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# CONTRACEPTIVE RESPONSIBILITY: TRUST, GENDER, AND IDEOLOGY

By

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ABSTRACT

CONTRACEPTIVE RESPONSIBILITY: TRUST, GENDER, AND IDEOLOGY

By

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In my dissertation, I explore how contraception influences women's (and men's) autonomy to expose social justice concerns contraception raises. I take a broad, social perspective and examine how dominant ideologies shape our attitudes and beliefs about contraception, specifically whom we trust to use contraception and whom we think should be responsible for contraception.

An important milestone for women's rights was the discovery of long-acting, reversible contraceptives, which enabled them to control their fertility. Yet, the ubiquity of these contraceptives and the absence of such options for men, coupled with traditional gender norms, has resulted in the social expectation that women should be the ones responsible for contraception. Women are oppressively socialized to assume the burdens of contraception, which impair their autonomy and reinforce their oppression. Men generally benefit from this arrangement because it enhances their autonomy by absolving them of contraceptive blame, maintaining their bodily integrity, and granting them greater sexual access to women.

A common justification for this gendered division of contraceptive responsibility is that women do not trust men to contracept. Empirical studies, however, show that women do trust their male partners with contraception. Differentiating between interpersonal trust and what I call "group trust" helps explain this tension. Both types of

trust depend upon and reflect ideologies, but the object of trust is a group in group trust rather than an individual. Unlike individuals, who are identifiable and have known characteristics, groups are amorphous with diverse and unconfirmed qualities. We consequently tend to defer to dominant ideologies about groups in order to determine their trustworthiness. Men as a group are not perceived to be trustworthy with contraception because of ideologies about masculinity. Although women are held responsible for contraception, they are distrusted with it due to the cultural stereotype that they are irrational.

I argue that we should strive for shared contraceptive responsibility between women and men as a way of alleviating social injustices. I claim that men have a moral duty to contracept according to the principle of nonmaleficence and because their of privileged social position. If we believe women have a moral duty to prevent harm to potential and actual fetuses and children, then this duty should be extended to men as well. Unprotected sex can also harm women by leading to unintended pregnancy.

While women should contracept to prevent unintended pregnancy, their ability to control contraception, not to mention sex, is often minimized in heterosexual relationships in a patriarchal society. Despite the dearth of male contraceptives, men's privileged social position gives them greater control over sexual decisions, including choices about contraception. Achieving shared contraceptive responsibility requires a profound restructuring of gender roles. I propose various strategies, like such as developing long-acting reversible male contraceptives and changing the way we teach sex education, that will engender a reconceptualization of gender roles.

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Although reproductive ethics encompasses many things, abortion is discussed much more than other issues in political, academic, and media realms. Since the birth of Louise Brown, the first "test-tube" baby, in 1978, reproductive technologies have also dominated these realms; Baby M, Dolly the sheep, and the McCaughy septuplets are just three examples of stories about reproductive technologies that received significant public attention. With a couple of notable exceptions—forced or mandatory contraception for women not deemed fit for reproduction (namely, poor women, women of color, and women with criminal records) and emergency contraception (which seems to have gotten lumped in with the abortion debate)—contraception has received very little recognition as an important ethical issue. Why is this? I argue that the focus on autonomy in bioethics, feminist theory, and philosophy contributes to why contraception as an ethical issue is neglected. Since the dominant perception of contraception is that it increases women's autonomy, many academics assume there are no ethical concerns to discuss. Once we look beyond a narrow focus on autonomy and incorporate ideologies, trust, and responsibility into our analysis, we not only paint a richer picture of our current contraceptive arrangement, but we also can see the social justice issues it raises. These social justice issues and their impact on autonomy make contraception an ethical issue worthy of analysis by academics.

[1] It is important to note that throughout this project I am discussing heterosexual activity unless otherwise stated.

**Why Is Contraception Ignored by the Public and the Media?**

Before explaining why contraception is neglected in the academic realm, I enumerate a handful of factors that contribute to the lack of attention contraception receives in the media and by the public in comparison to abortion and reproductive technologies. Part of my reason for doing this is that topics that generate media and public attention often subsequently spark academic and political debates (e.g. Terri Schiavo and euthanasia). First, contraception is much more common than either abortion or reproductive technologies. Indeed, 98% of U.S. women have used some form of contraception in their lifetime—a percentage that far exceeds the percentage of women who have had an abortion or used a reproductive technology (The Alan Guttmacher Institute, 2008b). Such ubiquity has normalized contraception, making it more socially acceptable and unthreatening (or at least less threatening).

Second, given the elevation of complex technology and of new discoveries in science and medicine, contraception technologies are seen as "unexciting" and "conquered" territory (except perhaps male contraceptives) because they do not do anything radically new. Contraceptive research is not perceived to be as groundbreaking as reproductive technologies research, so it does not generate much public excitement, though the birth control pill was an important scientific breakthrough when it first came out.

Third, unlike abortion and reproductive technologies, contraception is not a rallying point for specific groups and organizations. Contraception does not fuel pronatalism like reproductive technologies do, nor does it stand in opposition to pronatalism to the degree that abortion does. Falling between the two extremes of

reproductive technologies and abortion on the pronatalistic scale, contraception is ignored for the most part since it cannot be used either to affirm or deny pronatalism, except for by those who believe sex is only for procreation.

Fourth, abortion and reproductive technologies, not contraception, are the main reproductive issues for middleclass white women—women who have more money, power, and social visibility and thus can more successfully make public demands. According to Dorothy Roberts, "The primary concern of white, middle-class women centers on laws that restrict choices otherwise available to them, such as statutes that make it more difficult to obtain an abortion" (300). For the same reason and because they are more likely to seek out these services, reproductive technologies are important for white middleclass women (Chandra and Stephen 39).

Fifth, contraception is not nearly as controversial as abortion or reproductive technologies. Part of the reason abortion and reproductive technologies are so controversial, and especially so for abortion, is that more is at stake than just abortion and reproductive technologies; these issues represent political ideologies. Contraception is not nearly as contentious because it is typically viewed positively, or at least neutrally. The dominant public perception of contraception is that it is both a need and a boon for women. In fact, contraception is sometimes viewed as a panacea for women's inequality. Besides religious objections to contraception (e.g. that contraception takes a life), most public concerns regarding contraception are not about contraception itself. Rather, they tend to be about the relationship between contraception and autonomy, especially how limiting women's access to contraception infringes upon their freedom. For example, recent price increases for contraception on college campuses have led to worries that

women will not be able to afford contraception and therefore will not be able to exercise their reproductive autonomy (Davey).

## Why Is Contraception Neglected in the Academic Realm?

The dominant cultural view of contraception as a source of women's empowerment extends to the academic realms of bioethics, feminist theory, and philosophy. Clearly, contraception has dramatically improved women's lives; there is no disagreement about that. What is surprising is that there is little to no debate on other aspects of contraception. This lack of discussion does not reflect a consensus; rather, it reveals an overlooked and thus unexplored topic. Part of the reason contraception is neglected as an academic topic is due to the strength of the dominant view that it is a positive force in women's lives. Since contraception is often unquestioningly accepted as a tool in increasing women's autonomy and reducing their oppression, there is little critical analysis of it. Such a one-sided perspective explains why most academic work on contraception centers on how it affects women's autonomy. Specifically, academic discussions have focused on how denying women contraception or forcing them to take it inhibits their autonomy. For example, Al Riyami et al. discuss how patriarchal arrangements limit women's ability to use contraception and hence their reproductive freedom despite other factors that tend to promote contraceptive utilization, like education and employment. Discussions of forced contraception are rarer, but are exemplified by Dorothy Roberts's work on how proposed laws target poor women of color's autonomy by mandating Norplant use.

Taking a broader perspective, most academic debates on contraception have revolved around autonomy because autonomy is a centerpiece in both bioethics and feminist theory. Since the emergence of the field of bioethics in the 1970s, autonomy has been a prominent issue. As Onora O'Neill asserts, "Much of medical ethics has concentrated on the individual patient, her rights and her autonomy; demands that medical professionals respect autonomy and rights have become a constant refrain" (2002, 4). We see this focus on autonomy in all realms of bioethics, in topics as diverse as organ transplantation, healthcare allocation, and clinical research. Moreover, the way autonomy is defined is usually the same throughout various realms. O'Neill concurs: "In bioethics, and in particular in medical ethics, autonomy has most often been understood as a feature of individual persons. It is generally seen as a matter of *independence*, or at least as a *capacity for independent decisions and action*" (ibid. 23). This conception of autonomy upholds individual, independent choice as the key to being autonomous.

A similar understanding of autonomy is also common in feminist theory. One of the central tenets connecting all varieties of feminism is the promotion of women's autonomy, which is often cashed out as, or at least includes, individual, independent choice. The goal of improving women's lives and ending their oppression is intrinsically intertwined with enhancing their autonomy. Consequently, much feminist theoretical and practical work has been devoted to finding ways of increasing women's autonomy. One prevalent method is to empower women with more choices and with the ability to make their own decisions. There are plenty of examples of this in reproduction, such as legalizing abortion, pushing for women-controlled contraception, and fighting for insurance coverage of reproductive technologies.

That the prevailing conception of autonomy in bioethics and feminist theory focuses on independent decision-making and choice helps us to understand why little critical analysis has been directed at contraception by academic feminists and bioethicists. The development of women-controlled contraceptives gives women more choices and enables them to make independent decisions. Thus, women are more autonomous thanks to contraception. End of story, at least according to an individual, independent choice conception of autonomy. Because this conception of autonomy reduces autonomy to individual, independent choice, when we rely upon it, we are unable to recognize how our autonomy can be diminished despite more choices and independent decision-making.

**Beyond Autonomy: Why Contraception Is an Important Ethical Issue**

We need to look beyond the limited conception of to individual, independent choice autonomy, as it conceals many ethical issues in contraception. Instead, I examine three topics that receive much less attention in both bioethics and feminist literature—ideology, trust, and responsibility—as they relate to contraception. Exploring the complex ways these three topics interact will not only expose unethical contraceptive issues and arrangements, but it will also reveal a richer and more accurate understanding of how contraception affects women's (and men's) contraceptive and overall autonomy than by relying on individual, independent choice autonomy. Contraception raises concerns of social justice that are obscured when we focus on people as independent beings making individual choices. Roberts makes this same point in discussing reproduction more generally:

> Reproductive liberty must encompass more than the protection of an individual woman's choice to end her pregnancy. It must encompass the full range of procreative activities, including the ability to bear a child, and it must acknowledge that we make reproductive decisions within a social context, including the inequalities of wealth and power. *Reproductive freedom is a matter of social justice*, not individual choice. (1997, 6)

Conceptualizing reproductive freedom as something individuals merely choose to exercise denies the ways it is experienced within a social context and hence bound up in various power dynamics. In order to disclose oppressive patterns, we must take a broader perspective than just the individual and investigate reproductive freedom on the social level. According to Marilyn Frye's influential account of oppression, oppression happens based on one's membership in a group and therefore cannot be detected if we only see independent and free-floating individuals—individuals who are not part of various social groups (1983, 8). Looking at individual women rather than communities of women makes it easier to overlook the deeply entrenched gender norms and ideologies in laws, institutions, and cultural practices that shape women's reproductive freedom.

In this project I paint a more nuanced picture of how contraception affects women's autonomy in lieu of the dominant understanding that contraception simply augments women's autonomy. While contraception definitely increases women's autonomy in certain ways, by incorporating social forces, like patriarchy, into our analysis, we discover how contraception also decreases women's autonomy in rarely acknowledged ways. Additionally, we can reveal how the current contraceptive arrangement affects men and their autonomy; according to individual, independent choice autonomy, contraception has little if any affect on their autonomy because women-controlled contraceptives are not thought to increase men's choices or ability for independent decision-making (though they do affect men's ability to decide whether to

father a child). Taking a social perspective, I examine how dominant ideologies shape our attitudes and beliefs about contraception, specifically whom we trust to use contraception and whom we think should be responsible for contraception. I choose to analyze trust and responsibility not only because they are both neglected topics within bioethics and feminist theory that raise important ethical concerns, but also because they reflect and reify social beliefs. Drawing on the work of other feminist trust theorists, I develop my own approach to trust to show that when we trust, we typically expect others to act in according with particular ideologies. Though my use of the concept 'responsibility' is less precise—I defer to a general understanding of this term—I claim that ideologies are also a factor in whom we hold responsible. Scot Yoder echoes this point: "The expectations that define the limits of moral responsibility will depend on the particular contexts in which we hold people responsible, and thus on our interests, values, and social practices" (27). Identifying the ideologies influencing whom we consider trustworthy and whom we hold responsible in the realm of contraception gives us a deeper understanding of the social forces involved. Examining this complex interplay among ideologies, social forces, trust, and responsibility provides us with the broad perspective needed to look beyond individual reproductive autonomy and expose oppressive patterns and issues of social justice in contraception. In particular, this perspective allows us to recognize how women's contraceptive and overall autonomy is unjustly inhibited by their cultural environment and their social group membership.

## Chapter Outline of this Project

This project is divided into two sections. The first section (chapters 2-4) addresses the current contraceptive arrangement[2] in the United States: what it is, why it is this way, and what its effects are on women and men. I argue that women are generally saddled with full contraceptive responsibility due to gender ideologies that shape whom we hold responsible and whom consider trustworthy with contraception. This arrangement is unjust since it limits women's autonomy, thereby reinforcing their oppression, while augmenting men's privilege. The second section (chapters 5-7) is devoted to my normative argument about our contraceptive arrangement, which is ultimately that women and men should share contraceptive responsibility as a way of alleviating social justice concerns. In order to buttress this position, I argue that men have a moral duty (or responsibility) to contracept according to the principle of nonmaleficence and because their of privileged social position.

I begin chapter 2 by providing a history of contraceptive responsibility, highlighting that prior to the mid-twentieth century, contraception was typically considered men's responsibility or at least a shared responsibility between women and men. After the invention of long-acting, reversible contraceptives (LARCs), contraceptive responsibility transformed into women's responsibility. Although contraceptives for women, especially LARCs, have dramatically increased women's reproductive choices and their ability to make independent reproductive decisions, contraception has also had a negative impact on women's autonomy. I argue that the current contraceptive arrangement is unfair for women because they are usually expected

[2] While there are many different contraceptive arrangements in the U.S., I am focused on the dominant arrangement, which is why I use the single rather than the plural. I will provide more information on this dominant arrangement in the next chapter.

to assume full contraceptive responsibility and its associated burdens, such as financial cost and health-related side effects, which often impair their autonomy. This situation is especially troubling because, even though many women may want to contracept and may in fact benefit from doing so, they are not unrestrictedly making this choice. Rather, by drawing on Paul Benson's work, I claim that women are oppressively socialized to be responsible for contraception. This socialization inhibits women's autonomy both by inflicting noncompliance penalties on women who do not contracept and by instilling women with the false belief that part of being a woman is taking care of reproductive matters.

Chapter 3 opens with a question: why do mass media journalists and those in the field of contraception research and development tend to assume that women will not trust men to contracept despite empirical evidence that women do trust their male partners with contraception? I believe the answer lies in differentiating between trust on the individual level and trust on the group level. Both types of trust depend upon and reflect ideologies. Borrowing from Amy Mullin's conception of trust as following social norms and Carolyn McLeod's conception of trust as having moral integrity, I develop my own account of interpersonal trust as the expectation that people will act according to moral ideologies in the relevant domain. I then define what I call "group trust," which is similar to interpersonal trust in most ways except that the object of trust is a group rather than an individual. Because the object of trust is amorphous and not personally known in group trust, people tend to defer to cultural stereotypes about groups in order to determine if the group upholds the ideology and if the group is competent to follow this ideology. In the last part of this chapter, I bring up some contraceptive ideologies that play a role in trust.

Presenting my conceptions of interpersonal and group trust and identifying various contraceptive ideologies sets the stage for me to analyze why many do not think women trust men to contracept and, additionally, to explore perceptions about women's trustworthiness with contraception.

Chapter 4 examines how gender ideologies affect contraceptive trust. I posit that men as a group are not trusted to contracept due to dominant ideologies of masculinity. Some of these ideologies portray men as incompetent, a quality that typically obstructs trust. For example, the cultural beliefs that men have uncontrollable libido and that they have trouble mastering domestic tasks suggest that they will not be competent to contracept correctly and consistently. Another reason men are often viewed as untrustworthy to contracept is that they are generally viewed as not morally valuing contraceptive ideologies. In particular, it is doubted that men morally value self-sacrifice for the following reasons: they are thought not to be as concerned about preventing pregnancy, they are socialized to be independent and self-interested, and they belong to the privileged group and thus are less accustomed to making sacrifices. Prima facie, women as a group are trustworthy with contraception because of their association with the private realm and the expectation that they are self-sacrificing. Furthermore, trust and responsibility usually go hand-in-hand, so it would seem that women are trusted. Yet, I argue that women as a group are not trusted to contracept, as evidenced by the numerous laws, policies, norms, and social forces (e.g. normalization and surveillance) that limit women's reproductive autonomy. The reason for this distrust is their perceived incompetence due to cultural ideologies that they are irrational and that they have a strong desire to become mothers. I claim that women are given contraceptive

responsibility despite the fact that they are not trusted because this arrangement benefits men.

Chapter 5 marks the transition to the second section of this project in which I make normative claims about how the contraceptive arrangement ought to be. I begin by highlighting a double standard with reproductive and contraceptive responsibility: women are generally held morally (and sometimes legally) responsible for fetal and child harm (e.g. Fetal Alcohol Syndrome and "crack" babies), yet men are not. I suggest that this discrepancy is the result of sexist ideologies, such as the belief that women's bodies are permeable and hence dangerous—a threat to an innocent fetus. Often, claims for women's responsibility are based on the principle of nonmaleficence. I extend this principle to men's actions to argue that men have a moral duty to contracept if their behavior will lead to health-related, economic, and/or social harms, broadly construed, to potential fetuses and children.

I make a similar argument in chapter 6, but instead of looking at potential beings, I turn to harms inflicted on people who already exist, women. The main harm I am concerned with is unintended pregnancy, for it often engenders health-related, economic, and social harms. While women should contracept to prevent unintended pregnancy, their ability to control contraception is often minimized in a patriarchal society and in heterosexual relationships. I draw from the work of Catharine MacKinnon and Andrea Dworkin to demonstrate how men control sex and use it to objectify and subordinate women. This power difference impedes women's ability to use contraception themselves and/or to negotiate that their partner to use contraception. I argue that, despite the dearth of male contraceptives, men's privileged social positioning enables them to more easily

contracept. For this reason and the fact that men's failure to contracept can harm women, I conclude that men engaged in heterosexual activity who are not interested in fathering a child have a moral duty to contracept. Men in monogamous relationships are included in this claim because relying on just women to contracept is problematic for at least two reasons: it reinforces a gendered division of labor and it demands another type of bodily invasion from women.

In chapter 7, I argue that women and men should share contraceptive responsibility as a way of alleviating the social injustices women generally face by being fully responsible for contraception, including limited autonomy, contraceptive burdens, and distrust. Shared responsibility means that women and men are both responsible for contraception—an arrangement that requires open conversations between partners (be they long-term lovers or one night stands). Achieving shared responsibility will not be easy, nor will it be quick. While practical strategies are needed to realize this goal, they alone are not sufficient. Deeper social change, and in particular reconceptualizing gender ideologies, must also occur. This sort of change requires both top-down and bottom-up. I suggest three such strategies that I believe will challenge our current dominant gender and contraceptive ideologies and cultivate new ones. First, we need to develop more contraceptives for men, especially LARCs. Second, we need to teach and promote shared responsibility for contraception in every realm: health care, families, schools, and society. Third, we need to empower women and strive towards more equal relationships between women and men.

These strategies will affect realms other than reproduction, which is precisely the point. Our current contraceptive arrangement cannot change without change in other

realms and change more broadly. The reason for this, which shines through in the case of contraception, is the interrelated nature of realms and the ideologies that run through them. Contraception is a great example of how ideologies affect everyday life: whom we trust, whom we hold responsible, and what sorts of policies and laws we support. The attitudes and decisions that emerge from ideologies have real consequences for real people. In the case of contraception, these attitudes and decisions have produced an unfair arrangement that impairs women's autonomy. Most discussions of contraception have focused on independent, individual choice, which has precluded recognition of the ways in which contraception decreases women's autonomy in addition to increasing it. It is only by examining these ideologies, and how they shape trust and responsibility, that these social justice concerns become visible.

## Chapter 2: Contraceptive Burdens and Women's Oppression

The burdens women as a group experience with pregnancy and childcare has received copious attention from feminist theorists and others (see, for example, Mullin 2005a, Kukla, Purdy, and Raymond). In contrast, there have been very few discussions, let alone detailed analyses, of the burdens women face contracepting (Oudshoorn and Beck-Gernsheim are notable exceptions). Part of the reason for this is that the topic of contraception in general has been neglected, as I pointed out in the previous chapter. Another reason is that most references to contraception are about women's empowerment, not contraceptive pitfalls. In a way, it is understandable that discussions typically center on the benefits of contraception since women's ability to control their reproduction has vastly improved their quality of life. When compared to the risks of pregnancy and childbirth, many claim the contraceptive burdens are not only acceptable, but also minimal (Hardon 1992). Furthermore, since many women do not use contraception (for a variety of reasons, including lack of access, cost, and dislike of side effects), numerous discussions about contraception, especially those involving social scientists, policymakers, and health advocates, revolve around the ultimate goal of getting more women to contracept. Because these actors examine the barriers that prevent women from contracepting, they do in fact recognize many of the burdens associated with contraception. Yet, they rarely acknowledge how these burdens affect women outside of causing them to not use contraception. In this vein, they look for ways to alleviate these burdens, such as subsidized contraception and methods with fewer negative side effects, yet rarely acknowledge the systemic injustice women face due to

the expectation that they will assume full contraceptive responsibility. The fact that women are expected to deal with all the health risks of contraception is commonly raised, but it is generally not discussed in the broader context of women's oppression. Additionally, even though some authors suggest that men should also be involved in contracepting, the focus of contraceptive discussions is still women—a focus that is rarely questioned and that reinforces the "naturalness" of women's contraceptive role.

My goal in this chapter is to begin to fill this gap in the literature by analyzing the current state of contraception in the United States and revealing how it perpetuates women's oppression. I began by providing a brief history of contraceptive responsibility in the first section. I show that, prior to the mid-twentieth century, women and men equally participated in contracepting because most of the available methods could only be used during sexual activity, immediately afterwards, or were related to the timing of sexual activity. Contraceptive responsibility was consequently shared between women and men, though some claim that it was mostly men's responsibility due to the popularity of the condom and to traditional gender norms. After the invention of the pill and other long-acting, reversible contraceptives (LARCs), contraceptive responsibility became, and stayed, aligned with dominant norms of femininity.

In the second section, I seek to answer empirical three questions in order to provide evidence for the contraceptive burdens women face: Who contracepts today and what methods do they use? How much does contraception cost? What are the health-related side effects and noncontraceptive benefits of contraceptives? I devote a subsection to each of these questions. In the first subsection, I point out that there is a large disparity both in the number and the diversity of contraceptive methods for women and men. In

particular, there are no LARCs for men, while many exist for women. These data show that women alone are responsible for contraception over two thirds of the time and that they are involved in practically all contraceptive use. In the second subsection, I uncover that female contraceptives tend to be expensive because almost all of them require medical involvement. Of female contraceptives, LARCs are generally the most costly since both a doctor's visit and a prescription is usually needed to use them. Contraceptives that depend on male participation, with the exception of a vasectomy, tend to be the cheapest because neither a physician visit nor a prescription is necessary. Although female contraceptives tend to be medicalized—that is, reliant on physician involvement—they are often not covered by private health insurance companies, which forces women to pay out of pocket for them. In the third subsection, I point out that the negative side effects associated with female contraceptives are greater and more serious than the ones entailed by male contraceptives. In particular, LARCs have severe side effects. However, the pill, the most popular LARC, also has numerous noncontraceptive benefits and is sometimes prescribed precisely for these benefits.

Finally, in the last section, I describe how the answers to the three empirical questions expose an oppressive pattern for women. Women are the ones who bear most, and sometimes all, of the burdens of contraceptive responsibility. Men benefit from this situation because they typically do not have to assume contraceptive responsibility and suffer from its associated burdens. This arrangement is unfair not only because it upholds unequal power dynamics, but also because women are oppressively socialized to assume full contraceptive responsibility.

## Historical Overview of Contraceptive Responsibility

In order to understand the current state of contraception in the U.S., we must first understand its history. Before the "contraceptive revolution" of the 1950s and 1960s, which lead to the development of hormonal and long-acting contraceptives, notably the pill, men actively participated in many forms of contraception. One reason for this is that contraceptive use was tied to the act of sex itself or to the timing of sex; therefore men had to be involved. All of the available contraceptives were used during sex, such as condoms, diaphragms, sponges, and withdrawal; immediately following sex, like douches; or were related to the timing of sex, as in the case of the rhythm method. That men's participation was needed to contracept, coupled with dominant gender roles, contributed to the view that men should be involved with contraception. Patricia MacCorquodale illuminates:

> Historically, contraceptive use has been seen as the man's responsibility. While this attitude may have originated with the early invention and extensive use of the condom, it has been reinforced by gender-role stereotypes. Insofar as men are expected to be protective, rational, objective, active, dominant, and independent, the traditional gender role accentuates the male role as decision maker. (57-58)

According to MacCorquodale, dominant ideologies about men solidified contraception as men's responsibility, as they, not women, were assumed to have the necessary characteristics to make decisions about contraception. The belief that men were held responsible for contraception is evidenced by the fact that prior to the 1960s, if a single man got a single woman pregnant, he was generally expected to marry her. The ideology behind this expectation was that a man should play a role in contracepting and if a woman unintentionally became pregnant, he was supposed to take responsibility for his actions and omissions by marrying her. While men may have been expected be

responsible for contraception, women were supposed to be "guardians" of sex, setting the boundaries of what was acceptable behavior (i.e. definitely not intercourse) (Coontz). This ideology still exists today and is explicitly taught in various abstinence only programs[3] (Doan and Williams 106).

Other authors and evidence suggests that while men were expected to participate in contraceptive use and decisions, it was also assumed that women would play a role. That is, both women and men were expected to take responsibility for contraceptive. The reason for this, argues Nelly Oudshoorn, is that "Prior to the introduction of new contraceptives for women in the 1960s, no stabilized conventions existed concerning the relationships between gender identities and contraceptive use" (13). Because the availability and effectiveness of contraceptives was relatively balanced between women and men, there was no dominant norm identifying contraceptive responsibility with just one group. We see this in the fact that both female and male contraceptives experienced popularity in the first half of the twentieth century: commercial douches were the most popular type of contraception in the 1940s and condoms in the 1950s thanks to improvements in condom quality and burgeoning awareness of the ineffectiveness of douches (PBS).

Although many believe that dominant ideologies shifted in response to the invention of the pill, Andrea Tone argues that this change emerged earlier, in the 1930s. Due to the Comstock Law of 1873, an anti-obscenity act that explicitly includes contraceptives as obscene material and prohibits their distribution via mail or interstate

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[3] For example, the following passage appears in the abstinence-only student workbook, *Sex Respect: The Option of True Sexual Freedom*: "because they generally become physically aroused less easily, girls are still in a good position to slow down the young man and help him learn balance in a relationship" (12). For more examples of the way abstinence-only education teaches girls to be the "guardians" of sex, see chapter 4 of Doan and Williams.

commerce, women had trouble accessing contraceptives, as clinics and private doctors were often not very convenient, discrete, or affordable (PBS; Tone 313). Seeing an opportunity to make a lot of money (and they did—in 1938 alone, they earned $250 million), the contraception industry began a campaign to encourage women to use their "feminine hygiene" products (Tone 306). Since they were labeled as hygiene products rather than as contraceptives, they were outside the scope of the Comstock Law. Tone explains how these hygiene products paved the way for the new dominant ideology that women should be the ones contracepting:

> The success of contraceptive manufacturers' campaign was twofold: not only did it encourage more women to use birth control, but it also ensured that the single largest proportion of those who did used female-controlled, commercially acquired contraceptives. The successful typecasting of women as contraceptive consumers reveals the centrality of industry to the history of birth control in America. (Tone 309)

By identifying women as the ones responsible for contraception, this campaign challenged the dominant belief that contraception was both women's and men's responsibility, or mainly men's responsibility according to MacCorquodale. In challenging the dominant ideology and presenting a counter-ideology, this campaign laid the groundwork for the ideology that women should be responsible for contraception to become dominant.

Most people agree that the major turning point in contraceptive history is the discovery of the female pill. The pill was the first contraceptive that was not used during or after sex or related to the timing of sex. The pill severed the link between sexuality and reproduction. It was a huge victory for women's rights, as it allowed women to control their fertility outside of all sexual activity and without men's participation or knowledge.

Moreover, the pill was, and still is, significantly more effective than reversible barrier methods.

The FDA approved the pill as a contraceptive in 1960 (it was originally approved in 1957 to treat severe menstrual disorders) and it was immediately popular. The number of American women using the pill increased exponentially, from 1.2 million in 1962 to 6.5 million in 1965 to 10 million in 1973. By 1964, the pill was the most popular form of reversible contraception, with 25 percent of all couples choosing it (PBS). Today, the pill remains the most popular type of reversible contraception, and in fact is the most popular type of all contraceptives (Table 3).

The overnight popularity of the pill as well as the subsequent focus of contraceptive research and development on female methods reinforced the shift in ideology that began in the 1930s: that women were the ones who are responsible for contraception. After the invention of female LARCs, "Men, no longer required to use condoms or to practice withdrawal, were essentially absolved from contraceptive decisions. Consequently, both researchers and service providers have focused almost exclusively on women" (Edwards 77). This focus on women corresponds with and reinforces the dominant norms that women should contracept and that men play no, or a limited role, in contraception. Moreover, the success of the pill, and other female LARCs, strengthens the image of women as contraceptive consumers that emerged in the 1930s, further distancing men from contraceptive decisions and use.

The case of contraception shows how technology shapes ideology. The current dominant contraceptive ideology is due, at least in part, to the available contraceptive technology: the plethora of female contraceptives and the paucity of male contraceptives.

Oudshoorn asserts: "The predominance of modern contraceptive drugs for women has disciplined men and women to delegate responsibilities for contraception largely to women. Contraceptive technologies thus constituted strong alignments between femininity and taking responsibility for reproduction" (14). Elisabeth Beck-Gernsheim echoes this claim, stating "Planned parenthood, at first a new option, now turned into a kind of duty [for women] ... More precisely, contraceptive technology became contraceptive ideology" (32).

This ideology has become so normalized and embedded in our culture that both women and men typically assume that women will take responsibility for contraception, a point I will return to later. Consequently, there is sometimes little discussion about contraception between sexual partners. As Jacqueline Darroch explains, "The heavy reliance on methods independent from intercourse has meant that sexual partners do not need to alter their behavior around intercourse or even discuss contraception in the context of sexuality" (90). Especially prior to the HIV/AIDS epidemic, men would often assume women were using a LARC, so they would not bring up contraception nor would they contracept. An example of this is seen in the movie *The Adventures of Sebastian Cole*, which takes place in 1983. Teenager Sebastian's stepfather asks him if he is being responsible about sex and Sebastian replies that every girl in high school is on the pill. Here, Sebastian is assuming that all girls are contracepting at least partially because of this dominant ideology (and perhaps also because he assumes that they are afraid of becoming pregnant). For both Sebastian and his stepfather, the main reason to use contraception is to avoid unwanted pregnancy. Since many people today also want to prevent the spread of STDs, they must use condoms (perhaps in addition to another type

of contraception). Male condoms have been around longer and so are more established and better known by the public, which is probably at least part of the reason why they are more popular than female condoms. Although the prevalence of condom use increased in the late 1980s and early 1990s due to the HIV/AIDS scare, female contraceptives remain the most popular methods by far, suggesting that the dominant contraceptive ideology remains strong despite the concern to prevent STDs.

## Overview of the Current Contraceptive Situation in the United States

### Who Contracepts and What Methods Do They Use?

The dominant ideology that women should be the ones contracepting shines through in the fact that women alone do the vast majority of contracepting. Moreover, the cultural assumption that women should be responsible for contraception is reflected in the methodological approach of social science research on contraception: most of them take women as the focus of their studies even when examining the prevalence of male methods. For example, the data in Table 4, originally published in Hatcher et al., summarize the contraceptive methods women rely upon, regardless of whether they are female or male methods. Studies that compare couples' statements on what contraceptives methods they are using have found women and men report quite differently (Becker 176).

Almost all women—98 percent—ages 15-44 who have ever had (heterosexual) sex have used at least one type of contraception (The Alan Guttmacher Institute, 2008b). There are 62 million women of reproductive age (ages 15-44) in the United States and 62 percent of these women are currently using contraception. (Of the remaining 38 percent

of women of reproductive age, 30 percent do not need to contracept for one of the following reasons: they are infertile, pregnant, postpartum, trying to become pregnant, have never had sex, or are not sexually active.) Sixty nine percent of the 62 million women of childbearing age, 42 million, are sexually active, but do not want to become pregnant. In order to prevent pregnancy, 89 percent of these 42 million women contracept. This leaves approximately 7 to 8 percent of all fertile women ages 15-44 who do not want to become pregnant who are not contracepting (Table 1). Given that the likelihood of pregnancy is 85 percent if no contraception is used, these women are at a serious risk for unintended pregnancy (Hatcher foreword). Of course, unwanted pregnancies can occur even when people are contracepting. Shockingly, 50 percent of unintended pregnancies in the U.S. happened to people who *were* using some method of contraception (Nass and Strauss 18). Perhaps this high rate is less surprising when we consider that a third of teenagers who use contraception use it incorrectly (Knudson 113). It is much easier to incorrectly utilize user dependent contraceptives like barrier methods, the pill, the patch, the vaginal ring, rhythm, withdrawal, and abstinence, which is reflected by the large difference between their failure rates for perfect use versus for typical use (See Table 2). In contrast, professionally administered contraceptives—sterilization (female and male), IUDs, Norplant, and Depo Provera—have a much smaller difference between their failure rates for perfect use and for typical use. Moreover, they have lower overall failure rates than ones that are user dependent (Table 2).

There are eleven female-only contraceptive methods, including sterilization (tubal ligation); barrier methods (the diaphragm, the sponge, the cervical cap, and the female condom); hormonal LARCs (the pill, the patch, injectables, implants, the vaginal ring,

and a progestin-releasing IUD); and a nonhormonal LARC, other types of IUDs. In total, 67.3 percent of contraceptive use depends on these female-only methods. LARCs constitute 39.1 percent of all contraception use. They are the largest subgroup of all contraceptive methods, with sterilization (both female and male) not too far behind at 36.2 percent. The pill is not only the most popular LARC, but it is also the overall most popular method of contraception at 30.6 percent of all contraceptive use. Tubal sterilization is a close second at 27.0 percent (Table 3). As seen on Table 4, the pill is by far the most popular contraceptive for women in their teens and twenties: over a third of women ages 15-19 and ages 25-9 use the pill, while almost half of women ages 20-24 rely on the pill. The popularity of the pill for women in their teens and twenties can be attributed to the fact that many of these women want to preserve their fertility (they may want to have biological children in the future), yet may not need to rely upon condoms because they are in monogamous relationships. As women get older and decide they do not want any more children, they often turn to a permanent contraceptive, which explains why the prevalence of sterilization increases as women age. The popularity of female sterilization increases about ten percentage points with every five year span, topping off at 46.7 percent for women ages 40-44 and making it the most common form of contraceptive for women in their forties. The remaining forms of female contraceptives account for just 9.7 percent of total contraceptive use.

In contrast to the large number and variety of female contraceptives, there are only two male only methods: vasectomy and condoms, which constitute 9.2 percent and 18 percent of contraceptive use, respectively.[4] Combined, these two male methods make

[4] Since spermicides are generally not used alone, but instead are usually used with barrier methods, I am not counting them as a separate contraceptive method.

up just over a quarter (27.2%) of all contraception. (It is worth noting that male methods account for only 17 percent of contraception use in the developing world (Nass and Strauss 112).) The percentage of people relying upon vasectomies as their contraceptive method rises slowly during women's twenties and thirties and reaches a high of 19 percent for women ages 40-44 (Table 4). Male condoms are the second most common contraceptive for teenagers at close to thirty percent. Their popularity remains in percentages in the twenties for women in their twenties and then drops to percentages in the teens for women in their thirties and forties. The decrease in condom use and the increase in vasectomies at women get older makes sense, as women in the thirties and forties are more likely to be in long-term monogamous relationships in which they are not concerned about spreading STDs, but do want to permanently prevent pregnancy.

The prevalence of condom increased by almost 50 percent from the late 1980s to the mid-1990s after the U.S. Surgeon General reported that condoms prevent the spread of HIV and other STDs (Hatcher 331). However, although condom use has gone up, its overall use and knowledge about it remain low, especially in light of the ubiquity of STDs (a recent CDC press release estimates that one in four teenage girls has an STD). According to research by Hatcher et al., "Only 20% of people who had 3 or more partners in the past 3 years always used condoms with their primary partner. Although knowledge of AIDS is very high, less than half of those surveyed said using a condom is a very effective way to prevent HIV" (15). While the lack of knowledge about condoms' effectiveness clearly contributes to their low use, as I will discuss in next chapter 4, dominant ideologies about masculinity also play a role.

In addition to female and male contraceptives, there are two methods—withdrawal and abstinence—that require participation from both partners (Table 3). Together, they account for just 5.6 percent of all contraceptive use. Including these two methods, men are involved with contracepting nearly one third of the time (32.8%). As previously mentioned, women *alone* are responsible for contraception in over two thirds of all cases. If we include withdrawal and abstinence, women participate in contraception in close to three fourths of all sexual encounters (72.9 %). If we add male condoms to this figure—and women often do initiate and participate in male condom use—then women are involved in 90.9% of all contraceptive use. Women's involvement is practically three times as great as men's. The only form of contraception that women do not actively participate in is vasectomy, which accounts for less than ten percent of all contraceptive methods used. Men, in contrast, are involved in only four out of the 15 methods (the 14 listed on Table 3 plus the vaginal ring) and only the male condom is in the double digits for popularity of use.

## How Much Does Contraception Cost?

For countries with universal health care systems, the price of contraception would probably not play a role in individuals' choices regarding which contraceptive method to choose for themselves. However, since the U.S. has a private insurance system, cost often does factor into people's health care decisions. The 45.8 million Americans who are currently uninsured (15.7 percent of the total population) have to pay for all medical expenses out of pocket (U.S. Census). One in five women aged 15-44, that is, women of reproductive potential, lack health insurance. These women are 30 percent less likely to

report using prescription contraceptives than women with health insurance (Culwell and Feinglass 226). This finding is not surprising given that prescription contraceptives are not only more expensive than non-prescription contraceptives, but they also involve the cost of a doctor's visit. Yet, this finding is troubling because it shows that financial concerns limit women's contraceptive choices, often leading them to rely on less effective, though cheaper, methods.

Even having insurance does not obviate financial concerns. Copayments can be high and often add up quickly. Additionally, insurance companies do not cover all health care needs. Patients themselves must pay for drugs and services that their insurance companies do not cover. Most insurance companies do not cover contraception, even though they pay for other "optional" drugs for men, like erectile dysfunction drugs. As Sheldon Segal exclaims, "Insurance Company Logic: $10 for 1 erection—we'll pay; $1 for 10 years of contraception—we won't pay" (86). As a result, women pay 68 percent more out of pocket toward their health care than men of the same age. Only half of the states mandate insurance companies to cover contraception to the same extent as they do for other prescription medications. Half of these states have provisions in place for providers, plans, or employers to deny contraceptive coverage for religious or moral reasons (Knudson 115).

Contraceptives range in price from free for withdrawal and rhythm to thousands of dollars for a tubal ligation. Although sterilization (both female and male) is the most expensive type of contraception, it is more cost effective over the long run because it is a one-time service (Table 5). The large upfront cost for sterilization, however, can be prohibitive for some people. For people with health insurance, sterilization is often an

appealing contraceptive option cost-wise because insurance plans are more likely to cover it than reversible contraceptives, so people do not have to pay out of pocket (Sonfield et al. 73).

Besides sterilization, LARCs are generally the most expensive form of contraception. LARCs are just as the name describes—long-acting, but not permanent—so they need to be maintained. Women take a pill daily, replace their patch or vaginal ring monthly, get their injection every one or three months, or have their implant or IUD removed and replaced every number of years. Maintaining these methods is expensive because it requires medical involvement. Women have to see a health care professional in order to get a prescription for the pill, patch, ring, or injectable (Table 6). Since these prescriptions get written out in women's names, the women are, by default, the ones who pay for contraception and whose insurance (assuming they have insurance) gets billed. Women also have to see a health care professional in order to receive their injection, implant, or IUD and to have the latter two removed. The upfront and backend costs for implantation (which can run hundreds of dollars) and removal of implants and IUDs prevent some women from choosing these contraceptives. In the majority of cases, the type of health care professional that women must see is limited to physicians, health care professionals that are typically more expensive and less accessible (Grossman et al. 796).[5] To summarize, in order to use LARCs, women must see a physician, which means paying for the doctor visit in addition to the contraceptive method. The cost of these doctor visits can add up quickly, especially for contraceptive methods that necessitate seeing the doctor on a regular basis, like monthly injectables. LARCs are not the only

[5] As Grossman et al. discuss, there is compelling evidence that many contraceptives would be just as safe and effective if they were demedicalized; that is, if they no longer required physician regulation.

type of contraception that depend on physician regulation. Two of the four female-only barrier methods, diaphragms and cervical caps, also require physician involvement, as doctors "fit" patients with these contraceptives. Additionally, as a surgical procedure, sterilization mandates physician involvement. But, neither barrier methods nor sterilization require a prescription.

