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**Men’s Narratives of Vasectomy**  
Rearticulating Masculinity and Contraceptive Responsibility in San José, Costa Rica

This article interrogates the modes by which cultural constructions of male contraceptive use emerge in Costa Rica by analyzing men’s narratives of vasectomy. Drawing on ethnographic research data, I examine men’s contraceptive decision making and perspectives on vasectomy and specify the ways they work through their vasectomy to rearticulate the relationship between masculinity and contraceptive responsibility and tensions in an emerging Costa Rican social modernity. Following Oudshoorn’s (2003) analysis on male contraceptive research, this article highlights contraceptive technologies and men’s narratives of these technologies as key sites for examining gender politics in contemporary societies and the materialization of new social orders. In the discussion, I argue that the men’s narratives examined here potentiate creation of an “alternative technosociality” (Oudshoorn 2003) in Costa Rica, in which men taking contraceptive responsibility does not constitute performing a subordinate masculinity, but simply another way of acting as men. [vasectomy, masculinity, contraception, responsibility, Costa Rica]

Of all the vasectomy patients I encountered while conducting ethnographic research, Juan1 (age 36) was the most receptive to being interviewed. As he recounted, after his wife gave birth to her second child in 2006 (she had a son from a previous marriage), she decided to have a tubal ligation. According to Juan, he and his wife were both in agreement that they did not want to have any more children. Both were satisfied with having one shared biological child, and they had dreams of starting a business together in the future. Knowing that his wife had already been sterilized, I asked Juan why he had decided to get a vasectomy. His response was heartfelt and illuminating:

Because I believe that I wouldn’t want to give a child to any other woman. If with my wife I have one child, and I feel very happy with her, very satisfied, and [if] I’m not going to have another one with her, then with nobody else. Many of the men here, because of their machismo, think that if in the future they break up with their wives---that they will probably enter into another relationship where the woman will want to have a child---I hope that I stay with my wife forever. But if it is not meant to be, the next person I would enter into a relationship with would know that I cannot have any more children. . . . They sterilized my wife after my daughter was born, and I took much longer to come to the decision, but I made it. In other words, it wasn’t something that I just decided to do overnight. It took four years. Thinking about it and analyzing it, over and over again, until today2 [Interview August 3, 2009].
Toward the end of the interview, I asked Juan how his wife felt about his decision to get a vasectomy. He said his wife felt very special, because right before the surgery she had said to him, “If you have this operation you will be declaring to the world that I am the only woman in your life whom you will be giving children to.” Juan said that he immediately responded yes and told her that he believed she was the only person who deserved that. As he stated affectionately, “For me she is my complement. She is my other half.”

Though Juan’s narrative seemed to me a sincere statement of his devotion to his wife, it also seemed to index a strategic engagement with the globally available ideology of companionate marriage—an ideal “situated . . . in the deployment of discourses about progressive gender relations as a means to claim a modern identity,” whereby emotional intimacy “is understood to be both one of the primary measures of success in marriage and a central practice through which the relationship is constituted and reinforced” (Hirsch and Wardlow 2006:14, 4) and which idealizes both individuals sharing responsibilities equally. Indeed, looking ahead, we find a striking similarity between the last sentence of the excerpt above and the last sentence of the second excerpt below, suggesting that, for Juan, it seemed that arriving at the “same” decision as his wife (which he and his wife seemed to suggest was symbolic of the strength of their marital bond) was confirmation of his inclusion in the category of “new Costa Rican men”—men who, according to Juan, used analytical reasoning to make decisions, rather than relying on “machista ideology” and Catholic church teachings. The following conversation more clearly evokes Juan’s hopes for his vasectomy to conjoin with the kinds of cultural changes he believed were currently taking place in Costa Rica—developments he seemed to perceive as positive and progressive.

Then there was the fact that in the 90’s, when the state authorized the woman to be able to get sterilized without the permission of the man, her husband, that changed [everything] radically. Because now the woman doesn’t think about having large families anymore. She thinks about getting educated. In getting prepared. So the mind-set has begun to change because what happened here was that the Catholic church was a dominant force in people’s lives. But as things changed over the years---those changes produced the results you see today.

And why do we [get vasectomies]? Because we are hopeful that maybe one day it will be different. That it wasn’t popular in the past was simply because the man never thought of getting operated [on] to not have any more children. The man, because of his machismo, never thought of getting operated [on]. . . . The man had the tendency to think that if he got operated [on] he would lose his virility, and that he wouldn’t be able to get erections, and that he wouldn’t be able to have sexual relations. And so, the man never thought of getting operated [on]. [Vasectomy] is a new tendency among Costa Rican men. And look, half an hour and I’m all set. Whereas for a woman, it would take much longer for her to recover. If you would have said that to my grandfather he would have shot you. Because of his machismo. . . . But not us. We are already a new generation. A generation that thinks, analyzes things, and sees things much more clearly.

Such statements suggest that Juan’s vasectomy was very important to his manly selfhood. Juan seemed acutely aware that by getting this surgery he was performing a masculinity that has been constituted as subordinate in Costa Rica. Yet, he seemed proud of his vasectomy. In fact, he stated that one day he would tell his (imagined) future male grandchildren about his vasectomy,
which he believed would show them a different, better way of being a man. Throughout the interview Juan continued to draw connections between his vasectomy and his claims to a modern social identity, highlighting the profound impact practical decisions about when and how to use contraceptives may have on identity and subjectivity (cf. Russell et al. 2000).

