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Hybrid Masculinity and Young Men's Circumscribed Engagement in Contraceptive Management

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Abstract

This research explores how gender shapes contraceptive management through in-depth interviews with 40 men and women of color ages 15 to 24, a life stage when the risk of unintended pregnancy is high in the United States. Although past research focuses on men's contraception-avoidant behaviors, little sociological work has explored ways men engage in contraception outside of condoms, such as contraceptive pills. Research often highlights how women manage these methods alone. Our research identifies how young men of color do help manage these methods through their engagement in contraceptive decision-making and use. Men accomplish this without limiting their partners' ability to prevent pregnancy. This is despite structural barriers such as poverty and gang-related violence that disproportionately affect low-income young men of color and often shape their reproductive goals. However, men's engagement is still circumscribed so that women take on a disproportionate burden of pregnancy prevention, reifying gender boundaries. We identify this as a form of hybrid masculinity, because men's behaviors are seemingly egalitarian but also sustain women's individualized risk of unintended pregnancy. This research points to the complexity of how race, class, and gender intersect to create an engaged but limited place for men in contraceptive management among marginalized youth.

Keywords

Gender; Men/Masculinities; Hybrid Masculinity; Contraception; Reproduction; Youth; Young Adults; Race/Ethnicity; Class

Traditionally women have taken responsibility for contraception (Oudshoorn 2003). Previous research has largely depicted men as detriments to women's reproductive goals. Men, particularly urban men of color, are often seen as irresponsible, untrustworthy, and hypersexual in this domain, without concern for reproductive health and family planning (Campo-Engelstein 2013; Dudley and Stone 2001; Edin and Nelson 2013; Wilkins 2012). Dominant cultural ideals for masculinity in the context of young men's health tend to encourage men's unhealthy risk-taking (Addis and Mahalik 2003; Connell 2005; de Visser and Smith 2006; de Visser, Smith, and McDonnell 2009) and contraception-avoidant

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behaviors (Oudshoorn 2004). Prior empirical work has shown that when men do engage in contraceptive management they often work *against* its use, particularly with condoms (Harvey, Henderson, and Casillas 2006; Tschann et al. 2002). This interference typically does not reflect men's pregnancy intentions but is often to exert dominance over women (Kane and Schippers 1996; Miller, Jordan, et al. 2010; Upadhyay et al. 2014). Since most contraception research highlights young men as either unengaged or detrimental, this paints a negative view of men's potential in contraception. Little research explores a wider range of ways men may engage and possibly support women in contraceptive management, particularly for methods other than condoms. In addition, the limited research available on men's supportive engagement is skewed towards more advantaged populations in terms of race and education level (Fennell 2011). We aim to fill this gap and explore how low-income men and women of color understand men's place in contraceptive management despite the structural obstacles limiting men in contraception (Gilliam et al. 2016; Merkh et al. 2009). Contrary to men refusing to be involved in contraceptive management or denying women's right to make reproductive decisions, we find that some men can mobilize a feminist discourse and enact a more egalitarian masculinity, insofar as they help partners with mutual reproductive goals and support women's control over their own bodies. This varies from traditional expressions of masculinity (Connell 2005; Lamont 2015), where men disengage from contraceptive management or engage in ways that infringe on women's reproductive agency, such as contraceptive sabotage where men destroy a partner's contraceptive method (e.g., flushing contraceptive pills down the toilet) (Northridge et al. 2017). However, young men also mobilize a patriarchal discourse, leaving the ultimate responsibility for unintended pregnancy prevention to women, and blaming women when contraception fails and mutual reproductive goals are not achieved (Oudshoorn 2004). In this way they reify traditional gendered divisions in reproductive labor, because women take accountability for contraception outside of condoms (Fennell 2011). These two discourses sustain a hybrid masculinity that reproduces and masks systems of gendered inequalities (Bridges and Pascoe 2014; Connell and Messerschmidt 2005). Men and women co-construct this gendered reproductive responsibility (Campo-Engelstein 2013; Schippers 2007), together sustaining men's overarching reproductive ambivalence.

GENDER AND CONTRACEPTION

Most research on men in contraception explores men's constraining influence on women (Miller, Decker, et al. 2010; Miller, Jordan, et al. 2010; Raine et al. 2010; Reed et al. 2014). When men do not want to use condoms, women have little power negotiating their use (Harvey, Henderson, and Casillas 2006; Holland et al. 1992; Tschann et al. 2002), especially in contexts such as low-income urban neighborhoods (Nehl et al. 2016; Weeks et al. 2013), where unintended pregnancy is often normative and anticipated for young women (Edin and Kefalash 2011). Men may partake in "stealthing," removing a condom without a partner's knowledge or consent as a way to exert power (Brodsky 2017).