Only two of the eleven female-only contraceptives—the sponge and the female condom—do not require seeing a physician. This means that 82 percent of female methods require at least one physician visit in order to acquire the contraceptive. Moreover, 36 percent of female methods require a prescription, which means women must continually renew their contraceptive by going to the pharmacy or doctor (Table 6). Most doctors will not continue renewing prescriptions without seeing their patients yearly, so the initial visit when the doctor prescribes the contraceptive is not enough to ensure continued access to the contraceptive. Vasectomy is the only male contraceptive that involves a physician, and no prescription is needed. All other methods that require men's participation (male condoms, female condoms, withdrawal, and rhythm) can be accessed over the counter, meaning no doctor's visit is needed (Table 6). Evidence shows that the medicalization of contraception—that is, positioning physicians as gatekeepers to contraception—increases cost and decreases access (Grossman et al.). People in a recent study echo this finding: in evaluating what contributes to unplanned pregnancy, 54 percent stated cost as an obstacle to contraception use and 66 percent claimed that an inability to obtain contraception played a role (Mauldon 27).

## What Are the Health-Related Side Effects and Noncontraceptive Benefits of Contraceptives?

As seen in Table 7, there are health-related disadvantages (dangers and side effects) for almost all types of contraception. The only contraceptive without any associated dangers is the female condom. Besides the female condom, all of the women-only methods have serious health-related dangers and side effects. The dangers and side effects of LARCs are especially great because pumping an otherwise healthy body with extra hormones can cause significant problems. For example, Hatcher et al. list the dangers associated with the most popular LARC, the pill, as "cardiovascular complications (stroke, heart attack, blood clots, high blood pressure), depression, hepatic adenomas, possible increased risk of breast and cervical cancers" (241). Brochure inserts for the pill warn of over 50 possible side effects (Knight and Callahan 112). Potential side effects of the pill include nausea, headaches, dizziness, spotting, weight gain, breast tenderness, chloasma (facial skin pigmentation), irritability, anxiety, depression, changes in libido, vaginitis, gum inflammation, and increased urinary tract infections (Hatcher et al. 241; Knight and Callahan 113). While some of these side effects diminish and sometimes disappear after the first few months as the body acclimates to the change in hormonal levels, some side effects persist. The patch and the ring presumably have the same side effects as the pill as they are all forms of combined hormonal contraception (Hatcher et al. 241). Other LARCs have equally serious side effects as the pill, such as uterine perforation, anemia, allergic reactions, pathologic weight gain, hair loss, menstrual cramping, spotting, possible bone loss, and adverse effects on lipids. Even female barrier methods excluding the female condom have the potential for adverse side

effects like vaginal and urinary tract infections, toxic shock syndrome, pelvic pressure, allergy, and vaginal irritation (Table 7).

Some dismiss these side effects as "minor." However, to the women who experience them, they often are far from minor. In fact, the most common reason women discontinue contraceptives, especially LARCs, is due to side effects (Nass and Strauss 119). The fact that most forms of contraception have discontinuation rates approaching 50 percent after one year of use shows that many women find side effects sufficiently intolerable to abandon their current contraceptive method (ibid. 125-6). When women discontinue a highly effective method, like a LARC, they typically turn to a less effective method, a nonLARC, because the side effects associated with nonLARCs are less significant than the side effects common to LARCs (ibid 20). It is important to note that just because women continue to use a particular contraceptive rather than discontinue it does not mean that they like it and/or are not bothered by the side effects. Indeed, women may continue contracepting with a specific method despite the side effects because they view it as their best worst option (ibid 115-6). Side effects not only cause women to stop contracepting, they also prevent them from starting to contracept with a new method. For example, many women are deterred from using LARCs due to their fear of potential side effects (ibid. 125-6).

The side effects associated with male contraceptives are not as severe as those for female contraceptives. Part of the reason for this is that there are no male LARCs, and LARCs typically have the most serious side effects. But the two available male-only forms of contraception—condoms and vasectomy—also carry fewer risks than their corresponding female-only contraceptives, female barrier methods and tubal ligation,

respectively. The only health-related danger for male condoms is allergy to latex, which can take one of two forms: "delayed hypersensitivity," which consists of a rash in the area of contact or "immediate reaction" (anaphylaxsis), which can lead to low blood pressure, trouble breathing, and even death (Medicinenet). While some people are born with latex allergies, these allergies are most commonly seen in people who have high exposure to latex (ibid). Severe anaphylactic reactions to latex are rare and are usually associated with medical procedures, not condom use (Mansell). For men who know they have a latex allergy, the health-related side effect of condoms can be easily avoided by using nonlatex condoms, available in polyurethane and lambskin (though the latter does not protect against STDs). Although female condoms have no adverse health effects, other female barrier methods have the potential to cause a variety of negative side effects, as mentioned above.

Vasectomy also carries fewer risks than female counterpart, tubal ligation. Both forms of sterilization carry the following health-related risks: infection, pain, anesthetic complications, and psychological reactions (Table 7). Few of the side effects of a vasectomy are long lasting, whereas a tubal ligation can lead to long-term complications. Tubal ligation runs the risk of abnormal bleeding, bladder infections, high risk of ectopic pregnancy (if women get pregnant), and post-tubal sterilization syndrome, which can include irregular and painful periods, mid-cycle bleeding, or no periods. Laparoscopy is the most common technique for female sterilization and the procedure itself poses greater risks than the procedure for vasectomy. The main reason for this is that tubal ligation is a more complex surgery even though, like vasectomy, it is an outpatient procedure. Tubal ligation surgery lasts double as long as vasectomy surgery (30 minutes versus 15

minutes) and involves double the incisions as vasectomy (two versus one). Whereas only local anesthesia is used for a vasectomy, either local or general anesthesia is administered for a tubal ligation (FWHC). In sum, "Compared with female sterilization, a vasectomy is simpler, safer, cheaper, and similar in effectiveness (Knight and Callahan 286-7).

Not all the effects of contraceptives are bad. As seen in Table 7, there are noncontraceptive benefits for most forms of contraception. For instance, both the female and male condom protect against STDs. The positive effects of the pill are probably the most well known: the pill generally "decreases menstrual pain, PMS, and blood loss; protects against symptomatic PID, some cancers (ovarian, endometrial) and some benign tumors (leiomyomata, benign breast masses), and ovarian cysts; reduces acne" (Hatcher et al. 241). Doctors sometimes prescribe the pill to women precisely because of these noncontraceptive benefits. For example, a doctor may prescribe the pill for a woman with ovarian cysts in order to prevent further cysts from growing. Other LARCs (except IUDs that are not progestin-releasing) may also provide noncontraceptive benefits including reducing the risk of seizures, protecting against ovarian and endometrial cancers, and decreasing menstrual cramps, pain, and blood loss (ibid.). However, these other LARCs are rarely prescribed solely for noncontraceptive use, implying that there are other medications that are better suited to treat the symptoms in part because they have a more favorable risk/benefit ratio.

## Contraceptive Burdens and Women's Oppression

Relying on the empirical information presented in the last section, I argue that the current contraceptive arrangement, in which women participate in the use of almost all

contraception and alone are responsible for two thirds of contraception, is unfair. This arrangement is unfair because it involves an oppressed social group, women, taking on the majority of the responsibility, and hence the associated burdens, of contraception, while the privileged social group, men, are typically relieved of this responsibility and its corresponding burdens.

Let me begin by outlining some of the burdens women face (often alone) in starting and maintaining contraceptive use. They see their physician to access nearly all forms of contraception. They visit the pharmacy if their chosen form of contraception requires a prescription. They pay for the doctor's appointment and the prescription. They learn to correctly use their contraceptive. Moreover, in order successfully contracept, they must gain general knowledge about both their contraceptive and reproduction (for example, women on the pill need to know that antibiotics can reduce the effectiveness of this method). In many cases, they regulate their contraceptive use; for example, they must remember to take their pill daily or they must anticipate sexual activity and insert their barrier method beforehand. They deal with side effects, which can be quite serious. They decide whether to continue with a particular contraceptive method or to switch methods (the latter would involve all the previous steps all over again). They feel the weight of contraceptive responsibility on their shoulders, the stress, worry, and anxiety that such responsibility produces. They suffer guilt and blame from others if an unintended pregnancy occurs.

Not being responsible for some or all of these burdens is a significant boon for men. They typically do not have to dedicate time and energy to contraceptive care, pay out of pocket for the usually expensive and sometimes frequent (e.g. monthly, four times

a year) supply of contraceptives, acquire the knowledge about contraception and reproduction needed to effectively contracept, deal with the medicalization of one's reproductive health, endure the bodily invasion of contraception, suffer the health-related side effects and the mental stress of being responsible for contraception, and face the social repercussions of their contraceptive decisions (such as whether to use a particular contraceptive or to switch contraceptives) and the moral reproach for contraceptive failures. People who contracept have to devote and sacrifice many aspects of themselves and what they value: their body, health (physical and mental), time, money, etc. These contraceptive burdens, devotions, and sacrifices limit people's freedoms. Since men are frequently not responsible for contraception, they are absolved from these burdens and thus their freedom is not infringed upon.

Women, in contrast, have minimized freedom since they are typically responsible for most, and sometimes all, contraception. Contraceptive responsibility and the burdens it entails reinforce women's already disadvantaged social positioning. These burdens are more wires in the birdcage, to borrow Marilyn Frye's analogy for oppression (1983). Separately, these burdens may seem insignificant, but when we look at them together within the social context of patriarchy, we recognize that they work systemically as a network that limits women's opportunities. Indeed, these burdens not only negatively affect women within the reproductive realm; they also have the potential for far-reaching effects in other realms. For example, that women have to shell out their own money for contraception (and for their reproductive care more generally) whereas men typically do not puts women in a worse off economic state. Another example: the negative side effects women can experience from contraceptives can prevent them from participating in

activities and can reduce their self-confidence (they worry about hair loss, weight gain, and spotting).

Some may object to my position that the current contraceptive situation is unfair and claim that since there are many more reversible contraceptive options for women (versus the one option for men, male condoms), it makes sense for women to assume contraceptive responsibility. Furthermore, some may state that the fact that the diversity of options is much greater for women is also a good reason women should be the ones contracepting. Women can choose from among sterilization, four barrier methods, and six LARCs. This argument boils down to the belief that those who have more (both in number and variety) options should take responsibility because they are better equipped to do so (given their expanded range of choices).

Yet, as Barry Schwartz argues, more options do not necessarily translate into enhanced autonomy. In fact, more choices of goods and services "may impair freedom by taking time and energy we'd be better off devoting to other matters" (Schwartz 4). While the number of female contraceptive methods may not seem overwhelming, there is still a lot of information to wade through in order for women to decide upon which method best suits their needs. Most women settle on the pill, but there is not just one type of pill; there are over 40 (NWHCR). Since the pill requires a prescription, it seems fair to assume that doctors assist women in making such decisions (or in some cases, just make the decisions for them). However, the relatively recent shift in medicine from the all-knowing, paternalistic doctor to the doctor who presents a variety of choices and has the patient make a decision means that the patient must undergo the stress of a decision making process. In Schwartz's words, "The combination of decision autonomy and a

proliferation of treatment possibilities places an incredible burden on every person in a high-stakes area of decision making [like contraception] that did not exist twenty years ago" (33). In sum, the mere fact that women have a greater array of contraceptive choices than men does not necessarily mean that women have increased autonomy and thus are better equipped to make contraceptive decisions. According to Schwartz's argument, women's contraceptive autonomy is actually impeded due to the overwhelming number of choices.

Men's contraceptive autonomy, in contrast, cannot be said to be inhibited by an abundance of options. However, I do think it is fair to claim that their autonomy is limited by a lack of choices, especially since there are no male LARCs. Just as too many choices can minimize our autonomy, so too can too few choices. Yet, despite the fact that men's only reversible contraceptive option is the male condom, this does not mean that men have no moral obligation to contracept. Indeed, minimal options do not relinquish our responsibilities, though they can make it more difficult to fulfill these responsibilities. For example, politicians, policymakers, children's advocates, the media and probably most people would not claim that parents who have access to fewer choices of food have less of a responsibility to feed their children than parents who have access to numerous and diverse food options. While the first group of parents may have more trouble providing their children with balanced and delicious meals, their responsibility to feed their children is not diminished. Likewise, the limited availability of male contraceptives does not reduce men's contraceptive responsibility.[6] The fact that women have more and perhaps better reversible contraceptives available to them is not a reason why *men* should

[6] As the philosophy saying goes "ought implies can." There are contraceptive options for men—male condoms and vasectomy—there are just fewer of them than are available for women. So, men *can* contracept.

not contracept, nor does it mean women should automatically assume full contraceptive responsibility. I make a positive case for why men have a moral duty to contracept in chapters 5 and 6.

The paucity of male contraceptives is problematic not because it affects men's contraceptive responsibility, but rather because it makes it more difficult for men to contracept and because it means that contraception is often shoved onto women. It is especially troubling that there are no male LARCs given their popularity and their unique characteristics. The absence of male LARCs means that if people are looking for certain qualities in their contraceptive, then their only choice is to depend on the women to contracept. LARCs combine two desirable characteristics of sterilization and barrier methods: the long-acting nature of sterilization and the reversibility of barrier methods. Since there are no LARCs for men, women must be the ones to contracept if they (and their partner) want a contraceptive method that is both long-acting and reversible. Another reason LARCs are so popular is that they, along with sterilization, have the lowest failure rates both for perfect use and actual use (Table 2). If people do not want to rely upon sterilization as their contraceptive method (perhaps they would like to have biological children in the future), yet are concerned about using the most effective forms of contraception, then their choices would be limited to LARCs—that is, women-only methods.

We need more male contraceptives, particularly male LARCs, so that men can more easily and effectively contracept and so that women are not saddled with most or all contraceptive responsibility. However, more male contraceptives alone will not necessarily result in an equally shared contraceptive arrangement. Gender ideologies play

a significant role in who should be responsible for contraception, as seen in the case of sterilization. Unlike the case of reversible contraceptives, the availability of permanent contraceptives is equal for women and men; both have one option available to them, tubal ligation for women and vasectomy for men. This equality of options might lead one might expect similar rates of tubal ligation and vasectomy. Yet, tubal ligation is practically three times more common in the U.S. (27 percent versus 9.2 percent for vasectomy). Worldwide, the same pattern stands: tubal ligation is much more prevalent than vasectomy. In fact, only two countries, Britain and the Netherlands, have vasectomy rates that are equivalent to tubal ligation rates (Ringheim 88, footnote). What can explain this large discrepancy? Gender ideologies seem to be (at least part of) the answer. Nelly Oudshoorn elucidates:

> In the second half of the twentieth century, the idea that women were responsible for contraception thus became the dominant cultural narrative as it was materialized in the contraceptive technologies, social movements, and in the gender identities of women and men. ... Consequently, contraceptive use became excluded from hegemonic masculinity. (14-15)

The alignment of femininity with contraceptive responsibility explains why tubal ligation is ubiquitous while vasectomy is not. Contraceptive responsibility is not part of the dominant cultural narrative of masculinity and consequently men are usually less inclined to be sterilized. Women, in contrast, associate contraceptive responsibility with femininity and thus feel like part of their duty as women is to contracept, including sterilization.

The case of sterilization shows how strong gender ideologies run. Even though vasectomy is a cheaper, simpler, and safer procedure and thus would probably be the best "objective" choice for monogamous couples who want a permanent contraceptive

method, men are far less likely to be sterilized. That vasectomy is more effective (0.1 percent failure rate versus 0.5 percent for tubal ligation, though this difference is probably not statistically significant (Table 2)) and that the health-related burdens associated with tubal ligation are greater in number and in seriousness than for vasectomy are usually not enough to sway people to choose vasectomy over tubal ligation. The gender ideologies regarding contraception are so deeply embedded in our culture that couples often overlook good reasons for having a vasectomy rather than a tubal ligation. Tubal ligation is consequently more popular and hence, like with reversible contraception, women typically bear the burden for permanent contraception. In order to move toward an equitable contraceptive arrangement we must alter our dominant gender ideologies, a task I discuss in more detail in the last chapter.

Although some readers may concur that women are unfairly saddled with the burdens of contraception, they may claim that this situation is much better than women's situation before the invention of the pill and other LARCs. The pill gave women the ability to independently and successfully regulate their reproduction. Prior to the pill, many of the contraceptive methods relied on male participation, making women dependent on men's decisions. Even if men and women both agreed to contracept, the available methods had high failure rates. Not only was the pill much more effective than other available methods, but it also was the first contraceptive that was long-acting, reversible, and not related to the timing of sexual activity. Because of the pill's characteristics, women could now regulate their fertility without the consent, knowledge, or participation of their partners. Being able to control their fertility has improved numerous aspects of women's lives outside of reproduction. Indeed, "The degree of

control women are able to exercise over their reproductive lives directly affects their education and job opportunities, income level, physical and emotional well-being, as well as the economic and social conditions the children they bear will experience" (Nadine Taub quoted in Andrews xiii).

I completely agree that the pill has dramatically improved the lives of women by enabling them to autonomously and effectively control their fertility. And this was precisely the goal of birth control advocate Margaret Sanger, who was the impetus for the discovery of the pill in the U.S by dreaming of a type of contraceptive, a "magic pill," that was as easy to take as aspirin (PBS). It should come as no surprise that "The three peaks of the political campaign for reproductive freedom—the 1870s, the 1910s, and the 1970s and 1980s—coincided with peaks of women's rights struggles" (Gordon 482). Feminists believed in and fought for greater reproductive freedom, including the women's ability to autonomously and discretely control their fertility. There is no question that, due to the pill and other contraceptive advances, the contraceptive situation women in the U.S. face today is vastly better than it was 60 years ago.

That said, however, the current contraceptive situation is still unjust. Women bear the brunt of contraceptive responsibility and the burdens it entails. In a way, the current contraceptive arrangement is more problematic than the previous one because its injustices are often hidden, or at least sidelined, by the dominant rhetoric of women's empowerment and equality. This sends the message that women should be content and grateful for the current situation, thus marginalizing and even silencing any complaints or suggestions for improvements that women may have.

Furthermore, this situation is unjust because women are oppressively socialized to assume full contraceptive responsibility. To understand how this is the case, it is useful to look at Paul Benson's work on oppressive socialization. Benson is concerned with developing an approach to autonomy that can account for the fact that certain types of socialization—specifically, oppressive socialization—can impair autonomy, while non-oppressive forms of socialization do not. Benson presents two types of socialization that are oppressive: "(1) coercive socialization that inflicts penalties for noncompliance with unjustifiable norms and (2) socialization that instills false beliefs that prevent people from discerning genuine reasons for acting" (Meyers summarizing Benson's view, 478). He uses the example of socialization of feminine appearance to explicate both types of oppressive socialization. The unjustifiable norms in first type of oppressive socialization are feminine beauty norms, which entail the "near constant effort to measure up to complicated and ever-changing standards governing one's looks" so as to be sex objects for men (Benson 386). Women who challenge this expectation are stigmatized and punished: "Women learn that their prospects for satisfying their basic interests in meaningful work, material security, social acceptance, and so forth can be expected to suffer dramatically if they do not achieve enough success at maintaining themselves as desirable sights for men's eyes" (Benson 387). More specifically, women who do not comply with this norm may be less likely to have friends and romantic partners and may be less likely to economically succeed (studies show that "plain" people make less money than "beautiful" people (Engemann and Owyang)). The second way the socialization of feminine appearance is oppressive is that it teaches women a falsehood that interferes with their decision making: that "feminine appearance is a necessary ingredient of a

woman's personal worth" (388-9). Women internalize the belief that their personal value is tied up in their appearance, which leads them to misconstrue some of the reasons there for them to act. For example, women may choose to get up early in the mornings to "fix themselves up" rather than getting much needed sleep because they believe their looks are a priority over their rest. Internalizing these falsehoods inhibits women's autonomy by preventing them from competently developing critical reflection skills regarding reasons to act in certain ways. Often women's critical competence becomes fragmented: they are receptive to reasons in certain realms, but not others (Benson 397).

Like the socialization of feminine appearance, the socialization of contraceptive responsibility (as well as reproductive and childcare responsibility more broadly) is oppressive in both ways. First, the expectation that women should assume full contraceptive responsibility is unreasonable, as it places the onus of responsibility for something that involves two people on just one person and that person is determined based on her social group membership. Moreover, as I argue in chapter 6, women's social positioning often makes it difficult for them to contracept. Yet because women are coercively socialized to contracept, women who do not contracept face noncompliance penalties, such as being labeled irresponsible or loose, or being accused of trying to "trick" men into marriage through pregnancy. Single women who become pregnant are stigmatized and blamed for their situation, while typically little to no blame is directed toward men. Women in monogamous relationships who do not contracept (and who are not trying to conceive) are often thought to be neglecting one of their domestic and feminine responsibilities. Furthermore, they are sometimes viewed as selfish because they want their male partner to contracept even though using condoms may decrease his

pleasure and having a vasectomy is often thought to be a type of emasculation. In sum, "In an age of planned parenthood and unlimited contraception, those [namely women] who do not want to use contraception ... gradually become 'different,' then 'suspect' (naïve, backward, irrational). Now the *nonuse* of contraception becomes stigmatized" (Beck-Gernsheim 33).

Second, the socialization of contraceptive responsibility instills women with the false belief that a necessary part of being a woman is taking care of reproductive and childcare matters, including contraception. Interwoven with this belief are gender ideologies about women, such as that they are naturally better caretakers and that they should be self-sacrificing. I will return to these ideologies in the next chapters. This false belief impairs women's ability to determine genuine reasons for acting. For example, if a couple decide that sterilization is their best contraceptive option, the woman may claim that she should be the one sterilized even though she has a history of severe adverse reactions to anesthesia. What motivates the woman in this case is the falsehood that women should assume contraceptive responsibility. Because she believes that contraceptive responsibility is an integral aspect of being a woman, she volunteers to be sterilized despite the serious health risk to herself.

The socialization of contraceptive responsibility interferes with women's autonomy by leading them to make choices that they probably would not make if there were not such strict noncompliance penalties (assuming they had not internalized the oppressive belief). Additionally, this impairment of their autonomy causes them to make decisions that are often not in their best interest. Women typically choose to be fully responsible for contraception even though doing so can be quite burdensome for them.

Since they have internalized the belief that they alone ought to be responsible for contraception, many women do not recognize that there are good reasons for men to share contraceptive responsibility. "A culture's ultimate defensive weapon [against change] is to make alternative ways of life unimaginable or imaginable only as bizarre or loathsome specimens" and this is precisely what oppressive socialization does (Meyers 2000, 487). In portraying men contracepting as absurd or highly undesirable, oppressive socialization teaches women that they should be the ones contracepting. What is so insidious about oppressive socialization is that it gives the impression of choice—that women autonomously choose to contracept—rather than acknowledging the coercive factors that leave women little choice but to contracept.

Women's belief that contraception is their responsibility is further buttressed and reinforced by other gendered and oppressive forms of socialization as well as gender ideologies. In the next two chapters, I will examine how our attitude of trust influences who politicians, contraceptive researchers and developers, the media, and everyday people think should be responsible for contraception. I will argue that the perceptions that men are untrustworthy with contraception while women are innately suited for reproductive tasks strengthens women's (and men's) belief that women alone should contracept.

## Chapter 3. Trust, Ideologies, and Contraception

In 2006, various mainstream news organizations in the English-speaking world picked up the story that male contraceptives were just around the corner, approximately four to ten years away from hitting the market. [7] In addition to conveying information about these new male contraceptives, a common theme running through the stories was the issue of trust, specifically, the question of whether men would and should be trusted to be responsible for contraception. It is very telling that trust, not empowerment or autonomy, was the common theme. The concepts of empowerment and autonomy are usually central to discussions of female contraceptives. Although trust is rarely explicitly mentioned in discussions of female contraceptives, women's trustworthiness is in fact a significant factor in contraceptive matters, shaping individual relationships, social norms, and public laws and policies. That discussions of trust are absent in practically all discussions of female contraceptives, but included in most discussions of male contraceptives, reflects dominant ideologies of gender roles and responsibilities.

Many of the articles about male contraceptives deal specifically with whether women would trust men with contraception. Some articles look at individual women's perspectives, such as Jennifer Christman in "What's in a Dame? Would He Even Take the Pill, If He Could?": "I asked some [female] friends if they would trust men, if male contraception became available, to bear the birth control responsibility. Not one of them

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[7] Mainstream mass media articles on male contraception published in 2006 include Bourke, Callaghan, Christman, Glenda Daniels, Eyre, Godson, LaMotta, Levenson, Macrae, Mason, No author (Male pill has no lasting ill-effects, study reveals), No author (Male pill may put the men in control of conception), No author (Sperm production recovers completely after stopping hormonal contraception), No author (Will birth control be his job?), No author (Would a male contraceptive pill work?), Nuzzo, Pirani, Randle, Richard & Judy, Ross, Sarler, Traister, and Wharton.

said yes." Other articles ostensibly discuss women's perspectives, but really seem to be talking about what the authors or particular groups of individuals believe to be women's perspectives. Take a look at these two quotations: "the field of male contraceptive development has been plagued by ... whether women will trust their contraceptive protection to a male method that they cannot verify is being used" (Darroch 91) and "critics [of male contraception] argue that men do not have the same motivation to prevent pregnancy and this will make it hard for some women to trust a man who says he has taken his [contraceptive] tablet" (Macrae). While the first quotation is one view from the field of male contraceptive development and the second reflects the view of some male contraception critics, both of these views are in fact these groups' speculation about women's opinion on trusting men with contraception. Few mass media articles I read had empirical evidence for women's thoughts on this topic, so the views of these two groups seem based mainly on social perceptions and ideologies. Interestingly, one mass media article that included empirical evidence, gathered from a survey of 1,900 women in Scotland, China, and South Africa, showed that only two percent of women would not trust their partner to use male contraceptive hormones (a form of male contraception) (Nuzzo). Some other articles about men participating in clinical research trials for male contraceptives did not give statistics on whether their female partners trusted them to be responsible for contraception; however, I assume that all the women trusted their male partners because they agreed to join the trials and not use any other form of contraception (Scott). Furthermore, social science studies published in academic journals confirm that women in committed relationships would trust their male partner to use contraceptives (Glasier et al., 2000; Martin et al., 2000; Weston et al., 2002). Also, many couples

already rely on male contraception, which presumably means that these women trust their male partners to use contraception. It is probably easier to trust men to use the available contraceptive methods since both condoms and withdrawal take place in the presence of women and vasectomy is a permanent procedure. In sum, although the empirical evidence shows that most women do trust their male partners to contracept, most articles I read claim that women will not trust men.

Hence, there is a disconnect between social perceptions and women's actual views on men's trustworthiness. I believe this disconnect can be explained by distinguishing between trust for individuals and trust for groups. On an interpersonal level, women generally trust their male partners with contraception. Yet, many—such as some mass media journalists, critics of developing new male contraceptives, and many groups and individuals in the field of contraceptive research and development (e.g. pharmaceutical companies, scientists, healthcare professionals)—assert that women distrust men as a group with contraception. This belief emerges from gendered and contraceptive ideologies and is reflected in semi-conscious actions individuals and groups take, such as journalists writing that women will not trust men with contraception and pharmaceutical companies choosing not to research male contraceptives. Those who think women distrust men to contracept are not themselves engaged in relations of trust, but rather are making claims about women's relations of trust with men regarding contraception. These claims do not seem to be based on empirically grounded evidence, but rather one's worldview, which is shaped by dominant ideologies. Although some authors present their views as empirically based, such as Christman who surveys "some friends," it seems odd that they did not do any research on the topic. We typically expect

journalists and reporters to provide an "objective," fact-based story. We even expect people who write editorials to rely on facts and not just present an unsubstantiated opinion. The ideologies at play in contraception seem so deeply embedded in our culture and our individual consciousness (and subconsciousness) that the authors of these articles do not even seem aware that they are deferring to ideology rather than facts.

My goal in this chapter and the next one is to illuminate some of the ideologies that lead many people, especially mass media journalists and those in the field of contraception research and development, to assume that women will not trust men to contracept. This chapter is divided into two parts. The first part centers on trust. I begin by examining some of the feminist literature on interpersonal trust and, in particular, the work of Amy Mullin and Carolyn McLeod. After outlining their conceptions of interpersonal trust, I draw on specific aspects of their approaches to build my own conception of interpersonal trust. Based on this conception, I postulate a type of trust that takes place not on an interpersonal level, but on a group level: what I call "group trust." Instead of analyzing whether one trusts an individual, in group trust we analyze whether one trusts a particular group of people. In the second part of this chapter, I explore some contraceptive ideologies, including the cultural understanding of contraception as private and taboo and the social norm that those involved in reproductive matters should be self-sacrificing. Laying out my conceptions of interpersonal and group trust and identifying various contraceptive ideologies sets the stage for me to analyze why trust is such a prominent theme in these mass media articles about male contraception and, just as importantly, why it is virtually absent in articles about female contraception.

## CONCEPTIONS OF TRUST

### Mullin and McLeod: Two Feminist Conceptions of Trust

While various feminist theorists define trust differently, the common theme running through all of these accounts is that trust is an attitude concerning our expectations of others. When we trust, we expect others to act in ways that are either helpfully (or at least not harmfully) directed at us (or at the subject of trust) or we expect that we and the object of trust share a belief in the "right" way to act. Both Mullin and McLeod insist that, in interpersonal trust, the truster must believe that the trusted affirms the same norm(s) or position(s) that she does in a particular domain. Mullin claims "we assume that the one we trust shares our own commitment to a particular social norm which we take to govern the trusted one's behavior in some specific domain" (2005b, 316). Likewise, McLeod states, "My trust, then, must entail the expectation that there is some similarity between what she and I stand for, morally speaking, in the relevant domain" (465-6). One of the important differences between these two theorists is that Mullin thinks what is shared between truster and trusted is a social norm, while McLeod asserts that it a moral claim. I will now describe and critique their approaches in more detail.

In recognizing social groups and incorporating social norms into her conception of trust, Mullin contextualizes and situates trust in our cultural reality. Indeed, Mullin explicitly posits that trust is mediated by social forces rather than something that occurs between free-floating individuals. She says that trust is grounded in our expectations that people follow social norms—placing society's, and not just the individual's, perspective at the center of trust. Mullin claims that social norms and other people besides the person

trusting and the person trusted not only play a role in trusting, but also in recognizing and understanding trust. For example, she states, "Since social roles and norms shape the content of trust, and trust is not solely of the interaction between truster and truster, it makes sense for the parties in a dispute about trust to ask other people questions" to help resolve whether there was a betrayal or not (2005b, 325). In sum, while Mullin's account of trust is of interpersonal relationships, by basing trust on adherence to social norms, she integrates social forces and the complex interplay between social forces and individuals into her conception of trust.

Though Mullin's conception of trust rests upon shared social norms, sharing a social norm is not enough to trust another. The reason a person values the social norm also plays a role in trusting. According to Mullin, "examples of trust ... are united by the central notion of the trusted's commitment to a certain norm for its own sake, rather than merely for rewards which can follow from adherence to it" (2005b, 322). Mullin's distinction between trust and reliance boils down to the difference between valuing a social norm for intrinsic reasons and valuing a social norm for instrumental reasons. When we value social norm X intrinsically, we are internally committed to X for its own sake. This type of deep commitment merits trust because it motivates us to make acting in a way that promotes X a priority. In contrast, when we value X instrumentally—we value X only for what it will get us, not for its own sake—we are not trustworthy because there is a greater probability that we will not act in a way to promote X. If acting to promote Y (be it a social norm or not) allows us to reach our goal better or faster, then our instrumental value of X may not be enough to persuade us to pursue X rather than Y. It is for this reason that we can only be relied upon, not trusted, to act according to X.

In contrast to Mullin's approach, other well-know conceptions of trust, such as the goodwill approach[8] and the moral integrity approach, only implicitly incorporate social forces. According to these conceptions, trust is based on our expectations of how others' actions will affect us—making the trusting individual the only focus. For example, Annette Baier, a proponent of the goodwill approach, puts the individual at the center of trust, claiming, "When I trust another, I depend on her good will toward me" (1986, 235). Trudy Govier, a moral integrity theorist, makes a similar move, stating "When we trust others, we expect them to act in ways that are helpful, or at least not harmful to us" (17). In focusing on the individual's viewpoint, the ways in which social forces influence the individual's expectations get sidelined. For example, the goodwill approach and the moral integrity approach both assert that we trust people who we expect will act according to these characteristics. Yet, what we consider good will and moral integrity depends on dominant norms and ideologies. By not directly addressing the role social forces play in interpersonal trust, these other accounts give the impression that trust is something that occurs between two atomistic individuals.

Although Mullin avoids the pitfall of conceptualizing trust as practically devoid of social context, her approach is not without its problems. One potential critique of Mullin's approach is that trust depends on social norms, many of which are not only problematic, but also oppressive. The concern here is that in accepting her approach, we are reinforcing and reifying these oppressive social norms. This criticism does not hold, as it is a misreading of Mullin. Mullin's account of trust seeks to represents what is occurring on a descriptive level when we trust, not on a normative level. If her account

[8] For more on the goodwill approach, see Annette Baier and Karen Jones.

involved a normative argument, then I think this criticism would be relevant. But because Mullin is merely describing how we trust, this critique does not reveal a problem with her account, only with oppressive social norms.

A more significant critique of Mullin is that she seems to reduce trust to social norms. As many examples can easily show, following social norms is not a sufficient condition for trust. For instance, there is a social norm in the United States that people stand in elevators facing the doors. If I were to go into an elevator and stand with my back to the door, thus looking at everyone else in the elevator, I would be violating the unspoken social norm of how to act in elevators. And while I am sure people would be uncomfortable—in fact, I know people would be uncomfortable because I have broken this social norm before—I do not think it is right to say that they would feel like their trust in me had been betrayed in that domain. The others in the elevator would probably find me odd and may be confused by my behavior, but I doubt they would describe their feelings as betrayal; betrayal is too strong of an emotion for this situation. They might expect me to break other social norms that have to do with social customs, such as drinking soup from the bowl rather than using a spoon, yet this does not mean they distrust me.

Perhaps Mullin would respond that trust involves more than just abiding by social norms; the reason the trusted person values the social norm also plays a role. In the case of trust, we assume that the trusted person intrinsically, rather than instrumentally, values the social norm. Mullin might retort that the others in the elevator do not feel betrayal because they do not think that I intrinsically value the social norm of how to stand in an elevator. If they did think I intrinsically valued this social norm, then they would feel like

I had broken their trust. However, since this is an example of a social norm that is rarely intrinsically valued, it makes sense that the others do not feel betrayal. (If they believe that I instrumentally value this social norm, then they may feel that I have been unreliable.) Mullin might claim that another situation, one in which people generally intrinsically value the social norm at play, would show that her conception of trust is not reducible to just social norms.

Yet, I am skeptical that the distinction between intrinsic and instrumental does the sort of work for her theory that she may think it does. That is, this distinction is riddled with problems to the extent that it detracts from her approach rather than strengthening it. Before we can even decide whether a person intrinsically or instrumentally values a social norm, we have to determine which social norm is at play. This is often not easy, since social norms are generally not discrete, unconnected beliefs. Furthermore, there may be more than one social norm that motivates a person to act in a particular situation. In order to determine someone's trustworthiness or reliability according to Mullin's approach, we must first know which social norm(s) she is committed to and then we can determine whether she intrinsically or instrumentally values it (them). Yet, ascertaining whether someone intrinsically values a social norm is no simple feat. As Mullin herself states, trust is rarely explicit (2005b, 325). Consequently, there is typically little to no discussion of what social norm governs the specific domain of trust and whether the trusted person intrinsically values it. The result is that the subject of trust must make assumptions about the values held by the object of trust based on what can be very limited information. In sum, identifying and assessing how people value social norms is an arduous process.

A deeper problem with the distinction between intrinsically and instrumentally valuing social norms is that it is conceptually unclear and confusing. The idea of instrumentally valuing a social norm seems odd. Valuing money instrumentally, for example, makes sense because money can get us the things we *really* (i.e. intrinsically) value, like a car or the ability to retire by age 65. In contrast, a social norm itself cannot help us achieve other things, though following it can. If we uphold a social norm in order to get something else, then what we are instrumentally valuing is not the social norm, but the action. For instance, there is a social norm to help one's friends. I, a talented carpenter, may build a handicap accessible ramp into my home so my friend Sylvia can more easily come over. I may do this for instrumental reasons—so I can see Sylvia more often, to assuage my guilt, to get her to do a favor for me in return—yet the norm is not what I instrumentally value. I instrumentally value the action, as it is the action that produces the outcome that I intrinsically value.

The idea of intrinsically valuing a norm also seems strange. I am not sure what it means to value the norm to help one's friends for the sake of the norm to help one's friends. To be charitable, perhaps what Mullin means by intrinsically valuing a norm is morally valuing it. What we are valuing in this case is clearer: the moral message of the norm (e.g. whether helping friends is the "right" way to act). This type of valuing of norms maps onto our lived experience, as, in everyday life, we make moral claims about the worth of various norms. Moreover, the degree of value we place on a norm affects our actions. If I morally value the social norm of helping friends, then I am more likely uphold it (i.e. to actually help friends) than someone who does not morally value this norm. The distinction between morally valuing versus not morally valuing a social norm

seems to be more useful for understanding trust than the distinction between intrinsically versus instrumentally valuing a social norm.

Turning to McLeod's work, we can get a better understanding of the role normative moral values play in trust and how they help us distinguish between trust and reliance. McLeod's presents a different explanation than Mullin for why breaking certain social customs does not result in distrust, but perhaps a lack of reliance. She states, "Trust and mere reliance are distinct because we expect trusted others, unlike those on whom we merely rely, to be motivated by a moral commitment" (McLeod 474). When we trust, according to McLeod, we expect people to act in a *morally* acceptable way, a way that matches up to our moral beliefs. While we may agree that there are standard ways to act dictated by social customs, most of us do not have a moral investment in these types of norms. We do not morally uphold standing in elevators facing the doors. Consequently, we do not feel like our trust has been betrayed by people who stand the "wrong" or "nonstandard" way in elevators. Instead, we are more likely to feel that these people cannot be relied upon to follow social customs.

In contrast to the elevator example, numerous social norms are morally grounded. For example, there is a social norm that people in committed romantic relationships will be monogamous. If we uphold this norm and find out that our partner has had sex with someone else, we would probably feel betrayed. The moral dimension to McLeod's approach to helps us understand why the emotions of betrayal are typically so much deeper than the emotions of disappointment due to lack of reliability. In the case of disappointment, we are upset or frustrated because our expectation was not fulfilled. For instance, my secretary forgets to bring me my morning coffee and I am consequently

grumpy because my morning ritual has been broken and I am without my necessary caffeine fix. With betrayal, in addition to the feelings we have due to our expectation not being met, we learn that the person we trusted does not have the same moral commitment(s) that we do in this particular domain. Especially in close relationships, such a discovery can be heart wrenching, as our relationships are often grounded in shared values and admiration for another's moral integrity. Furthermore, knowing that trusted people do not share our moral commitments is troubling because it suggests that they may not care about us as much as we care about them. If my partner does not morally value monogamy and she cheats on me, I may worry that she does not love me that much; otherwise, she would uphold a commitment to monogamy. Even if the person we trusted claims to share our moral commitment(s) in a particular realm despite her actions to the contrary, we are still upset that she hurt us by failing to maintain her moral integrity.

One critique of the moral integrity approach (as well as the goodwill approach) is that it cannot explain why we can feel our trust has been betrayed even when a person acts with moral integrity (or goodwill). For example, high school student Naomi confides in her friend Tom that she is extremely depressed and even suicidal. Tom is very concerned about Naomi and informs her parents immediately. They set up an urgent doctor's appointment for Naomi, which tips her off that Tom has spilled her secret since he is the only person she told. While there is clearly controversy regarding when it is ethical to break someone's confidence, some would claim that Tom acts morally here and even more would agree that Tom's reasons for action are morally motivated. Even if one believes Tom acts morally, Naomi nonetheless feels betrayed. McLeod might respond

that her approach can accommodate this situation, as it is a case in which the truster (Naomi) and the trusted (Tom) have different understandings of what it means to have moral integrity in this particular domain. Yet, Naomi could believe that Tom has "an enduring commitment to acting in a morally respectful way" toward her and that his actions follow from that commitment—in short, that he has and acts from moral integrity—and still feel betrayed by his behavior (McLeod 468). In other words, Naomi can feel betrayed even if she thinks Tom acted morally. The main reason Naomi feels betrayed is that there is a morally charged social norm that friends keep each others' secrets—a norm that she thinks (consciously or nonconsciously) that she and Tom both uphold. Tom violated this social norm, which leads to broken trust despite the fact that Naomi may believe that Tom acted with moral integrity. This example suggests that we expect more than just moral integrity from people we trust; we also expect them to act according to shared social norms. Acting with moral integrity is not sufficient for trust, though it is necessary. The same generally holds true for the relationship between trust and adhering to social norms: acting according to social norms is necessary for trust, but not sufficient.

### Trust as Following Morally Shared Ideologies

So far I have highlighted the major strengths and weaknesses with Mullin's and McLeod's conceptions of trust. My conception of interpersonal trust is basically a combination of the strengths of their accounts. I borrow Mullin's idea that trust involves following social norms, though I broaden it to include ideologies, and I draw from McLeod's claim that trust has a moral dimension. My conception of trust is as follows:

when we trust, we expect people to act according to morally shared ideologies in the relevant domain and we assume they are competent to do so. Since I explained why a moral dimension and adherence to social norms are each necessary, though not sufficient, components of trust in the previous section, I will not reiterate those arguments here. Rather, I want to focus on how incorporating ideologies into my conception leads it to deviate from Mullin's and McLeod's approaches.