Like other birth control methods, vasectomy has been the subject of debate in Costa Rica. However, over the last decade, as the viability and popularity of this surgery have increased (see al Día 2007; La Nación 2008), it has become a key site for evaluative statements about the state of men and masculinity in Costa Rica. Indeed, for many Costa Ricans like Juan, the recent increase in vasectomies not only points to interesting demographic shifts in contraceptive use, but also signals the advent of a cultural shift in local constructions of masculinity. As Lydia (a nurse who prepared patients for vasectomy at the hospital where I conducted research) confided, “Before it was not like this that men would come in to have this surgery. You know, because the man is very machista. But now everything has changed, and men are more willing to have a vasectomy. And now many are coming in for a vasectomy here in Costa Rica.”

This article interrogates and extends our understandings of the modes by which cultural constructions of male contraceptive use emerge in Costa Rica by analyzing men’s narratives of vasectomy. Using Costa Rican men’s sense making about this particular contraceptive technology, I extend Oudshoorn’s analysis on masculinity and contraceptive research by exploring “the work that goes into changing the contraceptive discourse to include men” (2003:10). I argue that Costa Rican men work through their vasectomy to powerfully rearticulate the relationship between masculinity and contraceptive responsibility and tensions in an emerging Costa Rican social modernity.

Though not every man linked their vasectomy so unambiguously to new formations of manhood in Costa Rica as Juan, most did frame their decision to get a vasectomy as “responsible” and “just.” The discursive strategies they employed to imbue this surgery with moral import suggested they were responding to some form of stigma. In recounting their experience of getting a vasectomy, most revealed encountering some bias against men who get these surgeries. In addressing this concern, they often critiqued dominant articulations of masculinity, which tend to link masculine virility not only to “erectile performance” (Loe 2004) but also to fertility. To counter local versions of this ideology, which most described as machista, they would often rearticulate masculinity to be inherent in something other than the ability to reproduce—linking manliness to paternal, conjugal, and reproductive responsibility.

By specifically contributing men’s views on vasectomy, this feminist-informed analysis contributes to a growing literature in medical anthropology on men’s active involvement in sexual and reproductive health (e.g., Inhorn 2004, 2007; Gutmann 2007; Inhorn et al. 2009; Inhorn and Wentzell 2011). Over the past decade, these studies have been guided by questions regarding gender asymmetry in the production and use of sexual and reproductive health technologies, including in vitro fertilization, erectile dysfunction treatments, and sterilization. Contributing to ongoing developments in the field of masculinities studies, these studies have sought to provide a corrective to the overdetermined perspective on men as disengaged from reproduction, which has influenced much of the feminist and public health research on reproduction and sexuality (Inhorn et al. 2009; Gutmann 2007). Using ethnography to illuminate the ways men “are shaped by their movement through distinct social contexts in which different masculine behaviors and practices are situationally operative” (Padilla 2011:159), these studies have argued for the centrality of anthropological investigations on men’s reproductive health and sexuality for understanding social inequalities in reproduction and gender relations overall.
In doing so, these scholars have called for more careful ethnographic description of men’s roles in reproductive decision-making, and also for more empirical analyses that explore the layers of meaning that men, as gendered and engendering social actors, attribute to fertility, contraception, and other reproductive practices and technologies in situated contexts that are always power laden. In response, this article highlights vasectomy and men’s narratives of this reproductive technology as key sites for examining gender politics and the materialization of new social orders in contemporary societies. In the discussion, I argue that the men’s narratives examined here potentiate creation of an “alternative technosociality” (Oudshoorn 2003) in Costa Rica, in which men taking contraceptive responsibility does not constitute performing a subordinate masculinity, but simply another way of acting as men. Additionally, I suggest that the men presented here be viewed as “embodying emergent masculinities” (Inhorn and Wentzell 2011), since their use of vasectomy as birth control in this context is encouraging them to inhabit manliness in new ways that diverge from stereotypes of local men.

Methods and Fieldwork

This article presents findings from an ethnographic study of vasectomy in San José, Costa Rica. Semi-structured interviews were conducted with biomedical practitioners, family planning providers, and male patients. These patients were either in the process of getting a vasectomy or had received this surgery. Discussion questions were designed to invite patients to narrate their experience of getting a vasectomy. As Garro and Mattingly have observed, narratives (or the situated stories people tell to convey the meaning of an experience or event) are useful to medical anthropologists because they shed light on cultural aspects of biomedical practice that often go unacknowledged (2000:5).

Field data were collected during 2009 at a regional social security hospital in San José.3 Research access was enabled by a prominent urologist who was introduced to me via e-mail by a Costa Rican anthropologist and medical doctor. This urologist kindly embraced my project and introduced me to hospital staff. With his assistance, and with permission from the hospital’s department of bioethics, I was given access to Outpatient Surgery (not the surgery room) and permitted to ask the urology department secretary about vasectomy appointments. Research access was also enabled by Nurse Lydia who allowed me to “hang out” with her in Outpatient Surgery and introduced me to patients as a researcher. In spite of her introductions, patients sometimes mistook me for a doctor, but I always made sure they understood my role as an anthropologist and researcher before asking for consent.

