# Sex and Herbs and Birth Control: The Complexities of Women's Access to Fertility Regulation

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## INTRODUCTION

When I first bring up the subject of fertility control in introductory women's studies courses, students take it for granted that effective birth control methods are products of the twentieth century, as are movements to legalize abortion. They are astonished to learn about the long history of women's interest in fertility regulation, and are amazed at the wide ranging evidence of emmenagogic and abortifacient techniques and preparations to be found in most cultures and time periods. (Strictly speaking, an emmenagogue is a substance which brings on delayed menstruation whether or not fertilization has taken place, while an abortifacient destroys the fertilized ovum and/or causes the uterine lining in which the blastomere or embryo is implanted to be expelled. In practice the actions of the two are virtually indistinguishable in the earliest stages of pregnancyC that is, approximately the first six weeks.)

The history of women's access to fertility control is complicated and contradictory. Sometimes in situations in which most methods of birth control and abortion have been formally restricted or prohibited, it turns out that most women have had access to safe and reasonably effective methods. Conversely, mere legality does not guarantee availability or safety.

This essay looks at three aspects of fertility control across cultures: the transmission and degradation of knowledge, the variable meanings of terms related to fertility control, and changing access to birth control and abortion. I am in no sense attempting to be comprehensive here. Rather, I would like to provide some examples in each category, give some idea of the complexity of the issues**,** and raise questions for further investigation.

## PRAYING TO ST. BRIDGET

Documents from the history of conscious human fertility control go back more than four thousand years. There continues to be debate about the efficacy of many of the preparations cited in ancient and medieval records, although more and more of them are displaying at least some contraceptive or abortifacient properties in modern laboratory tests. There is also much controversy about how widely disseminated fertility control knowledge could have been in various time periods and cultures, but the weight of evidence has been tilting toward the conclusion that information was usually accessible.

Herbal methods of birth control were probably known by many European women into the 16th or 17th centuries, and some understanding of effective emmenagogic preparations survived until the 19th century in widely-used compendia

of folk medicine such as Gunn or Buchan. But for the most part, the knowledge became adulterated, corrupted, lost, or devalued by women as well as by medical professionals.

In other parts of the world, folk traditions endured longer. But by the end the 20th century, most women had lost the contraceptive and abortifacient knowledge that women had once possessed, and were largely at the mercy of westernized medical professionals for their reproductive health needs. There are numerous examples of incomplete or erroneous transmission of what were once effective birth control practices. Evidence suggests that earlier generations of women knew far more than their grandchildren and great-grandchildren about family planning.

*Herbal Teas in the Southwestern U.S.*

During the six years that I have been teaching a course on "Women as Healers" at Arizona State University, a few of my students have related to me their experiences with traditional teas given to girls. It is the custom among some families of the Southwest of Mexican, Hopi, Navajo, Gila, and Pima origin to regularly administer some sort of herbal tea to their post-pubescent girls. Among the ingredients my students have mentioned are avocado seed, aloe, rue, mints, juniper, and a variety of desert plants, many of which have been shown in laboratory tests to have emmenagogic or abortifacient properties. In general, my students had not known about the contraceptive possibilities of the teas, nor for the most part did their mothers or grandmothers. It remains a question exactly when women of the Southwest ceased knowing why their ancestors had created the custom of using the tea.

*St. John's Wort*

Today many know St. John's Wort as a "mood regulator" widely sold over the counter in health food stores and groceries in Europe and the U.S. Less widely known, however, is the fact that traditionally the herb was known for its contraceptive effects. Furthermore, because of its estrogenic properties St. John's Wort can interfere with and inhibit the action of modern fertility drugs. It follows that if failure to become pregnant is at the root of a woman's depression, then St. John's Wort is just about the worst thing she could take. Yet in a series of interviews my students conducted with herb sellers in the Phoenix area, none of them mentioned the fertility control aspects of the herb (although one herbalist in San Francisco did), nor did they caution against possible drug interactions with modern fertility enhancement and birth control pills.

*Pennyroyal Tea and Pennyroyal Oil*

When I was a graduate student doing research in Leningrad (now St. Petersburg), I lived in a dormitory with students from all over the world. Once, I casually offered pennyroyal tea to an Algerian acquaintance. She drew herself up to

her full height, sneered, and said sarcastically, "Thank you very much! But I do *not* need it!" Her reaction puzzled me greatly, and I wondered whether I had somehow misunderstood her Russian. It was only later that I realized that she had thought that I was insulting her by implying that she was in need of an abortion. Pennyroyal, like other members of the mint family, has been used in many cultures and time periods as a key ingredient of emmenagogic and abortifacient preparations. In 1982, my Algerian acquaintance (and the Siberian friends from whom I later learned about this) knew that quite well; I, however, did not.

