A workshop on dis:connection in contraception in two parts

Part I: Negotiating reproductive respon-sibility

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Fig. 01
(Photo: Christoffer Voigt)

Contraception is considered a private matter. It is decided between two people, organised as discreetly as possible, and is thus negotiated in seeming silence. Yet it is precisely this apparent privacy that conceals a central tension: while decisions about contraception are made in intimate contexts, their prerequisites, risks and consequences are anything but private. They are unequally distributed, politically framed and shaped by institutional conditions.

In feminist theory, this shift is nothing new: 'the personal is political',[1] especially where questions of bodies, sexuality and

1 The slogan is attributed to second-wave radical-feminist Carol Hanisch.

reproduction are negotiated. Because contraception often appears as an individual issue related to self-determination, it is simultaneously outsourced to the private sphere, while its societal facets slip out of view. Who bears the risks? Who has access to knowledge? Who has access to methods, counselling, resources, and who does not? These questions concern not only individual bodies, but also interpersonal relationships and political structures, and thus the question of justice and equality.

These very questions were addressed at the workshop on equitable contraception in practise, which took place in November 2025 at the Käte Hamburger Research Centre global dis:connect. It became clear that contraception magnifies gender roles, attributions of responsibility, economic logics and political priorities. Contraception was not discussed as a purely technical issue, but as interwoven processes of negotiation between individuals within societal structures, within political-regulatory institutions and within discourses.

Still no pill for men? Questioning the contraception gap

A central question of the workshop concerned the so-called 'pill for men'. While the pill for women*[2] has been established as a contraceptive method since the 1960s and has become a standard method alongside the condom, the 'pill for men' has remained largely a utopia despite decades of research. At the same time, contraceptive methods such as the IUD and sterilisation for women* are becoming increasingly popular,[3] indicating growing demand for expanded contraceptive options – a trend that scholars associate with falling acceptance of the contraceptive pill. Meanwhile, the contraception gap between genders remains persists, with research and medical options for men*[4] remaining limited.

This gap refers to the structural inequality in contraceptive options, the distribution of responsibility and the medical assessment of risk. While a wide range of medically recognised hormonal and mechanical contraceptive methods exist for women* – from the pill to IUDs to implants and sterilisation – men* are left with only condoms or vasectomies.[5] This structural

2 This term refers to women and people who can become pregnant, and the associated contraceptives for ovulation suppression.
3 See the recent survey by the Federal Institute for Public Health (BIÖG) on sexual education, contraception and family planning: *Faktenblatt: Sexualaufklärung, Verhütung und Familienplanung*, Bundesinstitut für Öffentliche Aufklärung, 7, https://shop.bioeg.de/pdf/DL-20251027-1600.pdf.
4 The term *men** refers to men and sperm-producing people.
5 Although the condom is the most widely used contraceptive method in Germany and often reflects shared responsibility in practice, its comparatively limited efficacy under typical use means that an additional method is required anyway.

inequality is due not merely to technical feasibility; it's a symptom of the interplay of ethical, institutional and economic factors.

The politics of contraceptive risk evaluation or why responsibility remains gendered

One example of contraception for men is thermal contraception, in which the testicles are heated by external sources or daily elevation into the inguinal canal, significantly reducing sperm production. Smaller studies in France and Switzerland, alongside widespread self-experiments conducted outside official testing modalities, report effective contraception with comparatively minor side effects.[6] We lack large-scale clinical trials, reliable Pearl Index data and systematic long-term studies. Theoretical risks, such as a potential association between undescended testicles and cancer, are frequently cited as reasons against systematic research, despite the absence of solid evidence. In France, thousands of men* already use thermal contraception, sometimes under medical supervision, without regulatory approval. The discrepancy between actual practice and regulators' caution reveals how the evaluation of contraceptive methods is strongly shaped by institutional priorities and risk perceptions and delimited to what is deemed investigable.

