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Publication Date

2018-03-01

DOI

10.1016/j.socscimed.2018.01.040

Peer reviewed

HHS Public Access

Author manuscript

Soc Sci Med. Author manuscript; available in PMC 2018 August 20.

Published in final edited form as:

Soc Sci Med. 2018 March ; 201: 44–50. doi:10.1016/j.socscimed.2018.01.040.

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.

Keywords

USA; contraception; condom; withdrawal; vasectomy; contraceptive counseling; gender

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, Klepinger, Billy, & Cubbins, 2010). Bertotti (2013) describes the range of activities required to prevent pregnancy as part of fertility work,

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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 & 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 & 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 & Kimport, in press), 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, LaVeist, & Bullock, 2007; Higgins, Kramer, & Ryder, 2016; Mann, 2013; Thorburn & 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, Lindberg, & Higgins, 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.

Background

Roughly three out of five women of reproductive age use contraception (Jones, Mosher, & Daniels, 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), 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, Turok, & Parker, 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, Fennell, Higgins, & Blanchard, 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 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 literatures 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, as a practical effect, these interactions may affect very private decisions about how couples and families distribute the domestic labor of fertility work.

Methods

This analysis draws on a unique dataset of contraceptive counseling visits of women of reproductive age seeking family planning services. Between August 2009 and January 2012, research assistants recruited patients at six clinics in the San Francisco Bay Area before their family planning visits and invited them to join the study, described as an investigation of patient-provider communication about contraception. The recruitment sites were family planning, primary care, and general gynecology clinics. They included both clinics that served primarily uninsured patients and large multi-site clinics whose patients were almost exclusively insured. Patients were eligible if they spoke English, were not currently pregnant or wanting to be pregnant, were interested in discussing contraception in their visit, and self-identified as black, white, or Latina (with this criterion designed to enable the parent study to address questions of counseling disparities). These eligibility criteria meant that the sample was not representative of the clinics' patient populations. The entirety of each participant's counseling visit was audio recorded using a device left in the room; no member of the study team observed these visits. All recordings were transcribed verbatim. Both patient and clinician participants completed written consent. Study protocols were approved by the institutional review board at the University of California, San Francisco.

Additionally, patients completed a pre-visit questionnaire, which included questions about current contraceptive use, fertility intentions, and demographics, and a post-visit questionnaire, which included questions about their selected method. Data from these surveys informed the sampling strategy described below. Patient participants were remunerated for their time with a $25 gift card.

The study collected data on 342 contraceptive counseling visits, representing 342 patients and 38 clinicians. Previous experience with the data (Kimport, 2017; Kimport, Dehlendorf, & Borrero, 2017; Littlejohn & Kimport, in press) sensitized me to the presence of underlying, unexplored patterns in how clinicians discussed—and failed to discuss—male body-based methods in the contraceptive counseling visits. Because the full set of transcripts is prohibitively large to analyze qualitatively, I designed a purposive sampling strategy to increase the likelihood of selecting counseling visits where a male body-based method was discussed.

First, I selected the visits of patients who reported in their surveys using a different method post-visit than pre-visit. Based on my experience with the data, I recognized that this change often signaled that the patient was dissatisfied with her current method (including male body-based methods) and thus, in the course of counseling, might be open to other methods, including (other) male body-based methods. Considering that research shows that many women discontinue female body-based hormonal methods because of negative experiences with side effects (Littlejohn, 2012, 2013), male body-based methods, which have no side effects on women's bodies, could enable women to avoid both side effects and pregnancy.

Second, since one of the focal male body-based methods is male sterilization, I selected the sessions where the patient reported in her pre-visit questionnaire that she did not want children in the future. As such, these were patients for whom vasectomy could be

appropriate. While clinicians did not have access to survey responses (the questionnaires were for research purposes only), I speculated that patients who reported wanting no future children might convey this to their clinician, providing the opportunity to discuss permanent contraceptive methods, including vasectomy.