While prior gender research mostly focuses on condoms, there are other contraceptive methods that present a unique context for studying gender. First, these alternative methods are for women's bodily consumption and require less partner cooperation, often allowing women more control over their reproductive intentions. However, these methods involve

additional labor, such as choosing the method and managing side effects (Harrington et al. 2016; Manlove et al. 2011; Wyatt et al. 2014), and this may further the uneven gendered divide in contraceptive and domestic labor (Hochschild and Machung 2012; Wigginton et al. 2014). Unavailable in existing literature is if and how men can help close the gender gap and engage in methods for women's consumption. Additionally, the social construction of the gendered body means that contraceptive consumption leaves women susceptible to larger cultural forces often limiting their ability to prevent pregnancy (Lorber 1993; Lorber and Martin 2011; Martin 2001), such as when internalized beauty standards encourage women to discontinue contraception due to perceived weight gain (Littlejohn 2013). Thus, hormonal contraception does not always provide women greater agency or gender equality. Given that these methods tend to replace condoms in longer, monogamous sexual relationships (Manlove et al. 2011; Upadhyay, Raifman, and Raine-Bennett 2016; Willig 1995), and the contraceptive pill remains the most popular reversible contraceptive method in the United States (Daniels, Daugherty, and Jones 2014), it is useful to investigate how gender works for these methods. To gain a full understanding of this process, we need to consider both men and women's views of contraceptive engagement, as women too can be particularly important to shaping masculinities (Campo-Engelstein 2013; Kane and Schippers 1996; Schippers 2007).

Hegemonic masculinity provides a framework for how men are discouraged from supporting women in contraceptive goals. Broadly speaking, hegemonic masculinity sets the cultural ideals for men's behaviors in different contexts, hierarchically privileging men over women and non-conforming men (Connell 1987; Connell 2005). More specifically related to reproduction, pressures to conform to hegemonic masculinity are associated with the expectation that men generally lack concern about physical and psychological health (Addis and Mahalik 2003; de Visser and Smith 2006; de Visser, Smith, and McDonnell 2009) and espouse a predatory, hypersexual heterosexuality (Pascoe 2006; Schrock and Schwalbe 2009). Thus, more egalitarian expressions of masculinity may be tied to greater involvement in and support for contraception, although this does not always entail substantial change in unequal power distribution between men and women (Lamont 2015). There is a growing literature on hybrid masculinities, which suggests that men negotiate masculinity in ways that mirror more inclusive behaviors and attitudes but leave larger hegemonic systems sustaining unequal gender relations between men and women undisturbed (Bridges and Pascoe 2014; Connell and Messerschmidt 2005; Messerschmidt 2010; Messner 2007). Hybrid masculinities often involve identity work in which white heterosexual men distance themselves from the privilege and power ascribed to them; men incorporate elements of subordinated masculinities and femininities into their gender performances, masking their privilege but still sustaining it (Bridges 2013). For this reason, extant literature on hybrid masculinities usually centers on white men of high socioeconomic status. However, hybrid masculinities are relevant to other groups of men, as well; they still may benefit from the privilege and power associated with identifying as men (Chen 1999), particularly in a highly feminized domain such as reproductive health.

Masculinities and Supportive Contraceptive Management

The limited research available tends to focus on irreversible contraception geared towards men's bodies. Vasectomy research shows that men often regard their contraceptive labor as heroic and expect "credit" (Amor et al. 2008; Terry and Braun 2011); since women are rarely lauded for their contraceptive labor, men's expectations of praise signal how men's seemingly supportive contraceptive engagement may still support larger gender inequity in relationships. Men often compensate for egalitarian behaviors with other acts deemed more appropriately masculine so as not to lose highly valued masculine capital, the social credit for appropriate masculine displays (de Visser and Smith 2006; de Visser and McDonnell 2013; de Visser, Smith, and McDonnell 2009; Gough 2013; Robertson 2007). For example, men whose partners have higher earning potential may make up for the perceived loss of masculinity by demonstrating athletic prowess. Further, young men may use egalitarian narratives when they describe their relationships with women, but often these narratives mask extant inequalities while retaining men's gendered identities as progressive, egalitarian men (Lamont 2015). In one of the few studies about men's supportive behaviors in reversible contraception, Fennell (2011) interviewed 30 young adults to show how men take responsibility for condoms and women for other methods, reflecting women's continued place in the domestic sphere. This research, however, is skewed towards high status white participants, and little contraceptive research qualitatively focuses on young men of color.