But, first, I point out a commonality among my conception of trust and Mullin's and McLeod's: the role of competence in trust. Most trust theorists,[9] including McLeod and Mullin, agree that incompetence can interfere with trust. According to McLeod, one common reason for an attitude of distrust is that "we are pessimistic, rather than optimistic, about the other person's competence" (477). In other words, if we are not confident in another's competence, we are likely to distrust her rather than trust her. Likewise, Mullin asserts that "when we trust, we assume ... certain forms of general competence. These involve competence (1) to recognize the social norm supposed by the truster and understand what it requires and (2) to act in accordance with one's own norms" (2005b, 322). Since my conception of trust is similar to Mullin's in that we both think trust involves the expectation that people will act according to norms (and ideologies in my account), these two forms of competence affect my conception as well. More broadly, incompetence can prevent trust in my account of both interpersonal and group trust.

[9] For example, Trudy Govier enumerates three aspects of trust and one of them is competence (1992, 18). Karen Jones directly incorporates competence into her definition of trust, stating, "trust is optimism about the goodwill and *competence* of another" (7).

Believing that someone is competent is necessary for trust. Since we usually trust people in particular domains, what matters is whether we think their incompetence affects what we trust them with. For example, Miguel is able to trust Latesha to water his plants while he is away on vacation because he knows she is competent at the task. He does not, however, trust her to borrow his car because she does not have her license and is an incompetent driver. That she is an incompetent driver does not interfere with his trust of her watering his plants because this incompetence will not affect her ability to water his plants. If, however, Miguel discovers that Latesha has some specific incompetency that will affect her ability to water his plants, such as she has a tendency to severely overwater plants, then this incompetency will rightly interfere with his trust of her to complete this task. Certain general incompetencies will also interfere with his trust of her. For example, if Latesha is chronically forgetful, then this may prevent her from remembering to water Miguel's plants everyday. Assuming Miguel is aware of Latesha's forgetfulness, it will factor into his willingness and ability to trust her. Our group membership can also influence our perceived competence, a point I return to in the next section.

Another commonality between my conception and Mullin's and McLeod's is the idea that trust involves taking a risk.[10] For example, Mullin states, "when trust is fully explicit, the truster is aware that there is an element of risk involved in the trust behavior" (Mullin 2005b, 325). When we trust, we make ourselves vulnerable by allowing for the possibility of broken trust and the negative moral emotions it engenders. These negative moral emotions are painful to experience and they can damage our relationships,

[10] Other feminist trust theorists also point out that trust entails risk. For example, Govier highlights the risk of distrust: "When we distrust, we fear that others may act in ways that are immoral or harmful to us; we are vulnerable to them and take the risk seriously" (17).

especially our relationship with the object of trust. Furthermore, broken trust can lead to potentially hurtful and dangerous situations for us, and for others. In the case of contraception, if men betray women's trust to contracept, then the women could end up unintentionally pregnant (and/or with a STD). Likewise, if women betray men's trust to contracept, then men could become a father against their wishes. As I explain in detail in chapter 6, there are numerous harms associated with unintended pregnancy and parenthood, more for women, but also many for men. Given these potential harms and the unpleasant moral emotions that broken contraceptive trust can produce, many people are cautious about trusting others, especially unknown others, with contraception.

I turn now to how my conception of trust differs from Mullin's and McLeod's. One significant difference is the role ideologies play in my conception. It is important to be clear about what I mean by the term 'ideology.' Although Antoine Louis Claude Destutt de Tracy originally coined this term to mean a "science of ideas," I am focusing on the more common meaning of this term in contemporary political thought as introduced by Karl Marx and Friedrich Engels. Louis Althusser summarizes Marx's definition of ideology as "the system of ideas and representations which dominate the mind of a man or a social group" (159). Indeed, I am using this term to refer to a broad and diverse body of cultural beliefs, stories, myths, images, tropes, expectations, norms, and so on that shape our behavior. Ideologies, according to Michel Foucault, emerge from "power-knowledge relations" (278). He argues that "power produces knowledge...power and knowledge directly imply one another; there is no power relation without the correlative constitution of a field of knowledge, nor any knowledge that does not presuppose and constitute at the same time power relations" (261). In other words,

social forces create knowledge and knowledge reinforces these social forces. For example, the social force of patriarchy produces the knowledge that women are not as smart as men and this knowledge perpetuates patriarchy through its disciplinary instantiations, such as paternalistic laws regarding women's body (e.g. limitations on abortion), normalizing forces that prohibit women's employment in certain jobs, and heterosexual norms that a man should be the head of household.

Ideologies exist and interact in deep, complex, and sometimes contradictory ways. They are not discrete or atomistic. Rather, they depend upon a social context and are often intertwined with other ideologies. Indeed, they are culturally specific, absorbed through socialization, and perpetuated by our use of them. We are typically not fully conscious of them, though we constantly depend on them to make sense of our world and guide our actions. In this way, they have a moral dimension, as we rely on them to determine and justify moral beliefs and actions. Part of the reason we are not fully conscious of them is that they are so deeply embedded in our cultural consciousness and social structures that they have been normalized. We often do not recognize them as ideologies. Rather, we generally take them for granted as "just the way things are," which is why it can be so difficult to challenge and uproot dominant ideologies. Through socialization, we are disciplined to become "subjected and practised bodies, 'docile' bodies"; that is, bodies who uphold ideology (Foucault 264). Two examples of socialized docile bodies are "women's cramped postures and attenuated strides and men's restraint of emotional self-expression (except for anger)," which are materializations of patriarchal beliefs about women's weakness and inferiority and men's strength and stoicism (Frye 1983, 14). While others sometimes explicitly tell us to behave in accordance with cultural

expectations (e.g. "good girls cross their legs" and "boys don't cry"), many of these ideological and behavioral norms are tacitly conveyed. Girls learn there are noncompliance consequences for sitting with their legs open—e.g. they are viewed loose and unladylike—and, likewise, boys recognize crying is socially stigmatized—e.g. boys who cry are considered weak, sissy, and feminine. Through these experiences, children nonconsciously internalize these ideologies and not only modify their behavior, but they also self-monitor and self-discipline their behavior.

The way I am discussing these ideologies is similar to concepts employed by other theorists. For example, Hilde Lindemann Nelson presents a narrower concept than ideologies, perhaps a subset of ideologies, that centers on narratives. She refers to the dominant narratives as "master narratives" and defines them as:

> the stories found lying about in our culture that serve as summaries of socially shared understandings. Master narratives are often archetypal, consisting of stock plots and readily recognizable character types, and we use them not only to make sense of our experience but also to justify what we do. As the repositories of common norms, master narratives exercise a certain authority over our moral imaginations and play a role in informing our moral intuitions. (Nelson 2001, 6)

Diana Meyers discusses an even more restricted concept than both ideologies and narratives. She focuses on dominant gender (or patriarchal or sexist) beliefs and expectations for women in the U.S and describes these "figurations of womanhood" as "the dominant system of tropes, mythic tales, and pictorial images that encode the various meanings of womanhood and norms applying to women in the United States today" (Meyers 2002, 25). Recognizing the role these figurations, and ideologies more generally, play in understanding our world, Meyers identifies them as "culturally certified concepts and interpretive schemas" (Meyers 2002, 24). For my purposes, I am not too concerned

about carefully distinguishing these terms, as they are all ways of conveying dominant and systemic social understandings.

Returning to my conception of trust, if trust requires believing we share moral ideologies with the object of trust, then how do we know what ideologies others uphold? The truth is that we often do not know, even with people we may know fairly well. When we do not know, we (consciously and nonconsciously) tend to assume that others believe the dominant ideologies. Since dominant ideologies are generally well-known and well-supported, they serve as our default option when we are unsure of what others believe. Yet, we also recognize that beliefs and ideologies are often culturally and group specific. In determining what ideologies others support (a process that is not fully conscious), we usually take into account their personal characteristics, including their group memberships. For example, Jessica opposes premarital sex. If she knows Caleb is a deep and active believer in Evangelical Christianity, then she may presume that he also rejects premarital sex. She consequently may trust him not to pressure her to have sex when they are alone together. However, if she does not know about his religious convictions, then she probably does not trust him with respect to this behavior because she would likely assume that he follows the dominant ideology that premarital sex is acceptable, even expected. In sum, which ideologies we expect others to follow depends on the cultural context and the social positions of the subject and object of trust. Regardless of whether the ideologies are dominant or not, it is imperative that the subject of trust believe that she and the object of trust have a shared commitment to the same moral ideology(ies).

The example of Jessica and Caleb shows that getting to know others, which includes learning about their moral commitments, improves our ability to make good

decisions about trusting them. When we have a deeper sense of who people are and what they value, we are able to determine with greater accuracy if we share the same moral commitments. Our ability to gauge whether we share moral commitments is lessened when we do not know people well since, as mentioned above, we typically assume they support the dominant ideology or a nondominant ideology prevalent in their community or group. Basing trust on unsubstantiated hypotheses about people's values results in a weaker trust relationship because we are less confident that we and the object of trust truly share the same moral commitments. Moreover, the probability of broken trust increases since it is more likely that we are wrong about the object of trust's moral commitments.

Regardless of whether we know someone well or not, ideologies will always be central in relationships of trust since trust is the expectation that people act according to shared moral ideologies. Yet, ideologies play another role in trust, a role that grows stronger the less we know someone. Ideologies aid us in determining what ideologies others' uphold. For example, two dominant cultural stereotypes in the U.S. are that "real" U.S.ers[11] are white and that people of Arab descent are terrorists. Tony, an airport security guard, does not trust people who are, or who he thinks to be, of Arab descent because he does not think they share his belief in protecting the U.S. Though Tony is not fully conscious of how these cultural stereotypes affect his relations of trust, they are reflected in his actions: more thorough screening of people he believes to be Arab than for people who he considers white. When Tony's next door neighbor, Fatimah, comes to the airport, he treats her like a white person even though he knows for certain she is of

[11] I use the term "U.S.ers" rather than "Americans" to refer to people who identify as members of the United States as a way of being more precise and less exclusionary because people living in countries in North, Central, and South America other than the U.S.A. also consider themselves Americans.

Arab descent. The reason he makes an exception for her is that he knows her personally and consequently he is able to judge whether she shares his moral commitment to protect the U.S. on her individual characteristics (for example, he knows she is in the Army and served in the Gulf War) rather than on her social group membership. For people he does not know personally, Tony relies on cultural stereotypes to assess their trustworthiness. I will discuss these ideas in more detail in the next section in explicating my conception of "group" trust. What I want to stress before turning to trust on the group level is that ideologies affect trust on the interpersonal level as well, as seen in the case of Tony.

## Group Trust

So far, I have been discussing trust on the interpersonal level. But there is another level on which trust occurs that deserves recognition and that was hinted at in the mainstream articles about contraception. The language used in these articles reveals that many journalists, scientists, and pharmaceutical company employees are skeptical that women will trust men as a group. I will provide more evidence for this claim in the next chapter, but first I want to explore this other type of trust, which I call "group trust." Whereas interpersonal trust examines trust on the individual level—does person A trust person B?—group trust takes a broader perspective and examines whether someone trusts a particular group of people—does person C trust group D? Group trust does not and is not meant to encompass the perspectives of all people. Like interpersonal trust, the trusting agent in group trust is an individual. So, when we talk about group trust, we are still looking at an individual's view. The big difference between interpersonal trust and group trust is who the object of trust is: in interpersonal trust the object is an individual,

while in group trust the object is a group. As I will show in this section, having a different object of trust changes the nature of group trust in some significant ways from interpersonal trust.

Group trust is not limited to discussions in articles and surveys about which groups people trust. It also has practical implications, as group trust is reflected in laws, policies, and social norms. For example, some states do not allow gays and lesbians to adopt children. Although politicians rarely use the language of trust to support these laws, one of the underlying reasons they pass such laws is that they uphold, or believe their constituents uphold, the ideology that gays and lesbians cannot be trusted to provide the "right" (read: heterosexual) type of environment for children. There is a dominant moral ideology that children should be raised in a two parent, heterosexual household. Many politicians and their constituents consequently do not trust gays and lesbians to raise children because they do not follow this moral ideology. This group distrust is manifested in laws prohibiting gays and lesbians from adopting.

As this example shows, because group trust concerns entire groups of people rather than specific known individuals, it relies more heavily on dominant ideologies. Dominant ideologies affect our determinations of a group's trustworthiness by shaping whether we think the group will act according to the relevant ideology in a particular domain and whether the group is competent overall and in specific domains. Because people engaged in interpersonal trust can generally identify and often know the object of trust, they are less likely to have to rely on ideologies to determine trustworthiness. Instead, they can base their assessment of trustworthiness on the specific characteristics of the person and the particular circumstances surrounding trust. In contrast, group trust

involves groups of people—and thus generalizations about these groups—and consequently such particularities about individual people or circumstances are less likely to be recognized. Assessing the trustworthiness of a group makes us more susceptible to stereotypes, meaning we are more likely to reduce groups to cultural tropes rather than acknowledging the diversity within groups. The more innocuous reason for this is that we are forced to make generalizations about the individuals who comprise the group in order so they all neatly "fit" within the group. For example, one may generalize that all women have the potential to become pregnant, even some women do not (e.g. women who are postmenopausal, infertile, MTF transgender, etc.). The less innocuous reason is that it is easier to fall prey to stereotypes in an oppressive (e.g. sexist, racist, classist, and ableist) world because they are so deeply and systemically embedded into our worldviews. For instance, one may generalize that people on welfare are lazy rather than acknowledge the systemic forces that lead people to go on welfare or highlight the achievements of people on welfare.

That group trust relies so heavily on dominant ideologies is clearly problematic. I agree with Lorraine Code that "epistemologically speaking, the use of stereotypes is always a crude and irresponsible way of not bothering to know, yet posing as though one does" (170n3). By extension, relying on ideologies to determine a group's trustworthiness suffers the same flaws. Ideologies typically reflect the perspective of the dominant group(s) and so it is not surprising that they usually positively reflect the dominant group and negatively portray the oppressed groups. Yet, although many ideologies are troubling, we *do* rely on them in group trusting. Like Code, I believe that "something very like stereotypes is in fact needed if knowledge, or language [or group

trustworthiness], are to be possible at all," but that we should strive for these stereotypes to be flexible, not dogmatic (162). We cannot change the fact that, descriptively speaking, group trust depends on ideologies. What we can change, however, are these ideologies themselves, though this is no easy feat. Additionally, we can change the way we approach these ideologies by recognizing that they are do not include everyone from a particular group and they do not convey some "essence" of what it means to be part of a specific group. I will return to some of these practical suggestions in the next chapter.

Even though I may not trust a certain group on the group level, I can still trust individuals who are members of that group on an interpersonal level. Say, for example, that I do not trust the group Jews with anything related to money because of the cultural stereotype that they are greedy and stingy. This distrust is not fully conscious, nor are the ways this distrust influences my decisions. My group distrust of Jews will probably affect my decision of where to invest my money, which charities I donate to, which restaurants I frequent, which companies I work for, etc. because all of these actions take place on the group level rather than the individual level. For instance, I may refuse to donate to Jewish charities and charities headed by Jews because I fear that the Jews working for these charities will keep some or most of the donated money for themselves rather than using it to advance the mission of the charity. My decision to avoid donating to certain charities is based on my generalized and universal view of Jews; that is, my belief that all Jews are greedy and stingy. However, I can make exceptions to this belief for Jews whom I know personally. A friend recommends her accountant, Rebecca, to me. Not knowing Rebecca is Jewish, I use her services and come to highly respect her and her work. After some time, I discover that she is Jewish, yet she does not fit the cultural trope that Jews are

greedy and stingy. Instead of changing my deeply seated belief about Jews, it is easier for me to tell myself that Rebecca is just the exception to the norm. By doing this, I am able to continue trusting Rebecca on an interpersonal level while simultaneously distrusting Jews on a group level regarding money.[12] What this example shows is that knowing someone personally allows us to make decisions about trust based on her individual characteristics rather than on general assumptions we may have about people based on their group membership. In this way, interpersonal trust is more accurate and avoids the aforementioned problems of group trust.

Another important difference between interpersonal trust and group trust is that when group trust is broken, there is not the same sense of betrayal as there is when interpersonal trust is broken. To understand why this is the case, I return to the example of some politicians (and their constituents) who think there should be a law preventing gays and lesbians from adopting children. Imagine that such a law fails to pass and that gays and lesbians are granted the legal right to adopt children. If gays and lesbians start adopting children, we would not say that these politicians feel betrayed by their actions even though they are acting in an untrustworthy manner according to the dominant ideologies the politicians maintain. One reason it does not make sense to label the politicians' feelings as betrayal is that betrayal seems to presume a relationship between truster and trusted.

On a certain level, it is difficult to conceptualize a relationship between an individual and a group, though such relationships clearly exist. For example, a teacher

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[12] According to Sartre, we can do more than make exceptions for members of groups we distrust in a particular domain; we can also make exceptions and befriend members of groups we hate. He states: "The sadistic attraction that the anti-Semite feels toward the Jew is so strong that it is not unusual to see one of these sworn enemies of Israel surround himself with Jewish friends. To be sure, he says that they are 'exceptional Jews,' insists that 'these aren't like the rest'" (47).

has a relationship with each of her classes and a child has a relationship with his immediate family. However, in both these cases, the group is bounded and well-defined; the teacher and the child can usually identify the members of the group. Furthermore, the teacher and the child have some sort of interpersonal relationship with all of the members of the group. The politicians cannot identify all the gays and lesbians in their state (let alone their district), which precludes their having an interpersonal relationship with all of them. Perhaps being able to identify all the members of a group and to have an interpersonal relationship is not necessary for an individual to have a relationship with a group. For instance, a politician may have a relationship with her constituents even though she cannot individually identify all of them. Maybe what is most important for a relationship between an individual and a group is that there is two-way communication. A politician can communicate to her constituents through public speeches, interviews, and laws she supports. Her constituents can respond to her at public meetings, by contacting her office, through public support surveys, and, ultimately, by voting.

Since many relationships, especially close ones (e.g. partners, best friends) are grounded in shared values and respect (even admiration) for the other's moral integrity, part of the sting of betrayal is learning that the person we trusted does not share our moral commitment(s) in a particular domain. Betrayal is also such an intense feeling because it suggests that the trusted person does not care about us, or at least not as much as we care about her. Without a relationship based on common values and care, when someone breaks our trust, our feelings are unlikely to be as strong as betrayal. That said, I think feelings of betrayal or disappointment can result from broken group trust. For example, a politician could feel betrayed by her constituents if they vote her out of office or a person

who considers herself Navajo could feel betrayed by the Navajo community if they refuse to recognize her as Navajo. Yet, in both these examples the individuals seem to have a relationship with the group and even two-way communication. When both of these two components are not present, the likelihood that broken group trust produces feelings of betrayal is greatly diminished.

Broken group trust, however, still leads to moral emotions, but emotions that do not depend upon a relationship for their existence, like anger[13] or disgust[14]. For instance, the politicians who oppose permitting gays and lesbians to adopt probably are angry and/or disgusted with gays and lesbians who choose to have children (via pregnancy, adoption, or any method) because they are violating the ideology the politicians uphold. Likewise, I may feel both anger and disgust at Jews in general when I learn that a Jewish company has bought out my favorite local store.

Some may object to my conception of group trust because they think it deviates from interpersonal trust in too many significant ways: group trust has a group rather than an individual as the object of trust, it relies more heavily on ideologies, and it does not usually produce feelings of betrayal when broken. The concern here is that I am stretching the definition of trust to include something that cannot rightly be considered trust. Yet, the last two aforementioned differences result from the first difference; that is, the fact that the object of group trust is a group causes group trust to depend more on ideologies and not lead to betrayal. Group trust will of course differ from interpersonal

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[13] According to Frye, "Anger is always righteous" (1983, 84). For more on anger, see her chapter "A Note on Anger" in *The Politics of Reality*.

[14] William Miller, for example, states disgust "marks out moral matters for which we can have no compromise" (1997, 194). Dan M. Kahan also believes disgust has a moral component, claiming that disgust is "brazenly and uncompromisingly judgmental" (1998, 1624). Martha Nussbaum's book, *Hiding from Humanity: Disgust, Shame, and the Law* discusses both these views on disgust and many others.

trust precisely because the object of trust is a group, not an individual. But some may still reject group trust as a type of trust on the grounds that one of the main ways to distinguish trust from reliance is that breaking trust causes feelings of betrayal, whereas unreliability merely leads to disappointment. I agree that the potential to produce betrayal is an important component to interpersonal trust and helps us differentiate between interpersonal trust and reliance.

If betrayal is not common to broken group trust, then what will assist us in distinguishing group trust from group reliance? First off, I do not think there is a clear line of demarcation between trust and reliance, even on the interpersonal level. But more importantly, the moral component of trust is what enables us to distinguish it from reliance. Broken trust produces moral emotions, like betrayal, anger, and disgust, whereas broken reliance leads to emotions that are not (or perhaps are less) moral, like confusion, frustration, and disappointment. The examples of the politicians opposing gay and lesbian adoption and me believing Jews are greedy and stingy show how broken group trust causes moral emotions. Let me give an example of broken reliance. Say I rely upon the Mexican community in my town to put on a parade for Day of the Dead. If there is no parade this year, I would probably be confused, frustrated, and disappointed. I doubt that I would use moral emotions to describe my feelings in this case because there is not (or there is less of) a normative and moral aspect to expecting a parade than expecting people to act in a particular way when raising children, for instance.

I recognize that this response will not satisfy those who believe that feelings of betrayal are a necessary component of a good account of trust, be it on the individual or group level. Perhaps referring to group trust as group expectation or something without

the word "trust" would mitigate this objection. But because I want my account of group trust to map onto the everyday language we use, I will not replace the word "trust" with a less contentious word. As the articles on male contraception shows, we do talk about trusting a particular group of people. I want my account of group trust to reflect the common language we use so that we can make sense of the difference between trusting individuals and trusting groups.

## CONTRACEPTIVE IDEOLOGIES

Now that we have an understanding of what group trust means, I will explore some of the dominant ideologies at play in contraception. Recognizing the dominant ideologies helps us to understand the discrepancy in contraceptive trust for men on the individual and group level, a task I return to in the next chapter. The extensive philosophical and feminist work on reproduction and childcare has shown how various ideologies shape our understandings, experiences, and actions within these realms. Because contraception fits under the umbrella of reproduction and childcare, the dominant ideologies at play in contraception are similar to those at play in other reproductive and childcare matters. Yet, how these ideologies influence contraceptive issues may not be readily apparent. Part of the reason for this is that contraception receives little attention in political, academic, and media realms. When contraception is addressed, the way we talk about it—specifically our focus on how it augments women's autonomy—tends to mask the underlying ideologies. Both of these ideas were discussed in chapter 1, so I will not reiterate those arguments here. Instead, I will point out how certain reproductive and childcare ideologies also shape contraceptive matters.

Although ideologies are socially situated and often entangled with other ideologies, it is sometimes useful to be able to discuss them individually. I may refer to particular ideologies by name to avoid cumbersome language, but this does not mean that I think those ideologies are separable from other ideologies and from a social context. In fact, my discussion will reveal the opposite conclusion: that ideologies depend on a social context and sometimes on one another. In this section, I focus on two contraceptive expectations. First, I examine the dominant ideology that contraception is a personal matter that should not be discussed by exploring how our legal and education systems make contraception private and taboo. Second, I extend the dominant ideology that pregnant women and mothers should be self-sacrificing to contraception to reveal that some degree of self-sacrifice, or at least of assuming burdens and accepting losses, is expected of those who contracept.

Before turning to these ideologies, it is important to note that although often considered in the abstract, reproductive and childcare ideologies, and hence contraceptive ideologies, are highly gendered: women are typically associated with the private realm and women are usually the ones expected to live up to the ideal of self-sacrifice. That women are the ones held responsible for reproduction and childcare plays a significant role in why these specific social norms are the way they are. If men were the ones traditionally responsible for reproduction and childcare, society would have created very different social ideologies for these realms—ideologies that would be more "masculine."

## Privacy and Taboo

Although there are policies and laws regarding reproduction and childcare in the U.S., as well as public debates about these policies and laws, these matters are generally thought to belong to the private realm. Not surprisingly, little public money goes to support for reproduction and childcare. In contrast, France, like many European countries, publicly assists in these matters: prenatal care is easily accessible and covered under their system of universal health care, pregnant women can take paid maternity leave months before giving birth, nurses make home visits to help parents and babies, and childcare is heavily subsidized by the government (Shapiro). Moreover, France also treats contraception as a public matter by including contraception in its universal health care system, providing free contraception in schools, distributing contraceptive information in various venues, and publically funding contraception campaigns (Boonstra). In 2000, France decided to add emergency contraception to its list of contraceptives offered in high schools, a move that was met with wide national support. The reaction in the U.S., however, was generally one of shock and outrage. Examining the U.S. cultural belief that contraception is private and taboo will help us understand why U.S.ers responded so differently from the French.

Like reproduction and childcare, contraception has historically and legally been relegated to the private realm in the U.S. In 1873, Congress passed the Comstock law and was the only Western country (at least at that time) to criminalize birth control. This anti-obscenity law specifically named contraception as a type of obscene material and prohibited its distribution through the public postal service and interstate commerce. This law not only made contraception illegal, but it also pushed it out of the public realm and

into the private realm. It was not until 1936—63 years later—that the Comstock law was over overturned by the court case *U.S. v. One Package*, which ruled that doctors can receive contraceptive information and methods through the mail unless illegal by state law. Due to this ruling, the American Medical Association (AMA) finally officially acknowledged contraception as a legitimate aspect of medicine (PBS). Previously, contraception was not considered a medical issue; it was merely a private matter. Yet, contraception was still not viewed as a public matter even after the AMA recognized it. As seen by a series of court decisions, reproductive rights, and specifically the right to contracept, were upheld by the right to privacy. For example, the 1965 U.S. Supreme Court case *Griswold v. Connecticut* ruled that the state could not prohibit the use of contraception due to couples' right to privacy. (At that time, eight states outlawed the sale of contraceptives and Connecticut and Massachusetts still had laws against disseminating information about contraception (PBS).) In this same vein, the Supreme Court decision of *Eisenstadt v. Baird* in 1972 stuck down a Massachusetts law that prohibited selling contraceptives to unmarried women (PBS). While these court cases show that contraceptive use has become more acceptable, not to mention legal, they also reveal that contraception is still firmly entrenched in the private realm. Our legal right to contracept is grounded in our right to privacy.

Outside the legal realm, contraception has remained a private matter in part because it is taboo. For example, abstinence-only education teaches children that contracepting is not something people should talk about or do. The social denial and rejection of children's sexuality also feeds into abstinence-only education, which is reflected in the main message of its educational programs: sex outside marriage is not

only morally wrong, but it will lead to horrible outcomes. According to *Sexuality, Commitment & Family*, an abstinence-only guide for teens, the serious psychological and social consequences of premarital sex include:

> loss of reputation, limitations in dating/marriage choices, negative effects on sexual adjustment—Premarital sex, especially with more than one person has been linked to the development of difficulty in sexual adjustment (Guilt has been found to be a pervasive problem in this regard.) ... development of emotional illness, loss of self esteem ... [and] confusion regarding personal value (e.g. 'Am I loved because ... I am a sex object?). (cited in Doan and Williams 116)

Abstinence-only education also teaches children that STDs are a likely outcome of sexual activity, usually going into graphic detail about the symptoms of STDs as a scare tactic to prevent teens from engaging in sex (ibid.).

Since the goal of abstinence-only education is to convince teenagers to delay sex until marriage, it is not surprising that it includes little to no information about contraception (Doan and Williams). Generally, the information it does provide on contraception is inaccurate. For example, the *Choosing the Best Life* curriculum informs students that research shows that only 5 to 21 percent of couples who use condoms do so correctly and, furthermore, that even when used correctly, condoms do little to protect against STDs (Cook). Although condoms, or at least their failings, are mentioned in abstinence-only education, contraception more broadly is not presented as a method to avoid pregnancy or abortion (Doan and Williams 120). Instead, abstinence-only literature focuses on the failure rates of contraception without any discussion of the advantages of methods, or how to access and correctly use such methods. Moreover, abstinence-only education links terrible consequences with contraceptive use, as seen this in passage from the abstinence-only *Sex Respect* workbook:

> The adults who thought that they were helping, found out that birth control was only an illusion of help. They discovered that the chemical forms of birth control damage the inside of a young girl's body in ways that can affect her fertility later on, too. They found that birth control shots, pills and implants affected a girl's moods and often made her gain weight. They found that many teens that [sic] used birth control had a 10 to 20% chance of getting pregnant anyway. They found that many more sexually transmitted diseases were being spread among teens. The abortion rates were much higher among people who used birth control that failed. The emotional and psychological effects of teen sex only got worse. (Mast 2001, 42).

The above passage perpetuates the myth of the uselessness of contraception and intentionally taps into girls' and women's fears of infertility, unwanted pregnancy, abortion, and STDs.

Furthermore, "the preponderance of negative associations with birth control ... is likely to dissuade young people from using birth control when they do become sexually active" (Doan and Williams 121). Teenagers who receive abstinence-only education are much less likely to use contraception not only because of their negative perception of contraception, but also due to their lack of knowledge of where to get it and how to use it. Moreover, since abstinence-only education teaches that premarital sex is wrong, teenagers may try to hide evidence of sexual activity (e.g. contraceptives) from others. Or they may be less likely to prepare for sex by using contraception because they do not want to intentionally go against the ideology that they should delay sex until marriage. Given the ubiquity of abstinence education—according to Landry et al., 57 percent of public schools teach abstinence as the only or the preferred option to prevent pregnancy and STDs, while only 10 percent teach abstinence as one of many options (33 percent of schools have no sexual education policy)—and that children who receive abstinence-only education engage in sex at the same rates as children who receive "real sex" education

(Kohler et al), there are a lot of teenagers who are not contracepting. The low contraceptive use among teens is the primary reason why the U.S. has the highest teen pregnancy rate of all "developed" countries. The reasons teenagers do not use contraceptive "include negative societal attitudes toward teenage sexual relationships, restricted access to and high costs of reproductive health services, ambivalence toward contraceptive methods and lack of motivation to delay motherhood or to avoid unintended pregnancy" (AGI 2001). All but the last of these four reasons are related to the taboo of sex and the privatization of contraception.

In addition to abstinence education, there are many other factors that contribute to the dominant ideology that contraception should not be talked about or used. Let me briefly mention one factor that affects all people and not just one group (i.e. children and teenagers) like the case of abstinence education. I turn now to the way sex is discussed and portrayed in the media. The media uses sex to sell products (e.g. material goods, magazines, TV shows, medical and health products) and since contraception is not part of a sexy image, it is excluded. Media images show people tearing off each other's clothes without any discussion whatsoever. As Anna Stubblefield argues, "these images propagate a paradigm of sexuality and romance in which women are 'swept off their feet' rather than actively planning for sexual intercourse" (96). These images also teach men not to actively plan for sex, but instead spontaneously engage in sexual activity. In short, the media reinforces the idea that discussion of contraception, and even contraception itself (which is conspicuously absent in movie and TV sex scenes), should not precede or be included in sexual activity.

## Self-Sacrifice

One of the prominent gender ideologies at play in pregnancy and childrearing is that women should be self-sacrificing (see, for example, Kukla and Mullin 2005a). This expectation of self-sacrifice stems from the oppressive socialization[15] of girls into caretakers; that is, into altruistic women who prioritize others' needs over their own. Women who challenge this unjustifiable norm of self-sacrifice face social penalties, such as fewer romantic relationships, having their children feel betrayed (an example Mullin discusses), and being labeled selfish and coldhearted. In contrast, women who uphold self-sacrifice are socially rewarded. Bobbi McCaughey, the famous mother of septuplets born in 1997, is a perfect example of how society praises self-sacrificing women. McCaughey jeopardized her own health (as well as the health of her fetuses—though this is rarely mentioned by the media) in order to birth the septuplets. Furthermore, after they were born, she devoted herself full time to caring for them. What makes McCaughey such a great example of a woman who lives up to the self-sacrificing ideal is not only the number of children she has, but also her eagerness and devotion to being self-sacrificing. That is, she seems happy being self-sacrificing. McCaughey was rewarded for her pronatalist, self-sacrificing behavior with intense media coverage (that still continues today—in fact, *Ladies' Home Journal* puts them on the cover every year for the septuplets' birthday), a phone call from President Clinton, and numerous substantial gifts (Charles and Shivas).

This coercive socialization instills in women the false belief that being self-sacrificing is an essential component of what it means to be a woman. By internalizing

[15] I discussed Paul Benson's concept of oppressive socialization in the previous and used self-sacrifice as an example.

this belief, women come to assert that "a real woman is a mother, or one who acts like a mother, or more specifically, like the self-sacrificing, nurturant, and care-taking mothers women are supposed to be" (Raymond 8-9). Furthermore, many women believe that their self-worth lies in their sacrifices for others, especially men and their children. Catharine MacKinnon makes a similar point in discussing care, claiming that "Women value care because men have valued us according to the care we give them" (39). The same holds true for sacrifices: women value sacrifices because men value women who make sacrifices for them. Since many women internalize the ideologies that women who do not sacrifice are "bad" (they are selfish, uncaring, and unwomanly) and that self-sacrifice is a necessary component of women's self-worth, their autonomy is impaired because they are unreceptive to reasons for rejecting self-sacrifice. Indeed, they will often not consider reasons that prioritize them or that suggest that self-sacrifice is not a necessary part of being a woman. Especially when we compare women and men on self-sacrifice, it becomes clear that most women value self-sacrifice for more than it being "objectively" the right way to act: they value it because they have internalized it and cannot imagine another way of being. For instance, the criterion most frequently cited by women of all classes as the mark of a good mother was putting her children first, whereas the social understanding of a good father is one who provides financially (McCormack 666). This empirical finding shows the ubiquity of the ideology of self-sacrifice among women and, furthermore, that this ideology is usually not thought to apply to men.

## Pregnancy and Childcare

There is a social norm that women should willingly, and perhaps happily, sacrifice themselves for their fetuses and children. Indeed, women are expected to sacrifice even if there is only the *potential* for a slight improvement or advantage for their fetuses or children. The implicit idea here is that women are to blame if their children do not turn out "right" since they are the ones capable of making sacrifices given that they are the ones who experience pregnancy and they are typically the primary caretakers of children. Put differently, good mothers produce good children through their sacrifices, so if the children turn out "bad," then the mothers must have been "bad," meaning they must not have sacrificed enough. As Rebecca Kukla argues in *Mass Hysteria*, pregnant women are judged according to how much effort they make, which includes their sacrifices, to ensure good birth outcomes, with those making the most effort viewed as the best potential mothers. She claims that "contemporary pregnant women are expected to be avid consumers of medical information, to actively participate in their own prenatal care, and to aggressively pursue good birth outcomes, while these outcomes are cast as testimony to individual maternal character" (Kukla 19). Pregnant women are expected to monitor and discipline their own behavior not only to ensure they are doing everything they can do for their fetuses, but also to affirm that everything they are doing is being done correctly. "According to this ideology," explains Mullin in *Reconceiving Pregnancy and Childcare*, "for pregnant women, no sacrifice that could benefit their future children should be considered too great, and they are expected to engage in extremely rigorous practices of self-surveillance and self-control" (Mullin 2005a, 97). Pregnant women are expected to carefully keep track of every aspect of their lives and faithfully report it to

their health care providers, who, along with others (partners, friends, co-workers, etc.), judge women on how successfully they are living up to the maternal destiny ideal.

In particular, due to their "permeable" wombs, pregnant women are expected to limit and give up any "toxins" that could harm the fetus, such as alcohol, drugs, and certain foods (e.g. fish, fatty foods), even though there may not be any empirical evidence that these substances cause fetal damage. For example, light (alcohol) drinking during pregnancy has not been shown to lead to Fetal Alcohol Syndrome, yet health care providers caution women not to drink an ounce of alcohol while pregnant. Furthermore, the government warns women not to drink through labeling on all alcoholic beverages and even Public Service Announcements on posters in restaurants and bars. Women who do drink while pregnant are chastised for putting their "desires" above the "needs" of their fetuses. Likewise, women who continue to use cocaine during pregnancy are chided for being selfish instead of giving up cocaine for the sake of their fetuses. These women are held morally culpable for producing "crack" babies, even though there is no definitive evidence that cocaine use leads to birth defects (Charles and Shivas). Pregnancy guidebooks guilt women into restricting their diet by implying that if a woman eats what she wants she does not have the fetus's best interests in mind. Women are supposed to sacrifice all sorts of food for the health of their fetuses, yet there is no scientific consensus that an occasional piece of chocolate cake, for instance, is deleterious for fetal development.

In addition to making all these sacrifices, pregnant women are not supposed to complain about them. In other words, one of the things women sacrifice is their ability to lament, and sometimes even just discuss their situation, even when nonpregnant people

with the same experiences are permitted to express their thoughts and concerns. For example, "when symptoms are considered to be those of a normal pregnancy, women are again supposed to cope, presumably on the understanding that they should have anticipated the impairments they experience, even if identical nonpregnancy-related symptoms would be thought to require rest" (Mullin 65). Even in situations that are not considered "normal" pregnancies, such as mandated bed rest for the third trimester, women are expected to agree without complaint because they are supposed to be happy to sacrifice whatever they can for their fetuses. It is interesting to note that bed rest has no empirically proven medical value, yet women are still supposed to amiably accept it because they are expected to do whatever they can even if the potential for improvement is slim (Bogdan-Lovis). In both cases, "normal" and "abnormal" pregnancies, the reason women's silence—their lack of complaint and discussion—is important is that in order to be self-sacrificing, they must ignore their own needs. If, however, they discuss their situations or, worse yet, complain about them, they are clearly paying attention to their own needs, which prevents them from being fully self-sacrificing. In sum, a good self-sacrificer is a silent self-sacrificer.

The same social norm of the silent self-sacrificer is also at play in mothering. While I will not go into nearly as much detail on how mothers are expected to be self-sacrificing, it is worth enumerating some of the similarities with pregnant women as well as some of the additional expectation for mothers. Like pregnant women, mothers are expected to sacrifice themselves for the betterment of their children, even if there is no empirical proof that certain sacrifices will help or if the potential improvement is minor. Additionally, mothers are judged by society and others by how their children turn out: it

often is assumed that "bad" children result from "selfish" mothers. In our "overachiever" society, women, especially white, middleclass, educated women, are supposed to ensure that their children become superstars by making sure that their children attend the "right" preschool, start learning a second language by age 3, etc. An additional way mothers are expected to be self-sacrificing is that they are supposed put others' needs ahead of their own: the needs of all their children, their male partners, and their public and private work. Regardless of the number of children they have, mothers are expected to balance and adequately meet the needs of all their children; women are blamed if one child feels less loved or it goes unnoticed that a child is failing a class. Moreover, especially when their children are young, women are expected to constantly be with them; Kukla refers to this as the proximity norm. Women who work in the public realm (often due to economic need) face social blame for "abandoning" their children.

It is important to note that although pregnant women and mothers make sacrifices for the sake of their fetuses and children, their fetuses and children are not the only ones benefiting from their sacrifices. Men are also benefiting, yet this is often not socially acknowledged. Men, as a group and as individuals, benefit from women assuming the majority of contraceptive responsibility because it absolves them of much of the responsibility and blame. Women shouldering most reproductive and childcare work not only gives men leisure time, but also allows men the freedom not to worry about these responsibilities. Additionally, because they know that women are the ones held socially responsible for pregnancy and childcare, men generally do not have to concern themselves with what these responsibilities entail, nor do they have to stress about successfully fulfilling these responsibilities and the consequences they will face if they do

not. Since men are generally not considered responsible for pregnancy and childcare work, they are rarely blamed for poor outcomes. Instead, women are typically pinned with full blame, and it is believed that if women had only been more self-sacrificing then they would have achieved better outcomes. This myopic view fails to recognize the ways that men are *already* involved in reproduction and childcare as well as the ways men *should* be in involved. Furthermore, not acknowledging that men benefit from women's sacrifices conceals the patriarchal nature of this arrangement.

## Contraception and Self-Sacrifice

Given that contraception falls under the reproductive and childcare umbrella, a similar version of the norm of the quiet self-sacrificer is also at play in contraception. However, why there is a social expectation of self-sacrifice for contraception may not initially be apparent. Some may argue the opposite: that contraception is a form of self-empowerment, not self-sacrifice, because it allows women to control their reproduction. I agree that contraception is empowering because it enhances women's autonomy. Furthermore, I think that most women are happy to put up with many of the inconveniences and burdens of contraception because it allows them to achieve their ultimate goal of being heterosexually active and avoiding pregnancy.

However, I maintain that contraception involves self-sacrifice, or at minimum, a willingness to accept myriad burdens, because it is, in many cases, a coerced responsibility resulting from oppressive socialization, as I argued in the last chapter. Although women significantly benefit by contracepting, they are still expected to assume various contraceptive burdens for the sake of their male partners. While women may be

motivated to contracept mainly because they do not want to become pregnant, this decision is also influenced by the dominant ideology that links femininity with contraceptive responsibility. Women may nonconsciously feel pressure to contracept due to noncompliance penalties and to their internalization of the belief that an essential part of being a woman is taking care of reproductive and childcare matters, including contraception. Other internalized norms, such as that women should tend to their male partners' needs, may also nonconsciously push women to assume contraceptive responsibility.

