Abstract: A necessary component to reproductive autonomy is being trusted to make reproductive decisions. In the case of contraception, however, women are considered both trustworthy and untrustworthy. Women are held responsible for contraception and because responsibility usually stems from trust, it appears that women are trusted with contraception. Yet myriad laws and forms of surveillance and normalization surrounding contraception make women seem untrustworthy. Relying on Amy Mullin’s conception of trust that we trust those who we assume believe in the same social norms we do, I argue that this tension results from two competing social norms. One norm governing contraception is that people should be self-sacrificing, a norm with which most women align due to traditional gender roles. However, there is a norm that women are irrational in general as well as in contraceptive matters and consequently should not be trusted to use contraception. In order to combat both these norms, I make concrete recommendations for increasing knowledge of contraception, normalizing its use, and trusting both women and men with it.

Competing Social Norms: Why Women Are Responsible For, But Not Trusted With, Contraception

A necessary component to reproductive autonomy is being trusted by others and society to make reproductive decisions. When we are not trusted, politicians pass laws to restrict our behavior (e.g., outlawing certain abortion procedures and preventing women under seventeen from purchasing emergency contraception) and society enacts surveillance and normalization to control our behavior (e.g., pharmacists refusing to sell contraception to women and people giving dirty looks to pregnant women who buy cigarettes or alcohol). Given the myriad laws and forms of surveillance and normalization surrounding contraception, it seems to be something with which we do not trust women. Yet, women are held responsible for contraception and because responsibility usually stems from trust, it appears that women are trusted with contraception. In this paper, I explore this tension to understand why women are seemingly both trusted and distrusted with contraception. Relying on Amy Mullin’s conception of trust that we trust those whom we assume believe in the same social norms we do, I argue that this tension results from two competing social norms. One of the social norms governing contraception is that people who use contraception should be self-sacrificing. Women are considered good self-sacrificers because of their traditional role as caretakers and the belief that they are “naturally” altruistic. Therefore, women should be trustworthy. However, there is a social norm that women are irrational in general as well as with contraception and consequently should not be trusted to contracept. In order to combat both these norms—contraception as self-sacrifice and women
as irrational—I make concrete recommendations for increasing knowledge of contraception, normalizing its use, and trusting both women and men with it.

The Role of Social Norms in Trust

A common theme running through most accounts of trust is that trust is the attitude that others will meet our expectations of how people should act. In everyday life, we normally do not discuss our expectations of people’s behavior with them, except with children and employees, because many expectations are tacitly shared. For example, almost everyone in Western culture knows that when there is a line for something that they should stand at the end. While the case of knowing to wait one’s turn in line may seem morally trivial since it is an example of social etiquette, it is, still an expectation we have of others. Expectations that are not merely etiquette but carry some moral significance are also rarely discussed, such as the expectation that people should remember their good friends’ birthdays. Given that there is minimal discussion at best and no discussion at worst of how people should act, how do people know what actions are socially and/or morally correct? The answer is that people learn how to act through social norms. While parents often explicitly tell children how to behave (e.g., wait your turn in line), children (and adults) also learn quite a bit about how they should act by observing the actions of others as well as people’s responses to these actions. For example, if a child sees that her grandfather is upset because a friend forgot his birthday, she learns that it is expected that people remember their friends’ birthdays.

In her account of trust, Mullin describes the importance of social norms: “In interpersonal trusting, 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. We further assume that the trusted one’s commitment to that norm is to at least some degree intrinsic rather than instrumental.” Let me provide an example to clarify. At some colleges, students are under the “honor code” to conduct their work with moral integrity. Jim and Kim both go to the same college where this honor code is in place. Jim intrinsically values the honor code and thinks it is immoral to violate it. Kim, in contrast, does not intrinsically value the honor code, but only instrumentally values it because it allows her more freedom, such as to the freedom to take her final exams whenever and wherever she wants during exam week. As pre-med students, Jim and Kim are both taking Organic Chemistry. They both need to get an A on the final exam in order to get an A in the class, which will ensure that they get into medical school. Given their different reasons for valuing the honor code, can we trust both of them to follow it when taking their exam? My intuition is that Jim is trustworthy, while Kim is not. Because he intrinsically values the honor code, Jim wants to act in accordance with the honor code. He normatively values the honor code and thus considers violating it morally wrong.3 While he may be tempted to cheat because he wants to get into medical school, he is less likely to cheat due to his deep commitment to the honor code. If he does cheat, we may chalk it up to weakness of the will or competing values (i.e., his commitment to the honor code and his desire to get into medical school). Whereas Jim can be trusted to follow the honor code because he intrinsically values it (this, of course, does not guarantee that he will follow it) since Kim only values the honor code instrumentally (it gives her more freedoms with exams), she finds it less morally troubling to violate it and consequently would be more likely to cheat than Jim in the same situation. We cannot trust Kim to follow the honor code, but we can rely upon her to adhere to
it because she instrumentally values the honor code. The honor code is important to Kim because it provides her with freedoms that she values. By valuing these freedoms, she indirectly values the honor code and hence is less likely to violate it than someone who doesn’t value the honor code at all. Another student, Tim, who does not value the honor code at all—neither intrinsically nor instrumentally—is the most likely to violate the honor code because it has no significance for him.