Race, class, and structural barriers shape men and women's gendered experiences in the contraceptive realm (Kossler et al. 2011; Maternowska et al. 2010; Merkh et al. 2009; Wigginton et al. 2016). Gilliam et al. (2016) show that young African American men do care about contraception, but structural barriers such as a disproportionate lack of education and support systems tend to limit their involvement. Family planning clinics tend to be viewed as strongly gendered spaces (Lowe 2005), and health care providers often encourage the feminization of these spaces (Kimport 2017), further curbing young men's access to information and ability to engage in this domain.

Research is limited on how structural barriers outside of those limiting men's access to information shape men's engagement in contraception. A more diverse range of structural determinants has been studied regarding reproductive health broadly. For instance, relationship, family, and community factors affect men's involvement in reproductive health (Kaye et al. 2014). Other structural barriers such as gang violence and incarceration often limit men's efforts to be supportive partners (Rios 2011; Rios and Vigil 2017). Young men of color are caught in a complex structural cycle that constrains their choices and limits their decision-making related to health (Bird and Reiker 2008; Weber 2012). However, Edin and Nelson (2013) show how men are sometimes able to work through these structural barriers —such as instability in jobs, education, neighborhoods and home life—to engage in the reproductive process. Research pertaining to how structural obstacles shape men's choices in the reproductive realm helps to unravel some of the stigma surrounding young low-income men of color, and we strive to follow in this tradition. We also aim to fill the gap on how a variety of structural barriers affect men's contraceptive management, since previous literature focuses on men's limited access to contraceptive information.

In this study we show how low-income men of color engage in contraceptive management, building on previous literature accounting for the structural obstacles that may influence their view of potential paternity and contraception (Gilliam et al. 2016; Merkh et al. 2009; Swisher and Wailer 2008). We identify how men's gender performances are situated within both egalitarian and patriarchal frameworks to reveal a hybrid masculinity: one that involves engaging in contraceptive management while upholding women's disproportionate responsibility for pregnancy prevention. We investigate how women co-construct masculinities in contraception. In this paper, we use "contraception" to refer to only hormonal contraception and the copper intrauterine device (IUD); we expressly exclude condoms in order to focus on a context particularly salient to underexplored gendered dynamics and masculinities.

METHODS

Our data come from semi-structured in-depth interviews conducted in 2015 with 40 unmarried men and women of color ages 15 to 24. This age range represents a period of high risk for unintended pregnancy (Finer and Zolna 2014). Participants were recruited at a clinic that provides reproductive health services at low or no cost to low-income youth in the San Francisco Bay area where contraception was available to patients at no charge. Participants were eligible to participate if they were in the desired age range and spoke English. They were not screened for contraceptive use or engagement. Clinic staff recruited patients from the waiting room. For three men and three women, we interviewed both partners of the couple. All participants provided informed consent and were given a $25 gift card as payment for their time. We use pseudonyms for participants to maintain confidentiality. The study was approved by the University of California, San Francisco's Institutional Review Board.

We used purposive sampling to ensure equal numbers of women and men, and a diversity of ages. Of the 20 men, 14 were there for family planning issues (three of these pertained to a current or suspected pregnancy, and 11 were for contraceptive management). The remaining six men we interviewed were there for sexually transmitted infection (STI) testing. Most (47 percent) were between the ages of 18–21. Almost half were Hispanic or Latino (45 percent), approximately one-fifth were multiracial (23 percent), 18 percent were black, 13 percent were Filipino, and one person was Chinese American. There were no white participants, although we did not exclude them intentionally. Most participants (70 percent) had sexual partners who identified with the same racial/ethnic category. Half (50 percent) had some college or an associate's degree, and most (65 percent) were employed.

The first author conducted one-to-two-hour interviews in person at the clinic using an interview guide developed by both authors. Men and women received similar questions, including family background, current partner(s), contraceptive use, and pregnancy. Participants were asked about all sexual partners, but later in each interview they were probed on one frequent sexual partner because issues of power, communication, and contraception were more salient. Consistent with feminist research methods (Charmaz 2006; Wertz et al. 2011), we allowed participants to describe important constructs in their own

words. We note that we asked participants for their racial identity, and many participants replied with their ethnic identity. We did not alter these identities.