U.S. women of European descent have perhaps become particularly ignorant about the wealth of herbal remedies that previous generations accumulated over the centuries. During the 1970s, some activists attempted to revive the earlier practices based on the fragmentary information that was available to them, occasionally with tragic results. For example, three women in Colorado died from taking pennyroyal oil in an effort to procure abortion. Pennyroyal tea can be effective early in a pregnancy; concentrated pennyroyal oil, however, can kill. The same is true of oil of tansy or rue, as well as ergot of rye. All have been used by women to terminate pregnancy, and when used improperly, all have been implicated in women's deaths.

*St. Bridget's Amulet*

A disconcerting (though amusing) example of degradation of knowledge of fertility control concerns St. Bridget's amulet. According to legend, St. Bridget was a medieval midwife and a patron saint of childbirth and women's diseases. Today, some Irish girls wear a St. Bridget amulet in which small pieces of seaweed are kept in order to protect themselves against unwanted pregnancy. The fascinating thing is that certain kinds of seaweed (kelp fronds or sea lettuce, for example) actually can act as a reasonably effective barrier pessary, especially if used in conjunction with a spermicide or motility inhibitor such as honey or wax mixed with lemon. There is a good chance that St. Bridget and her apprentices knew this (contrary to what most people would now imagine, medieval and early modern Catholic clerics and nuns frequently discovered and recommended emmenagogic and abortifacient substances). Young Irish women today, however, seem to have no notion of the sensible, traditional way to use the seaweed and are left only with the absurd practice of putting seaweed pieces around their necks and praying to St. Bridget!

**"A LITTLE BIT PREGNANT"**

In the course of my research on fertility control across cultures, I have become increasingly aware that the casual and unthinking use of certain common words can lead to misunderstanding. Key terms such as "abortion," "pregnancy," and "infanticide" do not necessarily convey the same meanings to everyone, and their significance can change across historical and cultural settings. Take, for example, "pregnancy." Seemingly, nothing could be more straightforward, as

exemplified by the old adage that one can never be a little bit dead or a little bit pregnant. Yet pregnancy is a culturally determined concept; it does not necessarily begin with the fertilization of the egg by the sperm. For most of European history, pregnancy was defined as beginning with "ensoulment" or "quickening" - the point at which the soul was imparted into the developing fetus, a moment often thought to be signaled by its first movement within the womb. Prior to that event (believed to occur some time during the third or fourth month after fertilization), a woman was not really pregnant, and anything she did was usually considered permissible. Since delayed menses was viewed as unhealthy in many cultures (including most of the indigenous cultures of the "New World" as well as many in Europe and Asia), and often a "clean" womb (i.e., one free of retained menses) was regarded as necessary for conception, various means to restore the flow were allowed. Whether or not one considered the process of menses restoration after fertilization as abortion clearly depended on one's definition of pregnancy.

The word "abortion" itself is a slippery one. There is evidence that most Catholic theologians prior to the 19th century used the word only in reference to deliberate termination of pregnancy *after* quickening. Many scholars have argued that English common law preserved the same distinction until at least 1800, as did most women in their own practical understanding of pregnancy and abortion.

Besides using the term "abortion" for the deliberate act achieved through herbal, chemical or instrumental means, most Western European and U.S. physicians in the 19th and the first half of the 20th centuries used "abortion" interchangeably with "miscarriage" to denote the spontaneous termination of pregnancy through natural or accidental causes. And many of the same doctors who reviled abortions when done by midwives or other unlicensed persons themselves performed hundreds if not thousands during the course of their careers. The distinction, for them, was that their abortions were "therapeutic" and therefore necessary. The fact that their "indications" for abortion included everything from obesity to high blood pressure to nervousness did not seem to phase them at all.

Nor were most 19th century physicians bothered by very late abortions up to the moment of full term delivery. So long as the "therapeutic" abortion was sanctioned by a licensed physician, it was viewed by most doctors as legitimate, and not to be confused with those performed by midwives or "quacks" at the behest of the pregnant woman. Thus, when physicians of the time railed against abortion, in most cases they did not intend for the term "abortion" to include the putative therapeutic procedures performed by their esteemed colleagues and themselves.

