Introduction

Sweet 16. That's how old Manuela (22 years old, Latina) was the first time she had sex with her boyfriend. They decided to take the proverbial plunge over a year into their relationship. Like many teenagers, they used condoms for birth control to start,[1] but they stopped that pretty quickly. After having sex only twice, in fact. They talked about what to do and, in Manuela's words, "We kind of thought of it together, but he kind of was the first one to say, 'I think you should just get on the pill.'" And get on the pill she did. Having a prescription for the pill made it even easier to decide what to do with her next sexual partner. They used a condom once but, unlike her experience with her boyfriend, they never talked about birth control. Instead, she said, "We just had sex and I don't know if he just assumed that I was on the pill, but we never talked about it."

Manuela's experiences with her first partners followed a similar pattern: condom use for a few encounters and the pill thereafter. No surprise there. It is often difficult for young people to consistently use condoms and not uncommon for them to switch to prescription methods like the pill at some point.[2] While Manuela had no problem relying on the pill when she first started having sex, it was only a matter of time before that division of labor stopped

working for her. What happened when she decided not to "just get on the pill"? Like many people who can get pregnant, she largely struggled to use birth control after that. Though either partner can dislike condoms, Manuela's interest in condom use was not the problem. Instead, it was an inability to get her partners to use condoms as she wished. With one partner, she refused to get on the pill after he asked her to, so they had sex without birth control. And with another, "The first few months it was condom all the time, and it was a new one every single time. But, after a while he's just like, after a while no."

Experiences like Manuela's show that much more guides young people's decisions about birth control than concerns about effectiveness.[3] Her partners did not automatically default to using condoms when the prospect of pill use was off the table, even though they too wanted to avoid pregnancy. Since the invention of the pill, it has not been uncommon for people to assume that women—especially those in long-term relationships—will carry the burden of preventing pregnancy by using prescription contraception.[4] Indeed, the pill is the most widely used form of birth control in the United States, and fewer than one in ten women use two methods of contraception (e.g., condoms and the pill) simultaneously.[5] Women from groups with high rates of unintended pregnancy, defined as pregnancies that were never wanted or occurred too soon, face especially intense scrutiny of their contraceptive choices. Contraceptive use, like housework, can be considered another form of domestic labor in which women routinely engage;[6] and, like housework, ideas about gender motivate behavior.

In *Just Get on the Pill,* I explore how gendered assumptions and expectations shape women's birth control experiences with their partners. The book is grounded in the stories of women like

Angelica (a pseudonym), who told me when it came to preventing pregnancy with her boyfriend, "I think he kind of just left it up to me to make sure that I'm grown and I need to take care of it. I think that was his mentality, like well, you're a woman, you're grown, handle your business type thing." Angelica did "handle her business"—by using prescription birth control—without complaint. Her inability to use her method consistently and her boyfriend's resistance to using condoms, however, resulted in a pregnancy. Angelica's narrative, and those of over a hundred other women, showed me how the division of labor in birth control plays out in women's lives. I argue that gender inequality in birth control use is not the result of either natural differences between male and female bodies or incidental differences in the effectiveness of "men's" versus "women's" methods. Women like Angelica are not left to shoulder the burden of preventing pregnancy without help from their partners simply because the birth control methods "designed for" women's bodies are more effective. Indeed, prescription birth control is quite ineffective for women who dislike it, lack regular access to it, or prefer not to use it. Instead, I show that parents, peers, partners, and providers socialize women into using "female" birth control methods and ultimately into accepting primary responsibility for preventing pregnancy—a phenomenon I call *gendered compulsory birth control.*

Just Get on the Pill demonstrates that gendered compulsory birth control has a number of overlooked, but nonetheless severe, consequences—namely, it undermines women's rights by reducing their control over their bodies, eroding their reproductive autonomy, and constraining their ability to have sex safely and without coercion. Using an intersectional lens, I show how Black and less advantaged women adopted novel approaches to the compulsory

birth control system, especially by refusing to begin prescription birth control when partners will not wear condoms. Nevertheless, researchers may sometimes inadvertently recast these women's strategies in the power-neutral language of *contraceptive inconsistency* or *nonuse* because the dominant family planning approach in the United States positions prescription birth control for women as the solution to unintended pregnancy. I show that compelling the use of prescription birth control as the sole "woman's method," especially when partners refuse to use condoms, ultimately harms women by making it more difficult for them to protect themselves from disease. Counterintuitively, it can also complicate pregnancy prevention because most women are channeled away from buying, carrying, and using condoms (a "man's method"), even if they have trouble using the methods assigned to them. In the end, I show that the gendered organization of birth control is not natural. It is unjust.