All interviews were audio recorded and transcribed, then analyzed using Dedoose software. The first author developed an initial set of open codes on the first five transcripts, and we used a grounded theory approach, revising the codes iteratively (Strauss and Corbin 1998). Both authors reviewed the codes and altered the codebook until reaching consensus (**Error! Hyperlink reference not valid.**). Coding focused on participants' descriptions of contraceptive decision-making and management, and examples of how interviewees described men's role (if any) in this process. Through constant comparison, we realized that there was a gap between engagement and responsibility for men in contraceptive management. The men's transcripts then were coded for different expressions of engagement and descriptions of responsibility in this domain. Women's interviews were coded for descriptions of their partner's engagement and how they understood contraceptive responsibility, which were compared to our findings from interviews with men. We also coded for external barriers men faced that influenced family planning. The first author wrote a series of memos detailing emerging patterns in how men talked about contraceptive management (Berg 2004; Lofland 2006). As she integrated the memos, she looked for interview data that either challenged or complicated the patterns she was seeing. These methods allowed us to identify how intersections of race, class, and gender affect masculinities in contraceptive management.

MEN'S ENGAGEMENT IN CONTRACEPTIVE MANAGEMENT

We first describe diverse ways low-income men of color engage in contraceptive management and then show that, despite these relatively high levels of engagement, participants discussed a gendered contraceptive responsibility. We identify two emergent discourses in participants' depictions of men's place in contraceptive management relative to women's bodies: one is a feminist paradigm of respect and support, while the other is a patriarchal model reifying women's primacy in domestic life. We also show how men navigate gendered identities within larger structural barriers to contraceptive management such as poverty, gang membership, and violence; and we show how these barriers shape men's behaviors and attitudes in contraception.

I'm Here to Support Her

Men showed a range of engagement in contraceptive management that reveals seemingly egalitarian expressions of masculinity. Our recruitment location was conducive to finding engaged men since most were there to accompany partners, although this was not the initial objective in our inductive process. Out of the 20 men we interviewed, 14 came to the clinic to accompany their partner. These men offered supportive words throughout their partner's appointments, and most men described support contrary to previous research. For instance, Terrell, who was 19-years-old and multiracial, accompanied his partner to clinic appointments for the hormonal IUD insertion and checkups. At the time of the interview Terrell and his partner decided to discontinue contraception to start a family. Terrell left during the interview to hold his partner's hand during the IUD removal in case she

experienced discomfort. Terrell described how gang membership restricted his support of a former partner with contraception, and then with the resulting unintended pregnancy. He said:

> I was still beefing [fighting with rival gangs], still trying to be this hood person … You got to worry about people putting a bullet in your head … It was kind of an ultimatum. I could pick the hood or I could pick my daughter and my family … But that was just bad timing, because as soon as I decided to make that decision, I went to jail. So it took me away for another couple of years.

Terrell discussed how incarceration limited time with his infant daughter and showed how much he wanted to help raise the child. He said, "All I cared about when my baby mama was pregnant—all I cared about was my daughter … I could care less about myself." Deciding with his current partner to remove the IUD represented contraceptive involvement he had not been able to provide his former partner, although throughout the interview he often expressed uncertainty about his future ability to help with a potential pregnancy and later childcare. He said, "Nothing goes according to plan. For my all 19 years on this earth, I planned something, and it never went according to plan." Like Terrell, other men described difficult structural circumstances working against their efforts to support partners, and they revealed a variety of ways they still managed contraception. Men pulled out cell phones during the interview to text their partners and check on them while in their appointment. Men described discussions with partners about contraception in the waiting room prior to the appointment, going over options and helping with the final choice. Mateo, 22-years-old and Latino, said, "[I came] to support my girlfriend and her decisions of getting different birth control, and I want to show her that I'm here to support her and make her feel like she's not alone and that she can count on me." He also described how his girlfriend's undocumented immigration status affected his views on preventing pregnancy. He said:

> If she does get deported, then she can't come back for five, ten years … So if we were to have a baby and not be married or something, then our baby wouldn't have a mom … That's why the whole marriage thing came up because … you never know …
>
> We've heard stories of people who get deported … and that's why we talked about marriage … And birth control—I know that we talked about having kids but later. So I guess that falls under the marriage/kids later kind of thing. And I guess that's why we [consider] different types of birth control.

