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Gendered Divisions of Fertility Work:  
Socioeconomic Predictors of Female versus Male Sterilization  
by

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**ABSTRACT**

Domestic labor researchers have examined a multitude of duties disproportionately performed by women, yet the responsibility associated with navigating a couple's fertility - *fertility work* - has been overlooked. Using data from the 2006-2010 National Survey of Family Growth ( $N = 1,415$ ), I examine how racial and socioeconomic factors affect the division of contraceptive fertility work among married and cohabiting women who rely on either their partners' vasectomies or their own sterilizations. Drawing theoretical connections between fertility work and housework, I use resource- and gender-based perspectives to assess whether women's or their partners' characteristics are stronger predictors of sterilization type, and if women's absolute or relative education level has a greater impact. Findings suggest that White and socioeconomically privileged women are more likely to have vasectomized partners than disadvantaged women. Male partners' characteristics were more closely associated with sterilization type than women's characteristics, lending greater support for the gender-based hypotheses.

Key Words: division of labor, fertility work, gender, housework, marriage, sterilization

Domestic labor researchers have examined a multitude of duties disproportionately initiated and performed by women, yet the labor and responsibility associated with navigating a couple's fertility - *fertility work* - has been largely overlooked. Like other forms of domestic labor, the time, attention, stress, and physical burden associated with avoiding pregnancy lies primarily on the shoulders of women. For example, only 15% of married and cohabiting couples in the United States rely on vasectomy for contraception, compared to 40% who rely on female sterilization (National Center for Health Statistics, 2010). Although the fertility work related to sterilization involves less time and attention than other forms of contraception, it deserves investigation because it requires physical labor by the party who undergoes the procedure, most often the woman. Notably, most forms of female sterilization are more invasive, costlier, more difficult to reverse, and associated with greater health risks than male procedures, especially with the advent of nonscalpel vasectomy techniques (Dassow & Bennett, 2006). Unlike vasectomies, tubal ligations are performed inside the abdominal cavity often under general anesthesia. Mortality is more common for female surgical procedures as are complications, such as infection, injury to surrounding organs, and ectopic pregnancy (Beckmann et al., 2010). Recently-approved tubal occlusion procedures, such as Essure and Adiana, can be performed under local anesthesia, thereby avoiding incisions and the serious side effects of general anesthesia related to surgical tubal ligation. Though rare, these transcervical procedures are associated with embedding, ectopic pregnancy (Palmer & Greenberg, 2009), and side effects of hysteroscopy, including uterine perforation, infection, and hemorrhage (Lentz, Katz, Lobo, & Gersenson, 2012).

Sterilization also requires emotional labor (Hochschild, 1983). Groat, Neal, and Wicks (1990) illustrated that the decision to sterilize can elicit anxiety about changing one's mind,

concerns about decreased interest in sex, fears that one's sexual identity might be incomplete, and worries about spousal infidelity. At the same time, sterilization can relieve the anxiety of potential unwanted pregnancies and, as a result, increase the frequency and enjoyment of sex (Groat, et al., 1990). Though either spouse may feel regret when one is sterilized, the one who undergoes the procedure faces the anxiety about of a postoperative body, identity, and future. That partner accepts "some degree of individual sacrifice" for the couple as contraception and unwanted pregnancy are no longer worries for either partner (Groat, et al., 1990, p. 256).

As with other forms of domestic labor, fertility work is not equally distributed among women. Research suggests that racial and socioeconomic factors affect the gendered division of labor, with some women more likely to have partners who share it. Using household labor as a theoretical lens (Fennell, 2011), I explore how racial and socioeconomic differences affect which women are most likely to face the health risks and emotional labor associated with sterilization and which women avoid them by having vasectomized partners. I will also examine whether women's or their husband-cohabiting partners' characteristics exert more influence.