Even a word supposedly as unambiguous as "infanticide" can have varying cultural significance. For example, in the 18th and 19th centuries, the conditions for European factory women were so horrible that many of them could not support their children, especially if they were born out of wedlock. Women and girls sometimes sent their babies to rural wet nurses who might take ten or twelve infants at a time. The likelihood of a baby surviving under these circumstances was not great, as

everyone knew, and in time the women might receive word that their children had died. One nickname for the practice was "angel making" (after all, the reasoning went, the little innocents would go to heaven). The women who engaged in the activity would have vehemently rejected the notion that they were deliberately killing their infants, of course. In some cultural contexts today similar phenomena are grouped under the terms "failure to thrive" or "passive infanticide," although in these cases, too, most mothers would no doubt recoil in horror from the word "infanticide."

*Abortion, Infanticide, or Misreporting*

Most scholars today are aware of the "fact" that in some provinces of China there are as many as 135 boys under the age of 5 for every 100 girls. (There are analogous gender differences in India as well.) The extreme demographic imbalance is generally attributed to the Chinese government's coercive population control policy. The most often-told story is that the one-couple-one-child maximum, along with the traditional Chinese preference for sons over daughters and the availability of amniocentesis, ultrasound, and legal abortion, have resulted in female fetuses being aborted at far higher rates than male fetuses.

Most commentators appear to have taken for granted that the imbalance is a result of abortion rather than infanticide or other causes. Yet differential abortion rates are perhaps the least plausible explanation. In utero sex determination at an early stage of pregnancy (when abortion is legal and safe) is inexact at best, especially since most Chinese couples would be relying on inexpert ultrasound operators rather than the more accurate and expensive amniocentesis. It is, in fact, quite possible that almost as many male fetuses are aborted as female ones.

A more credible explanation for the extreme gender differences could be some sort of passive infanticide of the "failure to thrive" variety. Girl babies might be given less food, allowed to ail longer before being given medical attention, etc. Another possibility, however, is that neither abortion nor infanticide is occurring on the large scale necessary to account for a 135/100 gender ratio. The social and political constraints of the one-child policy might lead to the systematic under reporting of baby girls in rural areas. In other words, villagers might be conspiring to hide their daughters from representatives of the central authorities so they can try again to have a son.

**THE DEMOGRAPHIC TRANSITION**

The term "demographic transition" refers to the population stabilization and in some cases decline that accompanied European urbanization and the Industrial Revolution. Many historians and demographers who study early modern Europe (for example, Philippe Aries, E. A. Wrigley, and Orest and Patricia Ranum) say that it was migration to the cities, combined with the unemployment created by mechanization, that first impelled people to think about fertility control. Families no longer needed many hands to help with farm work; children thus became economic

liabilities rather than assets.

These scholars have maintained that it was only in the context of industrialization that limitation of offspring became desirable, and they assume that effective techniques were developed accordingly. In their view, economic exigencies led to a need for smaller families, and this need inexorably and inevitably led to the development and increasing use of effective birth control.

There are, however, some problems with this theory. Contrary to the assumptions of the demographers, methods of contraception and abortion might very well have been more effective before the demographic transition of the 18th century than after. Industrialization, in fact, appears to have been characterized by the degradation of knowledge that was described earlier in this paper. What occurred was not the sudden emergence of birth control, but rather a change in the methods employed to limit family size. While herbal contraceptives and abortifacients declined in popularity and became conflated with patent medicines of dubious utility, the use of instrumental abortion appears to have increased dramatically.

Many writers have commented on the efforts of formally-trained, overwhelmingly male physicians in this time period to wrest control of women's health from the hands of midwives and other largely female practitioners. "Regular" physicians worked tirelessly to disparage women's knowledge and expertise, and to limit midwives' access to the traditional tools of their trade such as ergot of rye and other natural substances. They also sought to prohibit women from independently using the new technologies (such as stem and cradle pessaries and uterine sounds) developed during the 18th and 19th centuries. Yet despite the physicians' best efforts, it seems that reasonably safe instrumental abortion became increasingly available in the 19th century.

Unaware of the complicated history of fertility regulation, demographers generally take for granted that the decrease in average family size that began in the 18th century was brought about by improved pre-conception birth control. In the rare instances in which they specify a possible method, they allude to condoms or the increasing restraint of working class men (i.e., withdrawal before ejaculation). But there is scant evidence either for increasing self-control of men or for major technical innovation in this period. The most important technological improvements in pre-conception birth control took place either much earlier (the silk sheath and gut condoms of the 16th century) or later (the rubber skin condom of the 1880s and the IUDs and pills of the 1950s and 1960s). The only 18th century inventions that would ultimately become significant tools for pre-conception fertility control, stem and cradle pessaries, were not created for that purpose at all, but rather were designed to correct cervical malformations and thus *increase* fertility.