Additionally, contraception involves self-sacrifice, or at least the willingness to take on burdens for others, because it is sometimes viewed as a tool that protects the life of potential children. Contraception serves the interests of potential children by preventing their birth to women who are assumed to be less sacrificing because they were not interested in having children (at least at that time). While we may not consciously think of contraception in this way, we nonetheless talk about the necessity of contraception to protect potential children, especially children born to women deemed unworthy of motherhood (e.g. women who are poor, of color, lesbian, disabled, and/or unmarried). For example, some politicians have suggested mandating long-acting contraception (in particular Norplant) for women on welfare as a way of preventing the birth of potential children who will, it is believed, be harmed by the environment in which they will grow up (see Roberts 1997).

Some may object to applying the language of sacrifice to contraception because women's sacrifice is usually associated with getting pregnant and having children—exactly what contraception is intended to prevent. In a way, women who contracept are

going against the traditional understanding of women's sacrifice as bearing and raising children. Thus, some may view these women as selfish, rather than selfless. Yet, as I hope to show, the responsibility of contraception, like that of pregnancy and childcare, involves considering what is in the best interest for one's children or future children and making sacrifices, or at least taking on burdens, toward that end. In both the case of contraception and the cases of pregnancy and childcare, women are expected to make sacrifices and assume burdens for the benefit of others and, furthermore, they generally want to make these sacrifices and assume these burdens. Because most women want what is best for their children and potential children, they are typically happy, or at minimum willing, to make sacrifices and assume burdens. Women often fulfill their own desires by serving the interests of others (whether these desires are authentic or adaptive is another matter). For example, a woman may meet her desire to be a good mother by giving up playing in her soccer league so that she can spend more time with her children. While this decision results in a personal loss for her, this woman chooses to take this loss in order to achieve her goal of being a good mother. The decision to contracept can also result in personal loss for women, such as the burdens discussed in the previous chapter and, as I will explain, the sacrifice of not becoming a parent even if one wants to. Like the woman who gives up soccer, many women choose to contracept despite the losses in order to achieve their ultimate goal(s). But just because a person chooses to go down a certain path does not mean that what she knowingly gives up is any less significant. Though she may choose to become a mother or to contracept for whatever reason (e.g. because it is what she wants, or because is her best worst option, or because she is coerced), she is nonetheless expected to accept the sacrifices and burdens of that choice, even if they are

unfair.[16] As exemplified the case of the pregnant women with unpleasant symptoms who are expected to "cope," people are often unsympathetic to others who experience a bad outcome due to a choice they made that they knew had the potential for a bad outcome. Mothers who are overwhelmed by the sacrifices they are expected to make for their children and women who contracept and experience negative side effects are sometimes met with sayings like "you should have known better," "you made your bed, now you have to lie in it," and "suck it up and deal." These responses can be, at least partially, attributable to the norm of silence that often goes hand-in-hand with expectations of sacrifice.

Some may still find the language of sacrifice too strong when referring to the burdens and losses women experience in contracepting. While I understand the concern of using this language, I will still do so for two reasons. First, I want to maintain consistency between broader discussions of reproduction and my discussion of contraception. In this vein, I want to illuminate how topics under the umbrella of reproduction—pregnancy, childrearing, contraception—share and are influenced by similar gender ideologies, including sacrifice.[17] Second, sacrifice is a stronger word than burden. The word "burden" refers to a large load, something one is forced to carry. The word "sacrifice" derives from "sacred," which refers to something holy, and thus carries the connotation that one is giving up or taking on something highly valued, significant,

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[16] Some may claim that this statement applies to all choices and, at a certain level, it does. In choosing any given path there are always things we must leave behind and losses we must accept. However, in the case of motherhood and contraception, women are expected to make sacrifices for the sake of others, something that is not universal to all choices. Furthermore, the associated burdens of motherhood and contraception are more significant than many other choices we make, say, choosing to eat a ham sandwich rather than a turkey sandwich for lunch.

[17] The same could also be said for other reproductive topics, especially infertility. However, I will not discuss infertility in this project. For more on infertility and sacrifice, see M. Kirejczyk.

and respected, that is, something holy. The line between a burden and a sacrifice is not always clear-cut. One may not want to classify many of the contraceptive situations women face as involving sacrifices, such as high cost of contraceptives and certain adverse side effects; one may instead consider them burdens. Yet, there are particular situations that do seem more in line with sacrifice. Considerable bodily invasion is one such example since our culture prizes (and legally upholds) bodily integrity and privacy. Also, the choice not to have a child is viewed a large sacrifice by many, since they see having a child as a sacred gift. Although not everyone will agree, I will continue to use the language of sacrifice to describe contraception because I think there are cases in which contracepting involves more than burdens; it entails sacrifices.

I turn now to idea that contracepting is a type of sacrifice some must make in order to protect potential children. John Arras and Jeffrey Blustein present this line of thinking in "Reproductive Responsibility and Long-Acting Contraceptives" when they discuss what it means to responsibly reproduce: "If one can reasonably be expected to predict that, should a person decide to reproduce, the resulting child's existence would fall below a certain threshold of acceptable well-being, the person can be blamed for reproducing irresponsibly" (S27). There is clearly disagreement about what counts as being below this threshold. Arras and Blustein enumerate a range of ideas of what is considered being below this threshold from least controversial to most controversial: child abuse and neglect, children with medical conditions, anything that parents do to "lower a child's potential" (e.g. drinking alcohol during pregnancy), and "parents who do not optimize their child's potential for a good life" (e.g. genetic enhancement). Regardless of our own view on what counts as below this threshold, the main idea behind

this threshold is that people should not reproduce if their potential children would be harmed in life. The potential parents are viewed as the ones responsible for causing this harm and, moreover, as the only ones who can prevent this harm. In order to be responsible reproducers, people who believe their potential children will fall below the threshold should take action to ensure that they do not reproduce either by using contraception or by abstaining from sex.[18] Even if these individuals would like to be parents, they should not reproduce because of the potential harm to their potential children.

Taking the perspective of potential children, Lisa Cassidy extends this argument even further, arguing not only that those people who may harm their potential children should not parent, but also that "those people who anticipate being averagely competent parents should not parent" (46). She concludes that only people who will make excellent parents should have children because "parenting is just too important to do in a way that is just good enough" (47). Although Cassidy intentionally avoids defining what it means to be a good parent besides referring to Sara Ruddick's three criteria of preservation, nurturance, and inclusion, her parenting ideal is in line with that of the self-sacrificer. She in fact recognizes this and, in presenting an objection to her argument, states that her position leads to the "self-sacrificing non-mother who has sacrificed having children for the children's sake" (Cassidy 53). While she objects to the gendered nature of sacrifice—that only women should be the ones expected to make sacrifices—she does not find people sacrificing their desire to have children problematic because she believes that morality should take others into consideration and that the potential children's interests

[18] Here, as throughout this project, when referring to sexual activities, I am limiting my discussion to heterosexual activities.

outweigh the potential parents' desires. Recognizing the effects our actions have on others and, in particular, not harming others to achieve our ends is not a controversial goal. Yet, not everyone would draw the same conclusion that Cassidy does: that people should sacrifice their desire to be parents if they would not be excellent parents. Many would argue that this sacrifice is too great. While Cassidy rightfully points out that "the belief that refraining from parenting is an undue sacrifice is a belief imbued with our culture's pronatalist values," this does not minimize the feeling that people have that not having children is an unbearable sacrifice (Cassidy 53). Many people, and especially those who observantly follow certain religions, believe that children are sacred—that they are gifts from god—and that having children is a necessary aspect of living a good (and even holy or moral) life. For them and for many others who may not be religious, not having children is a significant sacrifice even if it is thought to be in the best interest of potential children.

This last point is what is most important to the argument I am making in this section: that the self-sacrificing parent ideology extends to potential parents. People are expected to make all kinds of sacrifices and take on numerous burdens to prevent certain types of existences for potential children, ranging from harmful and life-threatening existences to Cassidy's "good enough," average existence. In short, people are not only supposed to keep their potential children's interests in mind when making various types of decisions that could affect these potential children, but they are also supposed to act in a way that will maximize their potential children's interests. If people believe they will make inadequate or even average parents, then they have a responsibility to ensure that they do not reproduce. There are just two ways to avoid pregnancy: abstinence or

contraception. Both alternatives require sacrifice. Being abstinent means not engaging in sexual, physical intimacy with one's partner(s), which is much more than a burden according to some, as it means denying our sexual and bodily expression. Using contraception entails myriad burdens and/or sacrifices depending on the type of contraception used, such as discomfort, minimized sexual pleasure, financial cost, maintenance, bodily invasion, interruption of sexual intimacy, and adverse side effects. Even though contraceptive use involves many burdens and sacrifices, there is still the social belief that people should do whatever they can, including sacrificing, in order to prevent pregnancies of children who would live below a certain threshold. This line of thought is what we mean when we say that certain people (e.g. drug addicts, teenagers, the terminally ill, etc.) should not have children because of the quality of life the potential children will have. Specifically, we often claim that it is not fair to potential children to bring them into the world under certain conditions. What underlies this claim is a belief that all people deserve a certain minimum quality of life and that choosing to give birth to people who we know will not meet this minimum is irresponsible, and perhaps even unjust, on our part.

Let me briefly state and reply to two possible objections to the argument that people should not reproduce if their potential children will have a quality of life below a certain threshold. First, those who believe that any life is better than no life will argue that these potential children are harmed more through the prevention of their lives than they would be by living. This comparison is problematic not only because it is comparing such vastly different things, but also because I am not sure how one quantifies the quality of nonexistence in order to compare it to the quality of life. Additionally, I do not think

we could argue that nonexistent beings are harmed unless we imagine that there exists a place where all the nonexistent beings hang out and wait for existence *and* that this place is such a bad place that any sort of life would be better in comparison. Second, while people may believe that parents who knowingly have children whose lives will fall below the threshold (however one defines it) are being irresponsible, this does not mean that they think these children should be prevented from living. It is true that some people will argue that the best way to protect potential children from living a life below this threshold is to prevent their birth. However, this argument does not entail that these potential children be denied life. In fact, this argument makes no claim about how these potential children should be treated once they become embryos, fetuses, and infants. The only normative claim this position affirms is that responsible people should ensure that their potential children have a quality of life at or above the threshold of acceptable well-being. To act otherwise, is to irresponsibly reproduce. There is no normative claim about what action, if any, we should take toward people who reproduce irresponsibly or toward children whose lives fall below this threshold.

Although there is no normative view about what action we should take toward those who irresponsibly reproduce, there is a social belief that people who unintentionally reproduce are blameworthy because it is thought that they could have prevented reproduction if only they had been willing to make more sacrifices. (However, this blame is most common with women considered unworthy of motherhood, such as poor women and women of color.) Just as in pregnancy and childcare, people are expected to sacrifice for potential children, and if something goes wrong (i.e. unintended pregnancy), it is assumed that it is the potential parents' fault for not making every possible sacrifice and

assuming every conceivable burden. For example, if they had been willing to use more than one form of contraception or a more effective form of contraception, then they would not have gotten pregnant. Or, if they had been willing to be abstinent, they would not have reproduced. This expectation of abstinence especially affects women, as due to the ideology that women are either virgins or whores, women who are sexually active are "bad," whereas women who abstain are "good." According to this dichotomy, women who become unintentionally pregnant deserve this fate because they are already "bad" by being sexually active. Additionally, as I will discuss in the next chapter, it is thought to be easier for women to abstain because they are believed to have a weaker libido than men.

Although I have sometimes discussed contraception in a gender neutral way, it is important to note that just as the self-sacrificing norms apply almost exclusively to women for pregnancy and children, the same is true for contraception. That is, the social norm that people should assume burdens and sacrifice for the sake of their potential children is generally expected only of women. While part of the reason for this may be that women are the ones who get pregnant and that the majority of contraceptives are for women, there are also sexist reasons behind why women are assumed to be the ones responsible for contraception, which I discussed in chapter 2. As the case of childcare shows, the expectation of self-sacrifice is applied mainly to women even though childcare, unlike pregnancy, is not something that is limited to women. In other words, men could just as easily participate in childcare as women, so it would seem like a general social norm about how to raise one's children should equally apply to women and men. However, there are gendered social norms for childcare: women are expected to be

self-sacrificing, whereas men are not. In fact, what these three cases—childcare, pregnancy, and contraception—reveal is that there are gendered expectations of how women should act towards others. The general pattern is that women are expected to be self-sacrificing. That is, they are expected to put others' needs before their own. This is also the case for male partners. Women are supposed to prioritize their partners' needs over their own just as they are expected to prioritize their children and potential children's needs over their own. There is not a corresponding social norm of sacrifice for men. In fact, quite the opposite: men are expected to independent, self-interested, and to prioritize their own needs.

Yet, some claim that the social norm for men is not so self-focused; they argue that men are also expected to be self-sacrificing by being the breadwinner. Indeed, some posit that men are expected to be self-sacrificing for the sake of their female partners and children by working long hours in the public realm in order to support them economically. While there is no doubt that many men work long hours to economically support their families and that supporting their families is part of their motivation for working, I do not think self-sacrifice is the correct way to describe their actions and/or commitment. Self-sacrifice necessitates placing the needs of another or others first; that is, doing what is best for another or others even though it entails some sort of burden or sacrifice of oneself. I do not think that the sole reason most men work in the public realm is for the sake of their families, as working in the public realm provides many benefits for men. For example, working in the public realm typically goes hand-in-hand with various "public" rights, such as governmental rights (the right to vote, to drive, etc.) and mobility within the public realm and between the public and privates realms. Moreover, having a

job, especially a "white" collar or well-paying job, is a sign of prestige, power, and success. Given the expectations and social pressures on men to be active, strong, and dominant, having a prestigious, powerful, and successful job increases their "masculinity." Men who are successful in the public realm are socially rewarded because not only do they adhere to the social norms of masculinity, but they also excel at them. Additionally, there is an expectation that men should economically provide for and protect their families. Men who are the breadwinners meet this ideal, thus affirming their masculinity and ensuring social acceptance. Men who are not the breadwinners—their female partners make more than them—or who do not work in the public realm are typically seen as weak and unable to fulfill their manly duties. In other words, they are viewed as feminine, and being labeled feminine (for example, being called a sissy, pussy, or girl) is one of the worst insults men can receive. Most men try to avoid association with anything feminine as a way of asserting their masculinity. Meeting the social demands of masculinity is extremely important to most men.

Since having a job in the public realm and economically providing for one's family are crucial social norms of masculinity, I think that the majority of men are motivated to work in the public realm because their self-worth and the perception they give to others are so closely tied into their adherence to these social norms. If these reasons do play a role in men's decisions to work in the public realm, then their decisions are motivated by self-interest, not self-sacrifice. In sum, working in the public realm not only grants men various rights and freedoms, but it also enables them to successfully meet various social norms of masculinity. If any other reason other than helping one's family motivates men to work in the public realm—and I really doubt that this is the only

reason—then I do not think we can consider their work in the public realm to be self-sacrificing. Furthermore, men's work in the public realm could only be considered self-sacrificing if this work is disadvantageous for them.[19] For some men, the perceived disadvantages are actually advantages; for example, working long hours means time away from the responsibilities of a house and family. While working long hours is disadvantageous for some men, given the numerous benefits men receive from working in the public realm and the fact that they are motivated to work in the public realm precisely because of these benefits, we cannot classify their work situation as overall disadvantageous or as self-sacrificing.

It is important to understand that this specific social norm of self-sacrifice does not apply to men—it only applies to women—as I turn to explore whether women and men are considered trustworthy with contraception in the next chapter. The differing gender expectations of women and men toward their children and partners plays a significant role in whether or not they are trusted with contraception.

[19] Clearly, there are cases of men working jobs that are disadvantageous to them, such as coal miners or meat packers. In such cases, men typically make great and many sacrifices for the sake of their families.

## Chapter 4: The Role of Gender Ideologies in Contraceptive Trust

In the previous chapter, I distinguished between interpersonal trust and group trust. I argued that we (people in general) are usually more likely to trust on the interpersonal level than the group level. Since trusting involves taking a risk, we are typically more reluctant to trust unidentifiable, amorphous groups than identifiable individuals because we perceive the risks associated with group trust, especially the possibility of broken trust, to be greater. Furthermore, I argued that interpersonal trust tends to be more accurate than group trust because the object of trust is known and hence trustworthiness is generally based on personal characteristics rather than ideologies. For this same reason, we are generally more confident about our relationships of interpersonal trust than group trust. That is, since in interpersonal trust we typically know the object of trust personally (at least to some degree), we feel more secure in our judgments about her competence and her moral commitments.

In this chapter, I apply this distinction between interpersonal trust and group trust to the case of contraception to explain why there a social perception that both women and men are untrustworthy with contraception, yet individuals tend to trust their partners to contracept. Differentiating between these two levels of trust illuminates the seemingly contradictory views, laws, and policies that relate to contraception and trust. On the interpersonal level, people are likely to trust their partner to contracept because they can assess trustworthiness on known characteristics instead of ideologies. In contrast, on the group level, the media, politicians, policymakers, and researchers and developers often semi-consciously defer to dominant gender ideologies, which typically lead them to

conclude that neither women nor men are trustworthy with contraception. Exposing some of dominant gender ideologies that contribute to women's and men's perceived untrustworthiness to contracept on the group level is important not only because it enables us to better understand the roots of this perception, but also because it is the first step in determing strategies to alter it.

This chapter is divided into two major sections: one on men and one on women. In the first section, I examine the language of trust used in mainstream mass media articles about new male contraceptives. I conclude that most authors are discussing group trust rather than interpersonal trust, though none of them explicitly say so. I argue that men are not trusted as a group due to dominant ideologies of masculinity. In the second section, I claim that, prima facie, women would seem to be trustworthy with contraception because of their association with the private realm and the social expectation that they be self-sacrificing. However, the cultural perception of women as irrational inhibits group trust and leads to various laws and policies that control women's reproduction. Part of the reason women are still held responsible for contraception even though they are not trusted with it is that this arrangement benefits men. In the end, I conclude that neither women nor men are going to be trustworthy as groups until our dominant gender ideologies change. Though a challenging goal, the importance of eradicating these gender ideologies extends beyond contraceptive trust: their elimination would create a more just and egalitarian society.

## MEN AND CONTRACEPTIVE TRUST

I began the previous chapter by laying out an apparent tension: women seem to both trust and distrust men with contraception. The distinction between interpersonal trust and group trust can help us make sense of this tension. Whereas the language of interpersonal trust focuses on individuals—for example, do women trust their partner to contracept?—the language of group trust presents a group rather than an individual as the object of trust—for example, do women trust men to contracept? References to women's partners suggest that women have a relationship with a particular man and therefore would be a case of interpersonal trust. Discussions of group trust use terms like "men" or "a man," which imply trusting all men or some abstract, universal man and not someone with whom women have an intimate relationship.

Conversations about group trust sometimes obscure who the subject of trust is by asking if women will trust male contraception rather than actual men. For example, in an article about an "instant pill," a pill men take before sex that reduces their fertility for only a matter of hours, experts claim that "it [the instant pill] is more likely to be trusted by women as they would not be relying on the man remembering to take his pill everyday" (Macrae). The second half of the previous sentence shows that these experts are really concerned about whether women will trust men to use contraception and not whether women believe that contraception will work properly. Here is another example: "the field of male contraceptive development has been plagued by questions of whether men will be willing to use systemic methods, and whether women will trust their contraceptive protection to a male method that they cannot verify is being used" (Darroch 91). Although the author asks whether women will trust male contraception, the end of

the sentence, "is being used," implies an agent that is using male contraception, men. So, the concern is whether women will find men trustworthy to use contraception, not whether the contraceptive method itself is trustworthy.

This distinction between interpersonal trust and group trust is significant because whether women trust or distrust men with contraception seems to largely depend on whether the scope of trust is individual men or the social group men. An empirical study by Glasier et al., which is cited by a few of the mainstream articles, asked women of various cultures if they trust their partner, not men in general, to use contraception. Their study shows that almost all women (98%) would trust their partner to contracept; that is, on the interpersonal level, the vast majority women trust individual men (i.e., their partner).[20] Yet, on the social group level, women seem less likely to trust men. Here are some examples of discussions of group trust in mainstream news articles:

> "One major question is whether men will stick to the routine and use the contraceptive prescription safely. This is an issue for women who wonder whether men can be trusted to take pills." (Addison 3)
>
> "I asked some friends if they would trust men, if male contraception became available, to bear the birth control responsibility. Not one of them said yes." (Christman)
>
> "The other grey area, says Baker [Peter Baker, director of Men's Health Forum], is whether or not women actually trust that men have had the injection just because they say they have. It's for this reason he thinks the method should solely be used by men in stable relationships." (Scott 1)
>
> "For a start, there are practical concerns. Never mind whether a man can actually be trusted to take a pill on a regular basis or not." (Sarler 12)

All these passages reflect doubt that women will trust men in general or some universal, unknown man to contracept. In sum, women are much more likely to trust their partners

[20] Clearly this one study should not be taken as irrefutable proof that women trust their partners to contracept. More empirical studies need to be conducted.

than they are to trust men as a group to contracept. The researchers in the Glasier et al. study also recognize this pattern, stating, "On the whole many women have rather cynical views of men in general which do not reflect their views of individual men—especially their partner" (649).

## Ideologies of Masculinity

In order to understand this disconnect between women's distrust for men as a group and their trust for their male partners, I turn to three dominant ideologies of masculinity that inhibit their contraceptive trustworthiness as a group. Two of them suggest that men are incompetent. First, there is a cultural belief that men have an uncontrollable sex drive, which interferes with their ability to contracept. Second, there is a commonly held idea that men are incompetent with domestic tasks, which impairs their ability to correctly use contraception. The third does not involve competence; rather, it deals with valuing the dominant ideologies at play in contraception and specifically the ideology of self-sacrifice. According to my conception of trust, when we trust, we expect people to act so as to uphold our shared our moral ideologies. Due to the social perception that men are self-interested, many women do not trust men as a group to act in a self-sacrificing manner.

## Men's Libido Is Uncontrollable

As exemplified by women's sexual objectification (see Bartky) and the medicalization of women's bodies (for a historical perspective, see Ehrenreich and English), women are often seen as just their bodies, as objects, and not as embodied

agents. Moreover, women are typically thought not to have control over their bodies, especially their bodily functions, such as menstruation and pregnancy. Rebecca Kukla states, "Female bodies, and especially pregnant and newly maternal bodies, leak, drip, squirt, expand, contract, crave, divide, sag, dilate, and expel" (3). In contrast, men are generally considered and treated as agents, not objects, and are thus thought to have control over their bodies. When it comes to libido, however, these perceptions about bodily control are reversed: women are viewed as being able to control of their libido, whereas men are not. Empirical research conducted by Emily Kane and Mimi Schippers confirms the dominance of this belief:

> Most Americans appear to believe that men's sexual drives are stronger than women's, and at least half perceive those differences as natural, which is potentially important given the role that beliefs about sexual drives have played in justifying men's sexual aggression and in depicting women as generally passive. (662)

Indeed, claiming men cannot control their libido men means that men cannot be held responsible with anything regarding sex, including sexual harassment, rape, and contraception.

Reasons given to support the difference between men's and women's libidos, especially from people who believe these differences are natural, often echo of biological determinism: the belief that our biology determines our desires, characteristics, and actions. According to biological determinism, because women have so few eggs (approximately 500 total compared to the millions of sperm men produce daily), women need to be selective in who they choose to have sex with. They should limit sexual encounters to men who they think would make the best fathers; that is, men who would produce the best genetic offspring and who would be able to provide amply for offspring.

Moreover, since women will be responsible for childrearing—investing significant time, energy, and resources into raising their children—they should be careful to pick men who will make this investment worthwhile. Women's passive sexual "nature"—their libido is believed to be weak and so they can easily control sexual urges—is thought to aid them in making good choices about mates. In contrast, men have no reason to be selective. In fact, because they have so many sperm and because they are not responsible for childrearing, they have no constraints on whom to have sex with. If we affirm a "biological" urge to procreate, then men are "naturally" inclined to have sex with as many women as they can.

The "spread the seed" versus "hoard the eggs" mentality is often used to explain, and justify, men and women's different sexual "natures." We see it used in everything from heterosexual courtship practices (see heterosexual dating guides such as *Men are From Mars, Women are from Venus*), to arguments about why heterosexual men are more likely to cheat on their partners than heterosexual women (see Greenfieldboyce for scientific research on the "monogamy" gene), to rape. It is assumed that our sexual nature is uncontrollable because it is natural, that is, biological. Human brains are biologically hardwired for us to act a certain way so as to ensure procreation and thus survival of the species. Whereas women long for a monogamous relationship to protect their investment—their children—men have trouble settling down and when they do, they often cheat because of their biological urge to procreate with as many women as possible. According to this view people cannot be held fully responsible for their sexual behavior because it is beyond their control; it is their nature. It is interesting to look at what it means to hold women and men responsible for their sexual behavior. The extreme of the

women's sexual nature is permanent virginity—being so selective that they choose not to have sex with anyone—and the extreme of men's sexual nature is rape—having sex with as many women as possible, which means forcing nonconsenting women to have sex.

It may seem contradictory that men are typically regarded as in control of their bodies save for their libidos. Yet, this tension is rarely acknowledged. That men are perceived as unable to control their libido is generally not seen as problematic because this arrangement is thought to be biologically necessary (that is, an evolutionary mechanism for ensuring the reproduction of the species). Since men's uncontrollable libido is typically viewed as natural, men cannot be blamed for it. Instead, it is men's uncontrollable libido that is to blame, as it inhibits their rationality, thereby preventing them from acting according to the social values and ideologies they uphold. For example, the teenage boy in Meat Loaf's song "Paradise by the Dashboard Light" is so "crazed" by his desire to have sex that he makes promises in the heat of the moment that he later regrets. Although men's libido is viewed as a barrier to rationality—a form of incompetence—that interferes with their ability to act the way they want to act, it is not thought to affect their overall competence. Instead, it is thought only to affect their competence in one realm: the sexual realm. Since this incompetence is limited to only the sexual realm, men's freedoms in other realms are not restricted. For instance, (white, property-owning) men have historically had the right to run for political office despite their "uncontrollable" libido because their libido is typically not thought to affect their political decision-making ability.

Women, not men, are typically blamed for men's uncontrollable libido. Indeed, women are often faulted for arousing men's libido with their sex appeal. Because

women's libido is thought to be either nonexistent or easily controlled and because they are assumed to know that men's libido is the opposite, they are culpable for arousing men's libido. We see this mentality when people talk about women who are "asking to be raped" because of the clothing they are wearing. The idea here is that most men cannot control their libido and if they see a woman who is dressed in a sexy way, they have no control over their desire to have sex with her and thus may rape her. Women are seen as responsible for causing their rape because of the clothes they wear (or the way they dance, the things they say, etc.) and they are told to dress a certain way (or dance a certain way, refrain from saying certain things, etc.) in order to prevent rape. In short, women are supposed to know that men cannot rein in their libido and consequently they should dress and act in a way that prevents them from turning men on.

As the above example shows, since women are thought to have a controllable libido, they are generally expected to assume responsibility for sex-related matters. Men, in contrast, cannot be trusted to act responsibly with anything related to sex due to their uncontrollable libido, which renders them irrational. According to this ideology, if one can control one's sex drive, then one can control anything sex-related. While this reasoning clearly has problems, which I will discuss shortly, it nonetheless applies to contraception: because men are not thought to be able to control their libido, they should not be held responsible for contraception. It is assumed that men's sex drive is so overwhelming that once turned on, all men can think about is sex. Consequently, they are unable to be responsible for using contraception. In other words, this argument posits that once men are turned on, they can no longer be blamed for their actions or held responsible for anything because their sex drive takes over, inhibiting their rationality and

making them incompetent. Thus, men are unable to think about using contraception or, in the case of rape, realize that a woman is saying no.

One of the problems with this line of thought is that it posits that any strong, biologically-based desires or needs are uncontrollable. While I do not believe men's libido is stronger than women's due to biological reasons, let us, for a moment, assume it is and explore whether we treat other biologically-based desires or needs as uncontrollable. One biologically-based desire or need is addiction. Alcoholics' bodies, for example, come to depend upon alcohol, thereby causing them to crave it, seek it, and feel like they need it. Although alcoholics have what feels like an uncontrollable need to have alcohol, there is a social (and medical) belief that addiction is something that can be controlled, though it may be difficult.

Some may dispute the comparison of libido and addiction, claiming that they are not analogous since libido is an innate urge, whereas addiction is a learned or social one. Though everyone may not agree, let us, again, for the sake of argument assume that libido is indeed a biological, innate drive, not something that is affected by environment. Given that people who believe libido is a biological urge usually support this claim with some form of biological determinism, I will compare men's libido to women's desire or need to have children, which is also often supported by biological determinism. People who support the idea that women have a "natural" desire or need to have children believe that this is an innate, biological urge, so in this way it is comparable to people who believe men's strong libido is an innate, biological drive. There is a widespread belief that women have what is colloquially referred to as a "biological clock": a device, thought to be hormonal, that tells them to reproduce. People seem to imagine this

biological clock to be similar to the body's "clock" that tells girls to start menstruation—just like the body's timer goes off and girls begin menstruating, so too does a timer go off and women begin to need/desire a child. Women's biological clock is considered extremely powerful because, like men's strong libido, it is thought to be an evolutionary mechanism to ensure survival of the species.

Assuming women's biological clock and men's strong libido are equally powerful given their biological nature and evolutionary origin, if one concludes that if men's libido is uncontrollable, then women's biological clock should also be considered uncontrollable. Yet, even if women very much desire a child, but they know that their potential child would fall below the threshold of what is considered a worthwhile existence, according to the ideology of self-sacrifice, they are expected to use contraception. Women's need to have a child is not thought to be so great that it causes them to dump all their birth control pills in the toilet. Nor is their biological clock is considered so powerful that it will lead infertile women to steal children off the street in order to become a mother. While many women may have a strong desire to have a child, there is a social expectation that they control this desire, which implies that they are able to control it. (However, as I will discuss later in this chapter, women are expected to go to great lengths to have children, including tricking men, because their drive to have children is viewed as so powerful.) In contrast, the social understanding of men's libido is that it is so strong that it not only leads them to reject contraception, but it also causes them to have sex with as many women as possible, even if it means rape. But if men's libido and women's biological clock are both equally strong and women can control their biological urge, then men should also be able to do so. Even if men's libido and women's

biological clock are not equally strong, women's ability to control their desire/need to have children shows that it is possible to control biological, innate drives. Thus, one should question whether men's libido is really uncontrollable or if there is just a societal belief that it is. Given that many men are able to control their libido, it does not make sense to think of men's libido as an innately uncontrollable drive. Perhaps certain men have uncontrollable libidos, but it seems a stretch to say all men have an uncontrollable libido. Plus, there are ways to help men control their libido; for example, certain medications reduce libido and even diminish it completely. (It is interesting to note that weak libido is usually considered a problem, even a medical condition, but a strong libido is generally considered neither a problem nor a medical condition.) And if men are able to control their libido, then they should be able to use contraception.

The claim that men cannot use contraception because of their uncontrollable libido only works for contraception that is used in the heat of the moment. There are only two available male contraceptives and just the condom requires use during sexual activity (vasectomy is a permanent, one time surgical procedure). It seems farfetched that men would not be able to think to use condoms during sexual activity because their rationality is inhibited by their libido. Yet even if this is true, it does not mean that men could not be responsible for other forms of contraception that do not need to be used during sexual activity, when their libido is presumably less strong. Many of the male contraceptives currently being researched are long acting methods that are taken on a regular basis and do not need to be used right before or during sexual activity. The question then arises as to whether men would be trusted to be responsible for contraceptives that are not used before or during sexual activity. This is the key question that researchers and

pharmaceutical companies are asking in order to determine if there is a market for male LARCs.

Returning to the idea that if one can control one's sex drive, then one can control anything sex-related, the belief that men's libido is uncontrollable leads some to think that men will not even be able to be responsible for contraception that is not used during or right before sex. Part of the reason for this is that it is thought that men's desire to "spread their seed" is so strong that they will not diligently use contraception. That is, men's subconscious, and perhaps in some cases conscious, desire to procreate prevents them from acting responsibly with contraception. Tied into this covert "need" to procreate is the belief that "real" men don't use contraception because it diminishes their masculinity. The social norm that men ought to be tough can lead men to take risks and to shy away from protecting themselves. In the case of contraception, this means that men may risk having unprotected sex, even with people they do not know well or at all. Additionally, men who use contraception may worry that others (e.g. their partner, friends, health care professionals, etc.) perceive them as feminine because they take on the caretaking, sacrificing role that women usually assume. I will return to this idea that contraception is women's work later in this chapter. This fear of feminization is also behind why men may be reluctant to use contraception: they worry that anything that affects their hormone levels will make them less manly. Many men believe that testosterone is a crucial factor in what makes them men. Though certain levels of testosterone in the body do result in what scientists, health care professionals, and laypeople usually classify as masculine characteristics, such as more body hair, more muscle tone, deeper voice, aggressive behavior, and stronger sex drive, the category

'men' is not just a biological one; it is also a social one. And there are many ideologies about what it means to belong to the category 'men,' one of which is that men have an uncontrollable libido. Most men want and feel pressured to adhere to these dominant conceptions of masculinity so that they are considered "real" men. Hence, even if they know that their libido is controllable, they may pretend it is not so they are not accused of being "feminine," that is, of having such a weak libido that it is controllable.

However, men in monogamous relationships may not feel as pressured to abide by the ideology of uncontrollable libido with their long-term partner as they do with others, such as friends and women they are causally dating. Some men may feel like they can just "be themselves" with their partner rather than (consciously and nonconsciously) worrying about living up to certain ideals of masculinity. Since men are probably more honest about their sexual drive with their partner than with others, their partner is better equipped to make an assessment of men's trustworthiness with contraception. Women can base their determination of trust on their partner's specific and known characteristics instead of gender ideologies and even the façade their partner may project in order to publicly uphold norms of masculinity. On the interpersonal level, women can recognize (though this may be semi-conscious) whether their partner's libido interferes with his ability to contracept. If a woman does not think her partner's libido affects his ability to contracept, then assuming there are no other factors that inhibit his contraceptive competence, she probably trusts him with contraception. Even if a woman believes her partner has a strong libido and that once he is sexually aroused he is unable to concentrate on anything but sex, she may still be able to trust him to use types of contraception that are not related to the timing of sexual activity, such as an implant or a daily pill. Given

that only two percent of women do not trust their partner with contraception, is seems that most women do not think their partner's libido prevents him from successfully contracepting (Glasier et al., 2000).

On the group level, in contrast, women are probably more likely to defer to dominant ideologies about men's libido and hence find men as a group untrustworthy to contracept. Likewise, journalists, contraceptive researchers and developers, and others are likely to assume that women will not trust men to contracept at least in part because they are also influenced by the dominant ideology of men's uncontrollable libido. Many journalists, scientific researchers, and pharmaceutical company workers further strengthen this ideology by pointing to men's libido as a reason why so few male contraceptives exist and/or are needed. Since many scientific researchers and pharmaceutical company workers, as well as some journalists, are mainly concerned with groups rather than individuals, they may not realize that most women trust men on an interpersonal level. Instead, they probably base their beliefs and actions (e.g. whether to fund research on male contraceptives or how to explain the lower rates of male sterilization to female sterilization in an article) on group trust, though they are unlikely to consciously recognize this is what they are doing or that there is a difference in women's trust of men on the group and interpersonal levels.

### Men are Incompetent with Domestic Tasks

As I explained in the previous chapter, contraception (as well as reproduction more broadly) has historically been relegated to the private realm. Women have also been historically relegated to and associated with the private realm. Reproductive work and

domestic tasks more generally have come to be classified as "women's work." This private/public dichotomy feeds into the dominant cultural perception that men are incompetent with domestic tasks. And this incompetence prevents many women from trusting men on the group level with domestic work, including reproductive work like contracepting.

Movies like *Mr. Mom*, *Three Men and a Baby*, and *Cheaper by the Dozen*—which all involve men trying to take care of children and other domestic tasks—are comedies precisely because of the cultural perception of men's domestic incompetence. These movies include scenes in which men do not know how to change a diaper, do laundry, or keep siblings from injuring each other—all things that the women characters are able to do easily. In contrast, movies like *North Country*, *The Contender*, and *Gracie*, in which women try to break into the men's world of mining, politics, and soccer respectively, are not comedies, but serious dramas. There are at least a few reasons for the different genres of the two sets of movies. First, the women characters *want* to enter men's world, whereas the men fall into the private realm for reasons beyond their control. Second, women entering the public realm is a threat to patriarchy because they are thought to be trying to usurp men's power. Men doing "women's work" is not threatening; in fact, in some ways movies about men working in the private realm reinforce patriarchy by portraying men doing women's work as silly and unnatural. Third, women's work is thought to be frivolous and easy, which is why it is funny to watch a man put on a diaper backwards. Men's work, however, is considered serious, important, and difficult, which is why allowing a girl to take a soccer penalty kick is both risky and scary.

In both sets of movies the characters are able to prove that they can succeed in the new realm. In the movies about men entering the private realm, the men usually return to the public realm, whereas the women do not return full time to the private realm (typically the women are balancing both realms simultaneously). This difference shows that work in the private realm is not worth taking on full time and permanently. While men are indeed capable of mastering tasks in the private realm, they choose to return to the public realm, which sends the message that men belong in the public realm and women in the private realm.

This gendered division of labor, which is presented as natural in these movies and by the media generally, leads us to believe not only that men are incompetent with domestic tasks, but also that this incompetence is normal. Men are not supposed to be good at domestic tasks because it is not in their nature. Women, in contrast, are thought to be naturally, that is, biologically, better at serving in a domestic role. Part of the reason for this, as I explained in the previous chapter and will return to later in this chapter in the second section, is that women are considered better self-sacrificers and many domestic roles, especially those surrounding reproduction and childcare, require self-sacrifice. Another reason for this is based on ideas about biological determinism. Since women give birth and breastfeed, they are the "natural" choice for caring for children. And because it is assumed that women must stay in or close to the house in order to care for children and because of the social belief that women are irrational, it makes sense that they should tend to the private realm. Since men are physically stronger, do not get pregnant or breastfeed, and are thought to be tougher and more rational than women, they are viewed as better candidates for the public realm. In short, according to this view,

women are biologically better suited to work in the private realm and men are biologically better suited to work in the public realm. Men are biologically disadvantaged when it comes to work in the private realm, and so it should not be surprising that they are considered incompetent with domestic tasks. While this does not mean that men cannot learn how to do private work well, it does mean that many of them start off as domestic bumblers, which is exactly what the movies about men doing domestic work show.

Additionally, there is the assumption (also seen in these movies) that even if men dedicate significant time to learning domestic tasks, they will never do as good of a job as women "naturally" do. Since women today still do the majority of the domestic work, though men's share of it has increased over time, they have the knowledge and experience to succeed in these tasks. It is this lifelong knowledge and experience—little girls learn domestic tasks from an early age both by observing and by direct instruction from their mothers—that accounts for any superior skills women have in the private realm, not their biology. Because little boys are typically not taught how to cook or change diapers, it is not surprising that they fumble with them at first. Given that men do not spend nearly as much time doing private work as women, it is also not surprising that their skills are not as honed as women's. In sum, it is this lack of knowledge and experience that makes many men incompetent with domestic work. Plus, since there is the expectation that men are incompetent with private work, there is little social incentive for them to strive towards success, nor is there much social blame if they do not excel, as there is for women. A man who has a repertoire of three dinners, boxed macaroni and cheese, franks and beans, and hamburgers, might be thought of as a kitchen wiz. In

contrast, a woman who has the same repertoire is considered domestically deficient. This comparison shows that the expectations of men are much lower because of their perceived incompetence. A recent commercial for Tyson chicken epitomizes these differing expectations: the mother in the commercial is praised for making a good and healthy dinner (consisting of Tyson chicken, of course) for the sake of her family (see Haskins for the video clip). The father makes frozen waffles for dinner when the mother is not around, but he is not really blamed for this, though he does look somewhat sheepish when this fact is mentioned. The message seems to something like, poor dad, he does not know how to cook anything more complicated than frozen waffles for dinner. Being incompetent with domestic tasks is obviously a form of incompetence that affects one's trustworthiness with domestic tasks. Due to the dominant ideology that men are incompetent with domestic work, women are not likely to trust men on the group level to do this work.[21]

While some men are competent with (and actually enjoy) domestic work, on the group level they are usually not trusted because they are viewed as abnormal and this abnormality is seen as a kind of incompetence. Indeed, men who enjoy working in the private realm are thought to be "odd," usually considered gay or perverted and typically the subject of jokes, as in the movies I mention above. Men who take too much interest in women's work, like cooking, fashion, and home décor, are often accused of being gay since "real" (masculine) men stick to interests in the public realm. (It is interesting to note that the many of the famous chefs, fashion designers, and interior decorators are straight men. Perhaps this shows how little trust we have for women and how strong patriarchy is

[21] This ideology is not the only reason women may be hesitant to trust or rely upon men with domestic tasks. Another reason stems from the power differential between women and men. Women may worry about asking men to do domestic tasks because they fear they will get angry or will refuse.

that we would rather employ men to do women's work at the top levels than to allow women to do it.) A man who likes women's tasks is not a "full" man, but only a feminized version of a man; consequently he must be gay because of the stereotype that gay men are not "real" men, but are instead effeminate men. Men who enjoy women's work, but are not thought to be gay are often labeled perverts. Parents and coworkers are sometimes suspicious of men who work with young children, such as preschool and elementary school teachers, because they fear they will molest the children. This fear stems from the convergence of at least two dominant narratives: first, that men have an uncontrollable libido; second, that men who want to do women's work have something wrong with them. Together, these narratives result in the cultural stereotype that men who work with children do so for the unnatural reason of wanting to have sexual relations with children. In sum, men being competent at and enjoying domestic work is seen as a type of incompetence that can prevent group trust.

