contraceptive laws become more liberal, allowed women to consider contraceptives to be acceptable. However, it also placed limits on a woman's reproductive autonomy through the language outlined above, where the Commission acknowledged a woman's need and right to control her fertility but not allowing her unconditional access to all methods of fertility control.

Through addressing abortion laws in Aotearoa, the Commission explored international abortion laws. In their comparison, the Commission quoted the United States Supreme Court in the recent *Roe vs Wade* 1973 case, which protected pregnant women's constitutional freedom to choose to have an abortion (Royal Commission on Contraception, Sterilisation and Abortion, 1977). They quoted one of the Supreme Court judges: "We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy and theology are unable to arrive at any consensus, the judiciary, at this point in the

development of man's knowledge, is not in a position to speculate as to the answer" (Justice Blackmun cited in Royal Commission on Contraception, Sterilisation and Abortion, 1977). In contrast, the Commission responded that it was not in the same position as the US Supreme Court because "all the witnesses who gave evidence before us [the Commission] were agreed that life begins at conception and pregnancy at implantation" (Royal Commission on Contraception, Sterilisation and Abortion, 1977). This statement was a dangerously simplistic way to address an issue the weight of the American legal system could not resolve.

The Commission heard from a number of different groups, religious organisations, medical professionals, anti-abortion groups, and women's rights organisations, the statement made by the Commission regarding the beginning of life claims to encompass the ideals of each. The Board of Jewish Ministers of New Zealand and Rabbi Mandel put forward submissions. The Jewish faith, life does not begin until 40 days after conception and that the death of the foetus after the 40 days does not constitute murder because the foetus is not a person until it draws its first breath (National Council of Jewish Women, n.d.; Zoloth, 2003). The Commission chose to ignore evidence that contradicted its simplistic view. It is also unlikely that women's rights organisations would have supported this statement.

As a result of these ideas, the Commission recommended that the abortion laws be amended to introduce a ministerial appointed panel of 'experts' to assess whether a woman should be allowed the requested abortion. Contradicting this recommendation, the Report also stated that panel systems "can be unwieldy and beset with administrative difficulties". Understanding that panel systems can cause delay, the Report said that, "for the woman concerned, undue delay will almost certainly cause great anguish and may cause serious



complications” (Royal Commission on Contraception, Sterilisation and Abortion, 1977). Aside from those acknowledged problems a number of medical or medical associated groups also submitted against panel systems, including the Royal College of Obstetricians and Gynaecologists, the Australian and New Zealand College of Psychiatrists, New Zealand College of General Practitioners, the General Practitioner Society, the New Zealand Association of Social Workers and the Department of Health (Milne, 1977). The College of Psychiatrists, College of General Practitioners, the General Practitioner Society and the Association of Social Workers were all in favour of liberalising abortion laws, particularly encouraging abortions as a decision to be made by women in consultation with their own doctor (Milne, 1977). Although the Commission understood and acknowledged the adverse effects of delaying abortions, as would almost certainly happen with a panel system, they offered no solutions to the problems of the panel system.

The Report contains a number of areas which have been written purely for the Commission to communicate their own perspectives. Choosing the panel system, which had the most difficulties associated with it, would have discouraged women from attempting to fight to obtain abortions. By making broad statements such as when life begin, they were excluding all those who did not believe the same and while giving credibility to those who did. All of which encouraged the medicalisation and restriction of abortion.

The medicalisation of abortion and women’s bodies helped to develop the power relationship between a woman and her doctor. Bartky (1990), Bordo (1993) and Sawicki (1991) all discuss how individuals and groups work to resist medical authority “in efforts to eradicate the non-reciprocal relations of power so often still characteristic of the physician-patient

relationship” (Sawicki, 1991). Clarke and Montini (1993) and Wynn and Trussell (2006) both discuss the ways doctors and medical groups work to maintain their position as gatekeepers over the different fertility control methods. This relationship allows the doctor to gatekeep fertility control services, especially those related to abortion. The introduction of the panel system would have also created a number of other gatekeepers including the abortion approval panel, and the Minister of Health, who would have appointed them and would have increased the medicalisation of fertility control in Aotearoa.