INEQUALITY IN THE PREGNANCY PREVENTION PRESCRIPTION

Although battles over the power to regulate women's reproductive experiences have a long history in the United States,[7] contraceptive behavior became the subject of regular public study only in the first part of the twentieth century. The American Medical Association declared contraception a medical issue in 1937, on the grounds that "the intelligent, voluntary spacing of pregnancies may be desirable for the health and general well-being of mothers and children."[8] This declaration gave physicians the authority to discuss contraception with their patients. The first study to examine people's pregnancy attitudes and behaviors was conducted just a few years later in 1941, when the Indianapolis study surveyed almost fifteen

hundred couples about their pregnancy attitudes and contraceptive behavior.[9] While the study sought to understand how to *increase* the fertility of married, white, Protestant women (because of eugenic fears about the falling birth rate for this group), demographers and public health experts later focused their attention on eugenic efforts to *decrease* population growth for groups whose fertility they categorized as "undesirable."[10] These attempts included contraception and sterilization campaigns aimed at eradicating the fertility of people of color, the poor, and the mentally ill.[11] The Indianapolis study introduced the idea of unintended pregnancy and put women's fertility intentions on the map as a public health issue.[12] Even at this early date, women were the focus of efforts concerning pregnancy prevention.

The establishment of a field of study dedicated to women's fertility and women's pregnancy intentions supported efforts to monitor women's reproductive experiences long after overt eugenic campaigns had faded. Since its publication in 1995, *The Best Intentions: Unintended Pregnancy and the Well-Being of Children and Families,* a book published by the Institute of Medicine, has been one of the most important publications to direct the agenda for research on pregnancy and childbirth.[13] The book opens by noting that nearly 60 percent of pregnancies in the United States at the time were mistimed or unwanted. The authors then argue that to reduce the incidence of unintended pregnancy, the United States must reformulate its cultural approach by establishing "a new consensus that pregnancy needs to be undertaken only with clear intent."[14] Every pregnancy, in other words, should be *planned* for every person. The committee notes that this goal "is directed at all Americans" and "emphasizes personal choice and intent."[15] Increasing contraceptive access, knowledge, and use were positioned as central to helping

people plan pregnancies, thereby reducing the number of unintended conceptions and abortions. The book did not contend with how focusing on planning and preventing pregnancy as the ultimate goal could have disproportionate consequences for women in general, and marginalized women in particular. Inequity in today's pregnancy prevention frameworks and strategies can be traced back, at least in part, to the recommendations in this book and the overlooked consequences of its arguments.

In the years since the publication of *The Best Intentions,* the percentage of conceptions labeled as unintended has remained high (e.g., 45 percent in 2011), and public health experts have doubled down on efforts to convince couples to use contraceptives during every sexual encounter.[16] While both partners contribute to conception, research on unintended pregnancy usually focuses on cisgender women. Of all unintended pregnancies that did not result in miscarriages in 2011, just over 40 percent resulted in a birth and nearly 60 percent resulted in an abortion.[17] Dissecting these data reveals that young women, women of color, and women who are poor or have low incomes are most likely to have an unintended pregnancy.[18] In addition, Black women and those with low incomes are more likely than women from other racial and class groups to have an abortion. Researchers note that while the nearly 70 percent of women who use contraceptives consistently and correctly account for only a very small fraction of unintended pregnancies (5 percent), the roughly 30 percent of women who do not use contraceptives, or use them inconsistently, account for 95 percent of all unintended pregnancies.[19] This focus on women ignores their partners as equal participants in sex and conception, de-emphasizing their actions in preventing or contributing to unintended pregnancy. Instead, many researchers and clinicians consider family

planning for the person with a uterus to be central to preventing pregnancy for couples.

From a public health perspective, scholars and policy makers view ensuring that each pregnancy is planned as not only a personal goal that cisgender women should strive for but also as a social imperative crucial to cutting economic costs and improving a variety of health outcomes.[20] As historian Rickie Solinger noted, the management of women's fertility has often been advanced as a tool for solving a variety of social problems, even as women's bodies and best interests are subordinated to a discussion of what regulating their bodies might accomplish.[21] In the case of unintended pregnancy, getting women to "plan their pregnancies" and reduce unintended births have been championed as important contributors to reducing poverty, improving childhood outcomes, and reducing rates of poor mental health (due to having children from an unintended conception).[22] In *Healthy People 2020*—a set of public health goals set by the Centers for Disease Control and Prevention every decade—family planning is portrayed as important because reducing unintended pregnancies saves the government money, and family planning clinics serve large swaths of women.[23] Thus, at both the individual and national levels, managing women's fertility is upheld as the cure for a multitude of public health concerns. *Just Get on the Pill* reveals the significant negative consequences of this approach for women's control over their bodies.