In contrast, on the interpersonal level, such competence aids in trust. A woman who believes her partner is competent with domestic tasks is much more likely to trust him with them than if she did not think he was competent. Furthermore, she is less likely to view his competence as odd or abnormal. Since she knows him personally, she probably does not think that domestic competence diminishes his masculinity. That is, she is unlikely to classify him as "gay" or effeminate because he does "women's" work. Instead, she probably positively views his competence and may think he is "more of a man" for it. His ability (and willingness) to take on domestic tasks may lead her to respect him even more. In short, it is her interpersonal relationship—the fact that a woman knows the personal characteristics of her partner—that explains why a woman

may laud and trust her partner with domestic work, while labeling men in general as "weird" if they do, and especially if they enjoy, such work. On the interpersonal level, women generally look beyond the cultural trope that men are incompetent with domestic chores and base trust on individual traits. This opens up for the possibility for women to trust their partners with specific domestic tasks, including contraception.

### Men Are Self-Interested

In the last two subsections, I described how ideologies contribute to the perception that men as a group are incompetent, which often leads women to view men as untrustworthy. Here, I move away from the topic of competence, but continue to reveal how ideologies can inhibit trust. Recall that when we trust, we generally expect people to act according to the dominant moral ideologies within a specific domain. Due to the social belief that men are self-interested, they are not trusted as a group to follow the expectation of self-sacrifice at play in contraception.

As discussed in the previous chapter, the ideology of self-sacrifice typically only applies to women as a group. Both women and men expect women to be altruistic and self-sacrificing in most aspects of their lives, especially in their relationships with men and children. The expectation for men is practically the opposite: men are expected to independent, self-interested, and to prioritize their own needs. Consequently, it is unlikely that men believe they should act in a self-sacrificing manner. In other words, it is doubtful that most men normatively value self-sacrifice as a quality that they themselves should strive toward. In contrast, most women semi-consciously believe that self-sacrifice is a moral characteristic that they should seek to embody. Because self-sacrifice

is an important ideology at play in contraceptive trust, women are at least superficially trusted to contracept since they value this ideology (I return to this claim in the second half of this chapter). Men as a group are not thought to be trustworthy with contraception because they are not thought to value self-sacrifice. Put differently, if women doubt that men share the moral ideology of self-sacrifice, then they will probably not trust men with contraception.

Some may object that it is not important whether men value the norm of self-sacrifice. What really matters in this case is whether men value the end of preventing pregnancy. Proponents of this objection may claim that if men value pregnancy prevention, then they should be trusted to contracept because the desire to prevent pregnancy will shape their actions, leading them to contracept. There is empirical evidence that shows that men are concerned about pregnancy prevention and are interested in using male contraceptives. For example, a survey of 9,000 men in 9 nine countries in 2005 revealed that 55% of men were willing to use male hormonal contraceptives, while only 21% were unwilling (Nuzzo). Another study showed one third of men would use male contraception as their main form of contraception (Macrae). And, according to Garesia Randle, various "studies show men are ready for a change [in contraceptive options] contrary to popular belief." Furthermore, men are *already* responsible for contraception in many cases, as nearly a third of heterosexual couples worldwide use a male-dependent form of contraception (Ringheim 79). Looking within the United States, James Knight and Joan Callahan claim that

> there does appear to be a growing interest on the part of men in sharing responsibility for family planning and a growing desire among men to achieve control over their own fertility. Given that more than 25 percent of the couples employing contraception in the United States rely upon the

> condom and that over half a million vasectomies are performed each year, it seems that a large segment of the male population is willing to share or assume the responsibility for fertility control. (304)

These examples show that both in the U.S. and abroad, not only are men willing to take responsibility for contraception, but in many cases they already do.

Despite this empirical evidence, however, the master narrative that men do not value the end of preventing pregnancy as much as women do persists. This cultural trope is usually presented as fact without much or any empirical backing in the literature, even the academic literature, as seen in these two examples: "men are, in general, less interested in controlling their fertility than are women" and "For men, the subject of pregnancy may cause concerns, but their level of concern tends to be lower than women's" (Knight and Callahan 11; Hatcher 21). One explanation for this phenomenon is that reproductive prowess is an important component of masculinity. Despite significant evidence to the contrary, "The idea that men want more children than women has been a very dominant representation of men, particularly non-white men" (Oudshoorn 120).

Another explanation, and one that is quite ubiquitous, is that men are not the ones who get pregnant. Since men are not at risk for pregnancy and thus do not have to deal with all the problems and challenges of pregnancy (e.g. the decision whether to carry to term or abort, the bodily changes, the stigma of being a single mother, etc.), they are less concerned about pregnancy and hence less willing to make the sacrifices (i.e. use contraception or abstain) to avoid it. On the group level, most women are not willing to depend upon men with contraception because they do not believe men sufficiently value pregnancy prevention and they do not want to suffer the consequences (that is, get

pregnant) due to men's perceived lack of commitment to pregnancy prevention. As Segal quips, "If he doesn't get it right, it is the woman who pays the price" (114). While some women are willing to rely on men to use condoms because they know they are being used and can check to make sure they are being used correctly, "it is questionable how many women would be willing to rely on men's use of a systemic, undetectable method [such as a male pill or gel], except in the context of a long-term, committed relationship" (Darroch 91).

The case of a long-term, committed relationship is an exception because the woman knows her male partner well and so she does not have to defer to cultural tropes to determine if her male partner sufficiently values the end of pregnancy prevention. Instead, the woman can judge her partner's commitment to this end based on his individual characteristics and not based on social perceptions about men generally. Looking at individual characteristics rather than general social beliefs will enable women to recognize if their partners do not fit the dominant narrative that men are less interested in preventing pregnancy. If their partners do not adhere to this social norm but instead sufficiently value avoiding pregnancy, then women can trust them to contracept.

Carol C. Korenbrot nicely summarizes these two reasons why men are thought not to value pregnancy prevention as much as women: "men are not as easily motivated to take responsibility for contraception as women ... both because the risks of pregnancy are more remote and because masculinity is socioculturally connected to maintaining full reproductive potential" (52). In short, because men are not thought to be invested in and concerned about preventing pregnancy to the same degree women are, they are less likely

to value self-sacrifice in their own reproductive behavior. Hence, many women view men as untrustworthy to contracept.

What can explain the discrepancy between the social perception that men are less or not interested in using contraception and the fact that men say they are interested and many men in fact use contraception? There seem to be many possible answers to this question, so I will briefly enumerate a handful of them. One way to understand this tension is to distinguish between the group level and the individual level. On the group level, many people, including policymakers, academics, women, and researchers, may perceive men as uninterested in contraception due to their semi-conscious acceptance of dominant ideologies. Yet, on the individual level, they recognize that some men express interest in contracepting. Another explanation could be that social perceptions and realities do not always match up. Sometimes one's perceptions about how life is differ dramatically from how life actually is. The reason for this may be due to an incorrect master narrative; the master narrative that men are not interested in contraception is wrong. Or, the actual realities are changing and the corresponding narratives and norms have yet to catch up: men are becoming interested in participating in contraception, but the narratives and norms do not yet reflect this. There are many reasons men could be becoming more interested in using contraception. An optimistic reason could be that our society is becoming more egalitarian and men want to assume shared responsibility for contraception. A cynical reason could be that increasingly stringent paternity and child support laws are causing many men to want to protect themselves from women who may deceive them into having a child. A historical explanation, like the one I provided in chapter 1, points to the fact that it is only recently that contraception has become

women's responsibility. Perhaps the reason men are interested using contraception is that they still feel that it is their responsibility. While the new expectation is that women should be the ones responsible for contraception, maybe some remnants of the older expectation are still at play. A more insidious explanation is that men do not want to let on that they are willing to use contraception because then they would be forced to assume contraceptive responsibility. Indeed, as previously discussed, men benefit significantly from not being the ones responsible for contraception. There are many other possible explanations. Doing empirical research to determine what explains this discrepancy would be useful, as it would provide us with a deeper understanding of the current, and historical, contraceptive narratives, norms, and realities.

While I agree that women who believe (consciously and/or nonconsciously) that men value the end of pregnancy prevention are more likely to trust men on the group level, this belief alone is not sufficient for trust. Valuing a particular goal often gives the façade of trustworthiness since the truster and trustee uphold the same end. Yet, valuing a particular end, in this case avoiding pregnancy, does not make one trustworthy. According to my conception of trust, one must value a moral ideology, not just an end.

For example, partners Tim and Demarco share the goal of having a healthy relationship. However, Demarco may not trust Tim to follow through on this goal because Tim does not value the social expectation of monogamy. Though Tim may be committed to a healthy relationship, since he does not normatively value the social norm of monogamy —an important component for many healthy relationships—Demarco does not trust him in this domain. This example shows that valuing a particular end does not make one trustworthy to achieve that end. Tim valuing a healthy relationship does not

automatically result in Demarco trusting him to be sexually faithful. Demarco needs to feel that he and Tim share the moral commitment to monogamy, one of the expectations at play in most romantic relationships, before he can trust Tim in this realm. Having the goal of being a healthy partner does not compare to the deep commitment that normatively valuing the norms and ideologies involved in a being a healthy partner does. This profound commitment makes trust possible, whereas having a goal does not. Having a goal only shows that there is something one desires; it does not convey the degree of one's commitment to engendering this goal.

Even if one normatively values a particular goal, this does not make one trustworthy in that realm. Mia may normatively value being a good mother, yet she not trusted as a mother by most people unless she affirms the dominant ideologies surrounding motherhood. As a single, working woman, many of her acquaintances do not trust Mia to be a good mother due to the dominant belief that married homemakers provide the best environment and care for their children. While valuing a goal perhaps gets us one step closer to be trustworthy, it is not enough because we also need to value the "right" ideologies for achieving this goal. The "right" ideologies will often be the dominant ideologies, though what is most important for trust is that the ideologies are shared between the subject and object of trust. Some of Mia's friends will trust her to be a good mother because they maintain a nondominant ideology about what it means to be a good mother, an ideology that they and Mia have in common.

Returning to the case of contraception, even if women (consciously and nonconsciously) believe men normatively value preventing pregnancy, they will not trust men to contracept if they do not think they share the same contraceptive ideologies. That

is, if women suspect (again, consciously and nonconsciously) men affirm the "wrong" ideologies, then they will probably not trust them with contraception. Wanting to prevent pregnancy may not be a strong enough desire for some men to act in accordance with contraceptive ideologies, especially an expectation as demanding, personally disadvantageous, and contrary to masculine gender roles as that of self-sacrifice. In order for women to trust men to contracept, men must value the norm of self-sacrifice for their own actions. There are at least two reasons that play into why many women may assume that most men do not value self-sacrifice. First, as mentioned above, men are usually socialized to be self-interested. Most women are aware of this on a semi-conscious level and thus are often skeptical that men will be self-sacrificing because it so strongly goes against how they were socialized.

Second, the power differential between women and men makes many women doubt that men, as members of the privileged group, will make sacrifices at all, let alone for something (i.e. contraception) that is generally perceived to only help women, not men. On some level, though perhaps not fully consciously, women recognize that privilege allows dominant groups to shove unwanted tasks and responsibilities onto oppressed groups; for example, women shouldering the majority of childcare work and people of color taking on most of the lower paid and dangerous jobs. That privileged groups often push responsibilities onto oppressed groups contributes to women's suspicion that men will not assume the sacrifices involved in contracepting. Given these power dynamics, women, as members of an oppressed group, are hesitant to trust men, a privileged group, with something that directly and so significantly affects them. Instead, they often cling to whatever perceived and real power and control they can. For example,

some women will conform to dominant beauty norms because they think it gives them power over men, such as the ability to have men to buy them drinks at a bar. In the case of contraception, this means that women generally do not want to relinquish contraceptive responsibility to men. Women are concerned about sharing contraceptive responsibility with a more privileged group, a group that could limit or deny their reproductive rights. According to Dixon-Mueller, many women, "although committed to furthering research on male methods so that men can share the responsibility for birth control and sexually transmitted disease prevention more equitably, are reluctant to depend on their male partners and want to maintain this control for themselves" (49). In other words, even if they believe there should be more male contraceptives and that men and women should share contraceptive responsibility, women are worried about the consequences of a privileged group actively participating in contracepting because such an arrangement could lead men to usurp women's (albeit limited) control over contraception.

## WOMEN AND CONTRACEPTIVE TRUST

The relationship between men's contraceptive trustworthiness and their contraceptive responsibility is more straightforward the relationship between contraceptive trustworthiness and responsibility for women. While many women trust their specific partner to contracept on the interpersonal level, on the group level, men are generally not trusted due to various dominant ideologies of masculinity. Not surprisingly, there is little social expectation that men will contracept. In the case of women's trustworthiness, although many men trust their specific partner to contracept on the

interpersonal level, women are typically not trusted on the group level. However, despite their presumed untrustworthiness on the group level, women are socially expected to assume contraceptive responsibility. In this section, I seek to uncover the patriarchal social forces and ideologies that contribute to women's contraceptive untrustworthiness and contraceptive responsibility.

As discussed in the previous chapter, there is an expectation that mothers, including potential mothers, should be self-sacrificing toward their children and that women should be self-sacrificing toward their male partners. Most women value this norm, in part because through oppressive socialization they internalize it and come to believe that their worth lies in the sacrifices they make for others. Hence, women would seem to be trustworthy to contracept. And, on the surface, women are trusted. Responsibility usually stems from trust, and women are the ones held responsible for contraception. On a social level, they are expected to contracept and, in fact, they do most of the contracepting: they alone contracept in two thirds of all cases and they participate in contracepting over ninety percent of the time.

Yet, at the same time, women do not appear to be trusted with contraception because of the numerous restrictions on their reproductive autonomy. A necessary component of autonomy is being trusted by others and the government to make our own decisions. When we are not trusted, politicians pass laws to restrict our behavior and social forces like surveillance and normalization limit our behavior. There are myriad laws and forms of surveillance and normalization surrounding contraception. Although the most restrictive laws, such as laws prohibiting the dissemination of contraceptives through the mail or interstate commerce (e.g. the Comstock Law) and laws forbidding the

sale of contraceptives to unmarried couples or single women, were overturned by the mid-1970s, there are still many limitations on contraception. Though I have mentioned some of these in previous chapters, I list a handful of such restrictions here to emphasize how, together, they systematically minimize women's autonomy and ability to contracept. For example, only two of the eleven female contraceptives—the female condom and the sponge—are available without medical involvement; most insurance companies do not cover contraception, a de facto way of restricting access to contraceptives (Segal 86); half the states that mandate insurance companies cover contraception have moral or religious "opt-out" clauses (Knudson 115); abstinence-only education ignores or misinforms children about contraception (Doan and Williams); pharmacists can refuse to fill prescriptions for contraceptives based on their religious or moral convictions, which can be an insurmountable obstacle for some women, especially those in rural areas; and President Bush proposed a new regulation that would redefine abortion to include many common contraceptives (AGI 2008c). Given these and many other restrictions, contraception seems to be a responsibility that the government and medical establishment do not trust women with.

What accounts for this tension: that women are apparently both trusted and distrusted to contracept? Despite the fact that women as a group are held responsible for contraception, they are not trusted because they are perceived to be incompetent due to cultural tropes that they are irrational and that they have a strong desire to become mothers. Women are expected to be responsible for contraception so that men do not have to shoulder this responsibility and its associated burdens. Even though they are not

trusted, women are permitted certain reproductive freedoms, namely a formal right to contraception, in order to successfully assume contraceptive responsibility.

### Incompetence Due to Irrationality

In "The Man of Reason," Genevieve Lloyd seeks to understand why masculinity is associated with rationality while femininity is excluded from it. Drawing on the history of philosophy as far back as Ancient Greek philosophy, Lloyd traces how the reason/emotion dichotomy came to map onto the man/woman dichotomy. Women's association with emotions and irrationality persists today. This dominant ideology contributes to why women as a group are often thought to have a limited ability to make good decisions and to act in accordance to their own values. In the case of contraception (and reproduction more generally), the worry is that women will not be able to act in a self-sacrificing way because of their presumed irrational and emotional nature. An example of blaming women's "irrationality" for "bad" decisions is seen in the way the media portrays women who drink during pregnancy: such women are stupid and are not capable of making a good decision on behalf of their fetus. The media, politicians, policymakers, and most men do not usually think that women are maliciously making decisions that go against the expectation of self-sacrifice. Rather, they semi-consciously believe that women's irrational nature makes it difficult for women to judge how best to act in a self-sacrificing way. In other words, women's irrationality is perceived to be like an overarching force that has the potential to affect any decision women make. While the media, politicians, policymakers, and most men are not concerned when women's supposed emotional nature affects women's choice in kitchen wallpaper style, they are

worried when there is more at sake with a decision, especially if the decision involves others (e.g. children, men, the public). Given that protecting children and fetuses is a strong social value and that many do not trust women to adhere to the norms and values they (women) believe in because of their presumed irrational nature, they do not trust women as a group with contraception. According to this view, women need to be protected from their own bad decision-making, which is why laws regulating women's reproduction and policies that insinuate that men should be the head of household are justifiable. In sum, the ideology that women are irrational leads some (e.g. media, politicians, policymakers, and some men) to distrust women with contraception because they consciously and nonconsciously believe women are incompetent at making good decisions and at acting according to their values.

The existence of unintended pregnancies—almost half of all pregnancies—feeds the belief that women are incompetent at being responsible for contraception (Finer and Henshaw). Part of the reason for this is due to the ideology of the "American Dream": it is assumed that if one works hard enough and makes enough sacrifices, one will achieve one's dream. This ideology translates to contraception: that if one works hard enough to prevent pregnancy and makes all the necessary sacrifices, one will achieve one's goal of avoiding pregnancy. Yet, no matter how much effort one puts forth and how much one sacrifices, contraception is never one hundred percent effective and there is always a chance of pregnancy. In fact, "Even a contraceptive method with an annual failure rate of one percent that is used from age 30 to age 45 will leave one woman in seven with an unintended pregnancy" (Potts 288). The existence of such failures leads some men, as well as some in the media, politics, and policymaking, to question women's competence

in being self-sacrificing. Although women may morally value the social norm of self-sacrifice, they are thought to be incompetent in executing it since there are unintended pregnancies. That there is a failure at achieving the goal of avoiding pregnancy makes women as a group seem untrustworthy.

On the individual level, men (including men who are part of the media, politics, or policymaking) are more likely to trust women, namely their partners, to contracept. Instead of relying on dominant ideologies, men can look at specific characteristics of their partners to determine their competence and trustworthiness with contraception. Presumably, many men consider their partners rational and trustworthy to contracept. Yet, as I will discuss more in chapter 6, some men, especially those who uphold traditional gender roles, believe women are inherently irrational and thus untrustworthy with contraception. Even though some men will not trust women on the individual level, the probability of trust seems greater on the individual level than the group level. Given that most women assume contraceptive responsibility in monogamous relationships, it seems likely that many men do trust their partners to contracept. This claim is strengthened by the fact that there are male contraceptives available, so men do have the option of contracepting themselves. So, if many men really did not trust their partner and were worried about unintended pregnancy (and perhaps STDs), then it seems likely that more men would choose to contracept. Perhaps some men decide not to contracept even though they do not trust their partner because they do not want to take on the burdens of contracepting or they semi-consciously believe that reproductive matters are women's work. While there probably are some men that depend upon their partner to contracept

even though they do not trust her, I believe (perhaps overly optimistically) that in healthy relationships, many men do trust their partner with contraception.

### Another Barrier for Trust: Women's Desire for Children

Women's perceived irrationality is not the only barrier for trustworthiness. Interestingly enough, another barrier is an extension of the ideology that women should be self-sacrificing: the idea that women should be accepting of—and moreover, excited about—children, whenever they should enter into their lives. Because women are thought to want (and even need) children, they are also thought to be welcoming of pregnancy, regardless of when and how it occurs. In fact, the social expectation may be stronger than just that women are always thrilled to discover that they are pregnant: women actively seek out children, perhaps so much that they are willing to deceive their male partners about their contraception use. For example, in the movie *The Wedding Singer*, Julia is engaged, but her fiancé will not set a wedding date. Her mother suggests that she get pregnant as a way of pushing her fiancé to move forward on the marriage. The mother's advice exemplifies the societal belief that women actively try to "trap" men into marriage by getting pregnant even though they tell their male partners that they are using contraception. While unwed motherhood is more common and more socially acceptable today, the societal belief that women will trick men about their contraceptive use in order to leverage something else (e.g. marriage, money, power, etc.) remains. The fear that women will deceive men about their contraception use runs deep: in the mainstream mass media articles I looked at, it was one of the leading reasons given for why men would be interested in male contraceptives. According to these articles, many men are interested in

male contraceptives because they would "protect" them from untrustworthy women. "Since a man could unwillingly and unknowingly impregnate a woman whom he trusted was using reliable contraception, he may prefer to rely on himself" (Ringheim 85). Indeed, male contraceptives "could shield men from the baby entrapment of duplicitous partners" and protect them from the economic costs of having a child, which some assert as a main reason men want to control their fertility (Christman; Ringheim 86).

The social belief that women desire children so badly that they are willing to deceive their partners about their contraception use leads some men to semi-consciously think that women as a group are untrustworthy to contracept. Like the social perception of women as irrational, this perception presents women as incompetent in this realm, thus making them untrustworthy. This cultural understanding portrays women as incompetent because it conflicts with the contraceptive ideology of self-sacrifice: according to this cultural understanding, women will deceive men in order to get pregnant, yet according to the ideology of self-sacrifice, women should make whatever sacrifices necessary to avoid pregnancy. Women's perceived desire to do whatever possible in order to *get* pregnant interferes with men's trust of them to do whatever possible to *avoid* pregnancy. However, as I discussed earlier in this chapter, it is also assumed that women should be able to control their urge to have children. So there is some tension here: women are thought to be able to control their libido and their "biological need" for children, though it is also believed that they will go to great lengths, such as deceiving men, in order to have children.[22]

[22] Women's strong desire for children is thought to contribute to the popularity of reproductive technologies.

While some men may be concerned that their partners will surreptitiously get pregnant, this worry seems less likely on the interpersonal level than the group level. On the interpersonal level men can judge their partner's trustworthiness to contracept without deception based on her personal characteristics rather than ideologies about women's desperate and "wild" desire to have children. Many couples (hopefully) discuss their contraceptive arrangements and their fertility preferences (e.g. if they want biological children, how many children they want, etc.). These sorts of open conversations help build trust between partners. In sum, it is likely that most men trust their partner to contracept on the interpersonal level more than they trust women to contracept on the group level.

**Why Women Are Still Responsible for Contraception**

The conclusion that women are not trusted to contracept is both odd and problematic for the same reason: women are held responsible for contraception. Typically when we trust people, we hold them responsible. Thus, it does not make sense that women are held responsible for contraception even though they are typically not considered trustworthy with it. While morality and legality do not always go hand in hand (as illustrated by controversial issues such as abortion, euthanasia, and the death penalty), ideally our legal system attempts to codify what is moral. Indeed, our legal system codifies various social norms and ideologies (e.g. do not kill, do not steal, respect private property, etc.) that politicians and presumably citizens believe are necessary for a moral and harmonious existence. Social contract theorists like Hobbes, Locke, and Rousseau think people have no reason to trust one another to act morally in the state of

nature; consequently, a social contract is necessary in order to ensure moral behavior. Social contract theorists assume all individuals value the laws of this country. While clearly not everyone values all laws, these theorists assume they should. For the sake of argument, let us go along with this assumption since our legal system does not make exceptions for people who disagree with the laws. Because it is assumed everyone values the laws, our government and other citizens trust individuals to follow them (which plays into why our legal system assumes innocence rather than guilt). Consequently, if someone breaks the law she is held legally responsible.

The main exception[23] to this is if a person is considered incompetent and this incompetence is thought to affect her trustworthiness. For example, people who do not have the mental ability to understand the laws, such as children and some mentally ill people,[24] are usually not held responsible for their crimes because their incompetence prevents them from being trusted to know and follow laws. Recall that Mullin outlines two types of competence in order to be trustworthy: first, that people are able recognize the social norm that they are supposed to follow and understand what it entails; second, that people are capable of acting according to the norms they uphold (2005b, 322). Because those involved in legal matters (e.g. lawyers, judges, psychologists, etc.) believe that children and some mentally ill people are incompetent in one of these two ways—either they do not recognize the laws and/or understand how to follow them or they are unable to act according to the laws even though they know them—they do not usually hold them legally responsible for breaking the law (or if they do hold them responsible,

[23] There are other cases where people are not held responsible. For example, diplomats often have immunity.

[24] While there are various forms of mental illness, from minor to severe, here I am taking only about the most severe forms of mental illness.

the consequences are different). Children and some mentally ill people are not held responsible because their incompetence is thought to be an inherent, and thus uncontrollable and unavoidable, part of who they are. That is, it is assumed that by virtue of being a child or having a certain mental illness, one will not have the competence to understand and follow the laws. Since this incompetence is a "natural" and inevitable part of being a child or mentally ill, our legal system does not hold these individuals responsible in the same way it does for competent individuals because it is not their fault that they lack this competence.

Returning to the case of women and contraception, it seems not only strange, but also unfair that our legal system, the medical establishment, and individuals consider women untrustworthy with contraception and yet still hold them responsible for it. Why is this? It reinforces patriarchy and benefits men. The current arrangement reflects men's semi-conscious desire not to be held responsible for contraception and to have to deal with the burdens of contracepting. However, men still want to have control over reproductive matters, though they may not be aware of this desire. By covertly and overtly insisting that women are irrational and therefore incapable of making good decisions, men, who are viewed as rational and thus capable of making good decisions, retain control over reproductive matters. They exercise this control through policies, laws, surveillance, and normalization that target women's bodies. Women are granted the (limited) freedom to contracept in order to relieve men of this responsibility.

Our patriarchal social forces and ideologies regarding the public/private dichotomy, gender roles, and sexist assumptions about women's bodies discipline women to assume contraceptive responsibility. Since reproduction is thought to be part of the

private realm and women are typically associated with the private realm, it is assumed that women should be the ones responsible for reproduction. Due to the gender ideology that women are naturally better caretakers—that they are innately loving, giving, self-sacrificing, and maternalistic—they are generally thought to be better equipped to be responsible for reproduction and childcare. Women's bodies are also thought to be better suited to contraception because they are often viewed as objects and thus are considered easier to control (I return to this point in chapter 6).

Claiming that women ought to be the ones responsible for contraception due to these reasons while simultaneously asserting that women are not trustworthy aligns femininity with contraceptive responsibility, while enabling men to keep their top-down political, social, economic, and interpersonal dominance over reproduction. Men benefit from this arrangement because they maintain power while at the same time avoiding contraceptive responsibility and all that it entails. Women assuming contraceptive responsibility increases men's freedoms: the freedom to have sex worry-free, the freedom to avoid bodily invasion by contraceptive medication and procedures, and the freedom of increased access to women. Catharine MacKinnon argues that abortion was legalized because the "availability of abortion enhances the availability of intercourse" (188). Contraception was legalized for the same reason—it increases men's sexual access to women. Women's ability to control their fertility is thought to increase their sexual activity because they are able to have sex like men, that is, sex without worrying about the consequences of pregnancy. For example, women can no longer use the "excuse" of potential pregnancy to avoid sex since there are so many female contraceptives.

Saddling women with contraceptive responsibility also benefits men because women, not men, are usually the targets of blame for contraceptive matters. For instance, women are often stigmatized for being sexually active—for falling on the "whore" side of the virgin/whore dichotomy—especially if they belong to one of the groups I discuss below. Additionally, if an unintended pregnancy results, women are blamed for not successfully contracepting. Since women are generally responsible for contraception, they are often pinpointed as the cause of "bad" outcomes, such as an unintended pregnancy. In contrast, men are often let off the hook occurs. For example, men today are not usually pressured into marriage due to an unintended pregnancy (the boyfriend of Bristol Palin, Sarah Palin's daughter, is a notable public exception).

Blaming women is especially unfair because the barriers to successfully contracepting are typically ignored. For example, Anna Stubblefield claims that some women risk not using contraception even though they know it increases the probability of pregnancy because of the cultural belief that women who use contraception are sexually promiscuous. She concludes that "Social norms such as those in the case of contraceptive risk-taking that assign blame to women for unwanted pregnancies while simultaneously coercing them to engage in premarital sexual intercourse without using contraceptives are oppressive" (Stubblefield 85). These competing social norms lead to a no-win situation for women: if they contracept then they are viewed as sluts, but if they do not contracept, then they run the risk of pregnancy. I will return to Stubblefield's work and some of these barriers to contracepting in the chapter 6.

It is important to note that certain groups of women—young, poor, unmarried, and minority—are considered less trustworthy and more blameworthy than others. While

it is true that these groups of women are more likely to have unintended pregnancies (Finer and Henshaw), rather than understand why this is the case, the media, politicians, policymakers, and others blame them for not upholding the self-sacrificing norm either by using contraception or abstaining from sex (see Roberts 1997 on the treatment of poor black women). Yet, many of these women cannot afford contraception and the Bush government continues to make it more difficult for women to get access to reproductive services. For example, on the national level, Title X, which provides public funding for family planning services, is underfunded and often under attack (Reproductive Rights). A state-specific example: in 2006, Missouri House Republicans voted to ban county health clinics from providing family planning services, including contraception (Temple). The stereotype that women belonging to these groups are sexually promiscuous leads some politicians to argue that if these women stopped having sex their problems would also cease. This argument assigns full blame to these women—insisting that the women are morally irresponsible for not being able to control their libido—while overlooking the way others (i.e. men and society) contribute. In reference to the Missouri ban on family services, Rep. Susan Phillips (R-Kansas City) said in an interview, "If you hand out contraception to single women, we're saying promiscuity is OK as a state, and I am not in support of that" (Shakespearsister blog).

In sum, implying that women are irrational is an easy way for politicians, policymakers, members of the media, male partners, and fathers to justify their control over women as well as to pin blame on them when something goes wrong. On both a conscious and nonconscious level, men do not want to acknowledge that women are rational because it would mean that women should be trusted with contraception. Thus,

women would no longer "need" men to control them and the reproductive realm in the way that men currently do. The idea that women are irrational is a key part of the patriarchal control over women not only in reproductive and childcare realms, but in all other facets of life as well (e.g. public life, political realm, education, etc.). The ideology of women irrationality is often subtly, thought sometimes explicitly, behind justifications of laws and social policies (in various realms) that convey distrust for women. The only way to move toward trusting women, then, is to deconstruct the cultural trope that women are irrational. I turn to this goal in the next section.

## Changing Our Contraceptive Social Norms

My analysis leads to a quagmire: neither women nor men are trusted as a group with contraception. What can be done to rectify this situation? There are at least two possibilities: change the contraceptive ideologies or change the gender ideologies. While changing one set of ideologies and not the other could make women, men, or both groups trustworthy, both need to be changed because they are both morally troubling. Yet, such change will not be easy, nor will it be quick. I offer some brief suggestions here, but will go more detail on these suggestions and others in chapter 7.

One suggestion is changing the contraceptive ideologies of self-sacrifice. I have already spent time (in the last chapter) explaining how the contraceptive expectation of self-sacrifice is problematic because it glorifies and upholds the social norm of women as self-sacrificing, but I will briefly add a few thoughts here. One reason I find this norm so troubling is that it is directed at a particular social group—women—in order to benefit another social group—men. Another reason is that the degree of sacrifice is so extreme:

"on a cultural level women are *expected* to donate themselves in the form of time, energy, and body" for others (Raymond 9). As discussed with pregnancy and childcare, no there is no such thing as too big a sacrifice, nor is there a chance or type of improvement that is too little to merit self-sacrifice. I recognize that some amount of sacrifice is necessary with contraception. However, as it currently stands, this expectation is both oppressive and unrealistic. It assumes that women should warmly welcome full reproductive responsibility and uphold this responsibility flawlessly. This ideology contributes to some men's feelings of betrayal in the reproductive realm, as few women live up to this self-sacrificing ideal. Indeed, the expectation of women to be superwomen/super-sacrificer—miraculously able to be successfully responsible for work, children, male partner, household, and still maintain her femininity—means that women who allow anything to inhibit their ability to be successfully responsible for contraception are not thought to deserve trust. Upholding this norm prevents us from accounting for the role of others: men, partners, families, and friends; of society: ideologies, societal norms, and oppression; and of factors about contraception: such as price, side effects, efficacy, and availability of options.

Another suggestion also involves changing a contraceptive expectation: the cultural belief that contraception should not be discussed. This belief is problematic because it relegates contraception to the private realm, which results in silencing women and placing women's reproductive issues outside the realm of public justice. The taboo on discussing contraception prevents children from learning how to properly use contraception and often leads to the belief that both sex and contraception are "bad." This expectation of silence should be changed and can be changed without harming women's

autonomy to use contraception. Many people, especially liberal theorists, assert the need for the privatization of reproduction (including contraception) so as to ensure people's reproductive autonomy. However, privatization and silencing are not the same, though many people are silenced by being pushed into the private realm. Furthermore, privatization does not guarantee reproductive freedom. According to MacKinnon,

> Private is what men call the damage they want to be permitted to do as far as their arms extend to whomever they do not want permitted to fight back. Epistemically, in gender terms, it means that male force is invisible. When aggression occurs, what is seen is consent. (191)

By privatizing contraception, our government makes it easier for men to control women's reproduction, while proclaiming that women autonomously make reproductive decisions. Moreover, this arrangement forces women to be responsible for contraception without any public support. Our government must move contraception (as well as reproduction and childcare) out of the private realm so that women can have reproductive autonomy backed by public rights. Brining contraception into the public realm will establish the unfair burdening of women with contraception as matter of social justice.

The government can make contraception a public matter through creating and funding public programs and goals. For example, public educators can normalize contraception by teaching children sex education that promotes its use. Government and nonprofit workers can lobby the media to include contraception in movies and television shows to normalize it and encourage partners to discuss it. Currently, contraceptive use is not included in media images:

> First, the prevalent images in the media of nonmarital sexual activity, which impart the message that such activity is both common and acceptable and thereby counter the norm against it, do not include images of contraceptive use. Second, these images propagate a paradigm of

> sexuality and romance in which women are 'swept off their feet' rather than actively planning sexual intercourse. (Stubblefield 96)

Given the far-reaching arms of the media, movies and television programs that include contraception use and/or discussion of contraception would be viewed by millions of people.

Yet, changing contraceptive ideologies is not enough for women to be viewed as trustworthy. The reason women are distrusted is that they are seen as incompetent and changing the expectation of self-sacrifice and/or the taboo of contraception will not make women seem more competent. What will make them seem more trustworthy is viewing them as competent. Believing that women are irrational leads people to think that they are incompetent. Thus, in order to see women as competent our government and its citizens need to assert their rationality. There are probably additional ideologies, as well as other factors, that contribute to the belief that women are incompetent. However, I do not have the space to discuss them all, so instead I have used the umbrella concept that women are irrational, which covers a lot of other ideologies that portray women as incompetent: women are emotional, unreasonable, flaky, irresponsible, stupid, and incapable of being profound or making good decisions. Eliminating the cultural stereotype that women are irrational will lessen or eradicate these other problematic tropes. Furthermore, eliminating this stereotype is necessary in order for women to be considered trustworthy not just with contraception, but in all realms of life.

Another benefit of increasing the social perception of women's trustworthiness is that this will enhance their autonomy. Believing that someone is incompetent justifies paternalism. Philosophers distinguish between weak and strong paternalism: weak paternalism involves acting paternalistically toward incompetent people (e.g. children,

mentally retarded individuals), whereas strong paternalism is acting paternalistically toward competent individuals. Most philosophers think that restricting the autonomy of competent people is morally unacceptable because these individuals are capable of making good decisions for themselves, whereas incompetent people are not. According to the trope that women are irrational, the government and men (i.e. women's partners, fathers, etc.) are justified in limiting women's autonomy because it is merely a form of weak paternalism. However, if women are viewed as rational, then the government's and men's actions that result from distrust (e.g. laws, surveillance) are unjust because they are cases of strong paternalism.

In order to move towards viewing women as rational, our legal system needs to stop treating them paternalistically. On a practical level, this means removing laws that regulate women's reproduction. In addition to granting women the negative freedom to make choices about their bodies, our legal system must provide them with the positive freedoms that enable them to make good choices (e.g. education, access to clinics, cheap or free contraceptives). Our government must strive toward gender equality in all realms, and not just reproduction, as a way of systematically affirming women's rationality since what happens in one realm affects other realms. Moreover, our government and private organizations should develop male contraceptives, especially long-term reversible options, as a way of achieving shared contraceptive responsibility. The lack of options for men makes it difficult for them to assume responsibility for contraception and this pushes contraceptive responsibility on women. Additionally, as I already mentioned, our government should make contraception a public matter. This would allow politicians, policymakers, and everyday citizens to recognize the challenges women face in

contracepting, as well as the role men and the government play in contraception, which would (hopefully) minimize the blame directed at women. In sum, viewing women as rational and moving contraception a public matter would allow women to freely exercise their reproductive autonomy and would limit unfair blame directed at them. Additionally, affirming women's rationality would increase women's overall autonomy by making them seem more trustworthy with matters outside of reproduction and childcare.

In conclusion, changing these contraceptive and gendered social norms is a long and difficult process, but one that is worthy of our most valiant efforts. Changing these beliefs will not only allow for women and men to be trusted on the group level with contraception, but it will also mean that we rely on a less problematic social norm in order to determine trustworthiness.

## Chapter 5. Paternal Responsibility and the Principle of Nonmaleficence

In the previous chapter, I explored some of the gender ideologies that contribute to men's perceived untrustworthiness regarding contraception. In our current contraceptive arrangement, this distrust usually absolves men as a group of contraceptive responsibility. Women, in contrast, are not only typically held responsible for contraception, but they also do the vast majority of contracepting. As I have shown in the previous chapters, the current contraceptive arrangement is unjust and oppressive for women. My goal in the second half of this project is to propose a more just contraceptive arrangement, one in which women and men share contraceptive responsibility. Specifically, I hone in on men's moral duty to contracept. Although I think this moral duty applies to both women and men, I limit my argument in this chapter and the next one to men's moral duty because it is typically ignored. Women's moral duty to their fetuses and children, in contrast, receives lots of attention. In examining the neglected topic of men and contraception, I seek to fill a void in philosophical conversations about contraceptive responsibility.

In order to claim that men have a moral duty to contracept, I draw on the principle of nonmaleficence, which states that we should act in ways that do not cause harm to others. One reason I turn to this principle is that is it frequently appealed to in discussions about women and reproductive responsibility. As I will explicate later in this chapter, there is a social fear that women will harm their fetuses and children. In arguing that women should act in a certain way so they do not cause harm, many politicians, policymakers, academics, and health care professionals rely upon the principle of

nonmaleficence. Yet, this principle is rarely mentioned in discussions of men and reproductive responsibility. Even though the number of discussions about men's reproductive responsibility pales in comparison to those about women, it is striking that the centerpiece of most discussions about women—their potential to cause fetal harm—is virtually absent from most discussions about men. The small number of discussions about men's reproductive responsibility, as well as the fact that these discussions rarely mention fetal harm, reflects dominant gender ideologies about who ought to be responsible for reproduction and who is capable of and causally responsible for harming fetuses and children. In this chapter, I apply the principle of nonmaleficence to the case of men's reproductive responsibility to argue that men have a moral duty to contracept if their actions could harm their fetuses and children.

This chapter consists of three sections. In the first section, I present the circumstances under which it is fair to expect people to act according to the principle of nonmaleficence. In the second section, I highlight the contrasting social views about women's and men's potential and likelihood to cause fetal harm, despite scientific evidence that both women's and men's actions can lead to fetal harm. There is a cultural understanding that women are very likely to cause fetal and child harm, reflected in limitations on women's participation in clinical trials and certain jobs, public service announcements telling women not to drink alcohol while pregnant, and extensive media coverage of "crack babies" and other babies thought to be "damaged" by women's behavior. Conversely, there is little public discussion of men and fetal and child harm, which implies that men do not (or cannot) cause such harm.

In the third section, I use the principle of nonmaleficence to argue that men have a moral duty to contracept if their behavior—past, current, or future—could harm the potential fetuses and children who result from their unprotected sexual behavior. This argument rests on the claim that moral responsibility often stems from causal responsibility. Since men have the potential to cause harm to fetuses and children, they should be morally responsible for preventing such harm. There are three ways for men to avoid harming fetuses and children. One way is to not partake in activities that can cause fetal and child harm. I recommend that men who are actively trying to father a child follow this method. If they are unable to avoid activities that risk harming a fetus, then they should contracept in order to prevent harm. The other two ways involve striving to avoid fathering a fetus either by abstaining from sex or by contracepting. Men who are not interested in fathering a child should abide by one of these two suggestions so as to obviate health-related risks to fetuses as well as economic and social harms that may befall children after birth.

Two caveats before moving on. First, I am limiting my normative discussion to moral responsibility. I am not endorsing state enforcement to ensure certain types of behavior nor am I condoning punishment for those who deviate from "acceptable" behavior. I am merely outlining what people should do if they want to act in a way that is responsible toward (and respectful of) their potential fetuses and children.[25] Second, there are numerous harms parents can inflict upon their children. Obviously, I cannot address

[25] While my discussion in this chapter and the next one focus on the moral duties individuals have, this does not mean the government does not have moral duties regarding contraception. I make recommendations for government involvement with contraception in chapter 7.

them all here. I consequently confine my discussion to health-related,[26] economic, and social harms, broadly construed.