The scientific aspects of the Report contained flaws. In spite of their insistence that life begins at fertilisation, which they claimed was based on scientific evidence, the Commission seemed unaware of some of the biological processes that occur. Throughout the Report, the Commission referred to conception as a moment, a process, and an event. They confused progesterone for progestogens (Milne, 1977; Royal Commission on Contraception, Sterilisation and Abortion, 1977). These are only some examples of inconsistencies and errors made throughout the report. They make several claims regarding life and the process of pregnancy, however, these mistakes suggest that they were only using the biology and science to further their own agendas, not because they fully understood them. The inaccuracies and inconsistencies made throughout the Report of the Royal Commission work to control women’s bodies and use of contraceptives and other fertility control methods. Based on the findings of the Royal Commission, the CSA Bill was drafted. This meant that the inaccuracies that have been discussed influenced the following legislation.

#### 4.2.2 Legislation

The Commissions lack of clarity regarding the biological details that should clarify conversations surrounding abortion and contraception, was reflected in the CSA Act. In the first draft of the Bill abortion was discussed as a ‘procured miscarriage’, which may or may not be done by the woman herself. The only clarifying difference between miscarriage and abortion was that miscarriage is “the premature expulsion of the embryo or fetus [sic] after implantation otherwise than for the purpose of inducing the birth of a fetus [sic] believed to be viable or removing a fetus [sic] that has died” (Rogers, 1977) and abortion is miscarriage that is obtained. During consultation, proposed amendments were more liberal and others more conservative. In terms of defining abortion, two more conservative changes were suggested, one put forward by National MP Barry Brill and one by Labour MP Gerald Wall.

Brill’s suggested amendment was the alteration of “expulsion” to “destruction or death of an embryo or foetus after implantation” (*Document Regarding Proposed Amendments to the Contraception, Sterilisation and Abortion Act 1977, 1977; Rogers, 1977*). This change was accepted, but only added more emotive language to the Act. The Wall amendment sought to clarify the terms of the clause allowing for the abortion if there is a risk to the health of the pregnant woman, by adding the phrase “and that such a danger cannot be averted by any other means” (*Document Regarding Proposed Amendments to the Contraception, Sterilisation and Abortion Act 1977, 1977; Rogers, 1977*). The addition of the Wall amendment would have resulted in loopholes such as that women who did not want to be pregnant going through the entire pregnancy in a coma because that would alleviate mental health issues (Rogers, 1977). Wall’s amendment was not accepted.

Drafting legislation on a topic with such polarising views was difficult and required compromises. This is evident in the final Act. Following the Royal Commission's suggestion. The original draft of the CSA Act included the Commission's recommendation of a panel system. However, following MPs' amendments this was changed to a system of certifying consultants<sup>24</sup>, requiring government-appointed certifying consultants to approve a woman's request for abortion, one of whom must be an obstetrician and gynaecologist (*The Birch Amendment*, 1977). This was more restrictive than previous abortion laws. The major flaw with this compromise was that very few people involved in the abortion argument agreed with this system, drawing criticism from both sides.

Although the certifying consultant system appeared to be more liberal than panels, it is still subject to the same feminist critiques. The certifying consultants still added gatekeepers controlling access to abortions and also increased the medicalisation of women's bodies. With the panel system, any individual panel members' personal morality would have been moderated by the views of other panel members. However, with certifying consultants, women's access to abortions was controlled by the individual's morality and beliefs regarding abortion. This put certifying consultants in the position of enforcing medical control over women when requesting abortions.

Managing women's reproductive lives comes in many forms including contraception and abortion. By addressing issues raised regarding abortion, particularly regarding women's agency, medicalisation of reproductive issues, and the rejection and acceptance of fertility

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<sup>24</sup> As discussed in Chapter 3.

control arise, all of which also apply to contraception – especially those contraceptive methods which hold a disputed position between contraception and abortion.

### 4.3 DISCUSSIONS IN THE PUBLIC SPHERE

The discussions and positions taken in the Report of the Royal Commission and the CSA Act 1977 were happening within closed groups that held positions of decision-making power. However, the same discussion and arguments, regarding the spectrum of fertility control, were also happening in the public sphere. Individuals contributed their views regarding all methods of fertility control including those that fell into the disputed area of contraceptives which could be considered abortions. Significant sections of these public discussions were focused on the Pill, as a pivotal contraceptive method, and the ECP, a controversial method. These public discussions occurred in letters to the editor and other published works, spanning almost sixty years.