## BACKGROUND

The question of whether couples who choose female sterilization differ racially and socioeconomically from those who choose vasectomy has not been addressed in the literature. Instead, available data on racial and socioeconomic factors compare individual women or men who have been sterilized to those who have not. Characteristics similarly associated with female and male sterilization include marital status, number of children, and age. Both sterilized women and men are more likely to be married or cohabiting, older in age, and have more children than those who are not surgically sterilized (Eisenberg, Hendersen, Amory, Smith, & Walsh, 2009; Godecker, Thomson, & Bumpass, 2001). In terms of race, income, and education, however,

trends among sterilized women and men diverge. African American and Hispanic women are more likely to be sterilized than White women (Bertotti-Metoyer, 2009), whereas White men are more likely to have vasectomies than other racial groups (Eisenberg et al., 2009). Likewise, education and income are negatively related to female sterilization (Bass & Warehime, 2009; Bertotti-Metoyer, 2009), but positively related to male sterilization (Eisenberg et al., 2009).

Similar to sterilization trends among individuals, higher education levels among married couples are generally associated with husbands taking on more responsibility for housework (e.g., Bianchi, Milkie, Sayer, & Robinson, 2000; Presser, 1994). Increases in women's income also result in a more equitable division of labor (Gupta, 2007; Killewald, 2011; Killewald & Gough, 2010). Less research compares distribution of domestic labor by race, but some evidence suggests that White couples do less housework than Black and Hispanic couples (Bianchi et al., 2000), and that Whites may have less egalitarian views and division of domestic labor (Cohen, 1998; Orbuch & Eyster, 1997).

Based on trends among individuals that link men's privilege with vasectomy and women's disadvantage with tubal ligation, and trends among couples associating privilege with a decrease in women's household labor, one could predict that advantaged couples would choose vasectomy more often than disadvantaged couples. If this pattern does exist, which partner is the driving force behind the contraceptive decision? Theoretical perspectives developed to understand the distribution of domestic labor provide a lens to examine this question.

From a resource perspective, one might expect that women's social position would play the primary role in assigning fertility work. According to these theories, higher-status women use their social and economic resources to leverage more favorable domestic conditions, such as reduced housework (Bittman, England, & Folbre, 2003; Brines, 1994; Killewald & Gough, 2010;

Schneider, 2011). Resource theorists have long debated whether women's influence stems from their status relative to their husbands or if their absolute status is the determining factor (e.g., Farkas, 1976). On one hand, bargaining or resource exchange theorists assert that women gain marital influence as their position relative to their husbands increases (Blood & Wolfe, 1960; England & Farkas, 1986; Scanzoni, 1982). The underlying assumption of bargaining theory is that women's relative position is "a key determinant of their relative control over the relationship and various aspects of their own lives and opportunities," (Blumberg & Coleman, 1989, p. 231). Consistent with this theory, Bianchi et al. (2000) found that women with higher levels of education than their husbands and earning large shares of the family income experienced a smaller gender gap in housework (see also Presser, 1994; Schneider, 2011). Higher relative education and income also have been associated with greater influence over the contraceptive method a couple chooses (Grady, Klepinger, Billy, & Cubbins, 2010).

From an autonomy perspective, on the other hand, women's influence in the relationship is the result of their absolute, rather than relative, position (Gupta, 2006, 2007). The autonomy perspective assumes that women have autonomous economic agency within their households that they use to lessen their domestic burdens. Accordingly, Gupta (2007) found that women's absolute (and not relative) income was negatively associated with their hours spent on housework (see also Killewald & Gough, 2010). Some of the decrease in time spent on domestic chores among higher-earning women is due to greater levels of outsourcing tasks, which is more closely associated with wives' incomes than their husbands' (Cohen, 1998; Killewald, 2011; Treas & De Ruijter, 2008). As resource-based perspectives, both bargaining and autonomy theories ultimately argue that women's status is the key factor in determining the gendered division of domestic labor.

Although some married and cohabiting women want to be sterilized themselves, it's reasonable to suppose that many would prefer to avoid the health risks and emotional labor of sterilization by instead relying on their partners' vasectomy. A resource-based perspective would suggest that White and socioeconomically advantaged women have more bargaining power to shift the sterilization responsibility to partners than do their disadvantaged counterparts.