All patients interviewed were recruited in the hospital. Patients included ten vasectomized men (one interview included the participant’s wife) and two pre-vasectomized men.4 Patients were 30 to 48 years old, with the mean age at 37; ranged in education level from incomplete elementary education to advanced collegiate degree; and had from 1 to 4 children, with an average of 2. Most interviews with patients were conducted in the recovery room for reasons of privacy and scheduling. In Outpatient Surgery, all patients wait in one room until their name is called for surgery. The recovery room is much more spacious, providing patients with individual beds and a greater sense of privacy—an important aspect when interviewing patients about their sexual lives. Taking Nurse Lydia’s advice, I began asking for patients’ consent in Outpatient Surgery. However, because of timing and lack of privacy, patients were reluctant to talk to me there. Out of respect for patients and for enrollment purposes, I shifted locations for
consent to Recovery because there were no other rooms made available to me. When I began asking for consent in Recovery, enrollment increased significantly. I gave consenting patients the option of being interviewed in Recovery or outside the hospital at a location and time of their choosing. Because vasectomy patients are required to stay and rest in the hospital for at least an hour, most consenting patients opted to be interviewed in Recovery.

Interviews with patients were conducted in Spanish. With patient consent, all interviews except one were recorded and later transcribed and translated into English. Interviews with patients covered religion, knowledge of contraception, prior contraceptive and fertility decisions, biomedical knowledge of vasectomy, acquisition of information on vasectomy, disclosure of vasectomy, fears or worries about vasectomy, and thoughts about the social implications of getting a vasectomy in Costa Rica. Analysis of patient interviews focused on performative aspects of responses provided, that is, how the narrator placed himself within a particular sociocultural and historical context, and also the cultural, political, and psychosocial work evident in the narrative he told. Contextual aspects were drawn from analyzing recurrent thematic elements and responses to perceived alternative views. To understand the work narrators did in constructing their accounts, I focused on identity or self statements, animating concerns, the ways narrators positioned themselves relative to others, and how narrators introduced various actors and institutions.

The following two sections explore the history and cultural politics of sterilization in Costa Rica and provide a theoretical background for understanding current gender asymmetries in contraceptive use. Drawing on anthropological and sociological accounts, I provide a context for understanding why and how Costa Rican men work through their vasectomy to rearticulate the relationship between masculinity and contraceptive responsibility.

Placing Vasectomy in Context

“Mas hombres deciden hacerse la vasectomía para no tener hijos” [More men decide to get a vasectomy to not have children] reads a headline from a September 2008 edition of La Nación, Costa Rica’s leading national newspaper. Like never before, vasectomy is in the Costa Rican public’s consciousness. And with good reason: Records from the Costa Rican Social Security Bureau show a 76 percent increase in vasectomies performed in social security hospitals between the years 2000 and 2003, and another 70 percent increase between 2003 and 2006. Vasectomy has become so popular that men sometimes have to wait two years to get the surgery in a social security hospital where it is provided quasi-free of charge (La Nación 2009).

Although the growing interest in vasectomy as a form of birth control has been remarkable to many locals—particularly because widespread popular representations suggest that many, if not most, Costa Rican men would never avail themselves of vasectomy because of machismo, religious beliefs, or other reasons—state family planning policies have had an impact on the current viability of vasectomy there. Indeed, over the past four decades, Costa Rica has shown continued devotion to “population discourse in which low fertility is linked to development and modernity” (Goldade 2011:547)—a devotion intimately connected to Costa Rica’s politically and economically strategic commitment to making health “a central and prominent feature of its national social identity” (Downe 1997:1577). Its national health care program offers citizens “free” access to a range of birth control technologies, and its family planning institutes have enthusiastically adopted the slogan: “A small family is a better family.”
Among the range of contraceptive technologies now available at social security hospitals and clinics, however, sterilization is a rather new addition. Prior to 1999, sterilization under nontherapeutic circumstances was illegal. In fact, when family planning campaigns began in Costa Rica in 1968, sterilization was not included as a viable option because of a religiously inflected penal code that severely punished anyone who caused permanent injury to a person’s reproductive organs, leaving them without the capacity to reproduce (Seiler 2001:115).

Although the Catholic church has been relatively weak throughout Costa Rica’s history as compared to its influence in other Central American states (Wilson 1998), its influence has been and continues to be felt at legislative, political, and moral levels, because Costa Rica is constitutionally defined as a Roman Catholic nation-state (Carranza 2007:57; Seiler 2001:126). The church’s legislative power is reflected in past penal codes regulating contraceptive technologies, particularly sterilization. When sterilization became permitted under a penal code instituted in 1988, legislators put in place certain restrictions to prevent its easy access. Women, as the primary users of most forms of birth control, were required to ask their husbands’ permission in order to be sterilized (marriage was a conditionality built into law) and also were expected to have children before doing so (Carranza 2007; Seiler 2001). Additionally, women were required to produce proof of a “therapeutic exception,” that is, a medical condition that necessitates sterilization (Carranza 2007; Seiler 2001:117).

In 1999 a change in policy largely motivated by feminist activism liberalized sterilization in Costa Rica (Seiler 2001), permitting any person over the age of 18 to undertake sterilization on her or his own terms, and stating that “doctors would not face penal liability for performing sterilizations” (Seiler 2001:126). It did not resolve the cultural tensions surrounding these surgeries, however: immediately after this policy was passed the head of the Catholic church in Costa Rica reasserted the church’s ongoing claim that “the sterilization of healthy organs represents a ‘mutilation’” (Seiler 2001:126).

Taking into account the history and cultural politics of sterilization in Costa Rica, it is not surprising that vasectomy rates were negligible prior to the year 2000, or that many people there have found the recent increase in vasectomies noteworthy. Though family planning policies, the 1999 decree, a struggling local economy, and changing ideals of marriage and family have been very important in shaping the “cultural feasibility” (Oudshoorn 2003) of vasectomy in Costa Rica, stereotypes of local masculinity and other factors have impacted views of the kinds of roles men are willing to take in reproductive decision making.

