

A NETNOGRAPHY OF GENDER STIGMA IN CONTRACEPTIVE USE IN INDONESIA AND UNITED STATES OF AMERICA

Bima Rafly Fachrezzi^{1*}

Siti Alfia Ayu Rohmayanti²

Ayu Mei Wulandari³

Ambarwati⁴

Ahmad Miftah Ainurrohman⁵

Teguh Panotogomo⁶

Ishiaka Adamu⁷

Saikou Touray⁸

^{1,2,3,4,5,6*}UIN Sunan Ampel Surabaya, Indonesia

⁷School of Social Sciences, Njala University, Sierra Leone, West Africa

⁸Gambia Bureau of Statistics, The Gambia, West Africa

Corresponding E-mail: bima.fachrezzi@uinsa.ac.id

ABSTRACT

This study investigates how women in Indonesia and the United States negotiate contraceptive burdens and gendered power relations through digital narratives. Using a netnographic design, 630 public comments from YouTube and Twitter/X were analyzed to identify recurring patterns of embodied suffering, unequal reproductive responsibility, and systemic critique of medical and pharmaceutical institutions. Findings demonstrate that contraceptive burden is not biologically inevitable but socially constructed through patriarchal norms that normalize women's pain while prioritizing men's comfort, a phenomenon we identify as threshold asymmetry. The study further develops the Islamic Feminist Reproductive Framework by integrating feminist theory, *maqāṣid al-syarī'ah*, and digital testimonies as forms of epistemic resistance. This framework positions reproductive justice as the intersection of gender equity and *ḥifẓ al-nafs* (protection of life). Practical implications emphasize the need for male-inclusive family planning, elimination of medical gaslighting, and partnership-based reproductive education. Recommendations for future research include expanding to other platforms, examining male narratives, and testing the framework across diverse Muslim contexts.

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Introduction

Contraception is not merely a matter of reproductive health in Indonesia, but also reflects the complex dynamics of gendered responsibility. Recent data from the National Population and Family Planning Board (BKKBN) show that the national prevalence of modern contraceptive use

* Corresponding author: Bima Rafly Fachrezzi, bima.fachrezzi@uinsa.ac.id

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(mCPR) remained at approximately 60.9% in 2024, still below the RPJMN target of 63.41% (BKKBN, 2025). Although this coverage appears relatively high, the distribution of contraceptive methods is highly uneven: women remain the dominant users through methods such as pills, injections, IUDs, and implants, while male contraceptive use remains minimal. For instance, data from 2022 indicate that only 2.48% of family planning acceptors were men, with condom use at 2.2% and vasectomy at 0.25% (BKKBN, 2023). This disparity in participation reflects the substantial social and medical burden placed on women. In many households, contraceptive decision-making and use are regarded as “women’s affairs,” while men are frequently exempted from responsibility, reinforced by both social norms and family planning service practices (Alspaugh et al., 2020). Furthermore, vasectomy is often stigmatized as something that diminishes or harm male identity (Zakiah et al., 2024). As a result, women not only bear the risks of hormonal side effects but also commonly face social pressure and sole responsibility if an unintended pregnancy occurs. In an Indonesian society still marked by patriarchy and traditional norms, this unequal allocation of contraceptive responsibility highlights reproductive power relations that remain imbalanced (Eva & Habib, 2024).

On the other hand, the dynamics of contraceptive use are also reflected in digital communication behaviors, especially among Gen Z, who are now entering marriageable age (18–27 years). Unlike previous generations, Gen Z tends to hold more egalitarian relationship values and emphasizes partnership in family decision-making, including pregnancy planning (Wiranti et al., 2025). However, when these expectations collide with the realities of traditional gender roles, they become more vocal in expressing their personal experiences (Rabia Hameed et al., 2025). Social media platforms such as TikTok, X (Twitter), and Instagram have become public spaces for “sambat” (venting, lamenting, or expressing disappointment) about household dynamics, including contraceptive burdens (Cetera et al., 2025). Across numerous posts, recurring narratives emerge, such as: “Why am I the one who has to use contraception? Why do men just show up and enjoy the results?” Such posts spark lengthy discussions and debates in the comment sections, indicating that social media functions as a site where gender stigma is produced and reproduced (Cetera et al., 2025; Rabia Hameed et al., 2025). User interactions shape public discourse on who should bear responsibility for contraceptive use (Alspaugh et al., 2020). This phenomenon underscores that social media is not only a space for sharing experiences but also a field of social negotiation in which values and norms related to gender roles are continually renegotiated (Wigginton et al., 2018). Because these conversations arise organically, spontaneously, and are produced by users themselves, netnography becomes the most relevant method for understanding how gender-related stigma surrounding contraception is constructed in digital spaces.