Eighty sessions met the first criterion and 52 met the second, with 31 visits meeting both, for a total of 101 visits. As a check on my sampling strategy, I searched all available transcripts for mentions of the two more rarely-mentioned male body-based methods: vasectomy and withdrawal. My strategy captured all but one visit where vasectomy was mentioned as a prospective method and two-thirds of all visits where withdrawal was mentioned.

I analyzed the transcripts for communication between patients and clinicians about male body-based contraceptive methods using thematic coding. I started by inductively and iteratively coding mentions of condoms, withdrawal, and vasectomy, attending to the context in which the method was first introduced (e.g. patient introduces), what information about the method was conveyed (e.g. efficacy at preventing pregnancy), language signaling the social value of the method (e.g. use of valenced descriptors), and how discussion of the method ended (e.g. segue to female body-based method). Additionally, I coded for discussion of men and men's role in contraception. I considered coding complete when no new codes emerged.

I then calculated frequencies of visits in which each method was mentioned and characterized each session in which a method was mentioned as containing either brief or extended discussion. Discussion was assessed as brief if it consisted of only superficial engagement with the method as an option for long-term contraception. It was considered extended if it was interactive and responsive to the patient's statements.

Sample Characteristics

Patients ranged in age from 16 to 53 years old (Table 1). The largest race category in the sample was white at 42%, followed by 31% Latina, and 28% black. Patients' educational attainment ranged, with nearly one-fifth reporting graduate education and about one-third reporting a high school degree or equivalent or less. The population was skewed toward lower income brackets (in part because one recruitment site primarily served college students); nonetheless, just under one-fifth reported incomes above $85,000. All patients had access to all available methods at no or minimal cost through insurance or public programs.

Thirty-six clinicians are represented across these visits: 35 women and one man. Clinicians ranged in age from 35 to 74 years old. Most (70%; n=25) identified as white, with seven identifying as Asian/Pacific Islander, two as Latino/a, and two as biracial (white and Native American; Latina and Asian); there were no black clinicians. Twenty-three clinicians were nurse practitioners, nine were physicians, two were certified nurse midwives, and two were physician assistants. Nine clinicians appear in only one session a piece, ten in two sessions each, and 17 in three or more sessions. In order to preserve the anonymity of the clinician participants, I do not include demographic data with their quotes.

Findings

Condoms, withdrawal, and vasectomy were only infrequently mentioned in the counseling visits, suggesting they were not central considerations in clinicians' contraceptive counseling. When these methods were mentioned, clinicians emphasized efficacy and the challenges of adherence when those features were comparatively "negative" (i.e. in discussions of condoms and withdrawal) but not when they were "positive" (i.e. vasectomy). Taken in the aggregate, these presentations framed male body-based methods as less preferred choices.

Not Talking about Male Body-Based Methods

At least one female body-based method was mentioned in each of the 101 visits. Male body-based methods, in contrast, were mentioned less frequently: at least one such method was mention in fewer than half the visits (n=42). The depth of communication about these methods also differed. In every visit, patients and clinicians engaged in extended discussion of at least one female body-based method. The majority of discussions about male body-based methods, however, were brief (see Methods section for description of how brief versus extended was assessed).

Male condoms were mentioned as long-term contraception in 32% of the visits. In most (72%) of these visits, the mentions of condoms were brief and clinician-initiated (Table 2), such as with a query as to the patient's current contraceptive use. One clinician, for example, asked her 38-year-old patient, "Are you using condoms all the time, every time?" After her patient replied, "Nope. The honest part about it is nope," there was no further discussion of condoms. Other brief, clinician-initiated mentions entailed the clinician listing various methods, including condoms, but no actual discussion of condoms as a viable option. For example, one clinician mentioned condoms only a single time, when she explained to her 42-year-old patient, "If you want to go non-hormonal, it's pretty much barrier methods that you're probably familiar with: diaphragm, condoms, or using a spermicidal gel or cream or film." There was no further discussion of condoms during the rest of the visit.