Alternatively, from a gender display, "doing gender" or "masculinity" perspective (Connell, 2005; West & Zimmerman, 1987), one might predict that men's social status compels the contraceptive decision. This theory assumes that gender ideology confines domestic labor to the feminine sphere, thereby discouraging men from engaging in "women's work". Research suggests that sharing domestic labor may pose a lesser threat to the masculinity of high-status men because their gendered worth is validated by their privileged position in society (Bittman, et al., 2003), demonstrated by college degrees and well-paying, prestigious jobs. Accordingly, Brines (1994) found that lower-income husbands who were economically dependent on their wives did little housework, possibly as an effort to "reclaim their constitutive masculinity" (p. 677). Pyke (1994) reported that men were less likely to share marital power if they viewed their wives' employment as a "threat rather than a gift for which [they] should reciprocate" - a more common feeling among unemployed men and those in low-wage or low-status jobs (p. 75). High-earning women also appear to participate in (re)establishing the domestic gender order by engaging in the traditional model of domestic labor, thereby retreating from the potential power of their relative economic position (Brines, 1994; Schneider, 2011; Tichenor, 1999). Exaggerating gender-specific domestic behaviors may serve to neutralize deviant identities of spouses in counternormative occupational or economic situations (Greenstein, 2000).



Because the compensatory form of masculinity that some lower-status men construct associates manhood with physical and sexual prowess (Pyke, 1996), and being that sperm and fertility are generally associated with the sexual prowess of “real” men (Moore, 2007), lower-status men may be more likely to associate vasectomy with emasculation than higher-status men. From a gender display or masculinity perspective, then, one might expect lower-status men to reject vasectomy more often than higher-status men as a means to defend or retain their masculine position. At the same time, women partnered with low-status men may do gender by taking on the contraceptive responsibility.

### *Research Questions*

Do race, income and education level affect married and cohabiting women’s odds of having a vasectomized husband-partner versus being sterilized themselves (i.e., sterilization type)? If so, which partner’s characteristics are more influential?

### *Hypotheses*

Drawing on trends among sterilized individuals, observations of socioeconomic effects on the gendered division of housework, and theoretical perspectives used to interpret the division of domestic labor, I created five hypotheses.

*Resource Hypothesis.* Women’s characteristics will have greater impact on sterilization type than husband-partners’ characteristics.

*Autonomy Hypothesis.* Women’s White race and absolute education and income levels will be positively associated with vasectomy.

*Bargaining Hypothesis.* Women with more education than their husband-partners will have greater probabilities of having vasectomized partners than women with less education than their husband-partners.

*Masculinity Hypothesis.* Husband-partners' characteristics will have greater impact on sterilization type than women's characteristics.

*Gender Display Hypothesis.* Husband-partners' White race and education level will be positively associated with vasectomy.

## METHOD

### *Data and Sample*

This study uses data from the 2006-2010 National Survey of Family Growth (NSFG), a cross-sectional survey of the National Center for Health Statistics. Using a nationally representative sample, researchers from the University of Michigan's Institute for Social Research conducted interviews for 48 weeks of every year between 2006 and 2010. The analysis and discussion here rely on a subsection of the 12,279 women interviewed - the 1,415 (11.5%) married or cohabiting women ages 20 - 44 who were surgically sterilized or had surgically sterilized husbands-partners (all referred to as partners hereafter). To compare couples with either him or her sterilized, I omitted from my sample the 46 women (3%) who reported that both partners were surgically sterilized. Bivariate analysis showed no distinctive relationship between dual-sterilization and the independent variables, suggesting that this exclusion did not bias the data. I limited the analysis to married and cohabiting women to focus on committed couples, with the understanding that they have similar patterns of contraceptive use compared to single women (Sweeney, 2010).

### *Variables and Analysis*

The dependent variable was sterilization type – female or male. Female sterilization was coded *0* and vasectomy was coded *1*. Independent variables included respondents' income, education and race-Hispanic origin (referred to as race hereafter), and partners' education and