This example shows the role norms play in trust. Other accounts do not explicitly include such norms. For example, the proponents of the goodwill approach posit that when we trust, we rely upon and/or have the optimistic attitude that others’ goodwill will positively influence their interactions with us. According to the moral integrity approach, trust entails expecting others to act with moral concern and respect toward us. Although I don’t have the space to discuss in detail these approaches, let me mention two reasons why they are less suited to contraceptive trust than Mullin’s theory. First, given that contraception is associated with the private realm and consequently is rarely publicly discussed, people learn contraceptive expectations through social norms. Any theory of contraceptive trust therefore needs to explicitly involve social norms. Yet, neither the goodwill approach nor the moral integrity approach does this.

Second, I am concerned with trust on a social level, what I term “social trust.” Whereas interpersonal trust examines trust on the individual level—does person A trust person B?—social trust takes a broader perspective and examines whether society as a whole trusts a particular group of people. While Mullin’s approach is based on interpersonal trust, because she recognizes social groups and incorporates social norms, it is possible to expand her theory to include social trust.

The other approaches base trust on our expectations of how others’ actions will affect us—making the trusting individual the focus—whereas Mullin grounds trust in our expectations that people follow norms—placing society’s, not the individual’s, perspective at the center. Because social trust looks at entire groups of people rather than specific individuals, it relies more heavily on social norms and stereotypes. Whereas people involved in interpersonal trust can acknowledge particular differences about the people and/or the circumstances, since social trust involves groups of people—and thus generalizations about these groups—no such particularities about individual people or circumstances can be recognized. Instead, social trust looks to social norms in order to determine whether a group of people is trustworthy.

Contraceptive Social Norms

One of the most dominant norms for reproduction and childcare is self-sacrifice: women are expected to willingly, and happily, sacrifice themselves for their fetuses and children, even if there is only the potential for a slight improvement or advantage. Implicit in this expectation is that women are to blame if their children do not turn out “right,” as it signifies that the women did not sacrifice enough. Since contraception fits under the umbrella of reproduction and childcare, it follows the same norm of self-sacrifice.

Initially, it seems odd that one of the social norms for contraception is self-sacrifice. 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, most women are willing to put up with the inconveniences of contraception because it allows them to achieve their goal of avoiding pregnancy.
However, contraception involves self-sacrifice because it is, in many cases, a forced responsibility. Women are often saddled with full contraceptive responsibility because there is a significant disparity in both the number and quality of available contraceptives: all contraceptives target women’s bodies except condoms and vasectomies; no male contraceptives are both long-acting and reversible; and male contraceptives have a higher failure rate. Problematic views of women’s bodies have both contributed to and reinforced this disparity: women’s bodies are typically understood as inherently diseased and in need of medical solutions to their “problems,” in addition to being thought to be less complex and more controllable than men’s bodies. Women’s perceived traits, especially their “natural” caretaking ability and their association with the private realm, buttress women’s contraceptive responsibility: “good” women not only tend to private tasks, but they also care for their partners’ needs, including their sexual and reproductive needs, and their children’s and potential children’s needs.

These reasons show that, while women may be grateful to assume contraceptive responsibility, if they want to avoid pregnancy and be “good” women, then they have little choice but to contracept. Women shoulder almost all the contraceptive burdens: maintenance, bodily invasion, adverse side effects, financial cost, etc. While these burdens may seem more like minor inconveniences that enable women to achieve reproductive autonomy, that there are few alternatives and that this arrangement systemically benefits men is troubling. Absolving themselves of contraceptive responsibility increases men’s freedoms: to have sex worry-free, to avoid bodily invasion, and to have enhanced sexual access to women. It also means that men do not have to take the blame for unintended pregnancies.