In the eight other cases where condoms were discussed only briefly, the patient herself introduced the method, for example volunteering a history of condom use. In most (75%) of these cases, patients both mentioned condoms and voiced their dissatisfaction with them. As with this 37-year-old patient, clinicians then responded by moving on to talk about other methods, rendering the brevity of condom discussion both appropriate and responsive to patient preferences:

> Patient: So, I don't really like them [condoms]. But, you know, it's better than ending up [with an] ectopic [pregnancy] again.
>
> Clinician: Mm hm. Yeah. Yeah. I mean, we could maybe put you on a birth control pill.

In other cases where patients reported using condoms and there was little discussion, however, there was no verbal expression of dissatisfaction, presenting the possibility that the brevity of engagement about condoms was not responsive to patient preferences. For

instance, a 42-year-old patient reported current condom use and then stated “I’ve been thinking about getting the Depo [contraceptive injection] or something but the side effects are so scary.” Her clinician only engaged with the Depo comment, saying, “Tell me what scares you. What type of side effects have you heard about?” The clinician probes the patient’s fear of Depo, but not her reasons for considering a change from relying on condoms. Such a focus on a patient’s fears is responsive to the patient’s articulated concerns. In this case, it also represents a pivot away from further discussion of condoms, and it is not clear from the transcript whether this shift is consistent with the patient’s preferences.

Withdrawal was mentioned even less frequently than condoms, coming up in just 15% of sessions, usually because the patient named it as her current or previous method (Table 2). The clinician introduced withdrawal as a method in just 4 cases (27%), typically in the form of a query about the patient’s current contraceptive practices. In the majority (80%) of the sessions where withdrawal was mentioned, discussion was brief (Table 2). Indeed, providers sometimes did not respond to patients’ report of using withdrawal at all, even as they asked questions about patients’ experiences with other methods they reported using. For example, responding to her clinician’s query about her current contraceptive method, a 36-year-old patient answered “withdrawal” and then described her concerns about hormonal contraception: “I have had really negative experiences with hormonal birth control […] It makes me depressed—it caused depression, anxiety, weight gain. It killed my libido.” The patient further reported that she had tried the non-hormonal IUD but it “came out,” which made her consider the IUD an undesirable and unreliable method. Her clinician responded sympathetically, saying “That all sounds like a killer,” and then circled back to the IUD, asking about the timing of placement and encouraging the patient to try it again despite her previous experience of expulsion. She said, “that [the IUD] would probably be the best method for you. […] Maybe it was just the placement [that was the problem].” The clinician did not respond to the patient’s report of using withdrawal nor ask questions about her experience of that method, and neither she nor the patient mentioned withdrawal again during the visit.

Finally, vasectomy was mentioned in only 8% of the sessions (Table 2). As a sterilization procedure, vasectomy is not appropriate for patients who want future children, but this sample includes 52 women who were potential candidates for relying on vasectomy based on their pre-visit survey response that they did not want future children. Twenty-eight of these women expressly communicated to their clinician that they did not want to have (any more) children, saying things like: “I don’t plan on having kids at all”; “I don’t want no more kids”; and “I do not want to be pregnant. Never again.” (Discussion of female sterilization was also rare: it was mentioned in just 19 of these visits (Kimport et al., 2017). This rarity is also consistent with the feminization of responsibility for fertility work, which holds that women should engage in ongoing fertility work and therefore choose contraception that preserves their fertility (Kimport, 2017).)

Discussion of vasectomy was often clinician-initiated and brief (Table 2). Sometimes it was brief because the patient vetoed the method. For example, when a clinician asked her 38-year-old patient if she wanted future children, the patient was clear: “Do I want another

baby? No, I don't." Having ruled out the contraceptive injection, pill, ring, and IUD, the clinician asked:

> Clinician: Well, have you thought about getting your tubal ligation?
>
> Patient: Not really.
>
> Clinician: Or your partner getting a vasectomy?
>
> Patient: We ain't talked about none of that […] But our thing is, like, okay, we know we don't need another baby.