## Harm and the Principle of Nonmaleficence

Before turning to what it means for men to abide by the principle of nonmaleficence with reproductive responsibility, I first lay out the circumstances under which it is fair to expect individuals to act according to this principle. In order to prevent harm to others, individuals sometimes have to take on harms themselves. For example, as discussed in chapters 3 and 4, women are typically expected to make myriad sacrifices in order to avoid harming their fetuses and children. Yet, many of these sacrifices are unfair because the degree of sacrifice is much greater than the degree of potential harm. In other words, women are often expected to make huge sacrifices to prevent very minimal potential harms. Such significant sacrifices are usually harmful to women (I pointed out some of these ways in previous chapters), which is why they cannot be justified if they are undertaken to avoid a slight potential harm to fetuses and children. This example shows that in order to determine if an action to prevent harms in others is justified, it is necessary to compare the harms engendered in trying to prevent harm to others with the harms experienced by others if we do not prevent harm.

In general, most politicians, policymakers, academics, and laypeople do not think it is wrong for individuals to take on some harm to themselves if it means they will prevent greater harm to others. This utilitarian logic is especially common in debates about various public health issues, such as quarantining individuals with a highly

[26] More specifically, I limit the type of health-related harms I discuss to those caused by parental behavior (e.g. parental smoking leading to low birth weight).

contagious and serious diseases, like tuberculosis. Most health care professionals would claim that, based on the principle of nonmaleficence, individuals with tuberculosis have a duty to prevent harming others (i.e. spreading the disease). Dr. Julie Gerberding, Director of the Centers for Disease Control and Prevention says health officials "usually rely on a covenant of trust to assume that a person with tuberculosis just isn't going to go into a situation where they would transmit disease to someone else." The media and laypeople seem agree that people have a duty not to spread dangerous diseases, as seen by the public outcry in May and June of 2007 when a man with a drug-resistant form of tuberculosis flew to Europe for his honeymoon (No author, "Man knew he had TB before flying to Europe").

Although being quarantined harms individuals with tuberculosis (e.g. they temporarily lose their freedom of mobility and some aspects of their autonomy), the harms they could cause to others (e.g. severe sickness and death of many) far outweigh the harms they face in being quarantined. Part of the reason many health care professionals and others do not think it is unfair for individuals with tuberculosis to assume some harms is that these individuals are causally responsible for harming others. Generally, people are not expected to take on harms to themselves to prevent harms to others that they have not caused. For example, many in the global North do not think they have a moral duty to prevent harms (e.g. poverty, disease, lack of education) to those in the global South because they do not consider themselves causally responsible for those harms.[27] Consequently, they do not donate money or time (such donations could be construed as harms to themselves) to those in the global South. Or, if they do give, they

[27] See Thomas Pogge for a compelling argument explaining how people in the global North are causally responsible for the situation of people in the global South.

do so based on altruism or some other reason, not because of a moral duty they feel they have due to the principle of nonmaleficence. Clearly, there are cases where people are expected to take on personal risks in order to prevent harms to others even though they are not causally responsible for these harms, such as health care professionals and firefighters risking their health and lives to aid others.

In the case of contraception, men are causally responsible for the existence of fetuses, a causal relationship that is generally shared with women (rape is a notable exception). Additionally, men's actions can cause health, social, and economic problems for fetuses and children that result from unprotected sexual activity. The harms men could cause by not contracepting are much greater than the harms they could face by using contraception. Furthermore, men benefit from contracepting: they prevent harms to themselves. I will return to these arguments later in the chapter.

**Contrasting Social Views about Women's and Men's Potential to Cause Harm**

As discussed in previous chapters, women are usually expected to make various sacrifices for their fetuses and children and "problems" or "imperfections" are often blamed on women. That is, women are typically identified as the cause of harm. And while it is no doubt true that women can harm their fetuses and children, placing the majority, and sometimes all, of the blame on them overlooks both the societal factors at play as well as the ways men cause harm to their fetuses and children. As Cynthia Daniels argues, "Debates over fetal risk are not so much about the prevention of fetal harm as they are about the social production of truth about the nature of men's and women's relation to reproduction" (579). The focus on women in discussions of fetal

harm reinforces the belief that women's bodies are permeable: that they easily spread harms to others, especially an innocent fetus (for both historical and current examples, see Kukla). Furthermore, the long history of medicine treating women's bodies as weak, inferior, and inherently diseased contributes to the worry that women's bodies will "infect" fetuses. In contrast, men's bodies as seen as stable, bound, and healthy; therefore they are not a risk to fetuses. Because men's bodies are thought to be stronger than women's, men are thought to be invulnerable to harm from toxics, or if they are harmed, they are assumed to become infertile and thus incapable of harming others (Daniels 1997, 583).

These sexist understandings of women's and men's bodies essentially fail to acknowledge any significant role for men in reproduction, further perpetuating the assumption that reproduction really only involves only one person: the woman. Clearly, human reproduction requires two people, yet "the man's involvement seems insignificant, amounting to nothing more than the ejaculation of a small quantity of seminal fluid. And even this has been codified in conventional wisdom as primarily a sexual act, rather than a reproductive one" (Sheldon 1999, 130). Men's role in reproduction is reduced to a one time event, whereas women's role in reproduction consists not only of pregnancy, but also anytime she is *not* pregnant (during childbearing age). The potential for women to become pregnant—the idea that women are constantly in a state of pre-pregnancy—was the main reason why the FDA issued new guidelines in 1977 that recommended prohibiting women of childbearing age from the early phases of clinical trials, except for life-threatening diseases (Sarto). That the harm to *potential* fetuses of *potentially* pregnant women was accepted as a legitimate reason for women's exclusion from

biomedical research for sixteen years shows how deep the fear runs that women will (perhaps unintentionally) harm their fetuses.

Although the FDA changed its policy in 1993 to include women in clinical trials in order to study sex/gender differences in treatments, clinical researchers continue to view women's bodies as dangerous to potential fetuses. A study by Cain et al. found that only 8.5% of all trials had no restrictions for women's participation; the rest mandated contraceptive use or sterility (862). Yet, "contraception was unnecessary in one third of the protocols studied (24-hour to 2-day drug use) because timing to menstrual cycles would prevent potential exposure during pregnancy" (863). How is it that these trials were allowed to mandate contraception for women when it was unnecessary? Many scientists and members of the FDA do not (consciously and nonconsciously) trust women to make good reproductive decisions. The protectionist mentality is so strong that 41.7% of the trials Cain et al. examined received FDA approval to mandate contraceptive use for women without providing any reasons (862). Furthermore, almost all the trials demanded a negative pregnancy test and 99.3% of trials requiring contraceptive use mandated signature certification or documentation that women are using an "acceptable" form of contraception—often a hormonal form—in order to participate. This "proof" was required even if the woman was celibate, lesbian, had a sterile partner, or was in a situation not conducive to reproduction (e.g. being in an intensive care unit) (864).

None of these sorts of restrictions are placed on men in clinical trials because men are rarely thought to transmit harm to fetuses. What is particularly egregious is that "even when studies were restricted to men because of known teratogenicity of the drug studied, *the reproductive control required was for female partners of subjects* ... No mention of

abstention, vasectomy, or sterility as a requirement to prevent fetal exposure by male subjects was included" (Cain et al 864; emphasis added). The targeting of women's bodies (the female partners of subjects) in this situation rather than men's bodies (the actual research participants) shows that while researchers recognize that men can harm fetuses, they refuse to hold men responsible for such harm. Instead, the responsibility for preventing harm is transferred to women, as is the implication of causal responsibility. Placing the onus on women to prevent fetal harm makes women seem causally responsible and hence blameworthy for any harm that does occur since it insinuates that they are the only ones with the power to stop such harm.

The cultural belief that only women cause fetal harm is not limited to clinical trials, but is also seen in public life. For example, warnings on alcohol bottles caution *only* against pregnant women drinking. There is no similar warning for men seeking to become fathers, though "paternal alcohol use has been found to cause low birth weight and an increased risk of birth defects" (Daniels 1997, 597). Nor are there any warnings about all the other harms that occur due to alcohol consumption, harms that often cause more overall damage and affect more people, such as drunk driving and crime. Although illegal in the United States thanks to the 1991 unanimous Supreme Court decision *International Union versus Johnson Controls Inc.*, the UK still permits employers to exclude women from certain occupations if there is potential harm to potential fetuses. Here again, women, rather than others, namely their mostly male employers, are held responsible for fetal harm: "the removal of the women, rather than the chemical is thus the solution to avoiding the risk" (Sheldon 1999, 144). No workplace chemical has been outlawed because of its effects on women's reproduction, yet there is a double standard:

the pesticide dibromodichloropropane (BDCP) was banned because of its harmful effects on male reproduction (ibid.).

As these examples show, the message that women can (and do) cause harm to fetuses is ubiquitous. More insidiously, these examples reveal that men are not usually viewed as causally responsible for fetal harms. Women, in contrast, are viewed as in need of constant protection because "*maternally mediated fetal risks are assumed to be certain and known*"; that is, women are "scientifically-proven" causal agents of fetal harms (Daniels 1997, 602). Additionally, due to the ideologies of femininity discussed in the last chapter, women are not trusted to be self-sacrificing and prioritize the needs of their fetuses or potential fetuses, despite the fact that they are generally held responsible for contraception. Men are typically not seen as causally responsible for fetal harm because of various dominant cultural beliefs, including: they are not thought to be able to prevent such harm, there is denial that men's bodies can cause harm, and men are usually not associated with reproduction. By upholding and perpetuating gendered beliefs, the media contributes to why men are not viewed as causally responsible for fetal harm. Cynthia Daniels, a political scientist, analyzed newspaper coverage of fetal harm over a ten year period and, not surprisingly, found a huge discrepancy in the number of articles about women (over 200) versus men (only 17) (ibid. 601). Daniels argues that five factors contribute to the minimal coverage of men's responsibility for fetal harm. First, whereas men are conspicuously absent from articles on maternal-fetal harm, not only are women always included in articles on paternal-fetal harm, but they are also mentioned as a possible source of harm. Second, as stated above, the risks women pose to fetuses are assumed to be "certain and known" (ibid. 602). Third, the knowledge of men's risks to

fetuses is presented as "qualified and limited" (ibid.). Fourth, men's responsibility is diminished by reference to "involuntary" workplace and environmental exposure, even when the toxin in question is an illegal or legal drug. Lastly, "the language and images of harmed children and 'crack babies' are absent from stories on men" (ibid. 603).

Because the perceived harms women can "inflict" on fetuses (e.g. FAS, low birth weight due to smoking, "crack babies," etc.) are ubiquitous, I will not enumerate them all here. What is interesting to note is that there is scientific evidence that many of the actions believed to be most risky are not as dangerous to fetuses as the way they are publically presented. For example, a study linked the prevalence of Fetal Alcohol Syndrome (FAS) to poor nutrition, a result of low socioeconomic class: women who consumed at least three drinks a day but ate balanced diets experienced a rate of Fetal Alcohol Syndrome (FAS) of only 4.5 percent, while women who drank the same amount and were malnourished had an FAS rate of 71 percent" (Daniels 1997, 587). While this study uncovers that FAS is mainly just a risk for poor women, women of all classes are targeted by the medical establishment and the public to abstain from alcohol while pregnant for the sake of their fetuses. It is not surprising that this study has not gotten much media attention, as it goes against the dominant norm that women should make extreme sacrifices to prevent their permeable bodies from causing fetal harm, even if the possibility for such harm is close to zero. Two other examples I mentioned in the previous chapter are that there is no definite evidence that cocaine causes fetal damage and that bedrest prevents problems in high risk pregnancies.

In presenting these examples, I do not mean to suggest that women's actions cannot lead to fetal harm. Rather, my point is that the risks of certain actions have been

overstated or that there is no evidence to confirm such harm. What I find troubling is that the laws, media, medical establishment, and the public typically hone in on and blame women for certain actions without adequate evidence. Yet, men are rarely reproached for their behavior even when there is scientifically confirmed, unexaggerated information that it can lead to fetal harm. For example, both alcohol use and smoking in men increases the chance of birth defects and low birth weight. Illegal drug use, such as cocaine, hashish, opium, and heroin, often results in abnormal sperm (Daniels 1997, 597). Studies documenting these harms began in the 1980s, and in some cases earlier, yet this information is still not widely disseminated (Daniels 1997, 579). As Koren et al. explain, this lack of dissemination is partially due to editors of science journals rejecting papers that violate scientific "believability"; in this case, the claim that men can cause fetal harm is not believable.

**Why Men Should Contracept According to the Principle of Nonmaleficence**

Given the knowledge that men's actions can lead to fetal harm, if we hold women responsible for behavior that can cause fetal harm, then we should do the same for men. According to the principle of nonmaleficence, men have a moral duty to contracept if they engage in potentially risky behavior. Before turning to this argument, however, I want to point out that the principle of beneficence, which states that we should act in ways that promote the welfare of others, is also at play in many arguments about how pregnant women ought to act. The principle of beneficence ties into to the social expectation that pregnant women and mothers should be self-sacrificing. Given the unique situation of pregnancy—that is, the fetus growing inside the woman's body—a

case can be made for women taking positive steps to ensure the welfare of their fetuses, such as taking folic acid. However, there are limits to what women should be expected to do, as such expectations can often lead to extreme, and problematic, self-sacrifice, as discussed in chapter 3. Since parenting is not sex specific (like pregnancy), the argument that children are entitled to positive rights is often extended to both biological parents (see, for example, James Lindemann Nelson). Since men's role during gestation is limited, it would be much more difficult to make a case that fetuses deserve positive rights from their fathers[28] while in utero, except in the case where men actively want to be fathers. I consequently will limit my discussion of the rights fathers owe their fetuses to negative rights. It is easier to claim that children deserve positive rights from their fathers and indeed much has been written on this topic, especially regarding the economic and social rights children should receive from their fathers (Onora O'Neill and William Ruddick's edited collection is an early example). Since many fetuses become children, it would be shortsighted to neglect the rights of children. The harm men can cause to their potential children is not limited to the act of conception. In refusing economic and social support—both positive rights—men are also causing harm to their potential children that could be avoided by contracepting. In the next two subsections, I explore the moral duties of men who do not want to father a child and those of men who are actively trying to father a child. I restrict my discussion to heterosexually active men for the sake of simplicity.

[28] While I think it is problematic to refer to pregnant women as mothers and their male partners as fathers, I use such language due to the lack of better terms that are not awkward.

## Men Who Do Not Want to Father a Child

Applying the principle of nonmaleficence to a potential fetus, men who are not interested in fathering a child have a moral duty to contracept. Since many common behaviors, such as smoking, drinking, drug use, and working with certain chemicals, can result in paternal-fetal damage, men who engage in any of these risky behaviors should use contraception as a way of preventing fetal harm. Because men have the potential to directly cause fetal harm, they should assume responsibility for their actions, and for the potential consequences of their actions, by using contraception. In some ways, this argument seems intuitive: if X causes harm to Y, then X should be responsible for preventing harm to Y. While I do not want to suggest that causal responsibility always leads to moral responsibility—a simple counterexample is killing in self-defense—in the case of paternal-fetal harm causal responsibility should lead to moral responsibility. As previously discussed, the media, the medical establishment, and even the legal system typically hold women responsible for actions they believe to cause fetal harm, even when there is little to no scientific evidence supporting such beliefs. Our reason for this usually depends on the principle of nonmaleficence; pregnant women have a duty not to harm their fetuses. The same argument should apply to men; if men are engaging in behavior that could lead to fetal harm, they should protect potential fetuses by contracepting.

Some may object that men's and women's circumstances between are not analogous because the potential for paternal-fetal harm occurs pre-conception,[29] whereas maternal-fetal harm mostly occurs during pregnancy. The claim here is that it is easier for women to prevent fetal harm because once they know they are pregnant, they can cease

[29] The manifestation of the harm (i.e. the disease or condition) may not be apparent until sometime during the pregnancy or even after birth. However, the cause of the harm occurred during conception when an abnormal or damaged sperm fused with an egg.

risky behaviors. The duty for men to prevent fetal harm is more onerous because by the time they find out a woman is pregnant, it is too late for them to prevent fetal harm. Consequently, men have to be proactive in preventing harm, which is more demanding than being reactive like women since it requires constant contraceptive use and/or continual abstention from risky behaviors. This objection fails because women also have to be concerned about pre-conception harms, as their behavior before pregnancy can cause fetal harm. In fact, women's responsibility to prevent harm seems more onerous because they have to worry about harms that can occur before conception and during pregnancy (as well as after birth if breastfeeding).

A stronger objection is that it is unfair to hold men responsible for fetal harm because they probably do not have the knowledge that some of their behaviors can result in fetal harm. As Daniels's media analysis shows, there is a lot of information about the ways in which women can harm fetuses, while information about men causing fetal harm is scarce. Most accounts of causal responsibility affirm that people should only be morally responsible for the consequences of their actions that they can foresee, those consequences that reasonable people have reason to expect may occur (see, for example, Gerald Dworkin). Yet, while some types of ignorance may absolve individuals from moral responsibility, other types do not. As many philosophers writing on epistemologies of ignorance argue, ignorance is often "actively produced for purposes of domination and exploitation" (Sullivan and Tuana; see their edited collection for some excellent articles on race and epistemologies of ignorance). Especially in a world filled with oppression, ignorance is typically not neutral or accidental. Marilyn Frye argues that ignorance "is

not a simple lack, absence or emptiness, and it is not a passive state...[it] is a complex result of many acts and many negligences" (1983, 118).

Men's ignorance surrounding paternal-fetal harm is also not a simple lack or an accident, but rather is a series of actions and omissions that reinforce men's domination. Although there are patriarchal social forces at play that shape men's beliefs and behavior, men are also morally culpable for their complicity with oppressive power structures. That many men are blinded by their privileged positioning is not a good reason to excuse them of moral responsibility. Men who resist dominant gender ideologies may come to suspect that women are not the only ones who can cause fetal harm; men can too. Even if men do not challenge gender ideologies, if they critically reflect on well-known scientific findings, such as that secondhand smoke is dangerous to others, they may conclude that their actions can also be harmful to potential and actual fetuses.

Some may oppose holding men morally responsible for fetal harm because they believe it is unreasonable to expect men to know about the possibility of paternal-fetal harm given the dearth of media coverage about it. However, this objection carries less weight as information about paternal-fetal harm becomes more commonplace. I found eight mainstream newspaper articles on this topic (using Lexus-Nexus) published during the two month period of February through April of 2008, whereas Daniels found only seventeen articles during a ten year period of the mid-1980s to mid-1990s.[30] Additionally, of the articles I found, the main topic of most of these articles was paternal-fetal harm. Interestingly, the majority of these articles were not published in the United States, but in other English-speaking countries (the UK, Australia, and Canada). While I do not

[30] The eight articles on paternal-fetal harm are by Goldberg, Jha, Laurance, MacRae, No author (Chromosomal abnormalities), No author (Fathers who smoke 'hit future generations'), Smith, Taylor.

endorse my research as following the rigors of social science, that I was so easily able to find so many (relatively speaking) articles on paternal-fetal harm does indeed seem to indicate a significant change from even just ten years ago. Perhaps I was able to find so many articles because my search was international and other countries are more likely to publish stories on paternal-fetal harm. Even if this is the case (and it may well be as four of the articles were published by British newspapers), given the internet and our globalized world, information is more quickly and easily disseminated, which means important stories such as these will hopefully spread to the U.S.

While it is true that more media coverage would make it easier for men to know that their behavior can cause fetal damage, individuals are commonly held morally responsible for their actions despite their ignorance. In fact, women are generally held morally responsible for fetal harm regardless of whether they know that their behavior can lead to fetal harm. One reason commonly given to explain women's moral responsibility is that women ought to have known better and to have been able to conclude, even without public knowledge, that certain actions could lead to fetal harm. This same logic is often used in other situations. For instance, when Shu is confronted about her habit of taking (or stealing) supplies from her company she may claim that she did not know her actions were wrong. Perhaps she though these supplies were for company as well as private use. Shu's boss, however, is likely to hold her morally (and perhaps financially and legally) responsible because the boss probably believes Shu ought to have realized that her actions were wrong notwithstanding the fact that there is no company policy that explicitly states this. In the case of fetal harm, the discrepancy in moral responsibility (i.e. women are usually held morally responsible while men are

typically not) has little to do with the knowledge women and men have about their ability to cause fetal harm. Rather, this discrepancy is a reflection of dominant ideologies and power structures.

Although some may not be convinced that men should be held morally responsible for fetal harm because men may be ignorant that their actions can cause such harm, there are other types of harms men can cause to future beings (fetuses and children) that they can, without question, foresee. I now turn to economic and social harms rather than health-related bodily harms. Additionally, instead of focusing on harms to fetuses, I take a more long-term view and examine harms to potential children that result from men's failures to contracept. For example, there are social harms to children by fathers who are not interested or not involved in their lives as well as economic harms that befall children of fathers who do not financially contribute to their well-being.[31] I do not want to imply that children who do not know their fathers or do not have relationships with their fathers are *necessarily* socially damaged. Yet, social science research shows that having an absent or uninvolved father increases the probability for a variety of social problems, such as behavioral problems, academic failure, unhappiness, and mental health problems (Amato; Boyce et al.).[32] While some men who were not interested in having children (or at least not at that time or with that particular woman) become great fathers, men who do not want children are probably more likely to be "bad," or simply not

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[31] Following empirical evidence, my assumption here is that, in situations where the biological parents are not living together, children will generally live with their mothers.

[32] My concern in making this argument is that it will be misconstrued and used to buttress claims that children need to be raised in heterosexual, two parent households in order to avoid harm. I do not agree with that claim. I think the reasons fathers (and mothers) can harm their children are complex and are beyond the scope of this chapter. What I want to make clear is that just because absent or uninvolved fathers can harm their children, this does not mean that present and involved fathers do not cause harm or provide an overall better environment for their children.

"good," fathers than men who do want children. It is true that we cannot always foresee how we will respond to a future situation. However, our interest in a certain realm typically affects our success in that realm, as our interest motivates and commits us. Following this reasoning, men who are interested in being fathers have the advantages of motivation and commitment to parenting that will help them succeed as parents, whereas men who are not interested in being fathers do not, at least initially, share these advantages, which may make it more difficult for them to be "good" parents. In fact, their lack of interest in being fathers may lead them to have little to no involvement in their children's lives.

Moreover, men who are not interested in being parents are probably less inclined to financially support their children. We generally prefer to spend our money on things and people we like, although this is often not possible because of financial obligations and basic needs (e.g. car payments, taxes, food, housing). Indeed, we are usually happy to spend our money on people we care about, while we are reluctant to give money to others we do not know, do not like (or even just feel neutral about), or do not think deserve our generosity. If people prefer not to be parents—they do not like the role of parent and/or they do not like their child(ren)—they may resist giving money to their child(ren). And given the number of women who take their male partners to court to get child support, it seems that many men do indeed resist financially supporting their children (11,406 women were awarded child support in 2005 and ten times as many women as men sought governmental assistance in securing child support (U.S. Census Bureau 2005a)). Even men who are willing to financially support their children may be in no position to do so, as raising children is quite an expensive undertaking. According to the U.S. Department

of Agriculture, the average cost of raising a child for eighteen years (not including college) ranges from $143,790 to $289,380, depending on income (Lino 2007, ii). While not all parents are economically prepared for the cost of raising a child, people who are interested in and actively planning on becoming parents have probably reflected on their economic situation and possibly started financially preparing for a child. In contrast, for people who are not interested in being parents, the cost of raising a child is likely not something that crosses their minds and consequently they have not financially prepared for a child. Fathers' lack of financial support can harm their children by placing them at risk for poverty or in poverty, with all of its associated harms. Beyond economic struggles, men's lack of financial support can harm children due to the increased probability of a strained relationship between biological parents over money.

Because the dominant social norms for fathers include the roles of breadwinner and disciplinarian, men who do not fill these roles, especially men who shirk them, are often viewed as unmanly (that is, weak and feminine). Furthermore, such men are thought to be harming their children not only because they do not contribute socially and/or economically, but also for a more subtle and sexist reason: men who do not uphold their fatherly duties challenge both the norms of masculinity and the heteronormative, patriarchal norms of what it means to be a family. Challenging these dominant norms is often thought to be dangerous to children—it will teach children that it is acceptable, and even desirable, to resist gender norms. These same concerns are raised against other types of "nontraditional" families, such as single parent families, gay or lesbian families, and even against heterosexual families in which the woman works outside the home. While I am in favor of challenging gender norms within the family (as well as in general) and

believe that doing so is beneficial to children, the dominant narrative is that families should consist of a heterosexual couple who follow standard gender roles and that families that deviant from this arrangement are hurtful to their children. This cultural understanding persists even though there is empirical evidence to the contrary (see, for example, Wainright et al.).

Although I do not think men's lack of social and economic support is harmful to children because it challenges gender norms, the other possible consequences of uninvolved fathers I mention above (e.g. poverty, behavioral problems) *are* damaging to children. Additionally, there is a cultural belief that men who are not socially or economically involved in their children's lives harm the children through this omission. Negative terms like "absent father" and "deadbeat dad" are used by individuals, politicians, and the media to refer to men who do not adequately fulfill their fatherly duties. These terms reflect the social belief that fathers ought to be involved in their children's lives. Our government, moreover, upholds the importance of father involvement through laws and policies, such as child support. In 2005, our government proclaimed the need for more than just financial involvement from fathers by allocating $150 million each year to promote healthy marriage and fatherhood through the Healthy Marriage Initiative of the Deficit Reduction Act. The goal of this legislation is "to encourage healthy marriages and promote involved, committed, and responsible fatherhood" (U.S. Department of Health and Human Services). Given the prevalence of the expectation of involved fatherhood (at least financially), it seems unlikely that men could genuinely not be aware of the cultural belief that absent fathers harm their children.

Returning to the objection to my position that it is unfair to hold men responsible for harm if they do not have the knowledge that their behaviors can result in such harm, I have shown that men do know that certain actions—namely, their social and economic absence—can harm their potential children. If men foresee that they would not be involved fathers, thus potentially harming their potential children, then they have a duty to contracept according to the principle of nonmaleficence. Some may object that it is misleading to compare bodily harms to social and economic harms because the former occurs from a one time event before birth—the insemination of abnormal sperm—while the latter takes place continuously over a child's lifetime. First off, it is worth pointing out that many of the bodily harms that occur during conception affect children throughout their lives (e.g. various birth defects) and not just during the fetal stage. Just as bodily harm can begin at conception, so too can social and economic harms. For example, pregnant women who do not receive emotional or financial support from their partners have a greater chance of facing situations that can adversely affect the fetus, such as stress and lack of prenatal care. Hence, bodily and social/economic harms are similar in that they can endure throughout a child's life. However, proponents of this objection are right to point out that the majority of paternal-fetal bodily harm results from a single occurrence while social and economic harms are due to a series of individual actions. Yet, this difference does not diminish my argument. If anything, the recurrence of social and economic harms strengthens my claim, as, assuming a similar degree of harm, recurring harms seem more pernicious than one-time harms. In sum, since men know that harms often befall children who have absent fathers, men who think they will not be socially and economically involved in their children's lives have a duty to contracept.

It is important to note that I am not making any suggestions about what men's roles should be in their children's lives after birth, or even after conception for that matter. My argument is merely that men have a duty to prevent harm to potential children by using contraception if their actions could cause harm. Beyond this, I do not make any normative claims about how the public and the government should respond to such men. I do not, for example, seek to answer the questions of whether such men should be held responsible for fetal harms if they use contraception that failed or whether the government should mandate child support from unwilling fathers. Careful responses to such questions merit their own papers.[33] Instead, my focus is on men's responsibility to prevent harm to their potential children. Men whose behavior, including their future behavior, could be harmful to their potential fetuses and children have a moral duty to prevent such harm by contracepting.

Some may object to my argument and claim that the expectation that men contracept is too demanding and perhaps even unfair. In comparing the harms men face in contracepting with the harms to potential fetuses and children, they may assert that the latter do not outweigh the former, so we cannot justify a moral duty to contracept. These opponents may even turn to the argument I made in chapter 2 that contraceptive responsibility is burdensome and oppressive for women in order to make a similar claim for men. While there may be an apparent tension between my argument in chapter 2 and my argument in this chapter, I think this tension is minor. Our current contraceptive arrangement is unfair for women because they are oppressively socialized to assume full contraceptive responsibility, which limits their autonomy. Men are not expected to

[33] For interesting responses to these questions, see Elizabeth Brake and Sally Sheldon (2003).

assume full contraceptive responsibility, nor are they oppressively socialized to make certain contraceptive choices that impair their reproductive and overall autonomy. What women and men who contracept share are some of the burdens associated with contracepting, like cost, negative side effects, etc. Yet, as I demonstrated in chapter 2, the burdens women face in contracepting are much more significant than those that men face. The costs, side effects, extent of medical involvement, and degree of bodily invasion are minimal for vasectomy, especially compared to female contraceptives, and even more nominal for condoms. Vasectomy is approximately a third of the price of tubal ligation and is much cheaper than female LARCs over a lifetime of use. Furthermore, the side effects of vasectomy are less in number and severity than for tubal ligation and females LARCs. Male condoms are one of the cheapest types of contraception, require no medical involvement or bodily invasion, and have only one health-related side effect: allergy.

Even though the burdens men experience in contracepting are fewer and less serious than those women experience, this fact alone is not a compelling enough reason for why men should contracept to prevent harm to potential fetuses and children. However, in comparing the burdens men experience in contracepting with the possible harm to potential beings if men do not contracept, claiming that men should contracept does not seem unreasonable. Not contracepting can cause health, social, and economic harms for resulting fetuses and children that are significantly greater than the burdens of contracepting. For instance, the birth defects and low birth weight that are caused by paternal smoking seem to be greater problems than spending $30 a year on condoms and dealing with the possibility that condoms may decrease sexual spontaneity and

sensitivity. I do not want to completely minimize the demands of contraceptive responsibility, as its associated burdens can take a toll on men. My point is that these burdens are minimal in comparison to the harms men can cause to potential children and fetuses if they do not contracept. Hence, according to the principle of nonmaleficence, the moral responsibility to contracept is fair because the harms experienced by men are much less than the harms their potential fetuses and children can experience. Like the example of individuals with tuberculosis that I described earlier in the chapter, the burdens and limitations men face in contracepting are justifiable because they are limited—in number, severity, and duration—and they prevent causing significant harm to others.

Furthermore, using contraception is not just about preventing harm to others; it is also about preventing harm to oneself, something that is outside of the principle of nonmaleficence. Using male condoms protects men (and women) against STDs. Contracepting also prevents unintended pregnancy. In the next chapter, I will discuss in detail the harms of unintended pregnancy for women. Here I will briefly mention some of the harms to men. While unintended pregnancy does not directly cause health-related harms in men since they do not experience the bodily changes of pregnancy, men can have indirect health harms due to pregnancy, like stress and insufficient sleep. Additionally, unintended pregnancy can entail economic and social harms for men. As previously stated, raising a child is quite expensive. Channeling their money to this end can adversely affect men's quality of life and even deplete their financial resources. If the biological parents are not living together, determining the father's financial contribution can be a legal, economic, and social nightmare. The role of father can also negatively affect men's relationships with others and in particular the mother of the child and his

own family. For instance, he may be pressured to stay with or live with the mother or there may be family tension if his parents want to be involved with their grandchild's life but he does not want such an active role as father. In sum, using contraception is a way for men to prevent harm to themselves.

Recognizing that men contracept not only to avoid harming potential fetuses but also for themselves minimizes the degree of sacrifice men are thought to be making for the sake of potential fetuses and children. Though many men contracept in order to prevent harm to potential beings, the desire (or even moral duty) to protect themselves also typically factors into why men contracept. Having two reasons rather than one to contracept means more support for one's decision. Yet, if one of the reasons men contracept is to protect themselves, then we cannot affirm that men are acting in a self-sacrificing way. I made a similar argument in chapter 3 when I claimed that men do not work in the public realm merely for the sake of their families; they also do so because they enjoy the associated rewards of prestige, power, and success. Men therefore cannot be said to be acting in a self-sacrificing way with regard to their employment because self-sacrifice necessitates placing the needs of other(s) first even though it involves some sort of burden or sacrifice for oneself. Likewise, men who contracept in part to protect themselves against STDs and/or unintended pregnancy are not being self-sacrificing. The reason this is worth noting is that when we are motivated by self-interest, even if it is only partially, then it is more difficult to assert that we are making undue sacrifices for others. We cannot parse out the burdens we accept only to prevent harm to others from the burdens we take on to prevent self-harm. Hence, determining if burdens are unfair according to the principle of nonmaleficence is more challenging since there are two

intertwined reasons for making such burdens: preventing harm to others and preventing harm to ourselves. That men contracept for themselves as well as others means that the degree of burden they take on for others is not so great. This point, coupled with my previous claim that the burdens men take on in contracepting are justified in comparison to the possible burdens to potential beings, leads me to conclude that men contracepting is not an unjust situation given the harms they prevent to both themselves and others.

### Men Who Are Actively Trying to Father a Child

Men who are autonomously and intentionally trying to father[34] a child have a responsibility to prevent harm to their future child. This argument relates to the one Arras and Blustein make that people who reproduce knowing that their potential children will fall below a particular threshold of acceptable well-being are reproducing irresponsibly (see chapter 3). The key idea here is that it is irresponsible and perhaps even unjust for parents to have children who they know will be harmed. Arras and Blustein provide various understandings of what counts as irresponsible reproduction and one is any parental action that could "lower a child's potential." Implicit in this understanding is that fetuses and children have the negative right not to be harmed. In order to act according to the principle of nonmaleficence and this understanding of responsible reproduction, men interested in having a child must refrain from behavior that could harm fetuses and future children. For men who want to father a child, this does not seem like a controversial claim. Another understanding of responsible reproduction that Arras and Blustein present is that parents should "optimize their child's potential for a good life"—an understanding

[34] It is interesting to note the difference between the verb "to father" and "to mother." The former, and its synonym "to sire" both have to do with impregnating a woman—they are limited to the onetime event of fertilization. In contrast, the latter refers to a lifelong process of caregiving and nurturing.

that is in line with the principle of beneficence. Even this more demanding understanding, which grants fetuses the positive right to welfare promotion, does not seem controversial for men who want a child. Contributing to the social acceptance of both principles is the assumption that parents want to do what is best for their children, as well as the expectation that parents should be self-sacrificing.

Men who do not think they can abide by these principles have a moral duty to contracept. In other words, if men know that their actions have the potential to harm their fetuses and/or their future children, they ought to contracept even if they want to become fathers. I do not want my argument here to be misconstrued as stating that only certain people are worthy of and thus should be allowed to reproduce. I reject reproductive paternalism: permitting the government, the medical establishment, or anyone else to make reproductive decisions for others or punish people for "bad" reproductive choices and outcomes. Yet, disagreeing with reproductive paternalism does not rule out the moral claim that people should not become parents if they know that their behavior has the potential to harm their fetuses and future children. For example, should a man who is a smoker have a duty to contracept to prevent the possibility of low birth weight and birth defects in his future children? Should a man who works an hourly job for minimum wage who is constantly in jeopardy of losing his job due to downsizing have a duty to contracept to protect his potential children from economic uncertainty and possible poverty? Should a man who travels for work and is only home on weekends have a duty to contracept because his potential children might feel socially abandoned?

In response to these questions, let me first state that I recognize that various factors, including ones beyond people's control like poverty and arguably drug addiction,

affect people's ability to adhere to the principles of nonmaleficence and beneficence. Because of the social circumstances that many disadvantaged people face, they may not be able to uphold the principles of nonmaleficence and beneficence in the same way or to the same degree that privileged people can. For instance, people who are poor are more likely to struggle to provide clothes, shelter, food, material goods, and so on for their children than people who are wealthy. It is important to acknowledge that being a good parent involves more than a focus on harm. Even though the men in the examples above have the potential to cause harm to their fetuses and children, they could otherwise be excellent fathers. Sara Ruddick posits three facets of good mothering: preservation (meeting children's basic needs), nurturance (meeting children's emotional and psychological needs), and inclusion (preparing them to be part of their social world). If men are able to mostly or fully meet these three criteria, then they are probably good fathers (assuming we think that the qualities used to define a good mother are the same as those to define a good father).

But even if we conclude that the men in the three examples above would otherwise be good fathers according to Ruddick's definition, should they still have a duty to contracept because of their increased probability to harm their fetuses and future children? I am hesitant to make a universal claim that in situation X all men should contracept because such an assertion fails acknowledge people's different social positioning. Indeed, my worry with having a blanket interpretation of what it means to adhere to the principles of nonmaleficence and beneficence is that this interpretation will reflect the values of the dominant group. Groups who do not meet the white, middleclass,

able-bodied, heterosexual norm would likely be prohibited or discouraged from reproducing (through laws, denial of rights, stigma, normalization, etc.).

Instead of enumerating all the situations in which people should contracept even if they want to have children, a better way to prevent harm to fetuses and children is to educate the public about potential risks. Equipped with this knowledge, people can make autonomous and informed decisions about reproduction that respects their cultural beliefs. This suggestion does not absolve people of reproductive responsibility. People who want to have children still have a moral duty to follow the principles of nonmaleficence and beneficence. However, they are the ones who determine what it means to uphold these principles and whether they are capable of doing so given their individual circumstances. If people do not think they can adequately maintain these principles, then they have a moral duty to contracept even if they want to have children. Some may be concerned that allowing people to make subjective decisions about what counts as following these principles will increase the probability of "bad" choices. While there is no doubt that letting people autonomously make decisions can result in "bad" choices, I think permitting people the autonomy to make reproductive decisions on their own is a better alternative than a top-down method that coerces or mandates the forms of acceptable reproductive behavior. My suggestion does not prohibit the government, medical establishment, or organizations from educating people about how their behavior can harm their fetuses and children and aiding people in making responsible reproductive decisions. In fact, I encourage such involvement, as it would be a real boon to individuals and society overall while avoiding reproductive paternalism.

In addition to the concern that people will make "bad" reproductive choices, there is also a worry that my position leads people to hold individuals responsible for every small action they take that has the potential to cause fetal harm. Although my position does not inherently entail such extreme measures, it is true that my position allows people the freedom to endorse such measures (e.g. the social norm that women should monitor every little thing they do to ensure that they are doing what is best for their fetuses and children). While some may suggest that this is a problem with my position because I support people making their own reproductive decisions, including what counts as harm and how to act to prevent it, I contend that this as a problem with our dominant cultural values. That is, allowing people reproductive autonomy is not the cause of extreme decisions; the social ideologies that lead to such decisions are. In chapter 3, I argued that the decisions we make reflect the ideologies we (consciously and nonconsciously) uphold. Although reducing people's reproductive autonomy would probably generate a particular desired outcome (i.e. the reproductive decisions that the government and/or other organizations endorse) and might lead to a shift in dominant ideologies, this approach is coercive and unjust. Furthermore, it may not be as successful as bottom-up strategies in transforming dominant ideologies (I return to why I think bottom-up change is more effective than top-down change in chapter 7).

In sum, men (and women) have a moral duty to contracept if they believe their actions have the potential to harm their future fetuses and children. What degree of possibility for harm is enough for people to contracept? For example, is a ten percent chance of birth defects significant enough for people to have a moral duty to contracept? I believe this decision is best left up to individuals. However, as stated above, I think

other agents—the government, medical establishment, and organizations—should educate people about these risks so that people can make informed decisions that reflect their personal values.

## Chapter 6. Social Privilege and Unintended Pregnancy: Men's Moral Duty to Contracept

Over half of all pregnancies in the United States are unintended at the time of conception, which means that annually three million women face an unplanned pregnancy.[35] According to Sheldon Segal, a population scientist, half of these unintended pregnancies—1.5 million—occur when contraception is not being used (136). Given that 5 million women who are fertile and sexually active do not contracept and that there is an 85 percent chance of becoming pregnant if no contraception is used, one would expect an annual number that is closer to 4.25 million for unintended pregnancies that result because contraception is not used (The Alan Guttmacher Institute 2008b; Hatcher 2004, foreword). Perhaps the reason for the difference in these two estimates is that not all women are sexually active on a regular basis; they may have cycles of high sexual activity and then cycles of no sexual activity. The failure rates for contraception (i.e. the likelihood that one would get pregnant) are based on a one year period of sexual activity. Underreporting and difficulty gathering accurate data may also factor into a difference in estimates. Regardless of the exact number, failure to contracept leads to millions of unintended pregnancies each year.

But failure to contracept only accounts for half of all unintended pregnancies. The other half occurs when people are using contraception. There are various factors that contribute to unintended pregnancy while using contraception including incorrectly and/or inconsistently using contraception, high failure rates for typical use of non-

[35] This number most likely does not include women have a planned, but unwanted pregnancy. That is, women whose male partners pressure, coerce, or force them to become pregnant. These pregnancies are intended, but only by the male partners, not by the women.

LARCs, and high discontinuation rates of all types of contraceptives (Table 2; Nass and Strauss 125-6). That so many—1.5 million annually—unplanned pregnancies occur while people are contracepting is worrisome (Segal 2003, 136). One way to reduce these unintended pregnancies is to provide better contraceptive education. Another is to encourage people to use LARCs, since they are the most effective type of contraception. I discuss both of these strategies in chapter 7.

Another strategy, which is the focus of this chapter, is men contracepting. If men contracepted, the rates of unplanned pregnancies for people who do not contracept would go down since one partner would now be contracepting. The rates of unplanned pregnancies for people who do contracept would also shrink if the couple was only relying on a female contraceptive, as using two forms of contraceptives is more effective than just one. I will recommend ways to encourage men to contracept in chapter 7. Here, I argue that, according to the principle of nonmaleficence, men have a moral duty to contracept if their actions (past, present, or future) could harm others. Instead of looking at potential beings—future fetuses or future children—as I did in the previous chapter, I focus on the harms inflicted on people who already exist, women. As in the last chapter, I am limiting the types of harms I examine to health-related, social, and economic harms. The main harm I am concerned with is unintended pregnancy, for it leads to these other types of harms. Furthermore, I am interested in unplanned pregnancy because men play a causal role in its existence, like they do for various harms to fetuses and children.