Competing Social Norms: Women and Contraception

Contraception as Preventing Harm to Potential Children

Even in our pro-natalist society, contraception is valued because it protects the life of potential children by preventing their birth to women who are assumed will be less sacrificing since they were not interested in having children (at that time or ever). In this way, contraceptive expectations resemble those at play in reproduction and childcare—women are supposed to put the well-being of their potential children ahead of their own desires. While we may not consciously think of contraception in this way, we nonetheless talk about the necessity of contraceptive responsibility increases men’s freedoms: to have sex worry-free, to avoid bodily invasion, and to have enhanced sexual access to women. It also means that men do not have to take the blame for unintended pregnancies.

John Arras and Jeffrey Blustein present this line of thinking in their discussion of 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.” Arras and Blustein enumerate a range of ideas of what counts as 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 how this threshold is defined, the main idea here is that people should not reproduce if their potential children...
would be harmed. The potential parents are viewed as the ones responsible for causing this harm and, moreover, as the only ones who can prevent it. 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 through abstinence or contraception. Even if these individuals would like to be parents, they should not reproduce because of the potential harm to their potential children.22

Taking the perspective of potential children, Lisa Cassidy extends this argument even further, asserting 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.”23 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.”24 Although Cassidy intentionally avoids defining what it means to be a good parent,25 her parenting ideal is in line with that of the self-sacrificer. She recognizes this and, in presenting an objection to her argument, states that her position could lead to the “self-sacrificing non-mother who has sacrificed having children for the children’s sake.”26 While she objects to the gendered nature of sacrifice—that just women should have children because “parenting is just too important to do in a way that is just good enough.”24 Although Cassidy intentionally avoids defining what it means to be a good parent,25 her parenting ideal is in line with that of the self-sacrificer. She recognizes this and, in presenting an objection to her argument, states that her position could lead to the “self-sacrificing non-mother who has sacrificed having children for the children’s sake.”26 While she objects to the gendered nature of sacrifice—that just women should be the ones making 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 outweigh the potential parents’ desires. Yet, many would argue that not parenting is too great a sacrifice to ask people to make. 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.27 Furthermore, that the desire to have children may be a social construct does not take away from the fact that people are expected to make what they view as significant sacrifices for their potential children.

Cassidy’s discussion makes explicit the sociocultural assumption that people who believe they will make inadequate or even average parents have a responsibility to ensure that they do not reproduce. There are just two ways to avoid pregnancy—abstinence or contraception—and both require sacrifice(s). The social norm of self-sacrifice leads to the conclusion that people who unintentionally reproduce are blameworthy because they failed to fully align with this norm. Just as in pregnancy and childcare, people are expected to make sacrifices 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. 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 virgin/whore dichotomy, women who are sexually active are “bad” and thus deserve the punishment of unintended pregnancy. Additionally, it is thought to be easier for women to abstain because they are believed to have a weaker libido than men.28

Femininity and Self-Sacrifice

Although I have carefully kept my discussion of contraception gender neutral, 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. 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 sexist reasons behind why women are assumed to be the ones responsible for contraception. As the case of childcare shows, the expectation of self-sacrifice is usually only applied to women even though childcare, unlike pregnancy, is not something that is limited to women. Men could just as easily participate in childcare as women, so it would seem a general social norm about how to raise one's children should equally apply to women and men. However, there are gendered beliefs regarding childcare: women are expected to be self-sacrificing, whereas men are not. In fact, what reproductive and childcare norms reveal is that there are broad gendered expectations of how women should act towards others. The general pattern is that women are expected to be self-sacrificing; they are expected to put others’ needs, particularly their children’s and male partners’, before their own. There is not a corresponding social norm of sacrifice for men. In fact, quite Competing Social Norms: Women and Contraception 73 the opposite: men are expected to be independent and self-interested, and to prioritize their own needs.29