#### 4.3.1 The Pill

One of the first times the use of the Pill was publicly discussed and globally conflated with abortion was soon after its development and introduction. A number of people involved in the creation of the Pill were Catholic. Because of this, they were acutely aware of the lack of contraceptive options for those in the Catholic Community since Catholic teaching does not allow couples to have sex without the intention of procreation. Those involved with the creation of the Pill considered it a safe contraception for women who did not want to go against Catholic teachings because the Pill does not interfere with the act, instead preventing ovulation. When the Pill was approved by the United States Food and Drug Administration, in

1960, many Catholic women embraced it as an acceptable contraceptive because the Vatican did not reject it (Gudorf, 2003; Hirsch, 2008; Koblitz, 2014; Marks, 2001; Munro Prescott, 2011).

Catholic women continued to use the Pill until Pope Paul VI issued his *Humanae Vitae*, in 1968. *Humanae Vitae* stated that “each and every marital act must of necessity retain its intrinsic relationship to the procreation of human life” and that “any action which either before, at the moment of, or after sexual intercourse, is specifically intended to prevent procreation” is condemned within the Church (Pope Paul VI, 1968). *Humanae Vitae* condemned all forms of artificial contraception, saying that any form of contraception is the equivalent to aborting a pregnancy. The use of withdrawal and natural family planning methods was also criticised, stating that they were not justifiable just because they were the lesser evil (Pope Paul VI, 1968).

Institutions claiming authority such as the Royal Commission and the Vatican conflated contraception and abortion. This was particularly problematic because their position could shape individuals’ acceptance of contraceptives, especially the Pill. When individuals were publicly debating the use of the Pill, some used the same arguments. However, others created their own.

One of the more public debates was about a book called *The Ultimate Con-traceptive*, published in 1990. This book was responsible for a large amount of misinformation spread throughout Aotearoa surrounding the Pill. *The Ultimate Con-traceptive* was written by a Dutch man living in Aotearoa named Emmanuel van den Bemd, a retired medical laboratory technologist, which gave seeming credibility to his work (‘Book “Misleading”’, 1990; Bradford, 1990; Chapple, 1990; Coutts, 1990; van den Bemd, 1990). He argued that “women have never

been told that the pill they are taking is made with very powerful synthetic steroids and maybe more powerful than the steroids taken by athletes these days”, “the pill was an overdose of hormones and the pill was at least 1000 times more potent than natural hormones”, and that “every woman is adversely effected by the pill either in the short or long term and 75% give up using the pill after suffering side effects” (Bradford, 1990).

The release of this book came with a nation-wide promotional tour, resulting in several articles, spreading this misinformation. Some articles were rebuttals of the book, including one by Dr Nick Bradford, a general practitioner and vice-chairman of the Contraception and Family Education Service, and one quoting Dr Christine Roke, the medical spokesperson of the NZFPA. Regarding the comments on anabolic steroids, Bradford pointed out that, when van den Bemd said that the Pill contains steroids he does not explain that oestrogen and progesterone are types of steroid hormones that occur naturally in women and that anabolic steroids that are taken by athletes are in fact more like testosterone than oestrogen. When refuting the comment that the Pill is 1000 times more potent than natural hormones, Bradford explained that, because the Pill contains synthetic hormones, rather than natural, and they are taken at a controlled dosage, the amount of hormones given are able to be altered to only be sufficient amounts to prevent ovulation. Regarding side effects and 75% of women giving up the Pill because of them, Bradford pointed out that actually a number of studies have shown that about 75-80% of women on the Pill do not even get side effects (Bradford, 1990).

The article quoting Dr Roke agreed with Bradford’s position (“Book “Misleading””, 1990). Both articles discuss the bias that van den Bemd had before researching and writing this book, as well as criticising his research methods. Bradford wrote “If you start from a biased position,

as I am sure the writer of this book has done, and if you are selective in choosing poorly done research, you can convince people that you are turning out the facts” (Bradford, 1990). “Dr. Roke says Mr van den Bemd selects only negative research on the pill and refuses to acknowledge all other medical research available” (‘Book “Misleading”’, 1990).

Van den Bemd used his career as a medical laboratory technician to give credibility to his claims. However, as a medical laboratory technician, van den Bemd would not have been involved in patient care or dispensing of contraception but, by placing himself as an expert due to his career, he placed the entire profession in a gatekeeping position, which was made possible by the Pill’s mechanisms of action not being completely accepted by the medical community<sup>25</sup>.