Notably, in my conversations with family planning providers, there was a clear indication that men who wished to be sterilized before the 1999 decree would never have been subject to the same forms of surveillance and scrutiny as women. Yet, very few men had made use of vasectomy as a form of birth control. Although many would suggest that “macho culture” is partly responsible for previous low rates of vasectomy, positioning men as gatekeepers to female sterilization in the 1988 penal code likely had a significant impact on how Costa Rican men viewed their role in contraception—seemingly assisting in the construction and stabilization of what Viveros Vigoya refers to as a “female contraceptive culture” in which “women . . . are overwhelmingly responsible for birth control” (Gutmann 2007:40), and, one could argue, also reproducing “hegemonic views that emphasize the intertwining of the male sexual and reproductive body” (Oudshoorn 2003:16).

Gender asymmetry in the use of sterilization as a form of birth control in Costa Rica is evident in the latest statistics published by the Population Reference Bureau in 2008: female sterilization is being used by approximately 21.4 percent of “married women of reproductive age
(15–49)” in Costa Rica, whereas vasectomy is being used by approximately 0.5 percent. It should be noted, however, that records from the Costa Rican Social Security Bureau indicate that the increase in vasectomies over the past decade has coincided with a decrease in tubal ligations performed in social security hospitals, though female sterilization remains the second most common form of birth control in Costa Rica—second only to oral contraceptives.\(^6\)

**Theorizing Gender Asymmetry in Contraception**

We still need to use protection for a little while longer, but now I feel at peace. I am very happy with [Marcos] because, you know, he’s supporting me, right? I have many female friends who say, “I’m going to have to get the operation because he doesn’t want to.” And to see that Marcos stepped up to get it done, hey, that’s a sign of his love for me, right? People talk about what it means to show someone that you love them, and right there, it’s not just anyone who would be willing to take on some pain for a little while just to relieve me of having to go through some more pain and suffering. And so now I feel at peace.

—Isabel

In *The Male Pill*, Oudshoorn (2003) writes, “Technologies do not reflect the essentialistic properties of bodies; they are the materialized result of negotiations, selection processes, contingencies, and technological choices, embodying socially and culturally constituted values and practices” (10). Using the concept of “sociotechnical networks” (Latour 1987) as a framework for understanding the delay in the development of modern contraceptives for men, Oudshoorn provides “a corrective to perspectives that create the impression that gender asymmetry in reproductive technologies is an inevitable result of technical logic” (9). She suggests, instead, that gender asymmetry in contraceptive technologies has been created through the stabilization of a complex system of practices and relationships involving clinics, laboratories, industries, doctors, patients, state regulations, social movements, the media, and cultural conventions shaping gender identities. Developing this framework further by applying the analytic of gender as performance, and also by drawing on the “social worlds” approach in the sociology of science (e.g., Clarke 1998), Oudshoorn argues that in order to change contraceptive discourse to include men, new sociotechnical networks surrounding contraceptive technologies would have to be formed, involving drastic changes to the terms of the relationship between contraceptive technologies and men’s social identities.

The epigraph above, taken from my joint interview with Isabel and her husband, Marcos, illustrates the discursive strategies I observed being used in Costa Rica to radically change the terms of these sociotechnical relationships there. By positioning Marcos in relation to her friends’ husbands and praising him for getting a vasectomy, Isabel articulates a masculinity that challenges the idea that contraception is women’s responsibility.

Isabel’s account strikingly connects Marcos’s act of getting a vasectomy with love. Seldom is a heterosexual male user of contraception figured as a loving person who is genuinely concerned about the health of his partner, particularly in the marketing of male contraceptive technologies (Oaks 2009). Although Isabel and Marcos would still need to use some form of birth control up until the point of azoospermia (i.e., the medical condition of a male not having any measurable level of sperm in his semen), there was a sense of calm about Isabel throughout the interview, indexed by her recurrent use of the phrase, “Now I feel at peace.” I would later learn that her precarious physical condition would have worsened with a tubal ligation. And yet,
even though this was the case, Isabel’s narrative seemed to suggest that Marcos was doing something quite extraordinary for her. This framing of vasectomy as an act of love and support for one’s partner recurrent among male participants.

My research suggests that, in Costa Rica, sterilization is aligned strongly with femininity, and culturally dominant views of manliness tend to link masculine virility to the fertile male body (see Inhorn 2004 on “virility–fertility linkage”). These gender–body associations are not unique to Costa Rica, as Connell writes: “True masculinity is almost always thought to proceed from men’s bodies—to be inherent in a male body or to express something about a male body” (2005:45). Recent work on the medicalization of masculinities and men’s sexualities has illustrated the social and subjective contingencies between male body work, such as the use of erectile dysfunction treatments, and achieving ideal standards of male embodiment (Loe 2004; Wentzell 2008). In The Rise of Viagra, Loe writes that “achievement of an erection with the potential to penetrate and ejaculate [has become] central to the ‘accomplishment’ of heterosexual masculinity, [partly due] to medical definitions of erectile functioning” (2004:77). For some men, then, “Viagra can be understood as both a cultural and a material tool used to achieve normal (and extranormal) manhood” (Loe 2004:26). Anthropological analyses of male infertility have examined the ways male bodily substances like fecundating sperm become essential to men’s social identities, particularly in contexts of stratified reproduction (see Inhorn 2004). In a study of male infertility in an Israeli-Jewish context, Goldberg (2009) writes that the achievement of (heterosexual) masculinity has become a challenge for many infertile Jewish men in the fiercely contested reproductive arena of Israel, because good sperm motility and high sperm counts increasingly are being made to signify Israeli-Jewish masculinity and male sexual ability. Examples such as these document the currency of ideas of “male sexual fitness” developed in the 19th century, which coalesced around a “patriarchal politics of life” focused on “regeneration, population, and nation” (Marshall and Katz 2002:44). Indeed, by situating the development of these gender–body connections within scientific practices shaped by cultural norms, and within projects of “stratified reproduction” (Colen 1995), these studies shed light on the underexamined linkages among masculinities, techno-medico-scientific apparatuses, nationalism, and state power. These linkages have given rise to stereotypes such as “real men must procreate to prove themselves men” (Gutmann 2007:42) and have helped sustain ideas that men have a natural aversion to contraception (Gutmann 2007).