Competing Social Norms
I turn now to the question of whether women are regarded by society as trustworthy with contraception. According to Mullin, to trust, we need to assume that the trusted group (1) shares our commitment to a specific social norm that will guide their behavior in a specific domain and (2) that their commitment to this norm is at least partially intrinsic. Women who value the contraceptive social norm of self-sacrifice for at least some intrinsic reasons should be trusted. However, even women who meet both of Mullin’s requirements for trust are often still viewed as untrustworthy. As I argue below, this is due to a competing social norm that regards women as irrational and emotional and that leads society to view women as generally incompetent, especially with major events and decisions. Believing people are incompetent can prevent us from trusting them. What matters is whether we think their incompetence affects that with which we trust them. Mullin recognizes the importance of competence in trust, stating “when we trust, we assume not only internal commitment to a social norm, but also 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.”30 In other words, in order to be trusted, people need to know what social norm is at play, what action it requires, and to act accordingly.31

Self-Sacrifice and Oppressive Socialization
The vast majority of women recognize the social norm of self-sacrifice in reproductive and childcare matters and understand that it means putting their children first and themselves last. Furthermore, most women abide by this norm and consequently are considered trustworthy. Such women, like Bobbi McCaughey, the famous mother of septuplets, are socially praised. McCaughey jeopardized her own health32 during pregnancy and then she devoted herself full time to caring for the septuplets. 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.33 McCaughey was rewarded for her pro-natalist, self-sacrificing behavior with intense media coverage, numerous substantial gifts, and even a phone call from President Clinton. 34 Women like McCaughey are viewed as trustworthy with reproductive and childcare matters because they not only fit the self-sacrificing model, but they also intrinsically value it. Although McCaughey may seem like an extreme case, she
is not. Mothers frequently make significant sacrifices for their children and many women would readily make the same sacrifices McCaughey did. The reason for this is that, given the ubiquity and strength of this expectation, almost all women intrinsically value self-sacrifice. I contend that the norm of self-sacrifice is a case of oppressive socialization, according to Paul Benson’s definition.35

Benson presents two ways socialization can be 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.”36 The norm of self-sacrifice is oppressive in both ways. In the first way, women internalize the norm of self-sacrifice. They normatively value it, insisting it is an essential component of what it means to be a woman. Indeed, women 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.”37 Furthermore, they 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.”38 The same holds true for sacrifices: women value sacrifices because men value women who make sacrifices for them. Moreover, women value sacrifices because society values self-sacrificing women, like McCaughey. In contrast, women who challenge this norm 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” if they do not meet the expectation of self-sacrifice.39 The pressure to be self-sacrificing is coercive because it impairs autonomy by making norm compliance a much more palatable option (social rewards, acceptance, and improved ability to achieve their personal, social, and economic goals) than norm rebellion (social punishment, ostracism, and diminished chance to achieve goals).

The second way the norm of self-sacrifice is oppressive is that it teaches women falsehoods: 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.40 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.41 In this case, women have trouble recognizing that their self-worth can lie in things other than self-sacrifice; they are unreceptive to reasons for rejecting self-sacrifice. As Diana Meyers asserts, “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.42 In making self-sacrifice appear to women as the only way they are valuable, combined with women’s internalization of this norm, oppressive socialization teaches women to intrinsically value self-sacrifice. Put differently, women intrinsically value self-sacrifice not only because they are instilled with the belief that it is the way women should act, but also because they cannot imagine alternative ways of being that challenge self-sacrifice. What is so insidious about oppressive socialization is that it gives the impression of choice—that women autonomously choose to value self-sacrifice—rather than having it forced on them. Some may object that there are good reasons to intrinsically value sacrifice for reproduction and childcare matters—for example, all types of reasonable sacrifices
are necessary in order to be a good parent—and that women are self-sacrificing
for these reasons. While I agree that other reasons factor into women’s valuing of self-sacrifice, I don’t think we can underestimate the role that oppressive socialization plays. Especially when we compare women and men on self-sacrifice, it becomes clear that women intrinsically 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. The criterion most frequently cited by women of all classes as the mark of a good mother is putting her children first, whereas the social understanding of a good father is one who provides financially.

Women as Untrustworthy

Prima facie, women would seem to be excellent candidates for trust since they intrinsically uphold the social norm of self-sacrifice. However, women are perceived as incompetent because of the social norm that women are irrational and emotional, which makes them incapable of making good decisions and of acting in accordance with their own norms. This norm is part of a dichotomy: the reason/emotion dichotomy. Women are associated with the negative half of the dichotomy and consequently they are thought to be irrational and emotional, whereas men are associated with the positive half and thus are considered rational and stoic.

