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Talking about male body-based contraceptives: The counseling visit and the feminization of contraception

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ABSTRACT

In developed countries, women bear the primary, and sometimes exclusive, responsibility for preventing pregnancy in heterosexual sexual relations. This unequal burden is not an intrinsic fact; it is the consequence of broad social narratives and interpersonal negotiations. The contraceptive counseling visit is increasingly recognized as a site of the discursive production of normative ideas about reproduction, suggesting that clinicians themselves may contribute to the assignment of responsibility for contraceptive labor to women (i.e. the feminization of contraception). Scholars have not yet considered how providers talk to patients about methods that are male body-based (i.e. condoms, withdrawal, and vasectomy) and, as such, may disrupt the feminization of responsibility for contraception. Using transcripts of 101 contraceptive counseling visits recorded between 2009 and 2012 in the San Francisco Bay Area, I investigate how clinicians discuss male body-based methods with female patients. Drawing on a constructivist approach, I find that clinicians generally devalued male body-based methods in their counseling. They did so by, first, failing to discuss them as options for long-term contraception. Second, when they did discuss them, clinicians tended to emphasize aspects of the methods that were presumed "negative" (e.g. the lower efficacy of withdrawal and condoms) but not features that patients might view positively (e.g. the high efficacy of vasectomy or the lack of side effects with condoms and withdrawal). In aggregate, these discursive practices marginalize male body-based methods as contraceptive choices. As a practical effect, this may encourage women to choose a method that does not best meet their preferences. At a structural level, by devaluing methods that could undercut the unequal division of fertility work, these discursive patterns contribute to the feminization of responsibility for contraception and the retrenchment of the unequal gendered division of fertility work.

In developed countries, women bear the primary, and sometimes exclusive, responsibility for preventing pregnancy in heterosexual sexual relations (Bertotti, 2013; Fields, 2008; Weber, 2012), even as men may be significantly involved in the decision to avoid or delay pregnancy (Fennell, 2011; Grady et al., 2010). Bertotti (2013) describes the range of activities required to prevent pregnancy as part of fertility work, characterizing the attention, time, stress, and physical burden as forms of domestic labor that fall disproportionately on women. This unequal burden is not an intrinsic fact: contraceptive responsibility was not always tilted toward women and, in fact, in some settings is considered the responsibility of men (Tone, 2002). The current Western feminization of contraception is the consequence of broad social narratives and interpersonal negotiations. Lowe (2005) argues that social stories about men's and women's innate sexual drives combined with the specific bodily experience of pregnancy in only "female" bodies build the broader social narrative that ascribes contraceptive responsibility to women. Fennell (2011) further finds that negotiations between sexual partners often discursively construct contraception as women's responsibility by citing the biotechnological constraints of the contraceptives themselves, such as the fact that most highly effective methods work primarily in concert with female anatomy.

Women's ability to control their bodies and their fertility has historically been understood as a feminist issue (Gordon, 2002) and access to contraceptive technologies is associated with positive social outcomes for (some) women (Goldin and Katz, 2002). The principle of women's autonomous control of their bodies, however, is distinct from the feminization of contraception. Whereas the former does not require that the intervention take place in women's bodies—insisting that a partner wear a condom, for example, can be consistent with a woman having control over her body and fertility—the feminization of contraception places the burden of contraception specifically on women and *women's* bodies. Certainly, many women want to use methods that operate in their bodies, and the ability to use a method covertly can be of great importance to women's safety and autonomy (Mathenjwa and

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Maharaj, 2012). But the placement of the contraceptive burden exclusively on women's bodies is not entirely consistent with the idea of women having bodily autonomy and control.

One overlooked potential contributor to the feminization of responsibility for the contraceptive burden is the contraceptive counseling visit. Stevens (2015) finds that contraceptive counseling is informed by providers' own normative expectations about appropriate motherhood. For example, providers may insist that women who do not meet particular normative characteristics (e.g. financial security) leave the counseling visit with a prescription contraceptive, thus privileging methods that operate in female bodies. In addition, clinicians discursively downplay the importance of consideration of side effects in women's contraceptive decision-making (Littlejohn and Kimport, 2017), potentially functioning to endorse female body-based methods over other methods. And women themselves—especially women of color and adolescents—report experiencing pressure from their providers to use particular, usually non-patient-controlled, forms of contraception (e.g. the intrauterine device [IUD]) (Downing et al., 2007; Higgins et al., 2016; Mann, 2013; Thorburn and Bogart, 2005). These methods all operate in female bodies, which points to broader counseling patterns of privileging female body-based methods.

Research has not yet considered how providers talk to patients about methods that are male body-based (i.e. condoms, withdrawal, and vasectomy) and, as such, hold the potential to disrupt notions of the feminized responsibility for contraception. This oversight is particularly consequential because male body-based methods are widely used (Higgins et al., 2014; Jones et al., 2014), have high rates of satisfaction (Al-Ali et al., 2014), and/or are very effective in preventing pregnancy (Trussell, 2011). They also each have features that many women report as extremely important to them in a contraceptive method (Lessard et al., 2012). The lack of examination of patient-provider interaction about these methods represents a gap in the descriptive literature on the discursive contributions of the counseling visit. It is also important because the current emphasis in the literature on female body-based methods may itself further the feminization of contraception (Daniels, 2008).