Changing the contraceptive discourse to include men thus requires work because of the convergence of value systems (sometimes guided by powerful religious institutions), legal regimes, scientific practices, industry priorities, clinical trial regulations, marketing strategies, social movements, and national interests (Browner and Sargent 2011:9). With respect to this article, it is important to highlight that “the physiological aspects of contraceptives, which separate sexual from reproductive functions, challenge hegemonic views of masculinity that emphasize the intertwining of the male sexual and reproductive bodies” (Oudshoorn 2003:16). In Costa Rica, local manifestations of these views seemed to situate men who get vasectomies in a sort of “in-between” position. Because despite the fact that all but one of the men I interviewed had fathered at least one child, my reading of their narratives did not seem to suggest that fulfilling this social obligation, which many interpret as proof of masculine virility, necessarily provided them with an easy way to counter challenges to their manliness for getting a vasectomy.
Men’s Narratives of Vasectomy: On Masculinity and Taking Responsibility

Because vasectomy, which enables men to perform sexually without being fertile, is at odds with culturally dominant ideals of masculinity in Costa Rica, male participants often expressed finding themselves in the position of needing to rearticulate the relationship between masculinity and contraceptive responsibility. In their narratives, they evoked culturally rooted beliefs that construct vasectomized men as feminized or adulterous. Because they considered these characterizations to be wholly untrue for themselves, their narrative accounts often incorporated elements that contested these pernicious stereotypes: the feminized man controlled by his wife and exhibiting some bodily shortcoming, and the hypersexual man who lacks control over his sexual desires and impulses (Gutmann 2007).

The ambiguous positions these men seemed to inhabit as a result of competing ideologies of masculinity at play revealed themselves especially in the ways they chose to position themselves relative to other men—and more specifically, in how they chose to distance themselves from (imagined) Costa Rican men who would find vasectomy unthinkable. Often they created this distance by employing the predominant cultural discourse of masculinity in Latin America, that is, through recurrent rhetorical juxtapositions of “machista” and “non-machista” men. Indeed, when making reference to (imagined) local men who might oppose vasectomy, they often would label them “machista” and populate their speech with words and phrases that seemed intended to index a person who is intensely committed to the hegemonic views of masculinity outlined above, that is, to “delegating the responsibility for contraception to women and safeguarding the unity of the male sexual and reproductive body” (Scale 2002:1; Oudshoorn 2003:16). As the following excerpt by Nicolás (age 30 and vasectomized) illustrates this characterization:

Here [the men] are machista. You can ask [any man] on the street what they think about vasectomy and they will say, “Not me! Not me! I wouldn’t let anybody mess with the family jewels! Let my wife be sterilized instead. She’s the one who’s having the kids. That’s her responsibility. It’s all her responsibility.”

My reading of men’s narratives about vasectomy suggests that this popular framing of local men provided these men both with a way to make sense of the recent increase in vasectomies and with a discursive strategy for imbuing their decision to get a vasectomy with moral import: Machista was considered a pejorative characteristic among all these men and was usually associated with cultural backwardness. In this way, “the vasectomized man” was made to signify not only what it means to be morally good and responsible but also a man in contemporary Costa Rica.

Vasectomy comes into conflict with key aspects of Catholic or Christian doctrine in addition to conflicting with what was described as machista ideology. Encounters with some form of Catholic or Christian morality were not unusual among these men. In many cases, these encounters were revealed as being significant to developing feelings of stigma, leading many to reinterpret religious values. The following narratives illustrate how these contested claims of morality and masculinity become complexly intertwined in the process of getting a vasectomy, showing these categories to be situationally operative. In the first narrative we find Andrés actively negotiating his parents’ conflicting views of vasectomy, highlighting the different investments individuals have in this surgery based on their situated knowledges. The second
narrative poignantly shows the “felt stigma” (Scambler 1984; Greil 2002)—that is, “the shame felt by the stigmatized because of their internalization of societal evaluation of their condition and the resultant sense that they have failed to live up to the standards of ‘normality’” (Greil 2002:106)—that may result from getting a vasectomy in Costa Rica, and, with the first narrative, also illustrates how reproductive decision making in this context is often contingent on both religious understandings and economic circumstances, among other factors (Hughes 2011). In the third narrative Marcos reconsiders his views on vasectomy after learning that his wife would not be able to have a tubal ligation as planned, which shows manly selfhood to be a performance ever in progress (Inhorn and Wentzell 2011:803; see also Connell 2005). All three narratives affirm Gutmann’s insistence that “masculinities develop and transform and have little meaning except in relation to women and female identities and practices” (1997:400). Mothers, in particular, figure as key players in these men’s reproductive decision making, and also in their constructions of vasectomy as an act of responsibility, spousal support, and shared suffering.