In spite of all the negative criticisms by doctors and the NZFPA, the information in van den Bemd’s book spread throughout the public. In a letter to the editor of *The Timaru Herald*, Richard Gunther said “Mr Bemd draws on nearly 40 medical journal articles and books” and that “Doctors are making a lot of money out of women who have to keep on returning to them for repeats, or check-ups, or treatment for side effects” (Gunther, 1990). Gunther even went so far as to suggest that the Cartwright Inquiry into treatment of cervical cancer at the National Woman’s Hospital covered up the link between “artificial steroid sex hormones and the increased incidence of cervical cancer” (Gunther, 1990). Gunther took van den Bemd’s argument as a way of calling attention to the medicalisation of women and contraception. He

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<sup>25</sup> As is discussed in the previous chapter.



did not do so to protect women's autonomy. Nor is this an issue that can be addressed with misinformation like that which came from van den Bemd.

When *The Timaru Herald* published Gunther's letter, they added a footnote from Dr S. D. Gee from the South Canterbury Health Services, countering Gunther's misinformation. Van den Bemd's book actually became popular enough that the publishers sold it internationally and had it translated into Spanish and Dutch (Coutts, 1990).

Arguments surrounding the Pill continued into the twenty first century. In 2001, one such argument took place through letters to the editor, of *The Evening Post*, regarding men's attitudes towards women who use the Pill. It was sparked by Paul Clarke, from Petone, writing regarding increasing sex-related crimes. Clarke stated,

the age of innocence for women disappeared in the 60's when they started swallowing both the contraceptive pill and the propaganda that went with it. The male regards the Pill as an open invitation to sex outside the law – in other words, as an excuse to rape and commit indecent assault. He doesn't now have to treat a woman as someone special, which she was before the Pill entered the scene.

(P. Clarke, 2001a).

Clarke's position suggested that men only need to not be violent towards women when they are able to reproduce and that they only have worth as reproductive beings. This letter faced instant backlash from women readers.

Responses sent to *The Evening Post* included sarcastic comments about how "recent letters to the paper inform us that condoning homosexuality and the invention of the Pill are to blame for the increase in sex attacks in Wellington... I didn't know the gay community and women were to blame. I thought the attacks were committed by heterosexual males! Furthermore, I

didn't know there were no instances of rape before the advent of the Pill." (Leary, 2001). Other responses contained more serious criticisms of men's attitudes towards women, "rape and sexual assault are not a by product [sic] of the Pill but a result of a lack of respect for women on the part of the men who rape" (Menzies, 2001). However, there were women who did not criticise Clarke's letter, instead supporting his position regarding the Pill "rape and sexual assault may have always occurred, but contraception has released males – to a historically unprecedented degree – from responsibility for sexual aggression" (Hammond, 2001). Each argument saying that the Pill had freed men to rape suggests that men's only concern regarding rape was that a child might result, failing to address the morality or violence of the act itself.

Despite these objections, Clarke and other men responded with even more superstitions surrounding the Pill and those who use it. Clarke wrote about how the introduction of the Pill came with "colossal increases in sexual abuse", increase of abortions "which is the worst form of child abuse, in fact it shows a hatred of children", and an increase in homosexuality "which is caused because women on the Pill lose their attractiveness", contradicting his earlier argument (P. Clarke, 2001b). This discussion around contraception ignited other debates around women's rights. A member of the Men's Equal Rights Association, Peter Zohrab, became involved in these debates. Zohrab focused on the issue of rights. Apparently under the Aotearoa "feminist legal system only men run any serious risk of punishment in relation to the sex act" and that "a woman can make a false accusation of date-rape and she will automatically be treated as a victim, with the man possibly facing indefinite detention" (Zohrab, 2001).

The attitudes of Clarke and Zohrab show some of the attitudes towards women as reproducers. Society has shaped women as mothers, labelling those who did not become

mothers as “superfluous” (Rout, 1914). Motherhood has been discussed as both a source of power and enslavement for women (Bordo, 1993; Hubbard, 2001; Sawicki, 1991). There were feminist scholars within second wave feminism who saw the Pill as both a way for men to escape responsibility and as a way to reject the societal roles placed on women (Sawicki, 1991; Wajcman, 2007, 2010). However, in more recent years, the Pill and other reproductive technologies have started to change societal attitudes towards women and their bodies (Sawicki, 1991; van Wichelen, 2016).

Sawicki (1991) has written regarding how both feminists and “anti-feminists” have reacted to new reproductive technologies. Radical feminists arguing that motherhood is a form of enslavement and new reproductive technologies only encourage that enslavement. “Anti-feminists” arguing that reproductive technologies only discourage reproducing (Sawicki, 1991). However, in contrast to this “anti-feminist” view, van Wichelen (2016) argues that reproductive technologies, such as international surrogacy, allow for a new family to be created, despite the legality of the actions of those involved.