To be clear, I am only discussing unintended pregnancies in this chapter. The moral duty to contracept is not at play in intended pregnancies since they are presumably

wanted and planned for by both partners.[36] I am assuming that the majority of unintended pregnancies are not actively or consciously desired by the people involved, at least at the time of conception. Of course, some women (e.g. women who were told they would never become pregnant, but they always wanted biological children) are thrilled to discover that they are accidentally pregnant. However, these women are in the minority. Most women are unhappy to find out that they are pregnant since they did not want to have a child (at least at that time), which is the reason why they were not planning on becoming pregnant. That 40 percent of unintended pregnancies end in abortion is evidence that many of these pregnancies are not wanted (The Alan Guttmacher Institute 2008a).[37]

While my distinction between intended (that is, wanted) and unintended (that is, unwanted) pregnancies may be slightly simplistic and hence not accurate for all cases, making such a distinction is very important for my argument in this chapter. I argue that unintended pregnancies in and of themselves constitute a harm to women because of the potential health, social, and economic harms they entail. While planned pregnancies also typically involve similar harms, that women autonomously choose to become pregnant is significant. Women who are unintentionally pregnant did not autonomously choose to become pregnant, making these harms a forced imposition rather than a foreseeable possibility of an actively chosen decision. Philosophers and laypeople often categorize things that are forced upon us as harms, such as rape and slavery, because they take away our self-determination. Unintended pregnancy also fits in this camp since it too diminishes one's agency.

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[36] However, there are other moral duties for people trying to conceive, as discussed in the previous chapter.

[37] We can probably assume that more unintended pregnancies would end in abortion if access to abortion services was more convenient, inexpensive, and less stigmatized.

My language in the previous paragraph implies that someone or something is forcing unplanned pregnancies onto women. Who then is this agent? In some cases, there is no identifiable agent to pinpoint. Even perfect compliance with contraception can result in a pregnancy. In such a case, it is just a matter of bad luck. In other cases, however, an agent can be identified. Some may suggest that women "force" unintended pregnancies on themselves by making poor contraceptive decisions (e.g. failing to contracept, inconsistently contracepting, using a less effective contraceptive, etc.). While women are and should be held responsible for contraception, their ability to control contraception is sometimes limited in heterosexual relationships within a patriarchal society. In these situations, those who are restricting women's autonomy—namely men and the government—are the agents who are forcing unintended pregnancy upon women. Here I will focus only on men's role in unintended pregnancy; I will return to government's role in chapter 7.

This chapter is divided into five sections. In the first section, I outline the harms associated with pregnancy, motherhood, and abortion in order to demonstrate that the harms to women that result from unintended pregnancy are real and serious. Referring to a recent Michigan court case that defined pregnancy as a form of "bodily harm," I discuss the impact pregnancy has on women's health. If women choose to carry their pregnancies to term, then they face numerous potential harms as mothers. There are also harms for women who decide to terminate their pregnancies. I argue in the second section that men have a moral duty to prevent the harms of unintended pregnancy because they are (at least partially) causally responsible and because they are aware of the potential harms of unintended pregnancy. Furthermore, I claim that the harms men may face in

contracepting—using current methods or future hormonal methods—are not unreasonable or unfair. In the third section, I draw from the work of Catharine MacKinnon and Andrea Dworkin to show how in a patriarchal society, men not only control sex, but they also use sex to objectify and subordinate women. I continue this argument in the fourth section, asserting that this power difference impedes women's ability to contracept. I contend that men have a moral duty to contracept both because their failure to contracept can harm women and because their privileged social positioning enables them to more easily contracept (that is, they face fewer obstacles in trying to use contraception). In the fifth section, I examine the specific case of whether men in monogamous (heterosexual) relationships also have a duty to contracept even if their partner already uses contraception. I identify two reasons why it is problematic for couples to make contraceptive responsibility just the woman's job: it reinforces a gendered division of labor and it demands another type of bodily invasion from women.

## Harms Associated with Pregnancy, Motherhood, and Abortion

### Harms Associated with Pregnancy

One the one hand, it is undeniable that pregnancy and motherhood are wonderful experiences for many women. On the other hand, however, even planned pregnancies have the potential to cause various types of harm, including bodily, mental, social, economic, interpersonal, and moral. In the global South, the leading cause of death for women in their prime is complications from pregnancy. Although only one percent of deaths from pregnancy occur in the global North, mainly due to better access to basic services (e.g. nutrition, health care), pregnancy can still result in bodily harm and medical

conditions (Mann 769). Following precedent from a previous judicial decision, the recent Michigan court case of *People v. Cathey* concluded that pregnancy is a form of bodily injury. Defining bodily injury as "physical damage to a person's body," the court stated that

> by necessity, a woman's body suffers "physical damage" when carrying a child through delivery as the body experiences substantial changes to accommodate the growing child and ultimately to deliver the child....These types of physical manifestations to a women's body during pregnancy and delivery clearly fall within the definition of "bodily injury," for the manifestations can and do cause damage to the body. (*People v. Cathey*)

Indeed, pregnancy can entail various nontrivial, though not life threatening, discomforts, such as weight gain, back pain, edema, and morning sickness. Furthermore, pregnancy can lead to life threatening conditions, such as gestational diabetes and hypertension. In addition to being painful, giving birth can also cause harms, like hemorrhaging, internal tearing, placental abruption, and nerve damage to the pelvic structures. In addition to physical harms, pregnancy and childbirth also have the potential to lead to mental health problems. Since being pregnant changes women's hormone levels, it can affect women's emotional well being and their overall psychological balance.

Claiming that pregnancy is inherently physically (and perhaps mentally) damaging is controversial. It is this sort of thinking that is often behind the treatment of pregnancy as a disease or disability. While pregnancy shares some similarities with disease and disability (see Mullin 2005a, ch. 2), my intention is not to classify it as either a disease or disability. Nor is my goal to support the conclusion reached in *People v. Cathey* that pregnancy is necessarily a bodily harm.

Rather, I merely want to point out the strong likelihood that pregnancy will lead to something we typically consider to be bodily harm. In our pronatalist culture, the dominant cultural view of pregnancy is that it is a positive event, and so the media, literature on pregnancy and motherhood, and even some health care professionals rarely classify the manifestations of pregnancy as harm. Furthermore, pregnant women rarely describe themselves as being harmed by their pregnancies (pregnancies that result from rape are a notable exception). However, most people would apply such a label if nonpregnant people experienced identical symptoms, so there is a double standard here: when pregnant women experience certain symptoms it is thought to be normal and therefore not harmful, yet when nonpregnant people have the same symptoms most people recognize them as harms and treat them accordingly. The reason often given to explain this discrepancy is the following: since women know that potentially harmful symptoms often accompany pregnancy and they still choose to get pregnant (or, at least, stay pregnant), their symptoms are not considered harms because they were autonomously chosen. Yet, even though women may choose to become pregnant this does not mean that they choose to have negative health effects, nor does it mean that they like or deserve these health effects.[38] Just as women use contraception despite its adverse side effects because it enables them to achieve their goal—not getting pregnant—so too may women choose to become pregnant even though there is the possibility of negative health outcomes because it is a way to attain their end of having a baby. Furthermore, since 50 percent of all pregnancies are unintended, many women are not autonomously

[38] According to some Christian scholars, all women deserve the negative side effects of pregnancy and labor because of Eve's original sin. For example Cardinal Robert Bellarmine states: "Wherefore the punishment of the sin is that women bear the fetus in the womb with disgust and labor, that they give birth with pain."

choosing to become pregnant. While some may want to label these women irresponsible and hence deserving of the side effects of pregnancy, I find this claim overly punitive. Moreover, this line of thought only confirms my claim that there are some serious harms associated with pregnancy.

Although all pregnancies have the potential to lead to serious physical and mental harms, it seems likely that unplanned pregnancies could be more risky than planned pregnancies. Women who are attempting to get pregnant are probably carefully monitoring their bodies for any sign of pregnancy. In contrast, because they are not actively trying to become pregnant, some women may not realize they are pregnant until they are further along in the pregnancy (or in some rare cases, until they give birth) in part because it is not something they expect to happen. Moreover, a small number of women who were not intending to become pregnant deny their pregnancies altogether (see Lundquist). The risk to women who are unintentionally pregnant is that in delaying or forgoing medical treatment, potential medical problems may go unrecognized and untreated. Women who were not planning on becoming pregnant may not feel emotionally equipped to handle the physical and mental manifestations of pregnancy as well as the idea of becoming a mother. It is not surprising then that such women are more likely to become depressed during pregnancy than women who are intentionally pregnant (Nass and Strauss 1). Women who are unintentionally pregnant are also at greater risk for other harms, including domestic abuse, as their male partners may be unhappy to find out that they are pregnant (ibid.)

## Harms Associated with Motherhood

The result of carrying a pregnancy to term—becoming a mother—can also lead to health problems, such as exhaustion, depression, and sore nipples from breastfeeding. Further, if we employ the World Health Organization's definition of health—"a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity"—then being a mother can adversely affect women's mental and social well-being (WHO Constitution, Preamble). Women comprise the vast majority of primary caretakers for children, a demanding and undervalued role that not only can lead to stress, but also can be socially isolating. Full time homemakers spend most of their time at home or in other gendered spaces where children are welcome, such as malls and playgrounds. Caring for children limits women's mobility, thereby minimizing and even precluding their involvement in the public realm, such as town meetings, academic lectures, social events, and public employment.

In addition to the health and social harms women can experience as a result of motherhood, there are also economic harms. These harms are often exacerbated for women who were not planning to have a child and thus have not made any economic preparations for such an event. Having a child in high school or college often makes it more difficult for women to complete their education, thereby diminishing better paying job opportunities. For working women, balancing employment and childcare is generally both economically stressful and emotionally exhausting. Many working women do not have family or friends to watch their children, so they turn to daycare, which is expensive: the average cost for an infant is $3,803 to $13,480 a year in the U.S. For a two-parent household, the cost of daycare is 10% of their household income. For single

parents, it is a staggering 30% of their income (Gruber). Furthermore, many U.S. women cannot take the time off they would like to after giving birth because they cannot afford to take unpaid leave. The U.S., Liberia, Papua New Guinea, and Swaziland, are the only countries in the world that do not mandate paid leave to new mothers (Stringer 4-5). Furthermore, the U.S. does not require employers to offer flexible time to its employees, exacerbating women's struggle to balance work and children. Sadly, "The United States is alone among developed countries, and virtually alone in the world, in its failure to support working parents and their families through flexible time and leave policies" (Stringer 1). This lack of governmental support deleteriously affects women's emotional, physical, and economic well-being, and this is especially the case for women who are poor and/or single. Indeed, the sheer cost of raising a child is overwhelming for many people and is even worse for women working pink collar jobs and women who do not receive financial assistance from their children's fathers. That the government does not assist all women and that those it does help are given minimal aid (e.g. Medicaid and welfare) leaves the majority of women vulnerable to the harms of working full time and mothering full time.

**Harms Associated with Abortion**

In addition to the harms associated with pregnancy and mothering, that there can also be harms for women who decide to end their pregnancies. Choosing to have an abortion is a difficult decision for some women, one that often elicits feelings like guilt and shame. Plus, there is a stigma attached to having an abortion; it is generally not something one openly shares with others, even if one needs to talk about it. In addition to

the social and emotional effects, abortions can range from physically uncomfortable to deadly depending on who performs the procedure. Since abortions are illegal in various countries, women have to risk legal repercussions to have the procedure. Even in countries where abortion is legal, it is often difficult for (adult) women to get an abortion due to cost, distance from abortion providers, gestation limits, and harassment from anti-abortion protesters (see Finer and Henshaw for more details). Women under the age of 18 face even more obstacles, including parental notification laws. A third of insurance companies do not cover abortion, so women are forced to pay out of pocket for a procedure that averages $341 to $1,067 (in 1995 dollars), depending on weeks of gestation. Even when abortion is covered, some women decline to use their insurance company because of confidentiality concerns, especially if their insurance is through someone else, particularly their parents or partner (Finer and Henshaw 57). In short, there are many challenges and potential harms women must deal with when they decide to have an abortion. These harms are not inherent to abortion. Rather, many of them are culturally created and mediated. In a society that accepts abortion, women would not have to overcome many of the aforementioned obstacles and thus abortion would be much less likely to cause harm.

### Men's Moral Duty to Prevent Unintended Pregnancy

The harms associated with abortion, pregnancy, and motherhood are well known. Because men causally contribute to pregnancy and they know that sex can lead to pregnancy and all its potential harms, they are morally responsible for such harms if they do not try to prevent them. There are only two ways for men to prevent the harms

associated with pregnancy: abstain or contracept. Thus, men who are sexually active have a duty to contracept according to the principle of nonmaleficence.

Given the myriad and sometimes extreme nature of the possible harms from pregnancy and motherhood, claiming that men should contracept does not seem unreasonable. That is, what is required of men to prevent pregnancy does not seem disproportionate to potential harms caused by pregnancy. As argued in the previous chapter, in order for the principle of nonmaleficence to be justly applied, the harms we incur in preventing harm must be less significant than the harms we could cause to others if we did not try to prevent harm. Men's moral duty to contracept to avoid unintended pregnancy is fair: the harms women may face from unintended pregnancy are much more serious than the harms men may experience from contracepting. Currently, the only reversible contraception men can use is the condom and the drawbacks to using a condom are minimal: small cost, minimized pleasure (for some men), and interrupting sex to put it on.

As a way of strengthening my claim that men have a moral duty to prevent harm, let us examine an analogous situation. Imagine that Sanjay has Chlamydia, a reversible and easily treatable STD. I contend that most people would claim that when Sanjay has sex with his partner, Olga, who does not have Chlamydia, he has a duty to wear a condom to prevent Olga from acquiring the disease. The reason for this is that Sanjay should avoid knowingly harming others (and perhaps in particular people with whom he has a close relationship). He knows that having unprotected sex would probably result in infecting Olga with Chlamydia. While Chlamydia is medically treatable, it can be a painful disease and one that can lead to serious consequences, including pelvic

inflammatory disease and sterility. Moreover, many women who have Chlamydia are asymptomatic and by the time they find out they have the disease, permanent damage has been done. Even if one discovers that one has Chlamydia immediately and avoids any permanent damage, there are other harms involved with contracting this disease, such as the cost of seeing a doctor and paying for the medication (especially if one is uninsured), the emotional stress of having this disease, and the effect on one's interpersonal relationships (especially with the partner from whom the disease was acquired). Given the potential harms Chlamydia poses, Sanjay should wear a condom to prevent Olga from experiencing these harms. Requesting that he wear a condom seems like a minor sacrifice in comparison to the magnitude of possible harms. If Sanjay did not wear a condom and Olga contracted Chlamydia, most people would hold him morally responsible because he knowingly inflicted a harm upon her that he could have easily prevented. And, in fact, some governments might even hold him legally accountable, though most cases involving legal repercussions for STD transmission center on HIV. For example, in 2006 "the California state Supreme Court ruled that 'constructive knowledge'—when it is reasonably foreseen by a reasonably intelligent person that their actions could lead to harm—of the possibility that HIV transmission may occur, is enough to allow for civil liability." Taking it one step further, the highest court in Switzerland proclaimed in July 2008 that all people with HIV can be criminally liable for spreading the disease, even if they are unaware that they have it (Bernard).

While many may agree that condom use is a fair burden for men to take on in order to prevent unintended pregnancy, some may question whether vasectomy and future hormonal methods are also fair burdens. The concern here is that hormonal

methods typically involve more bodily invasion and entail worse side effects. First off, it is important to note that even though vasectomy and future hormonal methods may be more effective than condoms, men do not have to choose one of the latter methods to act according to the principle of nonmaleficence. What matters is that they choose a method that they believe is the best choice to prevent pregnancy given their values and the circumstances. Clearly, we might be suspicious of an educated man in the U.S. who decides that his contraceptive method will be to eat ice cream daily.[39] Most people would regard him as not taking his contraceptive responsibility seriously. But if a man prefers using condoms—a method that has been empirically shown to significantly reduce the probability of unintended pregnancy—to other male methods, then he is upholding his moral duty to contracept even though he is not using the most effective form of male contraception.

Even though male hormonal methods are years away from hitting the market, I want to examine whether the burdens they entail are justifiable according to the principle of nonmaleficence. However, this is somewhat difficult to do since there is limited information about what the burdens of these male contraceptives are. Some reports say there are few or no serious side effects, while others warn of prohibitive side effects. On the one hand, scientists have developed a male injectable contraceptive that has no short-term side effects and a type of male contraceptive pill that does not show any long-lasting side effects (Scott 1; No author April 29, 2006). On the other hand, some scientists are concerned about the side effects of testosterone—a commonly used component in male

[39] Different cultures may have different beliefs about what is the best way to contracept. While I know of no culture that claims that ice cream works as a contraceptive, I want to allow for various cultural perspectives. The social context I am focusing on is the U.S., where ice cream is not considered an effective form of contraception, but condoms generally are.

contraceptives—that can include decreased levels of HDL ("good") cholesterol, the potential to contribute to prostate cancer, and effects similar to steroids such as lean muscle weight gain, acne, and temporary shrinking of the testes (Nuzzo F3). Additionally, another potential contraceptive worries some: a male contraceptive that is being researched after scientists realized that some drugs that treat schizophrenia and high blood pressure also prevent ejaculation. Journalist Fiona Macrae states that "side-effects including dizziness and drowsiness mean these medicines could not be marketed as contraceptives."[40] Although the lack of an ejaculation does not affect the quality of orgasm, urologist Harry Fisch, claims this side effect will prevent many men from considering this contraceptive: "I don't think a lot of men are going to take this ... The ejaculate coming forward is a significant part of a man's sexuality" (Macrae; Fisch quoted in Traister). Even with this limited information about male LARCs, it is clear that the side effects are more significant than with condoms. This is not surprising since hormonal methods for women tend to have more dangerous side effects. Most of the male LARCs under research are hormonal methods; one notable exception is the Intra Vas Device (IVD), "four flexible cylinder-shaped, medical-grade silicone pieces designed to block sperm from traveling through the vas deferens" (Randle).

Let us assume that the side effects for male hormonal methods are comparable to those for female methods. Are the burdens of hormonal methods too great in comparison to the possible harms of unintended pregnancy to justify their use as a way of fulfilling men's moral duty to prevent harm? Let us return to the example of Sanjay and Olga to respond to this question. Chlamydia is easily treated and cured with antibiotics. Is it fair

[40] I am not clear, and Macrae never explains, why these side effects prevent this drug from being used as a contraceptive. One of the concerns with contraceptives is that they are taken over a long period of time, but so are drugs to treat chronic conditions like schizophrenia and high blood pressure.

for Sanjay to undergo antibiotic treatment to prevent transmitting Chlamydia to Olga? Legally, Sanjay has the right to refuse medical treatment. Furthermore, he cannot be legally compelled to bodily invasion for the sake of another as decided in the Pennsylvania court case of *McFall v Shimp*.[41] Robert McFall took his cousin David Shimp to court to mandate that Shimp provide him with the bone marrow transplant he needed to live. The judge ruled that our right to bodily integrity supersedes the medical needs of others to use our bodies, even if it is a matter of life and death:

> Our society, contrary to many others, has as its first principle, the respect for the individual, and that society and government exist to protect the individual from being invaded and hurt by another. ...For our law to compel the Defendant to submit to an intrusion of his body would change every concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual and would impose a rule which would know no limits. (*McFall v Shimp*)

While we cannot and should not legally force Sanjay to take antibiotics, taking antibiotics to ensure that Olga does not acquire Chlamydia does not seem overly burdensome. I am not claiming that Sanjay must take antibiotics instead of or in addition to using condoms. Again, my position is that he has a moral duty to prevent harming Olga and there is more than one way for him to fulfill this duty (e.g. condoms, antibiotics, abstinence). In contrast to the potentially serious symptoms of Chlamydia, the majority of common side effects of antibiotics are mild, such as nausea, diarrhea, and increased sensitivity to sunlight. However, some people have some severe reactions that can be life-threatening, usually due to allergy (WebMD). Additionally, antibiotics are typically taken for a matter of days, whereas the health consequences of Chlamydia can last a lifetime. While there is no doubt that taking antibiotics involves more bodily invasion than

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[41] Pregnant women are sometimes not afforded the right of bodily integrity, as seen by the history of forced c-sections in the U.S., most famously the case of Angela Carder (see Minkoff and Paltrow).

condoms, given the short duration of treatment and the minimal side effects, the harms of antibiotics seem much less than the harms of Chlamydia. One more point: taking antibiotics also behooves Sanjay, so it is not as though he is expected to be self-sacrificing. In sum, antibiotic treatment is a fair way for Sanjay to prevent spreading Chlamydia to Olga.

For many of the same reasons, using hormonal contraceptives is a fair way for men to prevent unintended pregnancy. The harms of unintended pregnancy are typically greater than the harms of contraception and men are (at least partially) causally responsible for pregnancy. Men who contracept are usually not doing so just for the sake of their partners; that is, they are not being self-sacrificing. Men often use contraception for other reasons as well, such as to prevent harm to themselves and to their potential fetuses and children. So, it is not the case that most men are motivated to contracept only because of their partners. They experience personal benefits in assuming contraceptive responsibility, including the ability to control their fertility and sometimes protection against STDs. Additionally, just like in my example of Sanjay, men can choose to wear condoms to prevent harm rather than taking a medication that involves more potential sides and more bodily invasion.

Some may reject this analogy of treating Chlamydia via antibiotics to using hormonal methods to prevent unintended pregnancy for a couple of reasons. First, the duration of use for antibiotics is short, while hormonal methods are used indefinitely. However, while this is true for female hormonal contraceptives, researchers are developing a male hormonal contraceptive that is taken before sex rendering men infertile for only a matter of hours (Macrae). Even if this short-term contraceptive is never

available to the public, it is not unreasonable for men to use a long-acting contraceptive given the long-lasting nature of the harms of unintended pregnancy, especially the social and economic challenges of raising a child. I do not want to imply a simplistic tit-for-tat comparison: the effects of unintended pregnancy are long-term, so it is fair that men contracept for the long-term. At the same time, however, comparing the duration of effects is important to get a sense the overall severity of the harms. While the economic and social challenges of being a parent sometimes never completely disappear, if male hormonal methods are similar to female hormonal methods, then their adverse side effects are likely to abate after a few months.

Second, the side effects of LARCs are probably more severe than those of antibiotics. This may or may be true depending on the type of male contraceptive. Even if it is true, the harms of unintended pregnancy are generally more serious than those associated with contraception, which may make the harms men take on justifiable. Furthermore, if at least some of the male contraceptives currently being researched become available to the public, men will have a choice in which one to use. Thus, like many women do now, they can try different types of contraceptives to see which one they like best and hopefully find one that has few or no side effects for them.

Assuming that the side effects of male hormonal contraceptives will be similar to those in female hormonal contraceptives (as I have), the harms men would take on in contracepting are justifiable in comparison to the harms of unintended pregnancy not only for women, but also for men and potential fetuses and children. Given that the harms of the currently available male contraceptives are generally much less serious than the harms associated female hormonal contraceptives, men who rely on these methods (e.g.

condoms and vasectomy) to fulfill their duty to prevent harm are not unduly burdened. In sum, the harms men may face in fulfilling their moral duty to prevent unintended pregnancy by contracepting are just.

## Unequal Power Relations Regarding Sex

Some may object to my overall argument so far and claim that it is women's, not men's, responsibility to prevent the harms of unintended pregnancy by using contraception. For many of the same reasons I have outlined for men, I agree that women should use contraception: not contracepting can harm both themselves and potential fetuses. That women also have a duty to contracept does not minimize or eliminate men's duty. Contraception is not a zero sum game in which if one person has a duty to contracept the other person does not. In short, both can have a simultaneous duty to contracept. While some may agree that both women and men have a duty to contracept, they still may insist that women's duty is stronger because pregnancy is something that only women experience. In other words, according to the dominant ideology, women should be the ones contracepting since "Pregnancy 'happens to them,' therefore they must 'protect themselves'" (Stubblefield 82). It is true that pregnancy is something that only happens to women; however, women alone are not causally responsible for it. Men also causally contribute to pregnancy (except in the case where women use anonymous donor sperm or where men's sperm was taken by force or by fraud). The fact that pregnancy "happens" to women does not mean that they are fully (or even more) responsible for preventing it. If anything, the opposite should be true: men should be held just as responsible or even more responsible for inflicting a potential harm on women

because this would be consistent with the general social pattern of assigning blame and taking legal action.

It is a common intuition that people are more concerned when their actions adversely affect others than when their actions only affect themselves, especially when the others are vulnerable or less powerful in some way. In other words, harming oneself or someone who is not vulnerable or less powerful in comparison does not generate moral outrage like harming someone vulnerable or less powerful does.[42] As an oppressed group, women have less power (e.g. political influence, access to resources, financial independence) overall as well as in the case of contraception. Even though there is this power imbalance, there is little to no moral outrage toward men who do not contracept (and thereby risk harming women). Part of the reason for this is due to the dominant ideology that women should be the ones contracepting. But it seems that a more subtle and subconscious motivation contributes as well: expecting women to contracept reinforces patriarchy by absolving men from responsibility and by usually blaming women for contraceptive mistakes (i.e. unintended pregnancy). This is the same sort of "blame the victim" rhetoric used to fault women for staying with their abusers and for "instigating" rape while simultaneously minimizing or ignoring men's roles and responsibilities. Many feminists have argued that blaming women for such events is unfair since women are not causally responsible for them; rather, they are a result of men's actions within a patriarchal power structure. I extend this argument to contraception. I am not positing that women have no control over sex, a claim that

[42] The saying "pick on someone your own size" reflects this concern for the less powerful. Until the recent Supreme court case *Kennedy v. Louisiana*, six states allowed the death penalty for child rape. That these states did not permit the death penalty for adult rape implies that violence against someone more vulnerable (and perhaps someone perceived as more innocent) is considered a more heinous offense (Greenhouse).

implies that women lack agency altogether in sexual matters. Rather, drawing on the work of Catharine MacKinnon and Andrea Dworkin, I argue that women's sexually subordinate positioning makes using contraception more difficult. In contrast, men face fewer barriers in contracepting because they tend to control sex (and women).

MacKinnon and Dworkin persuasively argue that under a system of gender inequality, men not only control sex, but they also use sex to dominate women. From an early age, girls absorb that they and their sexuality are defined by male use. MacKinnon states:

> Gender socialization is the process through which women come to identify themselves as such sexual beings, as beings that exist for men, specifically for male sexual use. It is that process through which women internalize (make their own) a male image of their sexuality as their identity as women, and thus make it real in the world. (MacKinnon110-111)

Through gender socialization, girls and women "train" to be sex objects for boys and men by learning the "right" (read: patriarchal) ways to dress and act and the "right" desires to have. For example, women realize that dressing in a feminine and sexy (but not too sexy) way will often result in positive male attention, whereas dressing androgynously typically leads men to ignore or mock them. As this example shows, women who succeed in being "real" women, that is, feminine women, are socially rewarded and those who do not are socially punished or ostracized. This example should not lead one to think these social rewards and punishments are trivial. The opposite is true: the rewards are often social goods (e.g. food, money, shelter) that ensure a certain quality of life and sometimes life itself, while the punishments are serious harms, like violence, rape, and even death. These rewards and punishments are ubiquitous and often extreme in order to ensure women's compliance with their sexual subordination. Indeed, through these rewards and

punishments, as well as gender socialization and cultural influences more generally, women learn not just to objectify themselves, but also to understand and identify themselves as objectified beings. This internalization of her own objectification reduces a woman's autonomy, for "conform[ing] in body and type and behavior and values to become an object of male sexual desire ... requires an abandonment of a wide-ranging capacity for choice" (Dworkin 139). In accepting themselves as objectified, women limit themselves to prescribed gendered social norms and roles. Furthermore, they actively reinforce their own objectification through their choices and beliefs, and through their often vehement rejection of feminism. As Dworkin sardonically remarks, objectification (and, more generally, patriarchy) "is the best system of colonialization on earth: she [all women] takes on the burden, the responsibility, of her own submission, her own objectification" (142).

Additionally, men generally play a significant role in women's objectification and subordination. One of the main ways men dominate women is by controlling their bodies; for example, limiting their mobility, denying them reproductive rights, restricting their options in the public realm, and, most importantly for my purposes here, controlling sex. According to Dworkin, men "use the fuck to create and maintain a social system of power over women, a social and political system in which the fuck, regulated and restrained, kept women compliant, a sexually subjugated class" (Dworkin 159). In order to uphold patriarchy, men reduce women and their bodies to objects—commodities—that they possess and control. "Women's sexuality is, socially, a thing to be stolen, sold, bought, bartered, or exchanged by others. But women never own or possess it" (MacKinnon 172). Even mundane and seemingly innocuous examples of heterosexual

interactions are based on men's dominance and ownership of women's bodies. For example, when a man takes a woman on a date and pays for everything, he often assumes that he will receive some form of sexual compensation—a sentiment summed up by the crude saying "he pays, she puts out." What motivates his belief that he deserves sex is the understanding of her body as something that he can (perhaps indirectly) purchase. This example shows that blatant and sometimes illegal examples of women's objectification, such as rape, pornography, and prostitution, and women's everyday and legal realities are part of the same continuum. Both the extremes and everyday realities systemically instill in women their inferiority and subservience to men by conveying certain messages about women's bodies: that their bodies are objects controlled by others and that their worth is limited to the bodily functions (e.g. sex, reproduction) they can provide for men. The everyday examples of women's objectification are, in some ways, more insidious than the extreme examples because they normalize men's access to women's bodies, thereby teaching men that they are entitled to women's bodies and teaching women that their bodies belong to men. Moreover, the normalization of women's objectification ensures women's subordination: "The legal fuck helped to create compliance by defining the woman's body as breachable, owned through the fuck" (Dworkin 159).

**Women's Subordinate Positioning Affects Their Ability to Contracept**

So far I have argued that women's objectification simultaneously reduces women's autonomy and grants men power over women's bodies. How does this power dynamic affect contraception? Because women have diminished bodily autonomy, they are often not the ones making contraceptive decisions. Social science research confirms

that the larger the power differential between women and men, the less control women have over their bodies and, specifically, their ability to contracept. In other words, relationships that conform to "traditional" (read: sexist) gender roles—ones in which men have significantly more power than women—typically limit women's ability to contracept. For example, a study in Oman, a highly gender-stratified society, showed that men alone decide whether or not they and their wives will use contraception in nearly half of all relationships (Al Riyami et al. 151). Even in less gender-stratified societies, like the U.S., studies have shown that men who uphold sexist gender roles are more likely to believe that they should be the ones making contraceptive decisions (Grady et al. 1996, 224). Moreover, "the higher the status of the man, the more likely he is to view himself as the dominant decision-maker, while the higher the status of his partner, the more likely he is to adopt a view of her as either an equal or as the dominant decision-maker" (Grady et al. 1996, 225). In relationships where there is a significant power differential and the man clearly sees himself as dominant, such as relationships involving physical violence and relationships in which the man is much older than the women, nonuse of contraception is higher (Manlove 271).

Overall, the general pattern of contraceptive use is that it is lower among women in unequal relationships than women in egalitarian relationships (Hartmann 52). Looking at gender ideologies and women's objectification help explain why this is the case. Men in unequal heterosexual relationships are more likely to uphold dominant gender ideologies. (The women in such relationships may not agree with such ideologies, but may be pressured or coerced into following them. However, there are women who strongly believe in such ideologies, such as conservative women and deeply Christian

women in the U.S.) Men in such relationships are likely to assert themselves as the dominant decision-maker because they have learned that men are more capable of making good decisions than women. Furthermore, these men may feel responsible for protecting their female partners, which they may interpret as making decisions for them. Part of what motivates many men to "protect" women is the gendered imagery of the knight in shining armor saving the damsel in distress; that is, the cultural belief that men are strong and brave, while women are weak and helpless. Additionally, women's objectification—the view of women's bodies are objects for men to possess and control—also leads some men to think that they are justified in making decisions about women's bodies because they "own" or have some sort of claim over women's bodies.

Yet, even for women in more egalitarian relationships, who ostensibly have the power to use contraception, there are subtle factors at play that diminish their autonomy and ability to demand contraceptive use. Women are socialized to be passive, to defer to men's judgments, and to believe that their bodies belong to men. Consequently, when a woman is making a decision about contraception (whether or not she has discussed it with her partner), there is a good chance that she will acquiesce to his opinion because she wants to please him both. Indeed, empirical evidence reveals that men's attitudes and preferences play a significant role in women's contraceptive use and contraceptive choice (Nass and Strauss 117). This is especially the case when decisions about contraception are determined during sex rather than beforehand. Studies in the U.S. have shown that women are more likely to "jeopardize contraceptive protection for an intimate male partner" (Manlove 272).[43] As previously discussed, one of the social norms for women is

[43] This same pattern seems to be at play in other cultural settings as well. For example, a study on contraception use by university students in China revealed that 47 percent of women would consent to have

that they be self-sacrificing, especially with their children and male partners. It is therefore not surprising that studies demonstrate that a large number of women and more women than men are willing to sacrifice their own protection from pregnancy and STDs for the sake of their partner. Put differently, many women choose their partner's desires over their own safety.

Prioritizing their partners over themselves can lead women to consent to sex they do not want, and more specifically, sex without contraception. Women may rationally consent to unwanted and unprotected sex because they perceive it as their best option. For example, women may have sex to get certain social goods and/or to make their lives more bearable. While women may not consciously understand the systemic nature of gender oppression, they do realize that using their sexuality is a way, and sometimes the only way, of acquiring certain things. That is, they understand that their bodies are objects or goods that they can trade for other objects or goods. "Women have needed what can be gotten through intercourse: the economic and psychological survival; access to male power through access to the male who has it; having some hold—psychological, sexual or economic—on the ones who act, who decide, who matter" (Dworkin 128). Moreover, women recognize, at some level, the power dynamic at play in their relationships, as many women find abiding by their partners' wishes is easier and better for them (in certain ways) than trying to assert their own wishes. Consequently, women may rationally consent to sex, and, more specifically, sex without contraception. Here I quote Robin West at length because she eloquently identifies some of the reasons women may consent to sex they do not want:

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sex even if their partner refused to use any form of contraceptive (and the women are not using form of long-acting contraception) and 19 percent said they would have sex but would take the morning-after pill (China Post article).

> A woman might consent to sex she does not want because she or children are dependent upon her male partner for economic sustenance, and she must accordingly remain in his good graces. A woman might consent to sex she does not want because she rightly fears that if she does not her partner will be put into a foul humor, and she simply decides that tolerating the undesired sex is less burdensome than tolerating the foul humor. A woman might consent to sex she does not want because she has been taught and has come to believe that it is her lot in life to do so, and that she has no reasonable expectation of attaining her own pleasure through sex. A woman might consent to sex she does not want because she rightly fears that her refusal to do so will lead to an outburst of violent behavior some time following—only if the violence or overt threat of violence is very close to the sexual act will this arguably constitute a rape. A woman may consent to sex she does not want because she *does* desire a friendly man's protection against the very real threat of non-consensual violent rape by other more dangerous men, and she correctly perceives, or intuits, that to gain the friendly man's protection, she needs to give him, in exchange for that protection, the means to his own sexual pleasure. A woman, particularly a young woman or teenager, may consent to sex she does not want because of peer expectations that she be sexually active, or because she cannot bring herself to hurt her partner's pride, or because she is uncomfortable with the prospect of the argument that might ensue, should she refuse. (West 318)

These reasons highlight the double bind women face: either have unwanted sex or suffer potentially serious repercussions. Given their limited control over sex, women often have trouble insisting upon contraceptive use. For example, a woman may worry that asking her male partner to use a condom would make him angry because he would think she wants to reduce his pleasure or that she does not trust him. A woman may be concerned to ask her male partner to wait while she inserts a cervical cap or diaphragm because she knows he gets mad when he does not get what he wants immediately or that he thinks these types of contraceptives reduce his pleasure. A woman may fear asking her partner for money and/or assistance accessing LARCs because she believes he does not want to pay for her contraceptive needs or because he wants to be the one making contraceptive decisions. In sum, the fact that the circumstances surrounding sex are unequal—men

typically control sex (when, why, and how it happens) and women often have sex in order to get social goods or to make their life (more) bearable—means women have diminished ability to use contraception themselves or ask their partners to use contraception.

Other factors that further diminish women's ability to contracept are gendered social norms about chastity and promiscuity. As briefly mentioned in a previous chapter, Anna Stubblefield argues that norms of chastity, which are group-specific for women, discourage women from using contraception due to " the belief that a woman who uses contraceptives has sex frequently and/or is sexually aggressive and therefore has abandoned the traditional role of female sexual passivity" (90). In other words, although women may want to use contraception, they may choose not to because they do not want to be labeled a "whore." Women are stuck in a no-win situation: they often have sex at men's will, yet protecting themselves from certain harms of sex (i.e. pregnancy and STDs) by contracepting is not a palatable option due to the social stigma. Consequently, as Kristin Luker discovered in her well-known study, many women engage in "contraceptive risk-taking" even though they know that not consistently using contraception could result in an unintended pregnancy. Women are generally held responsible and blamed for unintended pregnancies. It is thought to be their fault because they knew unprotected sex could lead to pregnancy and they still chose not to use contraception. Yet, blaming only women is unfair, as doing so not only ignores the role men play in reproduction—further absolving men of contraceptive responsibility—but it also overlooks how the patriarchal structuring of society affects and, more specifically, oppresses women. For example, in order to meet the norms of feminine passivity, women

should not actively plan or prepare for sex but rather wait for men to "swept them off their feet." Likewise, during sex women should not make requests or, worse yet, demands, but instead let men make decisions. These gendered norms contribute to women's oppression by teaching, encouraging, and coercing them to act in a particular way—not contracepting—and then blaming them for the results of that action—unintended pregnancy. In Stubblefield's words, "Social norms such as those in the case of contraceptive risk-taking that assign blame to women for unwanted pregnancies while simultaneously coercing them to engage in premarital sexual intercourse without using contraceptives are oppressive" (85).

Contracepting is easier for men because, unlike women, they do not face norms of chastity. Gender ideologies suggest that it is normal (and hence good) for men to be sexually active and so preparing for sex by carrying condoms does not carry the same sort of negative connotation that it does for women. In fact, men who carry condoms are likely to receive a positive response for being "studs," that is, for being sexually active and even promiscuous. However, men who use contraception contradict another gender ideology: men are supposed to be so tough that they do not need protection, including protection against pregnancy (and STDs). While men may feel "feminine" or "weak" for using contraception, that they are (heterosexually) active somewhat counters any perceived weakness, as having sex is an important signifier of their masculinity. Moreover, men who contracept often reap social benefits since women may see them as "sensitive" and "responsible," as men who care about their female partners and take action to protect them. In other words, by contracepting, men fulfill the cultural expectation that men should care for and protect women.

Men's privilege enables them to more easily contracept both because they are equipped with the power and confidence to make such decisions and because they face fewer obstacles and disadvantages in doing so. In short, the reason it is easier for men to contracept is due to an unjust social structuring, oppression. The word "easier" should not mislead readers to think that men have only a minimal advantage, like a one inch height difference in a slam dunk contest. Men's advantage is hugely significant. It is systemic, permeating every aspect of their lives and granting them rights, privileges, and power—typically at women's expense. As discussed in chapter 2, women unfairly bear most of the burdens for contraception. In order to achieve a more egalitarian contraceptive situation, men too must contracept. Indeed, since men contribute—perhaps inadvertently or unknowingly—to this unfair contraceptive arrangement, they should work to alleviate it. And considering men's privileged positioning, they have the potential to make great changes.

**Why Men in Monogamous Relationships Have a Duty to Contracept**

Some may claim that it is not always necessary for the man to contracept; it is sufficient for the woman to contracept in a monogamous relationship if the couple has discussed it and sees this as their best option. Couples may believe that using condoms in addition to a more effective, LARC is not worthwhile due to cost, potential decreased pleasure, minimal extra protection against pregnancy, etc. If couples think it is only necessary for one person to contracept, it makes sense why they would choose the woman given the greater variety and more effective forms of female contraceptives. However, I am concerned that the disparity in female and male contraceptives will

continue to serve as an excuse to saddle women with full contraceptive responsibility. In other words, my worry is that men will be able to absolve themselves of contraceptive responsibility due to the lack of equally effective male LARCs. I advocate for the development of LARCs for men to ease the contraceptive burden women currently face. If there were LARCs for men available, then sharing contraceptive responsibility would hopefully be a more palatable and real option.

In the meantime, until these male contraceptives become readily available, do men in monogamous relationships have a duty to contracept? Some may argue that such men do not have a duty to contracept so long as they take responsibility in other spheres. This position relies on the belief that it is acceptable for couples to split responsibilities—she weeds the garden, he mows the lawn, she cooks dinner, he washes the dishes, and so on—if they do so fairly. Many couples are able to divide their responsibilities so that neither partner has more time-consuming, physically difficult, or emotionally demanding tasks than the other. Prima facie, adding contraception to the list of responsibilities to split seems like a good idea. However, I think there are a couple of problems with this solution. First, depending upon how the tasks are divided, couples many be perpetuating traditional gender roles. For example, if she cares for the children and the household—private realm responsibilities—while he is publicly employed and takes care of financial tasks—public realm responsibilities—then this couple follows a gendered division of labor. If women take on the responsibility for contraception, then this gendered division of labor is further reinforced, as contraception is a private task. Moreover, women taking on contraceptive duties strengthens women's association with reproduction, making it seem "normal" and "natural" for women to assume contraceptive responsibility.