**Andrés: “But I can’t afford to have any more children”**

Two weeks before his vasectomy, I met Andrés (age 32) for an interview at his workplace. Before the start of the interview he asked me if anyone else had agreed to participate in the study. I honestly responded that two other men had agreed. My response seemed to provide Andrés with some relief because he immediately changed his reserved disposition toward me and began to engage me in friendly conversation.

Andrés had been married for the last nine years and had two children. When I asked him why he had decided to get a vasectomy, he responded that it is “much easier and faster for a man” and that the operation for a woman is “more complicated.” Later, however, it became clear to me that Andrés was not well informed about the physiological aspects of vasectomy. In fact, he admitted during the interview that he was quite worried about his upcoming surgery. He asked me to clarify the differences between male and female sterilization, and then asked me what effects a vasectomy would have on his body and his sexual functioning.

Despite his uncertainties, Andrés said he would likely go through with the surgery because he was relying on his mother’s embodied knowledge of female sterilization. Apparently, his mother had had a difficult time recovering from her tubal ligation, and so she wanted him to make a “responsible” decision in this regard. Andrés also had discussed his decision to get a vasectomy with his mother-in-law, who agreed with his mother because “the economy is very tough these days” and also because “the surgery for a woman is more invasive, requiring longer recovery.”

Though Andrés had consulted his mother-in-law, he had no intention of discussing this decision with his wife. When I asked him why, he succinctly stated, “I don’t really plan these types of things with her.” Although this form of consultation and disclosure was atypical among the men I interviewed, it nonetheless reflected a common theme found throughout the men’s narratives, namely, women’s suffering in childbirth and contraception.

Although he had received support from key women in his life, Andrés did encounter strong resistance to this decision. His father, who had been sterilized in 2005 after having a child with his second wife (not Andrés’s mother), was actively discouraging him from getting a vasectomy. Andrés attributed this resistance to what he described as his father’s religious awakening. He said his father had been attending mass regularly over the past few years and also had become involved in a variety of proselytizing activities through his local Catholic church.
Andrés self-identified as Catholic, however, he believed that his vasectomy would be fine in the eyes of God because it was being done with a sense of responsibility. But when he told his father that he was going to get a vasectomy despite the church’s position—because he believed that he could not afford to have any more children, and also because he believed that more children would be a risk to the future of his current family—his father insisted that getting this surgery would still be a great sin. Andrés trusted that his father had his best interest in mind, so this left him with a quandary, having to weigh his mother’s embodied knowledge of female sterilization and her justifications for a man getting a vasectomy against his father’s stance on the surgery based on his understanding of Catholic teachings.

Carlos: “I didn’t want anybody to know what I was going to do to myself”

“To not have any more babies” was the first response I received from Carlos (age 39) when I asked him why he had decided to get a vasectomy. When I asked him if there was anything else that had influenced his decision, he made reference to other factors, including his and his wife’s discomfort with condoms, the potentially harmful effects of oral contraceptives, and his wife’s religiosity. Though he had referred to multiple factors, his wife’s Christianity was a point of emphasis in his narrative. “My wife is of the Christian religion,” he said, “and so some methods of planning she doesn’t see them as good. I mean, because of the religion, it is not to her liking. And so, I saw more viable the option of me being operated.”

As the interview progressed, it became apparent that Carlos’s views of his wife’s religiosity had also affected other aspects of his decision-making process. At the time of our interview, only four other people had knowledge of Carlos’s vasectomy: his brother, one of his sisters, his boss, and his wife. Carlos had not discussed his decision to get a vasectomy with his wife prior to the surgery, however. As he recounted, his wife came to find out about his vasectomy only because she wanted to have sex with him and he couldn’t engage in sexual intercourse at that particular moment because it was soon after his surgery.

On the day of Carlos’s surgery I had observed that an adult man had accompanied him, rather than a female partner, who is the usual person to accompany a vasectomy patient. When I asked Carlos who had accompanied him that day, he said, “Yeah, my brother was with me because I didn’t want anybody to find out. I didn’t want anybody to know what I was going to do to myself. Really, it is a very personal decision. It’s not of any importance to anyone else.” Later I asked Carlos how his wife—who was six months pregnant at the time—reacted when she found out about his vasectomy. He said,

She was bothered because I didn’t tell her about my decision. And well . . . it was a combination of feelings. Because anyway, if you look at it from the other side, that it was for her good as well, so that she wouldn’t have to use contraceptive methods that would cause her physical or psychological pain—And then she accepted it. Because in the beginning we had only thought about having one baby. Because I wanted a boy. But since we are expecting a girl, later on she told me that if it doesn’t come out a boy, that the boy—-[And] well, by then I had already had the surgery.

Toward the end of the interview, I asked Carlos for his thoughts on the gender asymmetry in sterilization in Costa Rica. He responded,
The man in this country always tends to be machista, in the sense that he thinks that it is the woman who should do the things. To the point that the woman is the one who should be responsible. Because there are occasions when the woman gets pregnant and the man says, “See, you didn’t take of yourself.” But it’s not just her responsibility. They are both responsible. And he tells her, “Why she wasn’t careful?” But why didn’t he take care of her?