race-Hispanic origin (referred to as partner race hereafter). The NSFG did not provide income data for partners. Income was measured as respondents' individual income in yearly dollars, reported by the NSFG as a multicategory ordinal-level variable. I condensed income categories into less than \$15,000, \$15,000 - 39,999, and \$40,000 or more to distribute cases fairly evenly but also expose the upper and lower ends of the income spectrum. Race and partner race were categorized as non-Hispanic White, non-Hispanic Black, and Hispanic. I excluded 78 non-Hispanic Other and non-Hispanic Other partners (5.2%) because their small sample size did not allow for individual multivariate analysis and their sterilization patterns were not similar enough to any other racial group to combine them. Education and partner education were categorized as high school diploma, General Educational Development test (GED), or less (referred to as high school diploma hereafter); some college or Associate's degree (referred to as some college hereafter); and Bachelor's degree or more (referred to as Bachelor's hereafter). Women's number of children (total live babies born) was a continuous control variable for the multivariate analysis, but reported in four categories for the bivariate table. Partners' number of children was discarded because it was not significant in the bivariate analysis, as were age and partner age. Because age is associated with both female and male sterilization (i.e., men and women are more likely to have a sterilization operation as they age), it was not significant when comparing women's odds of being sterilized to having a sterilized partner.

I analyzed the relationship between sterilization type and the independent variables in three steps. First, I created crosstabulations to examine the bivariate effects of the independent variables. Second, I constructed three multivariate binary logistic regression models to calculate a woman's odds of having a vasectomized partner and to determine whether her or his characteristics were stronger predictors of vasectomy. For all three logistic regression models, I

reduced race and partner race to White and Black-Hispanic to allow for sufficient cases in each cell. I chose referent categories for each independent variable that would result in positive odds ratios for easier interpretation: Black-Hispanic, less than \$15,000, and high school diploma.

Finally, I used coefficients from the full regression model to calculate predicted probabilities that women with two children would have a vasectomized partner. Dividing women into those with White versus Black-Hispanic partners, I created probability scenarios to highlight the effect of his and her education, and her income. These scenarios illustrate the unique, relative and combined effect each variable played on a woman's probability of having a vasectomized partner. For all 8 estimates, I used the prediction equation  $\log(\pi / 1 - \pi) = \alpha + \beta_1 X_1 + \beta_2 X_2 + \dots + \beta_K X_K$  to determine the log odds,  $\exp(\text{logit})$  to determine the estimated odds, which I then converted into probabilities using the formula  $\text{odds} / (1 + \text{odds})$ .

## FINDINGS

### *Bivariate Analysis*

Table 1 displays bivariate crosstabulations. In all but three categories of the independent variables (highest categories of income, education and partner education), greater percentages of women were sterilized than their partners. Even so, the independent variables were strongly associated with sterilization type.

Table 1 about here

*Race and Partner Race.* White women were more likely than women in the other racial categories to have a vasectomized partner (41.7%). Only 16.8% of Hispanic and 8.1% of non-Hispanic Black women had vasectomized partners. The same pattern emerged for partner race. Of the White partners, 42.5% were vasectomized compared to only 13.6% of Hispanic and 9.3% of Black partners.

*Income, Education and Partner Education.* Increased income for women and higher education levels for both women and partners were associated with greater percentages of vasectomy. Only 23.4% of women earning less than \$15,000 had a vasectomized partner, compared to 50.2% of women earning \$40,000 or more. Similarly, only 18.4% of women with a high school diploma had a vasectomized partner, compared to 60.8% of women with a Bachelor's degree. Partners with higher levels of education were also more likely to have vasectomies. Over 59% of partners with a Bachelor's degree had vasectomies compared to 18.2% of partners with a high school diploma. These data suggest that women's income and race, and the education level of both partners were important factors for sterilization type.

#### *Multivariate Logistic Regression Analysis*

Table 2 displays the multivariate logistic regression analysis. The odds ratios (OR) indicate the odds of using male sterilization compared to female sterilization while holding constant all other variables in the model. Values greater than one indicate increased odds. The first model examines the effects of women's characteristics, including race, income, and education. The second model examines characteristics of partners, including race and education. The full model takes into account both her and his characteristics.

Table 2 About Here

*Women's Characteristics Model.* Women's race, income, and education were strong predictors of vasectomy. White women had 3.15 times greater odds of having a vasectomized partner than Black-Hispanic women. Women who earned \$40,000 or more had 1.6 times greater odds of having a vasectomized partner than women earning less than \$15,000. Women with a Bachelor's degree had 4.34 times greater odds of having a vasectomized partner than women with a high school diploma. Those with some college had 1.65 times greater odds than women

with a high school diploma. Overall, the positive relationships between vasectomy, Whiteness, education, and income from the bivariate tables remained in this multivariate model.