In Mateo's experience, immigration laws made delaying pregnancy with his partner important because he feared forced separation. His strong pregnancy intentions then motivated his engagement in contraception because he felt that having a baby was not a realistic option. This reflects how immigration status, ethnicity and gender intersect and young low-income men's choices are often constrained (Bird and Rieker 2008; Maternowska et al. 2010). Similar to Terrell, Mateo's words reflect how men's depictions of structural hardships highlight their concern for preventing pregnancy and their effort to support partners, both in contraceptive management and more generally in their relationships.

Examples of men's engagement applied most clearly to the men accompanying partners at the clinic, but it also applies to the six men at the clinic for STI (sexually transmitted infection) testing. Many men described prior discussions with their partners about contraceptive options. Other men also described helping women properly use birth control. Jackson, who was 22 and identified as black, discussed how his girlfriend was unable to complete her high school education because she needed to work multiple jobs. He felt it was important for her to go back to school. He talked about how his father had conveyed the importance of education and of delaying pregnancy until he and his partner achieved a high school degree. Jackson showed that financial constraints and educational aspirations motivated his desire to help prevent pregnancy, reminding his girlfriend to take the contraceptive pill. He said:

> [My girlfriend] would just sort of [ask] me … can I remind her [to take the pill] sometimes … If I am with her I ask her from the beginning—because I probably see them. I say, "Did you take your pill?" And she will either be like, "Yeah" or "Thank you for reminding me. I forget. So, I'm going to take it right now."

Jackson also mentioned abstaining from sex when his girlfriend missed a contraceptive pill. This exemplifies men's strong engagement in contraceptive management and how women partners were involved in co-constructing masculinity in contraception (Campo-Engelstein 2013). Similar to the way Jackson's girlfriend initially asked for reminders to take the pill, another participant mentioned that his girlfriend asked him each month to remind her to remove the contraceptive ring on time. Each month she would tell him the date to remove the ring, and he would remind her on that day. Other men described discussions with partners about menstruation and concern when their partner told them a period was late.

Interviews with women at the clinic supported the men's narrative, and, among the subset of women who decided on and managed contraception with a partner, women often described shaping their partner's involvement, similar to the men's descriptions of women partners.[1] For example, Olivia, 16-years-old and black, said she decided to start contraception again after previously using the contraceptive pill and shot. She had discussed this with her partner, but she planned to initiate further conversation because she wanted his full support before starting contraception. She said, "He said he was cool with it, but I don't know. I would like to talk to him more about it before I actually really go through and do it again." Other women mentioned teaching partners about different contraceptive options. Jasmine was 19-years-old and identified as Moorish American. She talked about how she taught her partner about different contraceptive methods so that he could support her in the management process. She said:

> He just wants to know [which I choose] … He like to at least be able to comfort me and make sure I'm okay … I totally understand. And that's why I'm happy that I am able to talk to him about birth control. Some birth controls, he didn't even know about. So … we was looking up stuff online. I was showing him what the birth controls looked like … And he was like, "Well, whenever we get to that time and

[1]It is important to note, however, that most of the women interviewed were not accompanied to the clinic by a male partner and often started contraception for health benefits, such as lighter periods, prior to meeting their current partner.

> you decide to want to do that, let me know." He's open to coming to my doctor's appointments with me … He's like, "I'll come with you." I like that.

Women also echoed men's feelings about structural barriers to men's engagement, such as the school system. For instance, women mentioned that schools did not effectively teach men about contraception. Angelica, age 20 and Filipino, would ask her partner to check her IUD strings to see that it was in place, and she initiated his help in teaching him about contraceptive options. She said, "My boyfriend didn't even know what the Mirena [hormonal IUD] was until I told him." She went on to explain how schools could better serve young men and women in their contraceptive goals through better education for men about different methods. She said:

> In health ed[ucation] they should actually tell the students about [contraception]. Like high school they have health education. So, I feel like [men] should know what females actually … use or what they can take to prevent getting pregnant.

In sum, almost all men in our sample described engagement in contraceptive management, regardless of whether they were at the clinic for a partner's appointment or their own STI testing. The men revealed how young, low-income men of color manage contraception despite structural barriers to their engagement. These barriers included limited contraceptive education as prior research has shown but also other structural determinants including gang violence, incarceration, immigration laws, and financial constraints. These structural constraints limited men's choices and often shaped the importance of delaying pregnancy, which further motivated them to help with contraception. Men's efforts in light of hardship helped to further distance their gendered identities from hegemonic ideals associated with contraception-avoidant behaviors and a lack of concern about health and reproductive issues (Addis and Mahalik 2003; de Visser and Smith 2006; de Visser, Smith, and McDonnell 2009). In many cases, women explicitly shaped how they wanted partners to help, and thus women co-constructed a more egalitarian expression of masculinity for men.