There are more plausible explanations for declining family size in the Industrial Revolution than contraception. First, there were increasing rates of instrumental abortion. Moreover, in the crowded, unsanitary conditions of cities in this era, epidemic diseases such as cholera, diphtheria, typhoid and influenza, could

be increasingly deadly, especially to children.

**WHAT WE SAY AND WHAT WE DO**

Often misogynist religious doctrines and repressive politics can limit women's access to abortion and even birth control. Bishop Obando y Bravo of Nicaragua has actually said that it is better to die of AIDS than to wear a condom, and official Catholic Church policy forbids abortion and all methods of birth control other than abstinence and rhythm. Cuba is the only country in Latin America with unrestricted access to birth control and legal abortion. Yet even in countries where abortion is technically illegal, access varies widely. During Sandinista times in Nicaragua, Doris Tijerino, the Chief of Police in Managua, announced publicly that she would not enforce existing anti-abortion laws. And in Colombia, a group of abortion clinics operate more or less without police interference, and even have Jesuit priests among their sponsors. (The priests argue that, when a woman decides in her mind to have an abortion, she has begun the process; the clinics are merely helping her to complete the abortion in safe circumstances.)

*Madame Restell and Patent Medicines*

In the U.S. and most of Europe during the whole of the 19th century, anyone who wished (from any class of the population) probably could have procured an abortion. Abortionists advertised openly (though their language was circumspect), and were rarely prosecuted and even more rarely convicted. Estimates of the number of illegal abortions performed annually in the second half of the 19th century in cities such as New York, Boston, London, Paris, Berlin, and Madrid ran into the tens if not hundreds of thousands. And women seldom died. For example, Madame Restell, one of the most famous and affluent abortionists in 1870s New York City, appears to have lost no more than five or six women out of her more than 100,000 patients.

Like most abortionists of her time, Madame Restell offered both herbal/chemical and instrumental options to her clients. She and her husband, who went under the professional name of A. M. Mauriceau, were the purveyors of two of the most popular and widely-imitated abortifacients of the late 19th century– "Portuguese Female Pills" and "French Female Pills." If her concoctions failed, or the woman came to her too late in the pregnancy for them to be effective, she resorted to instruments such as the uterine sound. Although antisepsis did not make a significant impact on gynecological surgery performed by licensed physicians until about 1900, most 19th century abortionists appear to have paid enough attention to the cleanliness of themselves, their instruments, and their work spaces to ensure astonishingly low mortality rates.

In addition to the abortionists plying their trade more or less openly in most cities and large towns of North America and Europe, vendors offered a huge range of

items purporting to limit fertility. Most were available from pharmacists and by mail order, and some were also sold door-to-door in small towns and rural areas. The so-called "patent medicines" of the 19th century claimed to treat all kinds of illnesses, from asthma to venereal disease, and many of the most popular also advertised fertility control as one of their purposes. Because of the new restrictions to be discussed below, makers of these products had to use increasingly veiled language to advertise. To most women, from prostitutes to "respectable" married ladies, however, the code was easily decipherable. Purveyors of emmenagogues and abortifacients wrote obscurely of "obstructed" or "suppressed" menses, "female complaints," "green sickness" (sometimes called chlorosis or amenorrhea) and "female weaknesses," and assured their customers that their preparations "which can never fail" would remove "female obstructions" whatever the cause. For example, a late 19th century Cherokee Pills pamphlet featured a "Warning to Married Ladies" which customers would have understood exactly as the sellers intended: as an advertisement for an abortifacient preparation.

Women also were known to utilize a wide variety of vaginal and uterine pessaries for purposes of fertility control. The invention and patenting of pessaries was a growth industry in England and the U.S. in the second half of the 19th century, largely because of the exceedingly high rates of prolapsed uterus and related conditions. Enterprising (and desperate) women were known to use these devices not to secure a prolapsed or retroverted uterus in its correct position (as the doctors intended), but to fix the uterus in a closed position once an obliging midwife or physician had manually retroverted the cervical opening.

In addition, a number of substances were advertised as post-coital contraceptive douches, especially in the early and mid-20th century. Cardui Wash, Zonite, Listerine, and Lysol were all touted for what was euphemistically called "marital hygiene" or "marital congeniality." Lysol, in fact, positioned itself as the best alternative to caustic sodas or salts—"gentle to sensitive membranes, yet ... effective in the presence of mucus and other organic matter." Was Lysol as effective as an instrumental abortion or the earlier homemade herbal teas and contraceptive douches? Probably not, although debate continues about the efficacy and safety of virtually all of the contraceptive and abortifacient techniques discussed above.