*Partners' Characteristics Model.* Partners' race and education were also strong predictors of vasectomy. White partners had 3.71 times greater odds of having a vasectomy than Black-Hispanic partners. Partners who had attained Bachelor's degrees had 5.4 times greater odds of having a vasectomy than partners with a high school diploma. Partners who had some college had 2.2 times greater odds of being vasectomized than partners with a high school diploma.

*Full Model.* Combining her and his characteristics in the full model suggested that his characteristics were more powerful predictors than hers. Her race lost significance in the full model though it was a strong predictor in the first model. The effect of her education was reduced, with no statistical difference between those with a high school diploma and those with some college. Women with a Bachelor's degree had 2.25 times greater odds of having a vasectomized partner than those with a high school diploma – compared to 4.34 times greater odds in the first model. The effect of her income remained largely unchanged in the full model. Women who earned \$40,000 or more had 1.54 times greater odds of having a vasectomized partner than women earning less than \$15,000.

The strength of partner characteristics in the full model diminished slightly compared to the partner characteristics model, but remained significant predictors of vasectomy. White partners had 2.4 times greater odds of having a vasectomy than Black-Hispanic partners. Partners with some college had 1.76 times greater odds of having a vasectomy than those with a high school diploma. Partners who had attained a Bachelor's degree had 3.16 times greater odds than partners with a high school diploma. The durability of partners' characteristics and vanishing strength of women's in the full model provided more support for the gender display

and masculinity hypotheses than the resource hypothesis. The fact that her Bachelor's degree and higher income remained significant in the full model supports the autonomy hypothesis.

### *Predicted Probabilities*

To more clearly illustrate the combined and relative effects of his and her characteristics, I used the full logistic regression model to calculate women's predicted probabilities of having a vasectomized partner versus being sterilized themselves. Figure 1 displays predicted probabilities of eight scenarios labeled and referred to in the text as (A) through (H). To simplify interpretation, I limited the scenarios to the strongest variables and predictor categories: respondent and partner education (high school diploma versus Bachelor's degree), income (less than \$15,000 versus \$40,000 or more), and partner race. Because race was not statistically significant in the full model, I held it constant at 0, the coefficient for Black-Hispanic women. The control variable, respondents' number of children, was set at 2. Table 3 displays the effect that each independent variable had on predicted probabilities.

Figure 1 About Here

*Impact of Her versus His Characteristics.* Partner characteristics had a greater impact on predicted probabilities than respondents' characteristics (see Table 3). Partner education had the greatest impact of all the independent variables. The mean impact of his Bachelor's degree was .23 ( $SD = .05$ ) compared to the mean impact of .16 ( $SD = .04$ ) associated with her Bachelor's degree. Partner race was the second most impactful variable. On average, women with White partners had .18 ( $SD = .04$ ) greater predicted probabilities of having a vasectomized partner than women with Black-Hispanic partners. Income had the least impact, with an average of .08 ( $SD = .03$ ) increase in predicted probabilities associated with women earning \$40,000 or more. These

findings lend support to the masculinity hypothesis that predicted his characteristics would have more impact than hers, and refutes the resource hypothesis that predicted the opposite.

Table 3 About Here

*Absolute versus Relative Impact of Education.* Women's absolute and relative education levels impacted predicted probabilities of vasectomy, but in opposing directions. In every scenario, women with Bachelor's degrees had greater probabilities of having a vasectomized partner than women with high school diplomas (see Table 3). The average increase in probability due to her Bachelor's degree was .16 ( $SD = 04$ ), with a minimum increase of .09 (scenarios C – A) and maximum increase of .20 (scenarios D – B). Though women's absolute education was positively associated with predicted probabilities, their education level relative to their partners' was negatively related. Probabilities of having a vasectomized partner were .06 to .08 greater if her education level was lower than his compared to scenarios that inverted their relative education levels (scenarios B – C and F – G). Thus, women were more likely to be sterilized themselves if they had more education than their partners. This finding contradicts bargaining theory that predicted women with greater relative resources (i.e., education) would shift the responsibility of sterilization to their partners. Instead, these findings support the gender display and autonomy hypotheses. Consistent with the gender display hypothesis, partners with lower educational status were less likely to have a vasectomy than those with a Bachelor's degree, potentially suggesting that they were less willing to undergo the procedure to protect a physical sense of masculinity. It might also signal that women who have attained greater education than their partners were doing gender by doing fertility work. As postulated by the autonomy perspective, women's absolute education level was positively associated with an