The clinician and patient proceed to discuss tubal ligation, but not vasectomy, in depth, despite both the potential of both sterilization procedures to meet the patient's preferences. In the other cases with clinician-initiated, brief mentions, the patient did not verbally respond to the suggestion and the clinician did not pursue further discussion.

Centering (Low) Efficacy

The length of discussion of a method is not necessarily, on the face of it, conclusive evidence that male body-based methods were devalued in the contraceptive counseling visit. The content of these discussions, however, does point to an overall discursive devaluing of male body-based methods. When clinicians mentioned condoms or withdrawal, they centered features of the method that were marked as negative. In particular, clinicians regularly highlighted the methods' low(er) efficacy, suggesting that the technology of these methods made them not effective enough at preventing pregnancy for patients to select them.

Counseling a 19-year-old woman, for example, one clinician cautioned that condoms "are not quite as effective as these other methods like the pill." Condoms do have lower efficacy than many female body-based methods, but are nonetheless effective at preventing pregnancy, especially compared to using no method (Trussell, 2011). Clinicians, however, did not generally convey this in their discussion of the method. In seven other sessions clinicians similarly characterized condoms as importantly less effective than other available methods. In all but one of these cases, the mention was brief, coupling the only mention of condoms in the session with an assertion of their low efficacy at preventing pregnancy. In other words, the singular method feature articulated about condoms was their lower efficacy.

This pattern of clinicians' emphasizing condoms' (lower) reliability in preventing pregnancy held in another seven sessions in which clinicians highlighted breakage and "accidents" in their discussion of the method. One clinician, for example, allowed that her 19-year-old patient could continue using condoms, but paired this statement with mention of method failure: "So, obviously you could just continue with condoms. And use Plan B for back up if the condom breaks." Another clinician similarly emphasized condom failure in her counseling of a 23-year-old patient:

> So I'm going to give you a prescription for condoms. And I can also give you something that's called Plan B. It's an emergency contraceptive pill. So sometimes condoms break, they come off, or you don't use them.

Broadly, clinicians' discussions of condoms were characterized by cautions about their reliability in preventing pregnancy.

In discussions of withdrawal, clinicians also centered efficacy—and usually portrayed it as very poor. In over half (n=8) of the visits where withdrawal was mentioned, clinicians presented it as only minimally effective or even as *in*effective over the long term, despite scientific evidence that use of withdrawal reduces the risk of pregnancy (Jones et al., 2009). Counseling a 31-year-old woman who reported using withdrawal, a clinician cautioned, "You know that withdrawal is better than nothing, but if you keep on using it sooner or later you're going to get pregnant." Another clinician jokingly described withdrawal as "one of those birth controls, that if you want to get pregnant, it's a good one to use [laughs]." Still another characterized withdrawal as "That's sort of Russian roulette," later continuing that "if you really don't want another baby, that's dangerous." In these cases, clinicians did not remark on any other aspects of withdrawal, including features like the lack of side effects associated with the method that might be appealing to some patients. As with many of the brief discussions of condoms, the only engagement with withdrawal during the visit centered a "negative" feature of the method and implied that withdrawal was not a reliable method for long-term contraception.

While efficacy was emphasized in discussions of condoms and withdrawal, associating the methods with a feature discursively marked as negative, there was no corresponding emphasis in discussions of vasectomy, which has a notably high efficacy. In fact, there was no mention of vasectomy's efficacy in the visits at all. To the extent that high efficacy is a positive feature of a method, then, vasectomy did not benefit from a discursive association with this feature.

Of course, not all clinicians centered and negatively marked the lower efficacy of condoms and withdrawal in their discussions of the methods. For instance, one clinician explained to a 53-year-old patient whose family history of pregnancy after age 50 made her nervous about relying on condoms alone,

> I think that you are getting a significant amount of birth control in a way for your age. […] I think that the combination of age and condoms is providing some excellent birth control and the failure rate of that—your age plus the condom—is pretty low.