Although many of the methods used to prevent or terminate pregnancy were often ineffective (this was especially true of the patent medicines and the post-coital douches), and women sometimes had to resort to instrumental abortion after less intrusive alternatives had failed, the point here is that women had access to a broad range of techniques for birth control and abortion. If we were to rely on law codes or the proscriptive pronouncements of clerics or doctors for our assessment of the options available to women in a particular culture or time, we would most likely overlook all the evidence of women's efforts to control their own fertility, and thus end up with an oversimplified view of the situation.

*Harmful Trends*

In the 19th and 20th centuries, there were significant changes in attitudes and policies on fertility control in the U.S. and Western Europe. I have identified four of those changes:

1) In the U.S. beginning in the 1870s, the "Comstock Laws" formally banned dissemination by mail of information about birth control and abortion, on the grounds of "obscenity."

2) In most jurisdictions of the U.S. and Western Europe, abortion under most circumstances was gradually criminalized, and pregnancy started to be defined by most doctors and jurists as beginning at conception.

3) In 1869, the Roman Catholic Church forbade virtually all abortion and in later years continued to harden its stance.

4) In the U.S. and Great Britain, doctors, rather than clerics, instigated most movements for the criminalization of abortion. Ironically, those same doctors were reluctant to discuss other methods of fertility control with their women patients.

Ultimately, these developments had negative implications for women's continued access to fertility control techniques and skilled professionals. Abortionists were gradually driven further underground during the 20th century, so that by the 1950s the horrific image of the unscrupulous back alley abortionist with his bloody coat hanger had largely replaced the earlier images of a prosperous, competent Madame Restell or the kindly, knowledgeable African American "granny midwife" known to generations of poor American women in the South.

*Recent Decreases in Access*

Affluent women can always obtain safe abortions, regardless of law codes or official religious pronouncements. For example, during the 1950s and 1960s, a common euphemism for abortion among wealthy American women was "Puerto Rican weekend." Women with the means to do so could fly to Puerto Rico and procure a safe, legal abortion. Normally, it was only less affluent or less knowledgeable women who had to resort to the back alley butchers.

However, one should not assume that liberal law codes or the relative lack of negative comments by physicians or other interested professional groups imply that women's access to safe and effective means of fertility regulation will necessarily be assured. In the U.S., as in many countries, access to abortion is decreasing for several reasons. Not only has *Roe v. Wade* been eroded by state laws requiring parental consent or notification, but also Hyde Amendment-type cuts in federal and state financing, and fetal rights court decisions have made obtaining abortions more difficult. An older generation of doctors (who remember the desperate situation of many women in the darkest days before the decriminalization of abortion in the

1970s) are retiring or dying. Most younger doctors appear less willing than their seniors to brave the gauntlet of anti-abortion picketers in front of clinics (or in extreme cases risk their lives) in order to ensure safe access to a full range of reproductive health options for all women.

In many countries, most notably in Eastern Europe, economic and political changes have also decreased access to fertility control. When the German Democratic Republic was absorbed by the Federal Republic, its progressive abortion legislation gave way to the restrictive law codes of the West. In the former Soviet Union, abortion is still legal (although under attack), but its cost has increased sharply, and its availability for the average woman has declined dramatically. Pre-conception forms of birth control are scarce or expensive. Many women have no wish to bear children in the present economic turmoil of Russia, but their options are limited indeed.

Most countries in the throes of marketization and neo-liberal economic policies imposed by the World Bank and International Monetary Fund have seen some decrease in access to fertility control, often because privatization drives have curtailed public sector spending on health and social services. In addition, the Bush Administration is exerting pressure on international funding agencies to avoid countries where the state funds abortion and other fertility control options. Thus, in many places the picture is becoming more gloomy.

One exception, however, is Vietnam, where the Vietnam Women's Union and the government are consciously trying to keep reproductive health clinics open and relatively inexpensive despite marketization pressures. Abortion prices have been kept reasonable, with a sliding scale of fees to accommodate the poor, and sex education and birth control campaigns that encourage responsible sexuality are sponsored by local Women's Union branches all over the country.

## CONCLUSION

Because of the complexity of the issue, it is not yet possible to write a definitive treatment of the history of fertility control. Much of what we know is incomplete or ambiguous. In particular, it is clear that in the absence of other kinds of evidence, official pronouncements or proscriptions with regard to birth control and abortion give us little or no insight into the reproductive and sexual lives of women in a particular culture or time period. In any case, we need more studies of the mechanisms of fertility control, and we need to pay more attention to the experiences of real women.

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