increased probability of having a vasectomized partner. This suggests that women with a Bachelor's degree may have had more leverage than women with a high school diploma.

*Compound Effects of Race, Education and Income.* Looking at the extreme low and high scenarios illustrates the strong compound effect of the multiple independent variables (see Table 3). The difference between the highest and lowest predicted probabilities was .63 (scenarios H, White – A, Black-Hispanic). All of the four scenarios that resulted in greater probabilities of vasectomy than female sterilization were characterized by high scores (White partner, He BA+, She BA+, \$40,000+) on at least three of the four variables (scenarios D, F, H > .5). Notably, each independent variable had the least impact on scenario A. For example, the impact of her Bachelor's degree generally ranged from .16 to .2, and the impact of his Bachelor's degree ranged from .23 to .28, but both had less impact on scenario A. Shifting her education to a Bachelor's degree (scenario C, .25) had an impact of only .09, and partner Bachelor's degree (scenario E, .38) had an impact of .15. Similarly, the impact of partners' White race ranged from .16 to .22, but only increased the probability of vasectomy in scenario A by .1, and the impact of her income was only .01 (scenario E, .09). Thus, increasing the value of just one independent variable had less impact on women's predicted probability of having a vasectomized partner than increasing the value of a second, third or fourth variable, indicating a compound effect.

### CONCLUSION

Though less than a third of married and cohabiting couples choosing sterilization relied on vasectomy, Whites and the socioeconomically advantaged were more likely to do so than others. Among women in the most privileged scenario, the predicted probability of having a vasectomized partner was nearly nine times greater than those in the least privileged scenario. The four scenarios resulting in greater predicted probabilities of vasectomy than female

sterilization were associated with racial, educational and economic privilege. These findings corroborate sterilization trends among individuals and generally support the autonomy, masculinity and gender display hypotheses but not the resource and bargaining hypotheses.

The resource hypothesis predicted that women's characteristics would have greater impact on sterilization type than partners' characteristics, whereas the masculinity hypothesis predicted that partners' characteristics would have greater impact. The multivariate analyses suggested that partner race and education were stronger predictors than her race, education, or income. In the final logistic regression model, her race lost statistical significance, income provided little explanatory power, and the effect of education weakened considerably in the presence of his variables. His race and education, conversely, remained strong predictors and were only reduced slightly by the presence of her variables. Correspondingly, his variables had, on average, nearly two times the impact on predicted probabilities as her variables.

The autonomy hypothesis predicted that women's White race and absolute education and income levels would be positively associated with vasectomy. Consistent with this hypothesis, women's high levels of education and income remained significant in the full logistic regression model and increased predicted probabilities in every scenario. This may suggest that advantaged women use their Bachelor's degrees and higher incomes to shift the responsibility of sterilization to their partners, independent of partner status.

The bargaining hypothesis, which predicted women with more education than their partners would have greater probabilities than women with less education than their partners, was not supported by these data. On the contrary, women with more education than their partners had lower predicted probabilities of having a vasectomized partner. Thus, rather than

granting women more influence in the relationship as the bargaining perspective predicted, having more education may have encouraged couples to do gender as discussed below.

Finally, consistent with the gender display hypothesis, partners' White race and education were positively associated with vasectomy. From a gender display perspective, one could interpret these findings to mean that advantaged couples were more likely to choose vasectomy because White and highly-educated men were more often willing to undergo the procedure than men with less education and of racial minority status. Disadvantaged men may have avoided vasectomy to compensate for their subordinate social status, especially if remaining physically "intact" and sexually potent was central to their notion of masculinity. In contrast, privileged men may not have interpreted vasectomy as a threat since their masculinity was regularly legitimized in the public sphere. At the same time, women partnered with lower-income men may have done gender by accepting responsibility for fertility work.