The clinician encouraged the patient to continue using condoms, rather than commence a hormonal method. Likewise, in three cases where the patient reported long-term use—and success—with withdrawal, clinicians counseled that the patient could continue to rely on the method: one told her 36-year-old patient, "If that [withdrawal] has worked for you your whole relationship, then you don't have to make any changes." Framing condoms or withdrawal positively, as good choices for long-term contraception, however, was uncommon.

Questioning Men's Commitment to Contraception

In addition to the focus on efficacy when it was comparatively low, some clinicians centered men's behavior in their discussion of male body-based methods, presenting resistance to

contraceptive responsibility as likely and immutable, rather than as a problem to be solved. Such discursive framing of men's (un)reliability can serve to marginalize methods that rely on men's participation, regardless of whether those methods' features meet patients' preferences. Additionally, it upholds normative expectations that women bear the responsibility of preventing pregnancy.

In 13 visits, clinicians emphasized the fact that condoms require the male partner's buy-in to be successful in preventing pregnancy, often privileging men's buy-in over the female patient's. Their counseling, in other words, centered the interests and behaviors of men—and not patients. In six sessions, after proposing condoms as a method, clinicians' first question was about whether their patients' sexual partner would wear a condom. For example, after recommending condoms to her 39-year-old patient, one clinician next asked, "And do you feel comfortable asking him to use a condom?" In emphasizing the importance of men's acceptance of condoms, clinicians sometimes even preempted questions about whether the method would be acceptable for the patient herself. Counseling a 23-year-old patient, a clinician first asked about the patient's partner's acceptance of condoms and then about the patient herself.

> Clinician: And how do you think he would be with using condoms?
>
> Patient: I think there should be no problem.
>
> Clinician: And how do you feel about him using condoms?
>
> Patient: I don't know.

As with information about the efficacy of the male body-based methods, the question of a partner's buy-in can be relevant to contraceptive decision-making: if a partner (or couple) will not use a method, it will not prevent pregnancy. Here, though, I focus on how clinicians discursively suggested that patients' first consideration in selecting condoms as a contraceptive method should be men's willingness to use them rather than their own preferences. By posing the question of men's willingness to use condoms as an open one, clinicians also tacitly constructed men's willingness to adhere to condom use and assume responsibility for pregnancy prevention as uncertain—and maybe even unlikely.

In four other sessions where condoms were mentioned, clinicians centered the idea that condoms require vigilance, suggesting that this made them a potentially bad choice. For example, after a 22-year-old patient reported bad experiences with bleeding changes with the IUD, Depo, and pill, and expressed desire for a hormone-free method, her clinician acknowledged that condoms fit the patient's clearly expressed preferences. Then, using a cautionary "but," the clinician characterized condoms as a non-preferred method because they require vigilance: "condoms are an option, but that means, you know, being on top of it every single time you have sex." Similarly, in counseling a 22-year-old patient, another clinician paired a positive framing of condoms as effective with a negative statement about the difficulties of consistent use:

> I actually think condoms are a really good form of birth control if you use them. They're very effective when you use them. The problem is people have a hard time sticking with them long-term. Over time, people tend to slip up.

In emphasizing the challenges around vigilantly using condoms, clinicians' suggested that patients consider ease of adherence in their evaluation of condoms as a method. Further, they presented the challenges of adherence with condoms as inherently difficult. Such a discursive rendering of adherence challenges, however, is not inevitable: research has found that clinicians problem-solve adherence challenges associated with other methods, like the daily pill, with patients (Kimport, 2017).

Clinicians similarly centered behavioral concerns in discussions of withdrawal, likewise presenting such concerns as largely un-addressable. In one case, when a 30-year-old patient asked why withdrawal was considered undependable, her clinician first acknowledged that there is not a clear answer but then posited men's behavior as a likely cause: "Are their partners not good at pulling out, or is there something else going on, or are they not doing it consistently? Sometimes they're pulling out, sometimes they don't." Another clinician, too, even as she allowed that withdrawal could be an effective method, suggested its unreliability lay in men's lack of psychological commitment to preventing pregnancy. In counseling a 44-year-old patient, she said, "Some guys are good at it and some aren't—they can't concentrate, can't predict, have ulterior motives." Both of these clinicians characterized men's withdrawal behavior as something that cannot be changed, either for physical or mental (i.e. ulterior motives) reasons.