The Royal Commission and the CSA Act 1977 are both examples of how small groups of people were able to mobilise their own personal moralities, using science as a support, to shape women’s reproductive autonomy. Above, I have shown how individuals in the public sphere were able to do the same thing in regard to the Pill. These actions were also used in public arguments regarding the ECP.

#### 4.3.2 The Emergency Contraceptive Pill

One of the newer developments in contraceptive technology is the ECP. With its controversial place between contraception and abortion, the ECP has been widely discussed. The public debates surrounding the ECP occurred in 1996, with the first attempt to make the ECP over-the-counter and then in 2002, when it was made over-the-counter. There have been a number of forms of the ECP, since the introduction of hormonal contraceptives. In 1979, Dr Margaret Sparrow – a Doctor involved with the Abortion Law Reform Association of New Zealand (ALRANZ) and the NZFPA – presented a paper titled “Postcoital Contraception”, outlining a number of different Emergency Contraceptives that were available at the time. The first version of the ECP was a high dose of synthetic oestrogen in diethylstilboestrol (DES), introduced in the 1940s for a number of uses, emergency contraceptives becoming one by the end of the 1960s. DES used a course of five doses, one a day, starting up to 72 hours following unprotected sex (Sparrow, 1979). Common side effects included nausea, so it was often taken with an anti-nausea medication, ectopic pregnancies and increased cancer risks in the children of women who took DES (Sparrow, 1979; ‘What They Don’t Tell You’, n.d.). Although how DES acts remains largely unknown, it has been shown that DES does affect endometrial and myometrial tissue in the uterus (Lackner & Tulsky, 1941). The effects on these tissue layers could prevent implantation of a fertilised egg, giving DES its emergency contraceptive effects. Following the discovery of the carcinogenic properties of DES, other high-dose, safer oestrogens were introduced, although, none were used for emergency contraception.

The second form of the ECP that was made available in Aotearoa was the Yuzpe regimen. The Yuzpe regimen was a combination of oestrogen and progestogen, a higher concentration of

the Pill. This ECP was a course of four tablets, the first two taken 72 hours after unprotected sex and another two 12 hours later. The main side effect was nausea, which was less severe than the nausea associated with DES because there was a 125 fold reduction in the dosage of oestrogen in the Yuzpe regimen, made possible through the addition of progestogen (Barnes, 1990).

The Yuzpe regimen was introduced in Aotearoa in 1978. In Dr Sparrow's 1979 presentation, she stated that, until there was more evidence, regarding safety and effectiveness she preferred to "confine this regimen to low risk cases" (Sparrow, 1979). This was a common fear of doctors following the introduction of the Yuzpe regimen. A decade later, in 1989, a study done for the NZFPA, Doctors Louise Kane and Margaret Sparrow found that these concerns had resulted in many not offering any form of ECP, especially as more people came to understand the long term effects of DES (Kane & Sparrow, 1989; 'Morning-after Pill Judged to Be Effective', 1989).

Following the Royal Commission, in September 1977, doctors employed at the NZFPA Auckland Branch wrote to Mary Batchelor – one of the four women MPs at the time – regarding the ECP. They supported the Commission's view, that the ECP should be made available to all women who had been raped (New Zealand Family Planning Association Auckland Branch, 1977; Royal Commission on Contraception, Sterilisation and Abortion, 1977). However, the doctors also raised the issue that not all women can take the ECP because of the high-dose oestrogens in DES, the ECP available in 1977. The Royal Commission recommended this particular use of the ECP because they wanted to remove rape as a reason for abortion, seeing the ECP as an alternative to abortion, despite their prior conflation of the two. However, the doctors from the

NZFPA, through outlining why the ECP was not a viable option for all women, were urging for legislation to include rape as a reason for abortion (New Zealand Family Planning Association Auckland Branch, 1977). The ECP being used as part of treatment for rape cases has been one of the narratives used to drive for the acceptance of the ECP (Wynn & Trussell, 2006). However, by placing it in such a position, there have been those, like the Royal Commission, that believe this would remove all needs for abortions in rape cases. It also places the expectation around the ECP that it is only used in such cases and a stigma around those who use it for other reasons (Wynn & Trussell, 2006).