While it is assumed that women will recognize the social norm that they are supposed to follow and understand what it entails—the first type of competence Mullin enumerates—the concern is that women will not act according to their norms—the second type of competence Mullin lists. Specifically, the worry is that women will not be able to act in a self-sacrificing way because of their presumed irrational and emotional nature. Although women may be committed to being self-sacrificing and may intrinsically value this expectation, they cannot help but act contrary to it because of their irrational disposition, which makes it difficult for them to judge how best to act in order to be self-sacrificing. For example, a woman who indulges her children’s every request may be doing so as a way of putting her child first (i.e., self-sacrifice), but others may view it as her irrationality (and lack of strength) that causes her to “spoil” the child. When women’s emotional nature “interferes” with their ability to make decisions on important matters, especially ones involving men and children, society usually responds in a paternalistic manner.

In addition to the general social perception that women are irrational, there are contraceptive-specific factors that contribute to the belief that women should not be trusted. First is the high rate of unintended pregnancies—almost half of all pregnancies in the U.S. are unintended. According to some calculations, a woman can expect to have 1.42 unintended pregnancies by the time she reaches forty-five. Despite our recognition that no form of contraception is 100 percent effective, the existence of so many unintended pregnancies leads us to question women’s competence with contraception. Second, and further eroding trust, is the knowledge that many women are unhappy with their contraceptive options, sometimes leading them to inconsistently and incorrectly use contraception. In fact, half of all unintended pregnancies occur when people are using contraception. Women’s dissatisfaction with available contraceptive methods is reflected in the fact that most types of contraception have discontinuation rates approaching 50 percent after one year of use. Women who are dissatisfied with their contraceptive method are at high risk for experiencing a gap in contraceptive coverage, and, at any given time, between 9–16 percent of sexually active women are not
using any type of contraception. Third, the cultural belief that women who use contraception are always prepared for sex and therefore must be sexually promiscuous leads some women to risk unintended pregnancy rather than use contraception. The salience of the virgin/whore dichotomy and the no-win dilemma it creates for women—if they contracept then they are viewed as sluts, but if they do not contracept, then they increase the probability of pregnancy—may diminish their trustworthiness to use contraception. Fourth, there is a cultural fear that women become pregnant deliberately to “trap” men. In other words, some men worry that women lie about their contraceptive use because they believe becoming pregnant will force men to commit to a relationship with them. The belief that women are deceptive about their contraceptive use diminishes their contraceptive trustworthiness even more. Fifth, until the introduction of the female contraceptive pill in the 1960s, men were generally seen as the ones responsible for contraception because contraceptive use was tied to the act of sex itself, sexual knowledge was synonymous with sexual experience, and dominant gender roles aligned masculinity with contraceptive responsibility. Although both women and men today tend to relegate contraceptive responsibility to women, the long historical association between contraceptive responsibility and men may still play a role in the social perception that women are not trustworthy with contraception. It seems not only strange, but also unfair that we as a society consider women untrustworthy with contraception and yet still hold them responsible for it. Why is this? In some ways, the answer is simple: this arrangement reinforces the patriarchal order by portraying men as the only ones rational enough to make contraceptive decisions (at least on the policy level) while absolving them from contraceptive responsibility and all that it entails. Women are forced to assume full contraceptive responsibility under the guise of neo-liberal choice, with the result that women not only make almost all of the sacrifices, but they are typically the sole target of blame for sexual activity that leads to any contraceptive failure as well as the contraceptive failure itself.

Given that male condom use accounts for 18 percent of contraceptive use in the U.S., one might think men share some of the blame for contraceptive failures. However, because contraceptive responsibility is so strongly aligned with femininity, we often focus on women when discussing male condoms even though this is only one of two types of contraceptives that specifically target the male body. For instance, many public health campaigns aimed at increasing condom use are geared towards women. Another reason men are often bypassed for blame even in cases where the male condom is the primary or only form of contraception used is that such cases are much more common in casual sexual encounters than in monogamous relationships. Wrapped into the virgin/whore dichotomy is the social norm that women should serve as the “guardians” of sex, setting the boundaries of what is acceptable behavior (i.e., not casual intercourse). Women’s role as sexual guardians contributes to the shifting in blame for contraceptive failures during casual sex from men’s role in male condom use to women’s inability to control their libido.

Moving Forward and Trusting Women

In order to move toward trusting women to use contraception, we need to deconstruct the social norm of women as irrational in general and as it relates to contraception. Such radical change, however, usually takes time and is accomplished piecemeal. To move us closer to trusting women, I make four suggestions based on expanding knowledge and trust—thereby fostering both women’s (and men’s)
autonomy—rather than distrust—which typically translates into paternalism and increased surveillance.