This study is grounded in the integration of two theoretical frameworks: *Feminist Theory* (Disch & Hawkesworth, 2016), particularly the concept of the gendered division of reproductive labor, and the perspective of Islamic Gender Justice through *the maqāṣid al-syari‘ah*. Feminist Theory (Disch & Hawkesworth, 2016) argues that contraception has long been positioned as women’s responsibility due to patriarchal social constructions that normalize unequal divisions of reproductive labor. The burden of contraceptive use is understood not as a biological inevitability, but as a product of gender norms continuously reproduced by culture, family, and health institutions. Within the Indonesian context, where religious values play a central role in social life, this study incorporates an Islamic theoretical lens as a counterbalance to the assumption that men hold unilateral dominance in reproductive decision-making. Islam, through the *maqāṣid al-syari‘ah*, emphasizes the protection of life (*ḥifẓ al-naḥs*) and lineage (*ḥifẓ al-nasl*), positioning contraceptive use as an effort to safeguard family well-being. Moreover, the concepts of *syūrā* (consultation) and *musyarakah* (partnership) within the family reaffirm that contraceptive decisions are neither the husband’s unilateral right nor the wife’s sole burden, but a process of joint decision-making.

Therefore, integrating these two frameworks allows the study not only to identify existing gender inequalities (critical analysis), but also to offer an Islamic value-based perspective on reproductive justice as an alternative solution suited to the Indonesian social context.

Research on contraception and gender relations has been conducted across various countries and social contexts, yet most studies concentrate on reproductive health, service access, and unequal household decision-making rather than on how these issues are negotiated through Gen Z's digital narratives on social media. Obare et al. (2021) and Burke & Lindberg (2024) show that partner power dynamics and male control influence contraceptive decisions and give rise to *contraceptive coercion* (Burke & Lindberg, 2024; Obare et al., 2021). Surdia et al. (2025), Boyce et al. (2025), Rochimah et al. (2023), and Muharomah & Zimmerman (2025) highlight the low participation of men in family planning and examine it through the lens of social norms and the *Theory of Planned Behavior* (Boyce et al., 2025; Muharomah & Zimmerman, 2025; Rochimah et al., 2023; Surdia et al., 2025). Other studies such as Ara et al. (2024), Idris et al. (2021), Spagnoletti et al. (2018), and Kelly (2020) focus on service providers, limited education, the role of religious institutions, and access to contraceptive methods (Ara et al., 2024; Idris et al., 2021; Kelly, 2021; Spagnoletti et al., 2018). Across this body of research, contraception remains positioned primarily as a health issue, rather than as a digital discourse shaped by gendered constructions. No existing studies explore how young couples articulate the imbalance of contraceptive burden through tweets, memes, or “sambat” posts on social media as forms of resistance and renegotiation of gender norms. Thus, the research gap lies in understanding how female in Indonesia and USA uses social media as a digital public sphere to critique unequal reproductive labor, and how these narratives reflect the clash between patriarchal values and demands for equality in modern marriage.

Based on the identified phenomenon, research gap, and proposed novelty, it can be concluded that although numerous studies have examined contraception, gender relations, and reproductive decision-making, no research has positioned contraception as a digital discourse issue and a site of gender negotiation among young couples, particularly Gen Z in Indonesia. Previous studies have largely focused on service access, education, or household decision-making, whereas the ways in which Gen Z expresses resistance to unequal reproductive labor through social media remain unexplored. Therefore, this study aims to reveal how newly married Gen Z couples discuss the imbalance of contraceptive responsibilities through digital narratives as a form of social critique and renegotiation of gender norms. Practically, this research provides insights for policymakers (BKKBN, healthcare providers, and premarital education facilitators) on the importance of designing contraceptive programs that actively involve men and on recognizing Gen Z's social-media communication patterns as a valuable source of policy insight. Thus, the study opens a new perspective that contraception is not merely a health issue, but also a matter of gender justice and social representation in the digital era.

Stigma, Male Contraception, and Reproductive Justice

The social stigma experienced by women—particularly those from Generation Z—in the use of contraception reflects gender norms that unfairly assign reproductive responsibilities to women (Bitzer, 2025). This stigma arises from a social framework that traditionally positions women as solely accountable for family planning and the consequences of pregnancy. As a result, women who choose to use contraception are often judged, while the historically limited availability of male contraceptive options has reinforced men's minimal responsibility in this area (Sitruk-Ware et al., 2025). However, contemporary studies have emphasized that male contraception must be viewed as an integral part of gender medicine and reproductive justice (Shi et al., 2025). The core demand of this line of inquiry captured in the phrase “It's Our Job, Not Her”—highlights the need for a social deconstruction of perspectives that place stigma and burdens exclusively on women.