Carlos’s response highlights the ways in which the discourse of machismo gets strategically used to attribute moral significance to the act of getting a vasectomy, but it also shows this popular discourse to be useful in the management of felt stigma, at least in this context.

*Marcos: “No, I will get it done. . . . Why shouldn’t I suffer a little?”*

I met with Marcos (age 40) a few days after his vasectomy. Recall that his wife, Isabel, also participated in the interview. When I asked Marcos to describe his decision-making process with respect to his vasectomy, Isabel’s ailments were key points of reference. Marcos did not initially want to be sterilized, but Isabel’s precarious physical condition compelled him to reevaluate his position on the surgery. Marcos and Isabel had consulted a doctor about Isabel getting a tubal ligation because a different doctor had told her that another birth could put her life at risk. But it turned out that getting a tubal ligation also would put Isabel’s life at risk. As Marcos said,

Yeah, you could say that the two of us made the decision. Because I was, to be honest, resistant to the idea of getting it done. The one who was going to have it done was my wife. But my wife has a problem in her midsection, I mean, lots of things, and she also has been diagnosed with hyperthyroidism. And so we talked about it, and the doctor told us, “Well, you are fine and healthy. She, on the other hand, could develop a serious complication because of her various conditions.” And so that’s why I decided to go through with it. I said, “No, I will get it done.” And hey, she has already suffered through two births and all that stuff. So why shouldn’t I suffer a little?

Though Isabel’s ailments were the primary motivating factors for Marcos’s decision to get a vasectomy, Marcos’ mother was also influential in his decision making. Having knowledge of Isabel’s medical conditions, Marcos’s mother fully supported his decision to get a vasectomy. Recalling one of their conversations, Marcos said,

Yeah, I talked with my mom about it because I have a very good relationship with her, and I trust that her advice will be good for me. And when I told her, “Hey, I’m getting this done,” she said, “Perfect!” She said that Isabel has already suffered through two births, and that she has already experienced enough pain, and so now it was my turn. And she actually made me even more willing to get it done.

After recounting this conversation, I asked Marcos if he felt different from other men for getting a vasectomy. Without hesitation, he responded, “This is being as much a man as any other. That’s to say, eh! be that what it may, not just because of the fact that I can no longer have children will I feel any less of a man.” Although Marcos was deviating from the norm by getting
a vasectomy, his impassioned response made it clear that he did not want to be perceived as being any less of a man for going against cultural conventions of masculinity, that is, for now being able to perform sexually without being fertile. His statement that “This is being as much a man as any other” suggested that he wanted others to view his decision to get a vasectomy as simply another way of performing manhood.

Discussion

Despite numerous ethnographic studies examining the social impact of reproductive technologies (Russell et al. 2000), and even less to methods involving the active participation of men (cf. Gutmann 2007; Oaks 2009). This absence in the literature is particularly glaring when one considers the fact that contraception “impinges on the lives of the majority of heterosexual couples in their childbearing years, irrespective of income or social status” (Russell et al. 2000:3). Though based on relatively brief ethnographic research, this article shows that contraceptive technologies, today, “constitute a crucial arena for understanding how particular forms of gender gain cultural dominance and others remain marginalized” (Oudshoorn 2003:15). More specifically, this article reveals that vasectomy and men’s narratives of this technology constitute key sites for examining the politics of gender within masculinity, and also (intergenerational) relations between men and women in contemporary societies. To better understand men’s active participation in reproductive arenas, my research suggests it is vital to closely examine how men imagine and inhabit manliness as they encounter contraceptives in situated contexts. Although limited, my data also suggest it is equally important to attend to dyadic communication, as this may help identify intimate contingencies, contradictions, individual investments, and power dynamics that may facilitate or complicate reproductive decision making, and, specifically, men’s contraceptive use (Russell et al. 2000; Bledsoe 2002).

The diverging forms of consultation and disclosure revealed in men’s narratives show that getting a vasectomy, as with the use of any other contraceptive, is not simply a matter of individual choice, but a constrained and interactive process, involving relations between men and women as well as between men (Russell et al. 2000; Lopez 2008).

I suggest that narratives constitute an especially useful resource for examining how “contraceptives operate in and represent a universe of culture, morality and emotion” (Russell et al. 2000:20), because the meanings one ascribes to important events in one’s life course “reflect expectations and understandings gained through participating in a specific social and moral world” (Garro and Mattingly 2000:3). Indeed, the stories told by Juan, Andrés, Carlos, and Marcos (with Isabel) illustrate how meanings attributed to the act of getting a vasectomy and the technology itself are contingent on the local cultural context and local moral worlds in which the man finds himself situated (Bledsoe 2002). This contingency is best illustrated by these men’s strategic use of the locally powerful discourse of machismo to make sense of the recent increase in vasectomies, manage felt stigma, attribute moral import to the act of getting a vasectomy, and set themselves apart from “irresponsible” and “culturally backward” men who oppose vasectomy. These men’s constructions of vasectomy as an act of shared suffering, spousal support, and paternal responsibility also would seem to highlight the legitimacy of claims of caring within a nation that is imagined as peaceful and tolerant (Huhn 2009). Notably, narrators’ strategic deployment of globally circulating discourses of marital love and family planning—discourses that make it possible to link vasectomy and responsibility, and which permit one to
answer the question “How does a heterosexual man show that he loves and supports his partner?” with “By getting a vasectomy”—suggests that, today, participation in a specific social, moral world may extend well beyond the local.