It was her Decision

Our interviews reveal men's engagement in contraceptive management, but we found that men's involvement was still circumscribed to further distance their masculine identities with more coercive expressions of masculinity. Diego, who was 17 years old and Latino, spoke of how his girlfriend lived with her parents and her father's verbal and physical abuse caused difficulties in their relationship as they both worked to finish high school:

> I know that she has a lot of problems with her dad … he's a mean guy … He will scream at her. He will tell her this and that. And then her mom and dad will argue 'cause of her dad. It's just annoying. And she will cry.

Throughout the interview Diego worked to contrast his own behaviors with those of his girlfriend's father; he wanted to show his efforts against these structural constraints to be a supportive partner, placing emphasis on how his relationship was "different … because we don't fight in front of people. If we're mad at each other … I wouldn't say anything. I would just stay quiet and be like, calm down. We're in front of people. We're not supposed to be doing this … I wouldn't scream at her in front of other people. I wouldn't do that, not even to her like that." Diego's efforts to distance himself from coercive masculinity also played a

large role in how he depicted contraceptive decision-making, because he often mentioned how he wouldn't "force" his girlfriend to use a method. Diego said:

> Well, we both talked about it a lot. We talked about every [method]. We saw the list. We were like, which one do you want? I asked her, "Which one do you want?" 'Cause I'm not the one who's going to get it. She is. If you want to get that, that's fine with me. If you feel like that's better for you and that's going to be a good fit for you, you should get that. I'm not going to judge you. For me it's whatever you want 'cause it's your decision. It's going into you … She's the one who makes the decision of whether or not to get it because I don't force her. I wouldn't force her to get something she doesn't want to get. So it was her decision to come over here [to the clinic].

Here Diego is involved and supportive in discussing contraceptive options with his partner prior to choosing injectable contraception; yet, similar to many of the other interviewed men, he downplayed his involvement to distance himself from domineering expressions of masculinity in contraception, such as forcing a woman to use a method; this is in contrast to prior research showing that when men engage in reproductive coercion it is often to *prevent* contraceptive use (Harvey, Henderson, and Casillas 2006; Northridge et al. 2017; Tschann et al. 2002). While acknowledging deference to his girlfriend's decision-making power reflects his respect for her bodily agency and his effort to work against structural barriers, Diego's words also convey a feminized responsibility for pregnancy prevention.

Diego is an example of how men produced a more patriarchal discourse where they anchored disproportionate responsibility on women for pregnancy prevention. Women's final say in contraceptive decision-making further reified women's reproductive embodiment. Yet simultaneously men kept their gendered identities as progressive, caring for partners through discussions of engaging in contraception despite structural obstacles, and rejecting dominant and coercive expressions of masculinity (Lamont 2015). This combination of engagement and disengagement was a common theme. For example, Sergio, a 20-year-old longshoreman who identified as Mexican, described difficulties he experienced and overcame with his girlfriend, including violence and drug use in his community. He explained how Latino stereotypes motivated his view of the importance of delaying pregnancy. He said:

> My girlfriend and me have been through hell and back quite literally … But we've pulled through everything. And I believe we're ready [for pregnancy], but we just need a [financial] foundation … Because I don't want to be the typical Latino living with his [parents] while being married. I want to be out there on my own.

Sergio described how he helped his girlfriend obtain an IUD after he learned about this contraceptive method from his sister. He knew of different methods and their relative efficacy, yet downplayed his involvement:

> Sergio: The lady explained … options to us. But I had an idea of it because of my sister … So, we just went with the highest percentage [of pregnancy prevention].
>
> Interviewer: And can you explain your partner's involvement in the decision?

> Sergio: Well, I didn't weigh into it at all. I just talked to her about it. But at the end of the day, she had to choose … I would say I was hardly involved in that. I was just talking. But overall the decision making on that is—it was her.

Sergio's dismissal of "just talk[ing]" as true contraceptive labor seemed to stem from respect for women's agency, yet it also reflected his masculine identity as a supportive albeit secondary partner in pregnancy prevention. Sergio's depiction of being "hardly involved" because "she had to choose" assigned greater reproductive accountability to his partner.