First, in addition to granting women the negative freedom to make choices about their bodies, we must provide them with positive freedoms, such as cheap or free contraceptives and doctor visits, that enable them to make good choices. Women today bear most of the financial burden of contraception and female methods tend to be more expensive than male methods because most require at least one physician visit and some involve a renewal prescription. Currently many insurance plans do not cover contraception and, of the twenty-eight states that mandate insurance plans to cover contraception, twenty of them have opt-out clauses for religious or ethical reasons. However, beginning August 1, 2012, new insurance plans will have to cover contraception without a co-pay to comply with the Patient Protection and Affordable Care Act of 2010. While this policy change is a move in the right direction, it does not address the contraceptives needs of women who lack insurance (a staggering 20 percent of women under age forty-five are uninsured) who, due mainly to financial constraints, are 30 percent less likely to choose prescription methods than women with insurance.

Second, as a way promoting contraceptive use and teaching correct contraceptive use, we should teach children comprehensive sex education rather than abstinence-only education. Unfortunately, abstinence-only education is ubiquitous—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). Abstinence-only education teaches children that contraception is not something people should discuss or use. Indeed, since its goal is to convince teenagers to delay sex until marriage, it is not surprising that it includes little to no information about contraception. What is especially troubling, however, is that the information abstinence-only education provides on contraception is frequently inaccurate. Now that research has shown that children who receive abstinence-only education engage in sex at the same rates as children who receive comprehensive sex education, we should move to eliminate the former and replace it with the latter.

Third, as a way of combating the stereotype that women who use contraception are promiscuous and of normalizing contraceptive use, we should lobby the media to include contraception in movies and television shows. Most media images show people tearing off each other's clothes without any discussion of contraception 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.” These images idealize spontaneously sexual activity and perpetuate the norm that women who are prepared for sex (i.e., who use contraception) are promiscuous. Furthermore, the media reinforces the idea that discussions 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.

Fourth, we should develop male contraceptives, especially long-term reversible options, as a way of achieving shared contraceptive responsibility rather than the current arrangement in which women are generally held responsible for contraception. The lack of options for men, especially long-acting, reversible ones, makes it difficult for them to assume responsibility for contraception and this pushes contraceptive responsibility on women. As I have argued elsewhere, male contraceptives (especially long-acting, reversible contraceptives) are necessary
in order both to alleviate the burdens women face by typically being the ones responsible for contraception and to enhance men’s ability to control their reproduction.78

Some may perceive these suggestions as mere Band-Aids and instead argue that in order to get at the root of the problem and actually move toward trusting women with contraception, we need to change the contraceptive social norm of self-sacrifice. While I think there are many good reasons to strive to eliminate the expectation of self-sacrifice for reproduction and childcare, as well as for women generally, I do not think that changing this expectation will make women more trustworthy. The reason women are distrusted is because they are seen as incompetent and changing this norm will not make them seem more competent with contraception. In recognizing the difficulty of usurping deeply entrenched social norms—contraception as self-sacrifice and women as irrational—my suggestions are concrete ideas for beginning the process of implementing change based on increasing knowledge of contraception, normalizing its use, and trusting both women and men with it.

Endnotes
1. Unless otherwise stated, throughout the paper I am referring to people engaged in heterosexual relations to achieve pregnancy.
3. In the case of the honor code, it seems obvious that intrinsically valuing the honor code entails viewing it as normatively correct. Let me provide another example—one in which the connection between intrinsically valuing a norm and believing it to be normatively correct is less obvious—to show that intrinsically valuing a norm always entails normatively valuing it. Miguel arranges to pay his friend and neighbor Miriam $50 to water his plants while he is away on vacation. First off, there is a question here of which social norm Miriam is committed to: that friends and neighbors should help one another out; that if you agree to do a job, then you should do it to the best of your ability; that humans should take care of plants; etc. I think that people can be simultaneously committed to more than one social norm, even if they conflict. Knowing what social norm people Competing Social Norms: Women and Contraception 79 are committed to is important for Mullin’s conception of trust, even if a commitment to different social norms will lead to the same action: all the possible social norms Miriam could be committed to should lead her to water Miguel’s plants while he is away. It is important for Miguel to know which social norm Miriam is committed to because his trust depends on a belief that they both intrinsically value the same social norm. Let us assume that Miriam is committed to the social norm that friends and neighbors should help each other out. If she intrinsically values this norm, this means that she values the idea that friends and neighbors should help each other for its own sake. Upholding this norm for its own sake presumes affirming it as good and worthwhile—that is, as normative, as the morally correct action. If Miriam intrinsically values this social norm, then it makes sense for Miguel to trust her. However, if she only values this norm instrumentally—because it means her friends and neighbors will help her out when she needs help or because it makes for smoother neighborly relationships—then Miguel should not trust her because her commitment to help him is secondary to her other priorities. She is only secondarily committed to helping him out so there is a greater chance Miriam would desert this job than if she intrinsically valued the job. I do not want to imply that people we rely upon will willy-nilly and unremorsefully fail to meet our expectations. Rather, people we rely upon have different priorities, which lead them to make different decisions than we would if faced with the same situation. That is, they do not value the same things we value for the
reasons we value them and consequently their actions may be different. Valuing things for different reasons is not necessarily a bad thing. However, we need to recognize when people value something intrinsically versus instrumentally because it will help us know whether to trust or rely upon them.