An important aspect of narrative, which links productively to recent theorizations on masculinity, is that it “mediates emergent constructions of reality” (Garro and Mattingly 2000:3; emphasis mine). Following Oudshoorn’s analysis of gender asymmetry in the development of modern contraceptives, I have argued that, among other factors, (religiously inflected) hegemonic views of masculinity, which delegate contraceptive responsibility to women and emphasize the intertwining of the male sexual and reproductive body, have significantly impacted Costa Ricans’ views and use of vasectomy as birth control. But as Williams has argued, hegemonies are not static or fixed or inevitable but “lived systems of meanings and values” (1977:109). Indeed, they have “continually to be renewed, recreated, defended, and modified,” as they are “also continually resisted, limited, altered, challenged by pressures not at all [their] own” (Williams 1977:113). As this article shows, Costa Rican men are getting vasectomies despite culturally dominant views of these surgeries. In the process, they are crafting narratives based on their lived experiences that attempt to expand the “cultural repertoire of masculine behavior” (Connell 2005:xix) available to local men. As elements of these narratives are bound to circulate, given the apparent similarities in rhetorical frames and discursive strategies employed by men and women in this study, I argue that the narratives examined here may potentiate destabilization of the current cultural system and contribute to the construction of an “alternative technosociality” in Costa Rica, in which men taking contraceptive responsibility does not constitute performing a subordinate masculinity, but simply another way of acting as men. In this way, these men can be viewed as “embodying emergent masculinities” in the sense that they are using “their experiences of changing reproductive and sexual health to live out manliness in new ways that diverge from pernicious stereotypes” (Inhorn and Wentzell 2011:802).

Also drawing on the work of R. W. Connell (2005) and Raymond Williams (1977), Inhorn and Wentzell have recently put forth the concept of “emergent masculinities” to shift the discourse on masculinity away from static binaries and essentialist tropes, which have stymied research on men’s involvement in reproductive health and sexuality. Inhorn and Wentzell point out that while feminist theorists have long shown gender to be a social construct that is fluid, contextual and embodied, there is a dearth of studies that examine the complex articulation of maleness and masculinity (2011:801). This is especially true with respect to heterosexually identified men, who often are constructed as naturally predisposed, or presumed, to act out their manliness in ways that conform to stereotypes (Gutmann 1996, 2007). The concept of emergent masculinities is thus intended “to account for ongoing, context-specific, embodied changes within men’s enactments of masculinity, particularly as they encounter emerging health technologies” (Inhorn and Wentzell 2011:802).

In their article, Inhorn and Wentzell apply this concept to two sites, which like Costa Rica, are “marked by powerful stereotypes of local manliness” (2011:802): the Arab Middle East and Mexico. Using ethnographic methods to examine Arab men’s use of assisted reproductive technologies to overcome male infertility and older Mexican men’s views of erectile dysfunction treatments, their analysis sheds light on “the ways that new medical technologies enable new forms of embodied masculine practice” (803). Although vasectomy is not new in the sense that it has been practiced since the late 1890s (Oudshoorn 2003) and in Costa Rica since at least 1971 (Guttmacher Institute 1975), I suggest that it be viewed as an “emerging sexual health
technology” in Costa Rica, because its availability and use has only recently become an important topic of public discourse. Indeed, in the sense that its use is encouraging men both to powerfully shift the linkages between masculinity and contraceptive responsibility and to imagine and inhabit new ways of living as men that differ from stereotypes of local men, vasectomy in Costa Rica may be viewed as a medical technology that is enabling emergent masculinities. In fact, a 2007 article in Al Día (a widely circulating daily newspaper in Costa Rica) reports that a growing number of young, local men have been availing themselves of vasectomy to never have children—an unintended consequence of the liberalization of sterilization that some biomedical practitioners I interviewed saw as undesirable. While this recent development may be particular to Costa Rica, it nonetheless illustrates that contraceptive technologies do “play an important role in stabilizing or destabilizing particular conventions of gender, creating new ones, or reinforcing or transforming the existing performances of gender” (Oudshoorn 2003:13). Moreover, it demonstrates that we should never presume men’s reactions or approaches to sexual and reproductive health technologies, even seemingly “old” ones that are made “new.”

Notes

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1 Pseudonyms are used for all study participants.
2 For direct quotes: An ellipsis represents text removed. Bracketed words are mine and are intended to provide clarification. A triple dash represents a long pause or a change in topic mid-thought.
3 This study received IRB approval from both the University of Iowa and the Costa Rican Social Security Bureau’s Department of Bioethics.
4 “Vasectomized” refers to men who were interviewed after their vasectomy. “Pre-vasectomized” refers to men who were interviewed before their vasectomy.
5 Whereas the wait for men to get a vasectomy in a social security hospital may be long, especially without the “right connections,” the wait for women to get a tubal ligation in the same hospitals is much shorter. Hospital staff suggest it is partly due to so few doctors trained to perform vasectomies and also that a tubal ligation may be performed within a certain period of time after a woman gives birth. All legally working citizens are obligated to pay into the national
health care plan managed by Caja (i.e., the Costa Rican Social Security Bureau) even if they receive or prefer medical service at private institutions.

6 Population Reference Bureau (2008): oral contraceptives are used by approximately 25.6 percent of “married women of reproductive age (15–49)” in Costa Rica; IUDs by 6.9, injection by 5.9, and condoms by 10.9.

7 One limitation is that this is based on one-time interviews with men who, mostly, were committed to getting a vasectomy. However, the wide range in age, education, and class enhances the validity of these findings and will serve as the foundation for a more expansive ethnographic study.

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