In the contraceptive counseling visits, clinicians centered concerns—and sometimes outright doubts—about men's commitment to contraception when the reliability of that commitment was integral to the success of a method, i.e. with withdrawal and condoms. In contrast, in their discussions of vasectomy, a method that poses no ongoing adherence challenges, clinicians did not center the comparable lack of importance of men's ongoing actions. As with method efficacy, condoms and withdrawal were thus described in ways that highlighted features that were discursively marked as negative, but those same features were not emphasized when they were comparatively positive aspects of a method, as in the case of vasectomy.

Discussion

In developed countries, women assume the primary burden for the domestic labor of preventing pregnancy (Bertotti, 2013; Fennell, 2011; Fields, 2008; Weber, 2012). Here, I illustrate how the contraceptive counseling visit can contribute to the feminization of contraception, providing a case of how gender inequality is discursively (re)produced in clinical encounters. I find that clinicians broadly devalued male body-based methods as means to prevent pregnancy. They did so by failing to discuss male body-based methods at all, by centering seemingly negative aspects of the methods when they did discuss them, and by presenting these "negative" features as problems too great to be overcome. In aggregate, these discursive presentations—including the lack of discussion—marginalize male body-based methods as choices for long-term contraception. Coupling these findings with provider and patient reports of encouraging—and sometimes even pressuring—women to choose particular female body-based methods (Downing et al., 2007; Higgins et al., 2016; Mann, 2013; Stevens, 2015; Thorburn & Bogart, 2005) exposes a pattern of clinicians discursively reinforcing the feminization of responsibility for contraception. Social

interactions like these that construct women and men as differently culpable for their health have implications for their treatment and health outcomes, potentially producing gendered health disadvantages (Dovel, Yeatman, Watkins, & Poulin, 2015).

This was probably not clinicians' intent. As verbatim transcripts of the counseling visits—and not interviews, for example—these data do not offer insight into clinicians' motivations. Clinicians may have discouraged patients from using condoms or withdrawal because of a bias towards medicalized methods, or declined to discuss vasectomy because of an inability to provide vasectomies and a preference for encouraging methods they personally can offer (see Shih et al., 2011). The focus on efficacy, for example, is consistent with many women's prioritization of method features (Lessard et al., 2012), and the buy-in of a sexual partner is an important aspect of some methods. Yet, whatever clinicians' reasons for their rhetorical construction of these methods, the aggregate effect is the same: their counseling discursively devalued male body-based methods. At the structural level, when male body-based methods are devalued in the contraceptive counseling visit, an avenue that could shift the unequal gendered division of reproductive labor is closed off. Simultaneously, the feminization of responsibility for contraception is reified.

On the question of whether counseling on withdrawal and condoms, in particular, is more accurately understood as the result of a bias toward prioritizing efficacy and/or medicalized methods, rather than the upshot of normative gendered expectations, scholarship on masculinity and reproduction suggests that efficacy, medicalization, and gender biases may not be so easily disentangled. There is a dearth of biomedical research into contraceptive methods that operate in male bodies (Daniels, 2008), and the rare occasions of such research operate differently than biomedical research on female body-based methods (Kammen & Oudshoorn, 2002). This low allocation of research resources is enabled, in part, by social beliefs that contraceptive responsibility is inconsistent with masculinity (Oudshoorn, 2004). In turn, this means that there are few male body-based methods people can choose (Daniels, 2008) and no medicalized methods that affords both high typical use efficacy and reversibility. The fact that the only reversible male body-based methods are low efficacy and do not require a medical visit to access, in other words, is not a coincidence. It is an effect of gendered biomedical processes.