Campaigns to reduce unintended pregnancy overwhelmingly focus on cisgender women, often without acknowledging how this focus affects contraceptive use in their relationships and sexual encounters. In the presidential address at the Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in 1999, for example, Dr. Frank C. Miller asserted,

"Contraception must be made available to teens who are sexually active, especially to adolescent girls for the prevention of unintended pregnancies as well as deadly STDs."[24] He implored clinicians to become leaders in their communities because "these are our sisters and our daughters, and they deserve better. They need our help."[25] Reflecting Dr. Miller's focus on the central role of women and girls in the discussion of birth control, contraceptive counseling guidelines state that while providers should discuss all methods with patients, they should discuss those considered particularly effective (i.e., prescription methods requiring women to visit medical providers) first.[26] Notably, even a 2014 policy statement on adolescent contraception released by the American Academy of Pediatrics suggested that providers begin by discussing the most effective contraceptive methods (which offer no protection from sexually transmitted infections [STIs]), even though adolescents and young adults accounted for 66 percent of all reported chlamydia cases at the time.[27] Some researchers have taken recommendations to prioritize effective contraception one step further by issuing calls for women to use prescription birth control that is effective for several years to reduce the "burden of unintended pregnancy."[28] With the rise of prepregnancy care, which focuses primarily on individual women,[29] the gendered surveillance of women's bodies will likely remain unchanged for the foreseeable future.

Perhaps because of the overwhelming focus on women in family planning, their partners have trouble accessing information on birth control. Many clinics have programs only for women, and, even when men do interact with health care providers, they are less likely than women to receive information on birth control methods.[30] This is particularly problematic because over 75 percent of men have become sexually active by age 20.[31] Thus, while both

men and women contribute to conception in heterosexual encounters, men do not experience the same pressures to "manage" their fertility. This fact is not lost on ordinary women. A young woman whom I call Jennifer, for example, wished there were "men's birth control" because pregnancy prevention "is sort of all up to me." Isabella also noted the unfairness of the birth control playing field, asserting "I think that it's also the guy's job too to have other methods. I don't understand, like there's all this research that goes into finding easier ways to implant things for women and things like that but there's not that much that goes into easier ways for men too. Because a lot of men find condoms a hassle."

Even as several social factors contribute to women's assuming primary responsibility for preventing pregnancy and birth, observers not uncommonly explain this inequality by citing "the reality" that the most highly effective methods of contraception are designed for women.[32] Such explanations assume that differences in the effectiveness of "men's" and "women's" birth control methods drive contraceptive behavior—an assumption predicated on first categorizing birth control according to people's bodies. From the notion that birth control methods with different levels of effectiveness are made for differently sexed bodies to the notion that cisgender women are responsible for preventing pregnancy because they bear children, unexamined assumptions about gender enjoy unmerited prominence in both popular and academic explanations for the gendered division of labor in birth control. Even justifications premised on clearly faulty logic, such as the belief that interventions target women because a single man can impregnate many women, abound. All of these explanations rest on biological determinism (the idea that biology explains behavior), which researchers have vociferously refuted in other domains.

Interrogating the veracity of such explanations is one of the central tasks of this book.

IMAGINING REPRODUCTIVE JUSTICE

Understanding women's experiences with birth control requires moving beyond thinking about individual women to thinking about the social world that enables and constrains their behaviors. In *Just Get on the Pill,* I analyze women's experiences using a quality of mind that considers the connection between a person's individual situation, the historical moment, and the workings of important institutions like families that make up society. This frame of mind—called the sociological imagination—pushes us to understand that individuals reside within a larger cultural and historical context.[33] From this perspective, women's reproductive experiences cannot be examined in isolation from the larger cultural, historical, medical, and legal forces that act on and through their bodies. I grapple with how social factors mediate the relationship between the meanings of women's fertility and the dominant public health frameworks for determining the best way to manage births. In *Just Get on the Pill,* I show that gender is central to this task and, with regard to the bodies of women, gender goes hand in hand with race and class.

In analyzing gender, I draw on social constructionism, which posits that social categories do not have inherent meaning, but rather acquire it as people come together to define and create meaning through social interaction. One of the key contributions feminist theorists have made to social science is the idea that sex and gender are not equivalent. *People* create and enact ideas about sexed bodies, and those understandings and behaviors help define what is called gender.[34] In this sense, biological sex refers to the