The women also depicted men's circumscribed involvement. Similar to the men, they felt that feminized accountability for contraception signaled men's deference to their decisions. Andrea, who was 18 and identified as Hispanic, described her current partner's limited conversations with her about contraception. She said, "He [my boyfriend] can't tell me, 'Hey, you can't take this.' Well, I'm going to take it anyway." Other women echoed these thoughts, often stating that a partner "can't say no." For women, men's circumscribed place in contraception ensured their freedom of choice because they were wary of the behaviors associated with hegemonic masculinity in this domain, although instances of coercive or restrictive male partners were rare in the women's interviews.

Often the men and women more explicitly depicted women's primacy in contraceptive management with a focus on women's bodies. Rather than viewing contraception as a highly effective means for achieving mutual reproductive goals together, the interviewees stressed the way that contraception and pregnancy only affect women's bodies and therefore should be primarily the women's responsibility. Rahim, who was 21 years old and identified as black, provided a clear example of this logic. He was in his second year of college and one of the few participants who disclosed having multiple sexual partners. The interview focused on his most frequent sexual partner. Rahim talked about injectable contraception and pregnancy as a risk for his partner alone.

> Rahim: I'm not in control of a woman's body and stuff. So if she want to be on birth control, that's on her. If she don't, that's on her. I'm not going to force nobody to do nothing.
>
> Interviewer: How do you feel about it being on her and that it's her body?
>
> Rahim: She ain't got to worry about getting pregnant, I guess. I think that's it. She [is] doing it so she won't get pregnant.

Rahim is consistent with larger patterns in our data, as he mobilized a patriarchal discourse assigning disproportionate contraceptive responsibility to women. Rahim did not share in pregnancy risk because his partner physically experienced unintended pregnancy.

Isabella, age 22 and South American, also described this connection between women's bodies and feminized responsibility. She said:

> [My boyfriend is] not worried about me taking [the pill] or not … I mean [men are] not the ones taking it … There's too much birth control for women, and if men really wanted to be aware of birth control and not getting anybody else pregnant,

> they would do something about it too. But apparently they don't. They always say it's all up to the woman.

Isabella showed how viewing the body as primary in determining uneven divisions of contraceptive responsibility reinforced men's privilege by holding women more accountable for contraception. The men's interviews echoed these ideas but also showed that they *did* care about unintended pregnancy; they showed that managing contraception effectively represented mutual reproductive goals. For example, Miguel, 16 years old and Brazilian, engaged in contraceptive management yet did not share responsibility for unintended pregnancy. His girlfriend and he had an unintended pregnancy, and, similar to many young people in marginalized communities, they seemed to lack information on how to properly use contraception (Gilliam et al. 2016). Throughout the interview, Miguel choked back tears and explained his confusion about the proper use of the vaginal ring. Despite this confusion, Miguel described himself as having been highly engaged in choosing the vaginal ring. He suspected his girlfriend was not replacing the ring at the proper time for its maximum efficacy, yet he undermined his involvement and denied responsibility in the process. He said, "I didn't think much of [the ring]. I thought it was just … her doing what she feels is right. So, I just completely went along with it … I mean it's her thing, it's not my medication or anything. So, she takes it in her own hands." Of all the interviews, his case was notably emotional, particularly regarding the unintended pregnancy. Yet Miguel still maintained that contraception was in her hands because it was her medication, even though contraception was for their mutual goal of preventing unintended pregnancy and the pregnancy was affecting him. Since contraception was "in her hands," he assigned her more responsibility for achieving their joint reproductive goals. When she did not meet their goals, he ultimately held her accountable for removing the vaginal ring too early. He said:

> I was like, "You should have told me." I told her, "Now that you're pregnant, there's not much we can do. But next time advise someone before you do something like that." … She didn't tell me she took [the ring] out. She told me to pull out, so I thought it would work … Honestly, I don't know if [she] planned [the pregnancy] or not. But it happened … I mean, it wasn't really my mistake since I didn't know.

Despite our findings that men may enact a relatively egalitarian masculinity such that they engage in contraception without detracting from women's reproductive agency, we found that this engagement is still circumscribed so that women take on a disproportionate burden for pregnancy prevention, reifying gender boundaries. We note throughout how the interviews with women support these findings. Contraceptive responsibility for men and women is largely rooted in the primacy of the body and the individualized risk of physically experiencing pregnancy. We show men's reproductive ambivalence through their use of two different discourses, one seemingly egalitarian and another more patriarchal, to establish a hybrid masculinity involving men's supportive but secondary place in contraceptive management (Bridges and Pascoe 2014). Women's embodiment of reproduction leads to women's primary responsibility and thus disproportionate levels of accountability in contraceptive management (Martin 2001). Similar to other work showing how men may engage in contraception to maintain their "good guy" status (Terry and Braun 2011), we also

show this through men's respect for women's bodies while they excuse themselves from more equal sharing in reproductive responsibility.