The mistrust of high-dose oestrogens resulting from the carcinogenic effect of DES and doctors' lack of understanding of how the Yuzpe regimen worked resulted in ECPs not being promoted or offered as an option to some patients (Kane & Sparrow, 1989; L. Young et al., 1995), so in 1989 and 1990, there was a push by the NZFPA and Contraceptive Choice to raise awareness of the ECP. In a 1990 article in *New Zealand Doctor*, Lyn Barnes wrote about the Yuzpe regimen and how it compared to the high-dose oestrogens. When discussing the way that the combination of hormones works, Barnes wrote,

when given before ovulation, post coital hormonal contraception delays ovulation for about seven days by which time the waiting sperm have perished. The hormones also affect the biochemistry and development of the endometrium rendering it inhospitable for implantation of the fertilised egg. At this stage of development medication has an all or nothing effect on the fertilised egg, so that either implantation fails completely or the embryo develops quite normally.

(Barnes, 1990).

The form of the ECP that is currently used in Aotearoa is Levonorgestrel (LNG), a progestogen, introduced in 1998. In 1979, when Dr Sparrow made her presentation, if a woman

was given progestogens as an emergency contraceptive, she would have had to take up to 35 tablets of the funded progestogen, which was often only given to women who were unable to tolerate synthetic oestrogen (Sparrow, 1979). With the introduction of LNG, this changed. To take a full dosage of LNG, a woman only needed to take two tablets, now one. Throughout the mid-1990s, LNG was compared to the Yuzpe regimen in a world-wide study run by the Task Force on Postovulatory Methods of Fertility Regulation from the World Health Organisation. LNG was found to be more effective at preventing pregnancy, with fewer women reporting side effects than the Yuzpe regimen (Task Force on Postovulatory Methods of Fertility Regulation, 1998). This made LNG the easiest and safest form of the ECP for women to take. LNG has also been proven to act only by preventing ovulation (Croxatto et al., 2001; Durand et al., 2001; Gemzell-Danielsson et al., 2014; Gemzell-Danielsson & Marions, 2004).

Since the usage of DES as an ECP, the ECP has been plagued with misconceptions, possibly the most influential of which was the labelling of the ECP as the “morning-after pill”, resulting in many women mistakenly thinking that because they had not taken the pill literally the morning after unprotected sex, it would be useless (Roke, 1996b; L. Young et al., 1995).

The most controversial and publicly discussed misconception was the widespread claim that taking it leads to an abortion. In a letter to the editor of *The Dominion*, a woman from Miramar wrote that “regarding the ‘morning-after pill’ which is to be sold over-the-counter, I point out that it is misleading and also erroneous to say that it is a ‘contraceptive pill’... The morning-after pill works as an abortion method in that it prevents the fertilised ovum (the child that has now begun its journey toward the normal course of events which is birth nine months later) from

implanting and growing in the mother's womb" (Hampton, 1996). Hampton was not alone, R. N. McIntyre asserted that the ECP acts as "an abortion pill" (McIntyre, 1996).

Hampton's and McIntyre's statements were made regarding the Yuzpe regimen – the recommended ECP in 1996 – which prevented implantation. The 1977 Commission and CSA Act defined contraception as anything that acts pre-implantation. However, many still morally believed that the ECP is an abortion, these views were so prevalent that they continued through to the discussion of LNG, which does not act after ovulation. In 2000, the Christian Heritage Party's health spokesperson still called the LNG ECP an abortifacient (C. Young, 2000). This shows that in spite of the new technology and medications, people's thinking did not evolve.

The evolving technologies and conflation with abortion placed different layers of control over the ECP, first, doctors gatekeeping information regarding the ECP because they did not keep up with the evolving technologies (Sparrow, 1979; L. Young et al., 1995). This can be seen in the way many medical practitioners were hesitant to prescribe the Yuzpe regimen following the health risks associated with DES. Although they were initially being cautious with this technology, this continued after the Yuzpe regimen was proven safe, and resulted in many doctors not distributing the information regarding ECP, allowing the idea that the ECP is an abortifacient to continue, when it does not act after ovulation. Many individuals continued to argue for the ECP to be controlled to the same level as abortion which depended on the morality of the doctor, would have again allowed the doctors to use their position to gatekeep this information, and required the abortion "system" to control ECP use.