There are several limitations of this analysis. I have identified some ways that male body-based methods are constructed in the clinical visit, but as an exploratory, descriptive analysis, these findings are not exhaustive. Future research should examine other dimensions of the construction of male body-based methods, including in visits with patients who express satisfaction with relying on a male body-based method. Additionally, although having complete recordings of the contraceptive counseling visits is a strength of this study in that it enables close analysis of discursive constructions in action, not only do we not know anything about clinicians' reasons for counseling in these ways, we also do not know how patients experienced this counseling and whether it had an effect on patients' decision-making. Patients, for their part, may have experienced this counseling as entirely appropriate or even as irrelevant to their contraceptive selection.

There are both theoretical and practical reasons to rethink how clinicians engage with patients about male body-based contraceptive methods. As a practical effect, the devaluing of men's role in preventing pregnancy in the contraceptive counseling visit means women may assume potentially unnecessarily onerous and disliked fertility work. Some women may simply choose not to engage in this fertility work, discontinuing contraceptive use for reasons such as disliking side effects (Littlejohn, 2012, 2013). The upshot of such actions is women who are not using any effective method to prevent pregnancy and are thus at even greater risk of unintended pregnancy. Future research should investigate whether counseling that devalues male body-based methods has a measurable effect on individual women's contraceptive method decision-making.

Theoretically, remaking contraceptive counseling to challenge, or at least not reify, the feminization of responsibility for contraception can reduce the burden of fertility work on women and, potentially, undo a structure undergirding gender inequality. By identifying how clinicians in contraceptive counseling visits can discursively perpetuate the feminization of responsibility for contraception, these findings offer insight into the ongoing production of the gendered division of reproductive labor. They also point to important opportunities to reexamine—and potentially challenge—the way this feminized burden is reproduced, which can help dismantle one aspect of gender inequality and lead to more patient-centered reproductive counseling.

Acknowledgments

The author would like to express great gratitude to Christine Dehlendorf for access to these data and for feedback on earlier drafts. Additionally, I deeply thank Shari Dworkin, Krystale Littlejohn, Lindsay Stevens, Sarah K. Cowan, Diana Greene Foster, and Antonia Biggs for their insightful comments on versions of this paper and Erin Wingo for copy editing. I am also indebted to the three anonymous reviewers of this manuscript for their engaged and constructive feedback. The data collection was supported by the Society of Family Planning and by grant K23HD067197 from the Eunice Kennedy Shriver National Institute of Child Health and Human Development (NICHD). The content is the responsibility solely of the author and does not necessarily represent the official views of the Society of Family Planning, the NICHD or the National Institutes of Health. Data analysis was supported by a grant from an anonymous foundation.

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Table 1

Patient Characteristics

	Patients (n=101)
Age	
25 and under	42 (42%)
26–35	32 (32)
36–45	25 (25)
46+	2 (2)
Race	
Black	28 (28)
Latina	31 (31)
White	42 (42)
Education	
<HS or equivalent	4 (4)
HS or equivalent	28 (28)
Some college or AA	32 (32)
4-year degree	19 (19)
More than 4-year degree	18 (18)
Annual Income (in $)	
0–14K	32 (32)
14,001–25K	25 (25)
25,001–50K	14 (14)
50,001–85K	13 (13)
85K+	17 (17)
Pregnancy History	
0	40 (40)
1	23 (23)
2+	38 (38)

Table 2

Initiation and Duration of Discussion* of Male Body-Based Methods

Method	Patient initiates	Clinician Initiates	Total
Condoms (n=32)			
Brief discussion	8	14	**22**
Extended discussion	3	7	**10**
Withdrawal (n=15)			
Brief discussion	9	3	**12**
Extended discussion	2	1	**3**
Vasectomy (n=8)			
Brief discussion	0	4	**4**
Extended discussion	3	1	**4**

*Discussion was assessed as brief if it consisted of only superficial engagement with the method as an option for long-term contraception. It was considered extended if it was interactive and responsive to the patient's statements.