Medical providers have a great deal of flexibility in how they present information about contraceptive methods to patients. Given the prospect that the use of male body-based methods may reduce (or even undo) the feminization of responsibility for contraception, how clinicians present male body-based contraceptive methods in the counseling visit has implications for women's health and reproductive autonomy. Below, I analyze how providers discuss condoms, withdrawal, and vasectomy with female patients in 101 contraceptive counseling visits. Using a constructivist approach, I find that clinicians generally spoke in ways that devalued male body-based methods. Clinicians rhetorically constructed male body-based methods as not-preferred methods by, first, failing to discuss them as options for long-term contraception and, second, when they did discuss them, tending to emphasize “negative” aspects of the methods. By devaluing methods that could undercut the unequal division of fertility work, these discursive patterns contribute to the feminization of responsibility for contraception and the retrenchment of the unequal gendered division of fertility work.

1. Background

Roughly three out of five women of reproductive age use contraception (Jones et al., 2012). This use is, pointedly, instrumental: a means to prevent pregnancy. As Higgins and Smith (2016) astutely note, people use contraception in order to have sex; they do not have sex in order to use contraception. To be sure, the possibility of sex without fear of pregnancy is possible only with reliable contraception. Nonetheless, there is evidence that women are not satisfied with the female body-based contraceptives they are using (Littlejohn, 2012, 2013).

Women prefer methods that are effective, affordable, and have minimal side effects (Lessard et al., 2012). Methods that operate in/on male bodies may meet these preferences for some women. Examining perfect use failure estimates (typical use discussed below), among couples who use male condoms consistently and correctly for one year, only about 2% will experience an accidental pregnancy (Trussell, 2011). This makes condoms potentially an effective method of contraception, especially compared to using no method, which is estimated to result in 85% of couples becoming pregnant in a year (Trussell, 2011). Condoms are available over-the-counter and associated with few side effects. Perhaps for these reasons condoms are a popular method, used in an estimated one in three sex acts among 15- to 44-year-olds (Higgins et al., 2014). Withdrawal has the potential to meet women's preferences too. With correct and consistent use of withdrawal, only 4% of couples will become pregnant in the course of a year (Trussell, 2011). Like condoms, it is quite popular; Jones et al. (2014) found that one-third of women respondents reported using withdrawal in the past 30 days. It also has no financial cost and no side effects, which make it a preferred method for some women (Ong et al., 2013). Vasectomy is an even more effective method, with only a 0.10% failure rate (Trussell, 2011), plus it has no side effects in women's bodies and no financial cost for women. It also has fewer side effects and lower risk for men than tubal ligation, a comparable female sterilization procedure, has for women (Shih et al., 2011).

Each of these methods also has features that may not meet individual women's preferences. Vasectomy is not an appropriate choice for women who want to have future children. Additionally, the *typical* use efficacy estimates—which account for how people actually use the method—for condoms and withdrawal are notably lower than efficacy estimates for correct and consistent use: 18% of couples using condoms and 22% of couples using withdrawal are estimated to experience a pregnancy (Trussell, 2011). For comparison, typical use estimates for the contraceptive pill, patch, and ring (all female body-based methods) predict that 9% of couples will experience an accidental pregnancy (Trussell, 2011). (Typical use estimates of vasectomy are only slightly lower than consistent and correct use estimates, at 0.15% (Trussell, 2011).) It bears noting that typical use estimates have been critiqued. Scholars have argued that user error is not random. The rate of error for a given couple using condoms, for example, decreases substantially over time (Sanders et al., 2012). Likewise, research suggests that measurements for withdrawal estimates, in particular, are unreliable (Jones et al., 2009). Moreover, recent updates of typical use estimates find that failure rates of some methods have decreased (notably to 13% for the male condom), although the reason for this trend is unknown (Sundaram et al., 2017). It also bears noting that where women in general or an individual patient would draw the line in regards to what they consider effective (or effective enough) has not been established and it is likely that that line would vary among patients.

The counseling visit is an opportunity for women who seek to control their fertility to learn about available methods and identify the contraceptive method that best meets their preferences. Choice of a contraceptive method is a patient preference-sensitive decision; among the many contraceptives available, there is no one best option from a medical perspective. Little research has considered how male body-based methods are discussed in this setting, representing an important knowledge gap given: 1) the fact that these methods may best meet some women's preferences, and 2) the emerging recognition that clinicians themselves contribute to normative constructions of pregnancy and motherhood (Stevens, 2015) and may discursively perpetuate the feminization of responsibility for contraception. Here, I contribute to the literature on medical sociology and the sociology of sex and gender by investigating how medical providers discursively construct male body-based methods in the counseling visit. To the extent that these methods are portrayed as poor choices for long-term contraception, these patient-provider interactions reify the assignment of the physical fertility work of preventing pregnancy to (only) female bodies. Further,

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