In 1996, following the announcement that the ECP would be made available over-the-counter, the NZFPA medical spokesperson, Dr Christine Roke, responded to an article in the practice nurse column in the *New Zealand Doctor*. This column contained “inaccurate information” on the ECP, including, that there is a risk of “fetal [sic] abnormality” and ectopic pregnancy, as well as claims that the ECP is an abortifacient (Roke, 1996a). Dr Roke addressed each of these issues: there is no chance of foetal abnormality because there is an all or nothing response, and “there is no increased risk of an ectopic pregnancy with the current Yuzpe regimen” (Roke, 1996a). However, Roke did acknowledge that there was an increased risk of ectopic pregnancy in earlier forms of emergency contraceptives (Roke, 1996a). When addressing the claim that the ECP is an abortifacient, Roke used the same definition as the Commission of when pregnancy begins, that pregnancy begins following implantation. Because the ECP only works before implantation, the ECP cannot be an abortifacient (Roke, 1996a). Roke says that “the nurse writing this article emphasises the client’s need for information. As health professionals we must be sure that we are giving correct up to date information” (Roke, 1996a), stressing how important it is that misinformation does not circulate, especially when coming from medical professionals.

The nurse who wrote the original column, Robyn Beckinsale, responded to Roke’s letter, providing an outline of doctors who had stated that there is a risk to a developing embryo and a risk of ectopic pregnancy, but it is rare (Beckinsale, 1996). Beckinsale addressed the issue of the ECP as abortifacient by explaining that it is important for each woman to know how the ECP works because of the possible moral implications:

Dr Sparrow admits that ‘it is not morally acceptable to some women because it acts after fertilisation has occurred’ and Dr Guillebaud [author] concedes that ‘others may disagree’ (on whether or not the ECP causes an abortion) and states that ‘it seems to me that a lot of the arguments are just about definitions’ – as the FPA spokesperson’s comments would seem to confirm.

(Beckinsale, 1996)

These arguments reiterated a number of different issues surrounding the ECP, failing to recognise that each form works in different ways, with different side effects, and that there is still no consensus on when pregnancy starts, and contraception becomes abortion.

The ECP has become a method of fertility control that sits between abortion and contraception, in terms of the biological timeline. Those who classify the ECP as an abortifacient restrict themselves to discussing older forms of the ECP to justify their position (Trussell, 2012; Wynn & Foster, 2012; Wynn & Trussell, 2006). The focus of scholars exploring this has often been the arguments against the ECP usually focused around the ECP being labelled as abortion (A. E. Clarke & Montini, 1993; Wynn & Foster, 2012; Wynn & Trussell, 2006). While some were based on the modes of action, most were based on the idea that because ECPs act post coitally they must be an abortion (Wynn & Trussell, 2006).

#### 4.4 CONCLUDING COMMENTS

Contraception and abortion exist on the fertility control spectrum. The Royal Commission and the New Zealand Parliament often conflated the two and manipulated definitions allowing them to place methods of fertility control into whichever category they saw fit. Although contraception was not the focus of either of these groups, the arguments put forward relating to abortion were also relevant to contraception.

The conflation of contraception and abortion, that I have described in this chapter, continued into discussions in the public sphere. Individuals attempted to use their personal moralities and beliefs, bolstered by limited scientific context shaped for their own use, to control women's agency to use contraceptives. The attitudes of these individuals also worked to influence the societal judgment of women who used contraceptives.

This chapter outlines how family and religious morality shaped the ways decision-makers such as the Royal Commission and New Zealand Parliament used science as a justification for their positions. Then how individuals, seeing this at policy level, used these same tools in the public sphere. All of which has built on previous chapters' arguments, showing how women's relationship with contraception was shaped in twentieth century Aotearoa.

## CONCLUSION

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Six years after the Pill was introduced in New Zealand in 1961, 20% of women of reproductive age were users, compared to approximately 8% of women in the United States and 3% of British women.

(Brookes et al., 2013)

As discussed at the beginning of this thesis, Brookes et al gave two reasons for this astonishing difference, the access pharmaceutical companies had to medical practitioners and the access medical practitioners had to women. By looking at these statistics and the reasons behind them, with all the additional research presented above, we can see how much of a role the medicalisation of women's bodies had on this uptake.

In 1901, access to contraception became limited to doctors, allowing doctors to gatekeep contraceptive information and contraception, making contraception and women's reproductive autonomy a medical issue. This gatekeeping was the primary source of contraceptives and contraceptive information throughout the twentieth century, remaining until the Pill was made available over-the-counter in 2017. Aside from the role played by the medical profession, other groups were also involved in these restrictions. Some of those discussed throughout this thesis include, MPs, the Royal Commission, other investigatory bodies, and Churches. These groups worked to shape women as contraceptive subjects by controlling women's autonomy and reproductive lives.

Women's bodies and reproductive autonomy have been controlled and shaped by those in positions of power, with arguments of morality or science justifying particular interventions.