The fact that these data support multiple hypotheses suggests that a combination of factors was at play. Women with higher social and economic status may have been more likely to resist having a sterilization procedure, and their similarly advantaged partners may have been amenable to the idea. Alternatively, lower-status women may have felt they lacked the authority to assert that their partners be sterilized, and their disadvantaged partners may have rejected the procedure.

Though social and economic advantage generally decrease women's responsibility for both fertility work and housework, the two forms of domestic labor vary by the relative impact of each partner. Most research suggests wives' characteristics are stronger predictors of time spent on housework (e.g., Cohen, 1998; Gupta, 2006; Treas & De Ruijter 2008), but the present study finds characteristics of male partners exert greater influence on fertility work. One reason

for this disparity might be the unique nature of contraceptive fertility work. Much of the decrease in privileged women's housework is the result of outsourcing labor by purchasing domestic services (Cohen, 1998; Treas & De Ruijter, 2008) or "opting out" of housework altogether (Killewald, 2011). In contrast, contraceptive fertility work cannot be outsourced (though some forms of infertility work can), and most couples are unwilling to opt out.

Therefore, contraceptive fertility work has a zero-sum element that housework lacks, and male participation appears to depend more on his characteristics than hers.

Another element of fertility work that differs from housework is the bodily nature of the labor. Concerns about physical effects may play a role in the sterilization decision. For example, Groat, et al., (1990) found that men were more concerned than women about pain and the potential of sterilization to affect sexual function. In addition, the medicalization of women's experiences results in regular doctor visits for pap smears, mammograms, contraception and childbirth (Reissman, 1983). This constant interaction with medical professionals and the common practice of having a tubal ligation at the time of childbirth likely affects the disparity between female than male sterilization. Just as other forms of domestic labor are affected by larger structures of paid labor, the distribution of fertility work is affected by the institution of medicine.

There are two primary limitations of this study. First, the NSFG lacks information regarding the income of male partners. This void limited my ability to analyze the impact of his financial status on sterilization type and the relative impact of her income.

Second, these data could not illuminate how the contraceptive decision was made. Without variables directly measuring power dynamics within the relationship, we cannot be sure that the resource, masculinity and gender display explanations accurately depict the data. One

might interpret these findings to mean that White and middle-class men are more disposed toward egalitarianism. But the mechanism of the contraceptive decision may be less about egalitarian attitudes and more about respect for research, the practice of weighing options, or other factors. Indeed, Terry and Braun (2011) argued that even vasectomized men who used egalitarian language, “perpetuated male privilege within contraceptive economies” by describing their vasectomy as “minor heroism” deserving of praise (p. 485). Similarly, these data do not take into consideration the quality of the relationship. Bean, Clark, Swicegood and Williams (1983) found that lower levels of couple communication were associated with female sterilization. If socioeconomically disadvantaged women generally have more vulnerable cohabiting and marital relationships, choosing female sterilization may be primarily a function of relationship quality. Even in this situation, however, there are structural constraints at work because the disadvantaged social position influences relationship quality that ultimately constrains her fertility work choices. In the end, it is noteworthy that disadvantaged women perform more fertility work than privileged women.

In spite of these limitations, this study is the only one of its kind to examine the effect of racial and socioeconomic factors on married and cohabiting partners’ choice of who will be sterilized. It is also one of the few to examine contraceptive work as a form of domestic labor worthy of analysis (see also Fennell, 2011). As such, this research broadens the domestic labor literature in a new direction. To further develop the concept of fertility work, future research should examine the time, attention, effort, physical effects and emotional labor related to other forms of contraception. Other aspects of fertility work, including attempting, sustaining and ending pregnancy, also deserve to be examined through the lens of domestic labor. That disadvantaged women are more likely to take responsibility for the physical and emotional

effects of sterilization than disadvantaged men or privileged women calls attention to race-, class- and gender-based disparities in fertility work and, thus, the need for further study.

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