4. Whereas trust requires intrinsically valuing a shared social norm, reliance depends only upon instrumentally valuing a shared social norm. See Mullin for more on the distinction between trust and reliance.


7. One could argue that these approaches do involve social norms, as what we consider goodwill and moral integrity depends on social norms. While I think one could make a case for this, I believe social norms need to play a more direct role in a conception of trust applied to contraception.

8. For example, Annette Baier puts the individual at the center of trust, claiming, “When I trust another, I depend on her good will toward me” (“Trust and Antitrust,” 235). Trudy Govier 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” (“Trust, Distrust, and Feminist Theory,” 17).

9. Social norms typically reflect the perspective of the dominant group(s) and so it is not surprising that these groups attribute positive characteristics to themselves and negative characteristics to the oppressed groups.

10. 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.” “Experience, Knowledge, and Responsibility,” in *Women, Knowledge, and Reality: Explorations in Feminist Philosophy*, ed. Ann Garry and Marilyn Pearsall (Boston: Unwin Hymin, 1989), 170n3. By extension I think that relying on social norms to determine social trustworthiness is problematic. Like Code, I believe that “something very like stereotypes is in fact needed if knowledge, or language [or social trustworthiness], are to be possible at all,” but that we should strive for these stereotypes to be flexible, not dogmatic (162).


13. Unless you also count withdrawal and the rhythm method, which target both women’s and men’s bodies.

14. These are qualities many monogamous couples are looking for, especially if they plan on having biological children in the future and if they are not concerned about preventing STDs.

15. Campo-Engelstein, “No More Larking Around!” “Although less than 20% of contraceptive use requires male participation [condoms, withdrawal, and rhythm], these methods result in well over half of all contraceptive failures in the United States.” Sheldon J. Segal, *Under the Banyan Tree: A Population Scientist’s
Odyssey (Cambridge: Oxford University Press, 2003), 114.
17. Clearly there are ways men could more actively participate with contraception: for example, men could help with the financial costs of contraception and could be emotionally supportive of women who experience adverse side effects. However, women are still the ones saddled with the adverse side effects, maintenance, bodily invasion, other negative effects, and the overall responsibility of contraception. The only exception to this is if a man uses condoms or had a vasectomy and he and his female partner share contraceptive responsibility (she too contracepts) or he assumes full contraceptive responsibility (she does not contracept).
18. MacKinnon argues that abortion was legalized because the “availability of abortion enhances the availability of intercourse” (188). I believe contraception is socially acceptable for the same reason—it increases men’s sexual access to women. Catharine MacKinnon, Towards a Feminist Theory of the State (Cambridge: Harvard University Press, 1989).
19. Although this protectionist rhetoric is used, these policies are usually racially motivated. See Dorothy Roberts, Killing the Black Body: Race, Reproduction, and the Meaning of Liberty (New York: Pantheon Books, 1997), 108–10, 112.
21. Ibid.
22. 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’s 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 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 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 we should take, if any, toward people who reproduce irresponsibly or children whose lives fall below this threshold.
24. Ibid, 47.
25. She only mentions that being a good parent involves adhering to Sara Ruddick’s three criteria of preservation, nurturance, and inclusion (Sara Ruddick, Maternal Thinking: Towards a Politics of Peace [Boston: Beacon, 1989]).
27. Ibid.