CONCLUSION

While research has identified a gendered division of contraceptive labor such that women alone manage hormonal contraception and the copper IUD (Fennell 2011), we reveal a seemingly egalitarian masculinity in that young men work with sexual partners in a variety of ways to effectively manage these methods, contrary to hegemonic standards in this domain typically discouraging men's supportive involvement (Connell 2005; Lamont 2015). Consistent with previous literature, we find that men often face structural barriers while supporting partners with contraception (Gilliam et al. 2016; Merkh et al. 2009), often magnifying their strong efforts to be progressive, caring partners. Often structural obstacles limit men's choices and further the perceived need to prevent pregnancy, motivating their engagement in contraception. This paper helps to further dispel the idea that young low-income men of color are indifferent to or disengaged in family planning; and it shows that men care about their partners and their mutual reproductive goals.

However, we also show that young men and women alike describe women as primary bearers of contraceptive responsibility despite how nearly every man in our sample described active engagement. Men highlight women's agentic bodies to reveal a narrative involving a seemingly egalitarian masculinity despite structural barriers, while they also mobilize a patriarchal discourse holding women disproportionately responsible for pregnancy prevention due to women's physical experience of contraception and pregnancy. This unequal gendered responsibility creates a hybrid masculinity that relieves men from holding an even share of accountability for their reproductive goals and thus preserves an unequal division of contraceptive labor (Bridges and Pascoe 2014; Connell and Messerschmidt 2005; Messerschmidt 2010; Messner 2007). Men have the luxury of dropping in and out of contraceptive labor, involving themselves enough to demonstrate that they are "good guys" who care about women partners and their bodily agency, while removing themselves from fully bearing the burden of reproductive responsibility (Amor et al. 2008; Lamont 2015; Terry and Braun 2011).

Women's greater responsibility for contraceptive management easily slips into an assignment of blame when unintended pregnancy occurs. This further reifies women's place in the domestic sphere, since they are viewed as responsible for the most effective forms of contraception (Fennell 2011; Oudshoorn 2003, 2004). So although young people view women's control over contraception as signaling their agency, and women too shape men's relatively circumscribed involvement (Campo-Engelstein 2013; Schippers 2007), these gendered spheres ultimately reinforce oppressive conceptions of what it means to be a "woman" and further the cultural enforcement of women's reproductive embodiment (Lorber and Martin 2011; Martin 2001).

This research has important implications for the intersectional study of gender, race, class, and reproduction; but there are a few limitations, in part due to our recruitment site. While the pregnancy prevention clinic helped provide us with participants who wanted to use

contraception, we were unable to explore how gender affects pregnancy prevention efforts among young people who are unable to reach a clinic. This clinic setting allowed us to illuminate masculinities among young, low-income men who face structural barriers that might limit their engagement and responsibility in the reproductive realm (Edin and Nelson 2013; Weber 2012), but future research might further explore our topic with more participants from each racial/ethnic subgroup. We also note that most of our sample of women were unaccompanied to the clinic, and therefore most did not discuss the same levels of engagement that the men revealed in their interviews. Future research could provide more interviews with couples, so that the women partners of more engaged men would be included in the sample. Regardless, interviews with women supported our main findings about contraceptive engagement and responsibility.

While our data reveal ways that men engage in a traditionally feminized sphere, there is room for progress in gender relations. Men can engage in contraceptive management without detracting from women's efforts towards reproductive goals; and the more contraceptive engagement and responsibility include men, potentially with the development of more male-focused contraceptive technologies, the closer this engagement comes to closing the gender gap in domestic life (Oudshoorn 2003, 2004). Our research suggests that men can support partners while sharing in a more equal distribution of responsibility. Men can take greater accountability for contraceptive management and share in the risk of unintended pregnancy, regardless of women's physical experience of pregnancy. In particular, blame cast on women for unintended pregnancy is strongly indicative of patriarchal forces. Because currently an egalitarian narrative of support and deference is juxtaposed with a patriarchal discourse excusing men from sharing equally in reproductive responsibility, the way men and women still have imbalances in contraceptive labor is particularly insidious; it will require changes in both men and women's gendered identities to begin to lead towards egalitarian gender relations.

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