Yet, through all these structural oppressions, women have worked subversively to protect their rights and reproductive justice. This was also the case for the use of contraception, either to accept it or reject it, within a settler state, shaped by the introduction of Christianity and western patriarchal principles, with a long history of eugenics logics and a perceived need by decision-makers to populate the country with a particular kind of citizen.

Eugenics logics and population control were driving forces behind most of the contraceptive-related legislations in New Zealand for the beginning of the twentieth century. Initially, the arguments were that contraception should be prohibited because white New Zealanders would stop reproducing. Arguments changing to support birth control clinics as a system to prevent those in poorer communities and with physical disabilities from reproducing. Changing attitudes allowed for access to contraception and contraceptive access to evolve. Contraceptive legislation encouraged the medicalisation of contraception by limiting accessibility to medical practitioners only.

Alongside these evolving attitudes contraception and fertility control were seen as threats to family, morality, and religion, many of those who worked to protect these ideals have been discussed throughout this thesis. Chapter one discussed the increasing population numbers, genetically 'desired' people through eugenics, morally upright non-delinquents, and holders of patriarchal power. All of which attempted to control women's autonomy and reproduction. As contraception was coming to be accepted as a private issue between couples in 1954, with both the establishment of the first NZFPA birth control clinic and the Mazengarb Inquiry, the focus of the defence of morality moved on to working to control adolescents as contraceptive users. The 'moral delinquency' that led to this change was blamed on many changing aspects of society,

including social housing, working mothers, and the availability of contraceptives. By blaming this need to control adolescents contraceptive use on working mothers, the Mazengarb Inquiry, as a group working to protect their ideal society, condemned parents, particularly mothers, who did not fit into the Inquiry's desired mould formed by a narrow family and religion-based morality.

The Mazengarb Inquiry was the first to officially state that religious morals shaped our legal system. The Royal Commission in 1977 also confirmed this. Both showing how important family and religious morals were within Aotearoa. By mobilising these family and religious morals, groups aiming to protect these societal ideals gained traction and criticised all changing fertility control laws.

Personal views of family and religious morality drove individuals to take part in these conversations and be involved in larger decision-making groups. These decision-makers, particularly MPs and medical professionals, were able to use their positions to control what forms of fertility control were accessible to women and which doctors were allowed to pass on this information. Medical practitioners acted through a series of gatekeeping activities, including preventing pharmacists from being able to distribute the ECP as an over-the-counter medication and lobbying against abortion laws that they felt would have degraded the position of their own profession. MPs worked through the legislative process, by manipulating how the CSA Bill was addressed and debated in Parliament, those who were against liberalising fertility control laws were able to influence who was available for the debate and how quickly other MPs had to address these issues.

The Royal Commission and the MPs involved in writing the CSA Bill also used their position to conflate and confuse contraception and abortion, permitting the controversy surrounding abortion to taint the acceptance of contraception. With contraception and abortion both existing on the fertility control spectrum, ambiguous definitions and confusing use of scientific terms allowed the Royal Commission and MPs to place and encourage further control of women's agency and reproductive lives. These actions encouraged individuals within the public sphere to take the same liberties. These individuals were able to make their positions known and encourage others through both published works and letters to the editor. These works helped shape the societal attitudes towards women who used contraceptives.

All of the events I have discussed throughout this thesis have contributed to Aotearoa women's relationship with contraception in the twentieth century. By engaging with the extensive archival research and the Feminist STS literature, this thesis applies more modern critique to historical events. Where social historians, such as Brookes et al, analysed the different societal aspects that lead to events like the uptake of the Pill, this thesis applies an analysis and critique to the aspects of society that allowed this to occur, like the effect that such an extensive medicalisation has on women's agency regarding their reproductive lives.

Feminist STS literature has posited a number of relevant themes. This thesis shows that the medicalisation of contraception and women's relationships with doctors has been central to contraceptive use in Aotearoa throughout the twentieth century, from the 1901 legislation banning the sale of preventatives, continuing today. The Feminist STS theme of how women's agency as reproductive beings has been shaped and how this influenced their position within

society has also been evident in the events and rhetoric that have been discussed throughout this thesis.

The research question with which this thesis began was, how has social, political, religious, and gendered institutions shaped women's relationship with contraception in twentieth century Aotearoa? The complex entanglement of medicine, policy, social infrastructure, and feminist activists discussed throughout this thesis, that variously tried to affect and mould women's reproductive rights is responsible for the different ways in which women's agency has been controlled, especially regarding their reproductive lives.



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