Second, using contraception, especially long-acting methods, involves bodily invasion—something not required by other responsibilities. Female barrier methods, such as the sponge, diaphragm, cervical cap, and female condom, are only used during sex, like the male condom, so their bodily invasion is temporary (though it is worth noting that their time within the body can be significantly longer than the male condom, as the male condom cannot be used until sex and specifically until the man has an erection, while these female methods can be inserted well ahead of sexual activity). In contrast, IUDs and hormonal methods are constantly inside women's bodies. Few responsibilities entail this degree of continuous invasion of bodily integrity (except perhaps pregnancy and breastfeeding). My concern with this bodily invasion is not just the negative side effects that often accompany it, as I discussed in chapter 2, though it is unfair that women as a group bear them. I am also worried about the effects such bodily invasion has on women's agency given that the body is "the basis of privacy and freedom in the material world for all human beings" (Dworkin 137). The bodily invasion women experience from contraceptives compounds and exacerbates their objectification, thereby minimizing their autonomy. LARCs add to women's everyday experience of having their bodies entered and occupied, often without their consent or because it is the best of bad options; other examples include sex (see Dworkin) and pregnancy (see Purdy). Some women feel violated by the presence of LARCs, especially hormonal ones since they can affect one's mental health. Even if women are fortunate not to have any negative side effects, many are not fond of the idea of constantly pumping hormones into their body or having a metal or plastic IUD sitting in their uterus for years at a time. Part of the unease here is providing medical treatment to an otherwise healthy individual (and the adverse effects

that it can entail), but just as concerning is the violation of bodily privacy and integrity. This violation is particularly problematic because there is no equivalent violation that men experience from other responsibilities. Women alone experience such bodily invasion, as none of the other responsibilities that a couple splits requires it.

Due to these two reasons—reinforcing a gendered division of labor and demanding another type of bodily invasion from women—it is problematic for heterosexual couples to make contraceptive responsibility just the woman's job. In the next chapter, I will describe my vision for shared contraceptive responsibility. Part of this vision involves LARCs for men. Until such male contraceptives are available, men in monogamous relationships should share contraceptive responsibility by using condoms (or having a vasectomy). If both partners agree that just the woman will contracept, men should, at the very least, acknowledge the unique problems at play with this arrangement and should try to find ways of mitigating them. For example, men may take on more private realm responsibilities so the gendered division of labor is lessened. Moreover, men should be supportive of women's contraceptive responsibility in all ways (emotionally, financially, etc.). I will discuss the various ways men can be supportive of their partners contracepting as well as how they can be more involved in contraceptive responsibility in the next chapter.

## Chapter 7. Achieving Shared Contraceptive Responsibility

In the previous two chapters, I argued that (heterosexually active) men as a group have a moral duty to contracept and that this duty is not dependent upon whether women contracept. That is, there are good reasons why men should contracept that hold independent of whether women do or should contracept. Throughout the dissertation, I have argued that although men as a group may not be trusted to contracept, this distrust does not absolve them of contraceptive responsibility. I made a positive case for why men have a duty to contracept that does not rely upon their trustworthiness. In doing so, I revealed that trust and responsibility do not always go hand-in-hand. Second, positing that men have a moral duty to contracept lays the groundwork for my overarching argument of shared contraceptive responsibility. By providing reasons why men should contracept that are independent of women contracepting, my claim that men should participate in and share contraceptive responsibility is strengthened.

In this chapter, I flesh out what I mean by shared contraceptive responsibility, which is more than just a numerical achievement (e.g. increasing the number of men contracepting). Shared responsibility means that women and men are both responsible for contraception and there are open conversations between partners about how to share responsibility for contraception. Then, I suggest three governmental strategies for working towards the goal of shared responsibility. First, the government, private pharmaceutical companies, and nonprofit organizations should focus efforts on developing contraception for men so that they have better contraceptive options, especially long-term reversible options. The lack of male contraceptives makes it difficult

for men to assume responsibility for contraception and they often push contraceptive responsibility onto women. Second, shared responsibility for contraception ought to be taught and promoted on every level: health care providers, schools, and laws. Health care providers need to encourage shared responsibility, which means including men in contraceptive discussions and decisions. Currently, men's reproduction is typically ignored in part because there is a lack of reproductive information and services for them. Schools should teach children accurate sex education that holds men responsible for sex, not only with regard to contraception but also for other issues, especially rape. Our government also needs to hold men accountable for sex through laws, policies, and social norms. Third, the government must strive towards more equal relationships between women and men. Studies have shown that men with more egalitarian views on gender roles are more likely to assume contraceptive responsibility and value shared contraceptive responsibility. Increasing women's education will enable them to make better contraceptive decisions. Studies have shown that the male partners of educated women are more likely to hold more egalitarian views on gender roles. Additionally, increasing women's power and opportunities in other realms, especially the public realm, will give them more power and opportunities in the private realm and with regard to reproductive issues.

### A Vision of Shared Contraceptive Responsibility

As described in detail in chapter 2, the current contraceptive arrangement is unfair and oppressive to women. A shared approach to contraceptive responsibility would mitigate many of the injustices most women currently experience. My vision of shared

contraceptive responsibility is not just about making numerical changes, such as increasing the number of male contraceptives or the percentage of men contracepting. Nor does my vision merely translate into a simple type of equality in which monogamous partners split contraceptive use fifty-fifty and casual sex partners both contracept. While I think these suggestions are a step in the right direction, they are not sufficient for shared contraceptive responsibility. Shared contraceptive responsibility means that both women and men take their reproductive health and responsibilities, as well as the reproductive health and responsibilities of their sexual partners, seriously. In order for this to possible, people must view both themselves and their partners as reproductive beings with reproductive responsibilities. Furthermore, they must be committed to fairly sharing contraceptive responsibility, which typically requires open and continual conversations between partners about sex, reproduction, and contraception.

I will not make any universal claims about how precisely shared contraceptive responsibility is achieved, as couples will have different circumstances, needs, and values. However, it will generally involve both partners contracepting at some point, perhaps at the same time or alternating. What is most important is that one person is not mostly or permanently saddled with full contraceptive responsibility, especially without the emotional, social, and/or financial support of her/his partner. In other words, any contraceptive arrangement that closely resembles the current one is unjust. Other contraceptive arrangements can be unjust even if they do not mimic the current one (e.g. mandatory contraception). Since I oppose reproductive paternalism and am only discussing moral, not legal, duties to contracept, individuals should determine the

contraceptive arrangement for themselves, in conjunction with their partners, that is best and fair for both of them.

Yet, given our dominant contraceptive and gender ideologies, it seems improbable that many people will elect fair—that is, nonsexist—contraceptive arrangements despite the fact that they may try to. Ideologies discipline our behavior and encourage us to act in ways that uphold current power structures. Since current dominant ideologies align contraceptive responsibility with norms of femininity, women are disciplined to assume this responsibility, whereas men are not. One previously discussed example that shows this is the following: even though both women and men have sterilization procedures available to them, the rates of tubal ligation are three times as high as vasectomy in the U.S. By extension, even if male LARCs were to hit the market tomorrow, it is doubtful that they would gain the popularity of female LARCs without any other cultural changes. Without a transformation of our dominant contraceptive and gender ideologies, it is unlikely that most people will start viewing men as reproductive agents with moral duties to contracept. Such a transformation is necessary for shared contraceptive responsibility to become not only socially accepted, but also the norm.

But how do we achieve such an ideological transformation? This sort of deep societal change will not be easy or quick. To achieve the most success, change must come from both the top-down and the bottom-up. Just implementing top-down policies may lead to behavioral changes, but they do not always usurp beliefs. Moreover, since these approaches typically target behavior, not beliefs, they generally do not address the factors that contribute to the behavior. For example, China's infamous "one-child" policy seeks to limit women's fertility. While the Chinese government and family planning

officials have been successful at altering women's reproductive behavior, they have been less successful in changing women's preference for wanting more than child, though some change has occurred. Part of the reason the one-child policy has struggled to transform women's fertility preferences is that it does not deal with women's motivations for wanting more than one child, such as the strong preference for a son and the need for more farm workers in rural areas. The one-child policy did not (and still does not) take women's perspectives into account and therefore it is not surprising that it conflicts with many women's views (Merli and Smith).

In analyzing development policies and programs like one-child, some feminist theorists[44] argue that top-down approaches are not only more likely to fail, but also that they are ethically problematic because they privilege one viewpoint—the viewpoint of people in power. These theorists suggest empowering women (and other oppressed groups) through participation as a way of improving development outcomes. Majid Rahnema explains the ideological transformation from a top-down approach to the more bottom-up approach of participatory empowerment from the point of view of development agents. They (social activists, field workers, and other development agents) began

> to attribute most of the failures of development projects to the fact that the populations concerned were kept out of all the processes related to their design, formulation and implementation. In their great majority, they started to advocate the end of 'top-down' strategies of action and the inclusion of participation and participatory methods of interaction as an essential dimension of development. (Rahnema 117)

These participatory programs were (and are) generally more successful than top-down programs (ibid.). This finding intuitively makes sense, as when people play an active role

[44] See, for example, Naila Kabeer, Gita Sen and Caren Grown, Saskia Wieringa, Jane Parpart, and Majid Rahnema.

in a designing and implementing a project, they are usually more invested in it and hence more likely to push for its success. In contrast, there is often resistance to top-down programs, especially if they go against cultural beliefs. Although people's acquiescence to top-down programs may eventually lead them to accept and uphold such programs and their corresponding beliefs, these programs are less likely to lead to deep, genuine, and long-lasting ideological change. Close to thirty years after the one-child policy was implemented, that this policy is the biggest determinant of whether most Chinese women become pregnant (and carry their pregnancies to term) shows that while behavioral change has occurred, ideological change has not (Merli and Smith).

Participatory and empowerment approaches are especially important when seeking ideological transformations that involve oppressed groups. "The theme of collective identity," according to Naila Kabeer, "underpins most empowerment strategies" (253). Actors in top-down programs and policies that do not incorporate women's voices are often unable to make connections among women's experiences so as to see oppressive patterns. Development workers and policymakers who examine the lives of individual women on a case by case basis, instead of looking to a general community of women, might view individual women as being ill used, yet not piece together the ways in which women as a group experience oppression precisely because they are a member of the group called 'women.' As Marilyn Frye posits, oppression happens based on one's membership in a group and therefore cannot be detected if we only see atomistic individuals who exist outside of social groups (8). Looking at individual women rather than communities of women makes it easier to overlook the deeply entrenched gender ideologies in laws, institutions, and cultural practices. Workers

and policymakers who listen to the experiences of women, or better yet, include women and give them access to the experiences of other women are more likely to recognize the systemic oppression that women as a group face. Moreover, women themselves need access to the experiences of other women (e.g. consciousness-raising groups) in order to understand the systemic nature of patriarchy. This access to other women's experiences is epistemically necessary for women to recognize their own oppression. Understanding the social nature of their oppression allows women to imagine and strive for alternative, nonoppressive social arrangements. In Kabeer's words,

> The social basis of male domination is often concealed through powerful ideological mechanisms, including the 'naturalization' of the status quo, so that women experience subordination as inevitable and interpersonal. Recognition of the shared aspects of subordination points to its collectively enforced, and hence collectively changeable, character and forms the basis of strategies for change. (253)

Having their voices heard and sharing their experiences with other women is an important aspect of women's empowerment. According to Saskia Wieringa, "the process of empowerment of women [involves] ... exposing the oppressive power of the existing gender relations, critically challenging them, and creatively trying to shape different social relations" (Wieringa 832-833).

Only by empowering women through participation and being heard can development workers, policymakers, and women themselves get the broad perspective to recognize, understand, and begin to work against the far-reaching tentacles of patriarchy.

Prima facie, participatory and empowerment approaches and top-down approaches may seem to be contradictory. However, this does not have to be the case. By including a diverse group of people in all stages of strategy development and implementation, it is unlikely that a top-down governmental approach will reflect the

view of just the powerful. Although such a strategy is top-down in that it is imposed on the public by the government, the decision-making process is bottom-up: listening to and involving the voices of people of all social positions. One of the main concerns with governmental top-down policies and programs is that the government is often inconsistent and sometimes even flippant in its decision-making processes. Indeed,

> the state is a contradictory force in the process of women's empowerment. It has the power to override certain kinds of local constraints and to provide the enabling conditions for women to mobilize around their own self-defined priorities. But where such activity conflicts with other interests of the state, it is unlikely to prove a reliable ally. (Kabeer 260-261)

However, if participatory and empowerment approaches were incorporated into top-down governmental decisions, then it seems likely that the government would be a more consistent and supportive force in women's lives.

In what follows, I argue that the government should seek to mitigate the oppressive burdens women face in assuming full contraceptive responsibility through (at least) three different strategies: developing new male contraceptives, teaching shared contraceptive responsibility, and promoting gender equality through women's education and employment. The exact details of such strategies are best left up to the diverse groups of people involved in the strategy decision-making. These groups of people should include women of all social positions, especially in leadership roles.

A main reason I focus on governmental strategies to achieve shared contraceptive responsibility is that although the government's support for women is uneven, the government plays a constant role in women's lives. Whether by omission or commission, the government shapes women's lived reality through laws, policies, and social norms (e.g. while certain types of violence against women are illegal, for other types of

violence, the government does not take a position and hence these types are permitted). Since the government does not play a neutral role in public life, it is important not to ignore its impact.

## Developing Male Contraceptives

One way to encourage men, especially men in long-term, monogamous relationships, to contracept is by developing male LARCs. For many men in long-term, monogamous relationships, neither of the two currently available male contraceptives is well-suited for their contraceptive needs: they want a long-acting contraceptive, particularly one that does not need to be used during sex, that is not permanent (in case they decide to have biological children). The lack of such options for men forces many men in monogamous relationships to rely on their partners to contracept.

Why are there so few male contraceptives and so many female contraceptives? The answer to this question is complex, and is deserving of its own project. However, it is worthwhile to enumerate some of the factors that have contributed to this discrepancy since they will have to be overcome if more male contraceptives are to be developed. As discussed in chapter 2, dominant gender ideologies have shaped who is thought to be responsible for contraception. That women are generally considered responsible for contraception influences the decisions of researchers, developers, and pharmaceutical companies about what type of contraceptive research to conduct and support. Dominant ideologies about women's and men's bodies have also played a role such decisions. Some scientists, physicians, and developers claim that it is more difficult to create male contraceptives because men's bodies are more complex than women's. They often

compare the reproductive systems of women and men bodies to support their claim: for example, women release one egg a month, while men produce millions of sperm a day; women's fertility is limited to a handful of days each month, whereas men are consistently fertile (see Knight and Callahan 12 for more examples). At play in these comparisons are implicit and sexist assumptions about the mind/body dichotomy: women's bodies are more simplistic and "nature-like" and men's bodies are more advanced and less "nature-like." Nelly Oudshoorn explains:

> Biomedical scientists and traditional philosophers have encouraged us to assume that women's bodies are simply closer to nature, and consequently easier to incorporate into biomedical practice. In this view, techniques to intervene in male reproductive bodies have not proliferated because the male reproductive system is by nature more resistant to intervention than that of women. (8)

The trope that women's bodies are more controllable and better suited for medical intervention underlies many scientists, physicians, and developers' beliefs and actions regarding contraception.

Some may claim that while cultural stereotypes may play a role in the discrepancy between the number of female and male contraceptives, developing contraceptives for women is in fact easier than for men. The belief that women's bodies are better suited for contraceptive research is prevalent, as many "Studies show there is also a common misconception that product development for men is more difficult than it is for women" (Randle). However, some scientists assert that men's bodies are in fact better suited to contraception and that "if scientists had simply followed nature, they would have developed male contraceptives rather than female methods" (Oudshoorn 46). Regardless of whether it is easier to develop female or male contraceptives, there are other factors that have contributed to the dearth of male contraceptives. Notably, it was not until the

1970s that scientists began researching new types of male contraceptives. Previously, scientists' work on male contraceptives was limited to improving the condom (ibid. 19). Scientists have been researching the relationships among hormones, contraception, and the female reproductive system since the 1920s—fifty years before research on male contraceptives commenced (PBS). Because it has been studied for so much longer, more is known about the female reproductive system and hence it is easier to develop contraceptives for women. Indeed, various "scientists ascribed the gap between female and male methods to a lack of fundamental knowledge of the male reproductive system, caused by institutional reasons" (Oudshoorn 46). Others active in the contraceptive realm, such as policymakers and activists, agree. For example, Elaine Lissner, director and founder of Male Contraception Information Project, states that the lack of knowledge about and research on men's bodies is what led to the discrepancy in the number of female and male contraceptives (Randle).

Although there are fewer male contraceptives, much more money is allocated to female contraceptive research. The distribution of research and development money in the 1990s was as follows: "60% high-tech female methods, 3% female barrier methods, spermicides, and natural fertility control methods, 7% to male methods, 30% to multiple methods (though mostly for women)" (Yanoshik and Norsigian 70). Some researchers who would like to study male contraception cannot due to lack of funding. For example, Richard Anderson, a professor of clinical reproductive science at Edinburgh University says that "most of the work [on male contraception] has been initiated by university investigators and the World Health Organisation. There has so far not been a lot of money from corporate companies" (quoted in Moss 12). Despite positive findings on a

male contraceptive pill, Anderson and his team at Edinburgh University have not been able to conduct trials because no pharmaceutical company will financially support them (ibid.). The main reason pharmaceutical companies decline to fund male contraceptive research is that they do not think male contraceptives will be lucrative. Pharmaceutical companies are mostly motivated by money: "Corporations do not view themselves as instruments of social change. They are in business to make money" (Segal 138). Indeed, pharmaceutical companies prefer to develop blockbuster drugs that will have many users and will generate a significant profit rather than work on contraceptives, for which there are an uncertain number of potential users (especially for male contraceptives) and which are usually not as profitable. To be fair, there are numerous obstacles that may make contraceptive research unpalatable, such as liability concerns, "insurance costs, unwillingness to cannibalize existing markets, and company image" (Segal 141). Yet, these obstacles affect research for both female and male contraceptives.

While public and nonprofit organizations also research contraception, "the contraceptive market is dominated by large pharmaceutical corporations" mainly because they have the money, resources, and power to conduct such research (Yanoshik and Norsigian 69). The World Health Organization (WHO) had been one of the more visible and active nonprofit organizations working on male contraceptives, but today it "focuses its contraception work entirely on females because it sees that focus as a key to issues in developing countries" (Oudshoorn 192-3; Dow 6). Given the limited budget of nonprofit organizations, it is not surprisingly the WHO discontinued its research on male contraceptives for practical reasons.

Since private pharmaceutical companies typically are not interested in developing male contraceptives and nonprofit organizations usually lack the resources to do so, if male contraceptives are to be readily available in the near future, then a third party, such as the federal government, needs to step in. Unlike most nonprofits organizations, the U.S. government has the money and the resources to devote to developing male contraception. Furthermore, in contrast to private pharmaceutical companies, the government is, or at least should be, interested in developing male contraceptives. Politicians often lament what they see as the prevalence of abortions as well as the high rate of unintended pregnancy, especially among teenagers and unwed women. The government's response to these "problems"—abstinence-only education—has not been successful. Instead of pouring more money into these failing programs, over one billion dollars and counting (Wire), the government should divert money to research on male contraceptives. Allocating money for male contraceptive research would be in line with other government initiatives aimed at involving men in, and in particular increasing men's responsibility for, reproductive and domestic matters.

As private companies continue to pull out of contraceptive research (both for female and male contraceptives), by default the government is going to play a larger role in this arena. For example, between 1970 and 1988, the percent of contraceptive research that received federal funding rose from 25 to 60 percent mainly because private companies were halting their research programs (Knight and Callahan 308). The majority of contraceptive product launches in the U.S. in the 2000s have been initiated by publicly supported programs, not private companies (Segal 138). Although the government has emerged as a dominant actor in contraceptive development, this does not mean that its

involvement is necessarily to the degree that it ought to be. Nor does this mean that the focus of such research is where it ought to be. The percentage of research devoted to male contraception is in the single digits, a clearly neglected area (Yanoshik and Norsigian 70).

The government (its politicians, policymakers, and citizens) *should* have an interest in contraceptive research because unlike most private companies, part of its inherent purpose is to promote justice. Whereas private companies are mainly motivated by profit, government players ought to be compelled to act according to what is good and fair. Indeed, the government should act as an agent of social change. According to this perspective, it is reasonable for the government to allocate money to contraceptive research, especially male contraceptives, both to decrease unintended pregnancy and abortion rates and to alleviate the social injustice women typically face by being fully responsible for contraception.

## Teaching Shared Responsibility

Although developing more male contraceptives, especially LARCs, will make it easier for men to contracept, it is unlikely that men will start contracepting at the same rates women do without any changes in dominant ideas about contraceptive responsibility. Technology (i.e. new male contraceptives) alone will not lead to deep changes in our current contraceptive arrangement. Education, among other things, is also a necessary factor. Sheldon Segal makes a similar point:

> Technology, in itself, will not encourage the positive involvement of men as supportive partners in reproductive health. This will take education, the building of comfort and capacity to discuss contraception, and the

> willingness to come to joint decisions on a matter so personal in the lives of husband and wife. (127).

Promoting shared contraceptive responsibility through education can pave the way for profound, ideological change. I suggest bottom-up and top-down three ways the federal government and other institutions can teach shared contraceptive responsibility.

First, the federal government can encourage (through funding) or even mandate that primary and secondary schools teach shared contraceptive responsibility in comprehensive sex education classes. The suggestion that the federal government shape the sex education curriculum is not new. In the last eleven years, the federal government has spent well over one billion dollars on abstinence-only education. Although all fifty states except California originally signed on to receive this federal funding, seventeen states now decline it. The decision to reject federal funding reflects many state politicians' dissatisfaction with abstinence-only education programs and preference for comprehensive sex education (Wire). Given the current movement against abstinence-only sex education, especially in light of the recent studies showing that it generally does not delay teenage sexual activity, it seems likely that many state governments would welcome federal funding for comprehensive sex education (Kohler, Manhart, and Lafferty). Although the federal government is free to endorse various comprehensive sex education programs, shared contraceptive responsibility should be a key tenet in all of them. Explicitly teaching children and teenagers not only to use contraception, but also to share contraceptive responsibility increases the likelihood that they will both contracept and share contraceptive responsibility. Stressing the importance of shared contraceptive responsibility before or around the time children and teenagers become sexually active prepares them to make good and just decisions about sex and contraception throughout

their lifetime. Currently, children and teenagers often learn about "normal" sexual activity through the media, which rarely includes contraception, or other sources (e.g. friends, pornography) unlikely to seriously and accurately discuss contraception. In contrast, comprehensive sex education programs send the clear message to children and teenagers that shared contraceptive responsibility is a normal, and expected, part of sexual activity. Normalizing contraception reduces its stigma and promotes its use. In sum, in giving states money for comprehensive sex education and perhaps even requiring that states adopt such programs, the federal government enacts a top-down method for teaching shared contraceptive responsibility to young people that can lead to deep ideological change in how these individuals view sex and contraception.

Second, and similar to the previous suggestion, postsecondary schools for health care professionals (e.g. medical school, nursing school) should include shared contraceptive responsibility in their curricula. In addition to teaching health care professionals the value of shared contraceptive responsibility, it is also imperative for these professionals to learn ways to pass this message onto their patients. That is, the point of changing the curricula is not only so that health care professionals recognize the importance of shared contraceptive responsibility, but also so that they encourage their patients to share contraceptive responsibility. Discussing contraception may be more relevant in certain realms of medicine (e.g. gynecology and internal medicine) than others (e.g. ophthalmology and orthopedics). However, although the study of medicine is divided into bodily sections and functions, the human body is not; consequently, various bodily sections and functions can affect others. There may be times when it is necessary

for specialists to discuss sexual activity and contraception, so it is useful for them to have an educational background and training in promoting shared contraceptive responsibility.

Additionally, including shared responsibility in the curricula is beneficial because it highlights that men are typically excluded from reproductive matters. Betsy Hartmann exclaims, "more often than not, family planning programs are geared exclusively toward women, ignoring the basic reality of male dominance or male responsibility for birth control" (52). Family planning providers are sometimes hostile to men, for example, not believing what men say if it contradicts their female partners' statements. Moreover, family planning providers often fail to discuss sex and contraception with men, even when the primary reason for the visit is treatment of a STD. Men generally do not think reproductive health includes them (Edwards 78). And as Hartmann and Sharon Edwards assert, it often does not. Here is another glaring example: whereas women are supposed to see a gynecologist once they become sexually active, there is no equivalent for men (ibid.). Expanding the health care professional school curricula the health care professional school curricula could also lead to structural changes that would foster shared contraceptive responsibility, such as more reproductive services directed at men and the potential burgeoning of the field of andrology (the medical specialization of men's health; that is, the male equivalent of gynecology (see Rankin)). The suggestion of incorporating shared contraceptive responsibility into health professional school curricula would not only effect ideological change for health care professionals, but also for their patients. This suggestion, combined with the first one (teaching comprehensive sex education at the primary and secondary levels), would reinforce the importance of shared contraceptive responsibility.

A third suggestion does not entail direct instruction, but rather indirectly shaping people's behavior through laws and policies. One way to indirectly promote shared contraceptive responsibility is to hold men legally responsible for their sexual and reproductive decisions. Examples of such laws already exist: forcing men to pay child support for children they fathered and classifying rape as a crime. Politicians and policymakers should work to strengthen existing laws and policies and strive to pass new ones, such as eliminating the statute of limitations on rape cases (New York recently eliminated their very restrictive statute; see Emily Goodman). Since morality and legality often go hand-in-hand, laws that hold men responsible for their sexual and reproductive decisions send the message that men have a moral obligation to act in certain ways regarding sex and reproduction and to assume responsibility when they do not. Creating legal consequences for men's sexual and reproductive choices teaches men to take responsibility for their actions, which hopefully pushes them to make better decisions and minimizes their ability to shirk from responsibility and blame. While laws alone will not engender a profound ideological transformation, they produce behavioral changes that can lead to ideological changes.

**Striving Toward Gender Equality: Women's Education and Employment**

While the previous two suggestions—developing male contraceptives and teaching shared contraceptive responsibility—focus on reproduction, it is important to look beyond the reproductive realm in order to make deep and lasting changes within it. Reproductive matters do not exist in isolation, but rather are strongly influenced by and reflect matters in other realms and in society at large. As Ruth Dixon-Mueller asserts,

"women's reproductive rights depend in fundamental ways on the exercise of women's rights in other spheres" (xii). In order for women and men to support the idea of shared contraceptive responsibility and for men to accept their responsibility to contracept, they must not only affirm gender equality, but also strive toward it.

Numerous studies have confirmed that there is a reciprocal relationship between gender equality and contraceptive use *and* between gender equality and shared contraceptive responsibility. Indeed, couples who more equally share power are more likely to accept contraceptive use (Hartmann 52). Patricia MacCorquodale elaborates:

> The more egalitarian an individual's gender-role attitudes, 1. the greater the likelihood of believing that contraceptive use and responsibility should be shared, 2. The more frequently she or he will have discussed contraception before having intercourse, 3. The more frequent and more effective the contraception used will be. (58)

Note that this reciprocal relationship exists for both men and women. A study by William Grady et al. shows that men "who held more egalitarian attitudes were more likely to think that men and women have a shared responsibility for contraception" (221). Likewise, women who maintain equal relations between women and men usually believe contraception should be a shared responsibility. In contrast, men who uphold traditional gender roles typically assume that contraception is "women's work." Similarly, women who follow traditional gender roles are more likely to believe they alone should take on full contraceptive responsibility. Although women who uphold traditional feminine roles may be held responsible for contracepting, they are not always the ones making contraceptive decisions. In some unequal heterosexual relationships, particularly those in highly gender stratified cultures, men make most if not all of the decisions surrounding sexual and reproductive matters (see, for example, Al Riyami et al.).

Women's education and employment are crucial for equal gender relationships. Education and work outside the home are significant sources of empowerment for women. It is well documented that female literacy is a necessary component for improving the lives of women and their families in "developing" countries. Specifically, education is "an essential factor in preparing people to lead healthy, socially rewarding, and economically productive lives (Hammad and Mulholland 103). In addition to improving women's lives more generally, women's education and employment are statistically shown to decrease women's fertility (Sen 1053). And this makes sense—when women have more knowledge and power they are better equipped to autonomously make decisions about their reproduction and, moreover, they have the capability to act upon their decisions (i.e. use contraception to control their fertility). Educated women not only feel more confident in making their own reproductive decisions; men are more likely to be respectful of educated women's autonomy. Men with educated partners typically support contraceptive use and are usually less likely to exhibit male dominance in the reproductive realm (Hartmann 52; Grady 223). In short, when women are educated and when they work outside the home, there is a greater probability that men will perceive them as equals, rather than as subordinates. And consequently men will be more willing to affirm women's ability to make their own reproductive decisions and to support their choices.

Given the considerable effect women's education and employment has on gender relations, governments (both in the U.S. and abroad) should prioritize girls' education and women's employment. Girls' education should be mandatory (as it currently is in the U.S.). Yet, in many places in the world, even if girls are legally required to attend school,

they often lack the ability to do so; for example, they have to work on the farm all day, they do not have transportation to the school, their parents prohibit them from attending school, etc. The obstacles girls face are complex and varied and are beyond the scope of this project. However, governments, perhaps in conjunction with nonprofit organizations, should strive to make education a reality for girls. Furthermore, governments should encourage women's work in the public sector through programs like affirmative action. Supporting women's education and public employment is a financially smart move for governments since it leads to reduced fertility and a greater percentage of citizens contributing to the economy. These approaches are also good from a social justice perspective, as they are a way of combating patriarchy. Women who are empowered through education and public employment are more likely to be able to negotiate contraceptive use, and more specifically, shared contraceptive responsibility. Additionally, women's empowerment has the potential to improve women's lives in all realms, not just the reproductive realm. For example, expanding women's economic opportunities and increasing their wealth will likely augment their overall health and the health care they receive.[45] Improving women's lives overall and minimizing, and possibly eradicating, unjust gender roles is beneficial both to women and to society overall.

### Achieving Shared Contraceptive Responsibility

Due to the systemic nature of oppression, patriarchy needs to be challenged on multiple fronts in order for the vision of shared contraceptive responsibility to be

[45] Countries with a more equitable distribution of income tend to have citizens with better health outcomes than equally wealthy countries with unequal distributions of wealth (Daniels, Kennedy, and Kawachi).

realized. The goal of this chapter has been to provide a few practical strategies for achieving this vision. Clearly, these are not the only strategies, though they are a good starting point, especially because they address different areas of change. Developing male contraception, and in particular male LARCs, is important because men are more likely to assume contraceptive responsibility if there are palatable contraceptive options available to them. Additionally, the availability of male contraceptives, and their eventual normalization, will encourage men to contracept. However, since the mere existence of male contraceptives will not change contraceptive ideologies, it is imperative that shared contraceptive responsibility is explicitly taught. Instilling children, health care professionals, and the general public with the belief that men ought to be and will be held responsible for their sexual and reproductive decisions lays the groundwork for ideological transformations about contraceptive responsibility. In order for deep and lasting ideological changes in the realm of contraception, there also needs to be ideological change more generally. Empowering women through education and public employment puts us on the path toward gender equality, which includes shared contraceptive responsibility.

Shared contraceptive responsibility is best way, and perhaps the only way, of achieving contraceptive justice. Working to eliminate contraceptive and gender ideologies that portray women as untrustworthy is an important step in increasing their reproductive and overall autonomy. Women's reproductive autonomy is also enhanced by holding men responsible for their sexual and reproductive actions. When men are held responsible for contraception, women no longer experience full contraceptive responsibility and all of its associated burdens. In an ideal arrangement of shared

contraceptive responsibility, neither partner faces limited autonomy, distrust, or unfair contraceptive burdens. Moreover, in such an arrangement, both partners are empowered and trusted to control their fertility, which typically leads them to make better decisions and have better outcomes. Improved decision-making not only benefits the agents of such decisions, but it also behooves other individuals (especially potential fetuses in the case of contraception) and society at large. Given the advantages of shared contraceptive responsibility, individuals and governments should strive to achieve it.

# APPENDICES

**TABLE 1: WOMEN AND CONTRACEPTION USE IN THE U.S.**

**(IN NUMBERS AND PERCENTAGES)**

| Category | Who | Number (in millions) | Percentage |
|---|---|---|---|
| A | People in the U.S. | 293.7* | N/A |
| B | Women in the U.S. | 149.1* | 51% of A |
| C | Women Ages 15-44 | 62 | 42% of B |
| D | Women Ages 15-44 Who Need to Contracept (They are fertile and sexually active and do not want to become pregnant) | 43 | 70% of C |
| E | Women Ages 15-44 Who Do Not Need to Contracept (They are infertile, pregnant, postpartum, trying to become pregnant, have never had sex, or are not sexually active) | 19 | 30% of C |
| F | Women Ages 15-44 Who Contracept | 38 | 62% of C and 89% of D |
| G | Women Ages 15-44 At Risk of Unwanted Pregnancy: Due *only* to not contracepting | 5 | 7% of D |

Due to rounding, numbers may not exactly equal 100.

* Source: U.S. Census Bureau. All other information comes from The Alan Guttmacher Institute, 2008b.

| TABLE 2: CONTRACEPTIVE FAILURE RATES, 2004 | | |
|---|---|---|
| **Contraceptive Method** | **Perfect use (%)** | **Typical use (%)** |
| Chance | 85 | 85 |
| Coitus interruptus (withdrawal) | 4 | 27 |
| Male condom | 4 | 15 |
| Diaphragm | 6 | 16 |
| IUD | 0.1-1.5 | 0.1-2.0 |
| Oral contraceptive | 0.3 | 8 |
| Intramuscular long-acting progestin (Depo Provera) | 0.3 | 3 |
| Rhythm | 9 | 25 |
| Spermicidal foam | 8 | 29 |
| Vasectomy | 0.10 | 0.15 |
| Tubal ligation | 0.5 | 0.5 |
| Source: Hatcher 2004, foreword | | |

| TABLE 3: CONTRACEPTIVE METHOD BY POPULARITY | | |
|---|---|---|
| **Method** | **No. of users (in 000s)** | **% of users** |
| Pill | 11,661 | 30.6 |
| Tubal sterilization | 10,282 | 27.0 |
| Male condom | 6,841 | 18.0 |
| Vasectomy | 3,517 | 9.2 |
| 3-month injectable | 2,024 | 5.3 |
| Withdrawal | 1,513 | 4.0 |
| IUD | 774 | 2.0 |
| Periodic abstinence (calendar) | 450 | 1.2 |
| Implant, 1-month injectable, patch | 461 | 1.2 |
| Periodic abstinence (natural family planning) | 133 | .4 |
| Diaphragm | 99 | .3 |
| Other* | 354 | .9 |
| TOTAL | 38,109 | 100.0 |
| * Includes the sponge, cervical cap, female condom and other methods.<br>Source: The Alan Guttmacher Institute, 2008b | | |

| TABLE 4: PERCENTAGE OF CONTRACEPTIVE USE BY WOMEN'S AGE | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Method** | **15-44** | **15-99** | **20-24** | **25-29** | **30-34** | **35-39** | **40-44** |
| Female sterilization | 25.6 | 0.3 | 3.6 | 16.0 | 27.7 | 38.6 | 46.7 |
| Pill | 24.9 | 35.4 | 47.6 | 36.6 | 26.8 | 10.5 | 5.5 |
| Male condom | 18.9 | 29.7 | 24.0 | 22.8 | 17.3 | 15.9 | 11.5 |
| Male sterilization | 10.1 | 0.0 | 1.0 | 4.2 | 9.8 | 17.6 | 19.0 |
| No method | 7.5 | 19.3 | 8.6 | 6.4 | 5.7 | 5.6 | 6.7 |
| Withdrawal | 2.9 | 3.3 | 3.0 | 3.5 | 2.7 | 3.0 | 1.8 |
| Injectable | 2.7 | 7.9 | 5.6 | 3.9 | 1.7 | 1.0 | 0.3 |
| Rhythm | 2.2 | 1.1 | 0.9 | 1.6 | 3.0 | 2.7 | 2.4 |
| Diaphragm | 1.7 | 0.0 | 0.1 | 0.3 | 0.4 | 0.5 | 0.3 |
| Implant | 1.3 | 2.2 | 3.4 | 1.9 | 0.6 | 0.3 | 0.1 |
| Spermicides | 1.3 | 0.8 | 1.1 | 1.6 | 1.4 | 1.0 | 1.8 |
| IUD | 0.7 | 0.0 | 0.3 | 0.7 | 0.8 | 0.9 | 1.2 |
| Other* | 0.1 | 0.0 | 0.1 | 0.0 | 0.3 | 0.1 | 0.5 |
| Female condom | 0.0 | 0.0 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 |

* Other includes cervical cap, sponge, and other unspecified methods.

Source: Hatcher 2004, 223

**TABLE 5: ANNUAL COST IN DOLLARS FOR CONTRACEPTION**

**(INCLUDES METHODS AND SERVICES)**

| Method | Public Provider Setting | Managed Care Setting |
|---|---|---|
| Tubal ligation* | 1190.00 | 2466.80 |
| Vasectomy* | 353.28 | 755.70 |
| Oral contraceptives | 228.96 | 290.00 |
| Injectable | 186.20 | 272.00 |
| Progesterone-T IUD (effective 5 years) | 155.22 | 359.00 |
| Female condom | 103.75 | 303.78 |
| Implant^ | 103.62 | 164.70 |
| Sponge | 68.89 | 124.50 |
| Male condom | 27.39 | 83.00 |
| Copper-T IUD (effective 10 years) | 18.22 | 46.10 |
| Cervical cap° | 6.33 | 10.33 |
| Diaphragm° | 5.00 | 6.00 |
| Withdrawal | 0 | 0 |
| Rhythm | 0 | 0 |
| No method | 0 | 0 |

*One time cost

^ Includes method, insertion, and removal divided by 5 years, which is the length of effectiveness for Norplant, the most common implant in the U.S. There are other types of implants with different ranges of effectiveness. For example, Implanon lasts for 3 years.

° Does not include spermicide cost or price of fitting (fitting costs $38.00 for a managed care setting and $15.59 for a public provider setting). Source: Hatcher et al. 245

| TABLE 6: MEDICAL INVOLVEMENT FOR CONTRACEPTION MEASURED BY PHYSICIAN VISIT AND PRESCRIPTION | | |
|---|---|---|
| **Method** | **Physician Visit^** | **Prescription*** |
| Oral contraceptives | Yes | Yes |
| The patch | Yes | Yes |
| The ring | Yes | Yes |
| Injectable | Yes | Yes |
| Tubal ligation | Yes | No |
| IUD | Yes | No |
| Implant | Yes | No |
| Cervical cap | Yes | No |
| Diaphragm | Yes | No |
| Sponge | No | No |
| Female condom | No | No |
| Vasectomy | Yes | No |
| Male condom | No | No |
| Withdrawal | No | No |
| Rhythm | No | No |

^ Physician visit means that the patient must see the doctor at least once in order to acquire the contraceptive.

*Prescription is defined as having to go to the pharmacy or doctor to continue renewing one's contraceptive method.

| TABLE 7: HEALTH-RELATED DANGERS, SIDE EFFECTS, AND NONCONTRACEPTIVE BENEFITS OF CONTRACEPTIVES | | | |
|---|---|---|---|
| **Method** | **Dangers** | **Side Effects** | **Noncontraceptive Benefits** |
| Combined hormonal contraception (pill, patch, and ring) | Cardiovascular complications (stroke, heart attack, blood clots, high blood pressures), depression, hepatic adenomas, possible increased risk of breast and cervical cancers | Nausea, headaches, dizziness, spotting, weight gain, breast tenderness, chloasma | Decreases menstrual pain, PMS, and blood loss; protects against symptomatic PID, some cancers (ovarian, endometrial) and some benign tumors (leiomyomata, benign breast masses), and ovarian cysts; reduces acne |
| IUD | PID post insertion, uterine perforation, anemia | Menstrual cramping, spotting, increased bleeding | None known expect progestin-releasing IUDs, which decrease menstrual blood loss and pain |
| Male condom | Anaphylactic reaction to latex | Allergy to latex | Protects against STDs |
| Female condom | None known | None known | Protects against STDs |
| Implants | Infection at implant site, complicated removals, depression | Tenderness at site, menstrual changes, hair loss, weight gain | May decrease menstrual cramps, pain, and blood loss |
| Injectable | Depression, allergic reactions, pathologic weight gain, possible bone loss | Menstrual changes, weight gain, headaches, adverse effects on lipids | Reduces risk of seizures, may protect against ovarian and endometrial cancers |

| TABLE 7 CONTINUED: HEALTH-RELATED DANGERS, SIDE EFFECTS, AND NONCONTRACEPTIVE BENEFITS OF CONTRACEPTIVES | | | |
|---|---|---|---|
| Diaphragm, cervical cap, and sponge | Vaginal and urinary tract infections, toxic shock syndrome | Pelvic pressure, vaginal irritation, allergy, vaginal discharge if left in too long | None known |
| Sterilization | Infection; anesthetic complications; if pregnancy occurs after tubal sterilization, high risk it will be ectopic | Pain at surgical site, psychological reactions | Tubal sterilization reduces risk of ovarian cancer and may protect against PID |
| Source: Hatcher et al. 2004, 241 | | | |

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