Moreover, by prioritising pregnancy as the central metric of contraceptive risk, biomedical and regulatory systems reinforce structural gender biases, marginalising men's* reproductive role and framing contraception as a predominantly female responsibility. A single-organism risk model prevails in pharmaceutical regulation. Benefits and side effects are assessed solely in relation to the body being treated. For male contraception, this means that hormonal and other body-altering methods are measured against a healthy male body; any deviation from this presumed 'normal state' is automatically regarded as problematic. By contrast, women's* risks are evaluated primarily in light of potential pregnancy: side effects of hormonal methods, for instance, are deemed acceptable when weighed against the medical risks of pregnancy, thereby legitimising their market approval.

A shared-risk model would instead assess benefits and harms relationally, relating male side effects to the health and social risks borne by a partner who could otherwise become pregnant,

6 See Samuel Joubert et al., 'Thermal male contraception: A study of users' motivation, experience, and satisfaction', *Andrology* 10, no. 8 (2022) https://doi.org/10.1111/andr.13264; Jean-Claude Soufir, 'Hormonal, chemical and thermal inhibition of spermatogenesis: contribution of French teams to international data with the aim of developing male contraception in France', *Basic and Clinical Andrology* 27, no. 3 (2017) https://doi.org/10.1186/s12610-016-0047-2.

thus accounting for both individuals' risks. If contraception were holistically understood as a shared responsibility in (hetero)sexual partnerships, men*, too, would be recognised as risk-bearing participants. Scholars advocate this relational model because it exposes how current standards obscure the distribution of risk between partners and thereby reproduce structural inequality.[7] Since regulators tend to neglect this relational model, health risks continue to be assessed differently depending on whose body is impacted. The result is a biomedical double-standard in which physically invasive interventions for men* appear ethically more problematic than comparable methods for women*.

The contraception gap under the lens of invisible labour, heteronormativity and sexual health

The contraception gap is therefore not merely a technological deficit, but a product of divergent standards in biomedicine and ethics that materialise in everyday negotiations between sexual partners. It involves continuous planning, information management and risk assessment, much of which remains invisible. Coordinating appointments, researching potential side-effects, calculating costs and monitoring adherence all constitute a cognitive and emotional load. While contraception is formally framed as a shared responsibility, in practice this labour is often carried disproportionately by the woman*, reinforcing the contraception gap.

Moreover, when reproductive health is normatively framed around pregnancy prevention, medical risk assessment and public discourse reduce contraception to a heterosexually defined practice. Other dimensions of sexual health are systematically neglected: prevention and testing strategies for sexually transmitted infections are treated as secondary, despite being relevant irrespective of gender, relationship structure and reproductive capacity. Queer lives and sexualities are marginalised, as dominant contraceptive discourses remain organised around heteronormative assumptions of pregnancy risk. This narrow focus matters. While reproductive risks continue to be framed predominantly as pregnancy risks, European public health authorities have reported sustained increases in bacterial STIs such as syphilis and gonorrhoea in recent years.[8] The shift in attention towards hormonal pregnancy prevention, coupled with the relative neglect of barrier-based protective strategies,

7 Christopher ChoGlueck, 'Still no pill for men? Double standards & demarcating values in biomedical research', *Studies in History and Philosophy of Science* 91 (2022) https://doi.org/10.1016/j.shpsa.2021.11.010.

8 'STI cases continue to rise across Europe', European Centre for Disease Prevention and Control, 2025, accessed 19 February 2026, https://www.ecdc.europa.eu/en/news-events/sti-cases-continue-rise-across-europe.

therefore constitutes not just a discursive imbalance but an epidemiological concern. A contraceptive policy oriented towards the management of reproduction fails to address central aspects of collective sexual health and simultaneously reproduces a heteronormative constriction of sexual responsibility.

Taken together, these dynamics reveal the contraception gap as a structural phenomenon rather than a mere technological absence. It is sustained by regulatory standards, research priorities and entrenched assumptions about whose body is expected to bear reproductive risk. As long as biomedical evaluation remains individualised, pregnancy prevention dominates sexual-health discourse, and the mental load of contraception is unevenly distributed, responsibility will fall asymmetrically. Closing the contraception gap therefore requires not only new methods, but a shift towards a genuinely relational understanding of reproductive risk and shared responsibility.

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