29. Interestingly, because men do not adhere to the social norm of self-sacrifice they are not viewed as trustworthy with reproductive and childcare matters. That men don’t fit this social norm is advantageous for them because it absolves them of any reproductive and childcare responsibility. Also contributing to the cultural belief that men are untrustworthy with reproduction and childcare is the norm that reproduction and childcare are considered women’s duties, not men’s.


31. It is worth noting that other approaches to trust also affirm the importance of competence. Carolyn McLeod claims that there is some consensus that what we trust in others is “their competence to do what we are trusting them to do and their motivation for doing it” (“Our Attitude Towards the Motivation of Those We Trust,” 465). For example, Govier enumerates three aspects of trust and one of them is competence (“Trust, Distrust, and Feminist Theory,” 18). Karen Jones directly incorporates competence into her definition of trust, stating, “trust is optimism about the goodwill and competence of another” (“Trust as an Affective Attitude,” 7).

32. She also jeopardized the health of her fetuses, though this was rarely mentioned by the media. See Sonya Charles and Tricha Shivas, “Mothers in the Media: Blamed and Celebrated—An Examination of Drug Abuse and Multiple Births,” *Pediatric Nursing* (Mar/Apr. 2002).

33. Clearly not all women who have multiples or many children are socially praised. Nadya Suleman, aka “octomom,” is one such example. In her case, factors such as race, class, religion, and marital status were strong contributors in the public outcry following the birth of her octuplets. D.-A., Davis, “The Politics of Reproduction: The Troubling Case of Nadya Suleman and Assisted Reproductive Technology,” *Transforming Anthropology* 17 (2009): 105–16.

34. Ibid.

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40. I am not going to defend these claims as falsehoods because I assume that most audiences, especially feminist-friendly ones, would agree with me that they are falsehoods.


42. Meyers, “Feminism and Women’s Autonomy,” 487.


45. I do not provide a thorough explanation for this social norm like I did for contraceptive social norms because the association of women with irrationality and emotion and men with rationality and reason has been discussed elsewhere in great detail. See, for example, Genevieve Lloyd, “The Man of Reason,” in *Women, Knowledge, and Reality: Explorations in Feminist Philosophy*, ed. Ann Garry and Marilyn Pearsall (Boston: Unwin Hymin, 1989).
46. As a pernicious example of this, through 1996, less than one percent of all AIDS literature dealt specifically with women and AIDS outside of their roles as vectors and vessels (Ruth Faden, Nancy Kass, and Deven McGraw, “Women as Vessels and Vectors: Lessons from the HIV Epidemic,” in *Feminism and Bioethics*, ed. Susan M. Wolf [New York: Oxford University Press, 1996], 266). This example shows that we were only concerned about women’s effects on others regarding AIDS and not about women themselves.

47. The field of women’s reproductive health is rife with such examples, including mandatory waiting periods for abortions and mandatory contraceptive use for women on certain teratogenic drugs (e.g., Accutane).


56. Anna Stubblefield argues 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, “Contraceptive Risk-Taking and Norms of Chastity.”


60. Reich and Brindis, “Conceiving Risk and Responsibility”; Campo-Engelstein, “No More Larking Around!”


63. The other type is vasectomy.

67. The Missouri ban on family services provides an example of how women, not men, are the focus of blame for both casual sex and resultant contraceptive failures. 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” (http://shakespearessister.blogspot.com/2006/03/poor-people-shouldnt-have-sex.html). Accessed February 18, 2008.
73. Doan and Calterone Williams, *The Politics of Virginity*.
74. For example, the *Choosing the Best Life* curriculum informs students that research shows that only 5–21 percent of couples who use condoms do so correctly and, furthermore, that even when used correctly, condoms do little to protect against STDs (Bruce Cook, *Choosing The Best Life: An Abstinence Focused Curriculum*, Leader Guide, 2nd edition [Atlanta: Choosing the Best Life, 2003]).
76. Perhaps such lobbying efforts can look to the movement to reduce cigarette smoking in movies and TV. See, for example, National Cancer Institute, *The Role of the Media in Promoting and Reducing Tobacco Use*, Tobacco Control Monograph No. 19. Bethesda, MD: U.S. Department of Health and Human Services, National Institutes of Health, National Cancer Institute, 2008.
77. Stubblefield, “Contraceptive Risk-Taking and Norms of Chastity.”
78. Campo-Engelstein, “No More Larking Around!”