Continuous advancements in male contraceptive methods—both hormonal and non-hormonal, such as transdermal gel formulations or receptor antagonists—have sparked an important sociological discourse (Kidula et al., 2025). These biomedical developments indicate that the primary barriers to sharing contraceptive responsibility are no longer purely technical or biological, but social and cultural. From a social perspective, the availability of male contraceptive options challenges the status quo by offering men a tangible opportunity to take an active role in family planning. This shift carries significant implications for global sexual and reproductive health, as it fundamentally alters power dynamics and responsibilities within relationships and society (Nguyen, 2024).

A social review must therefore include an analysis of society's readiness to accept this redistribution of reproductive responsibilities. Empirical evidence from online behavior shows substantial public interest in the development of male contraception (Melo, 2025). Web-traffic data and Google Trends demonstrate rising curiosity about emerging male contraceptive methods, indicating that Gen Z and the wider public are actively seeking alternatives beyond methods targeted exclusively at women (Web-traffic and Google Trends data, 2025). This demand has the potential to translate into real market uptake, suggesting a latent consumer base capable of transforming the contraceptive landscape (Brewer & Nguyen, 2025). Such collective willingness indirectly reinforces this study's claim that contraceptive responsibility should be shared (*shared responsibility*).

Another key social issue concerns how the acceptance of male contraception will shape constructions of masculinity. In Indonesia and West Africa, decisions regarding male contraceptive use often confront cultural norms about ideal male roles, where male contraception may be perceived as a symbol of "weakness" or as a rejection of traditional reproductive expectations (Ermi Nurmalia, 2021). The success of methods such as synthetic androgens must be accompanied by a shift in social discourse one that frames male involvement in contraception as an act of responsibility rather than a threat to masculine identity (Thirumalai & Amory, 2021). In this context, Gen Z's netnographic discussions become crucial, as social media serves as a space where new definitions of gender responsibility and masculinity are being negotiated and contested in real time.

Contraception in Medical Perspective

Contraceptive use in Indonesia remains heavily dominated by women. According to the latest data from the Ministry of Health of the Republic of Indonesia (2021), 48.5% of women of reproductive age use hormonal contraception, particularly injectable methods. Survei Demografi dan Kesehatan Indonesia (SDKI) 2017 further shows that modern contraceptive methods such as pills, injectables, and IUDs are far more commonly used than male methods such as condoms or vasectomy (Priskatinda & Ronoatmodjo, 2021). This pattern reflects a long-standing social bias in which fertility regulation is regarded as a woman's responsibility, mirroring traditional gender norms and reinforcing unequal reproductive role distribution.

Female contraceptive methods both hormonal and non-hormonal are associated with a range of side effects that influence physical and emotional health. A study involving 232 users of hormonal contraception found that 76% experienced side effects, with the most common being menstrual irregularities (44.4%) (Matthew et al., 2023). Meanwhile, non-hormonal methods such as the copper IUD may cause severe dysmenorrhea and heavy menstrual bleeding (Xu et al., 2021). Although not all women experience these effects, the consequences of fertility regulation are often borne by women's bodies, reinforcing the disproportionate health burden placed on them.

On the other hand, male contraceptive methods ranging from condoms and permanent methods such as vasectomy, to traditional methods such as coitus interruptus, and even emerging hormonal candidates currently under investigation to suppress sperm production—remain significantly underutilized. Even when men receive adequate education about male contraception,

implementation remains low. Multiple studies emphasize that the primary barrier is not the availability of methods but deeply rooted social constructions that frame family planning and fertility management as women's responsibilities. Ultimately, this phenomenon indicates that contraceptive use is shaped not only by medical factors and knowledge but also by gender norms that place a disproportionate reproductive burden on women

Method

This study employs a netnographic approach (Kozinets, 2020; Kozinets & Gretzel, 2024) to address the research objectives, complemented by a grounded theory-informed analytic strategy. This design enables an inductive examination of how Gen Z women in Indonesia and West Africa articulate their views, stigma experiences, and perceptions related to contraception, reproductive responsibility, and gender roles within online discourse, without imposing a predetermined theoretical framework. The literature review was conducted in two phases: an initial assessment to identify conceptual and empirical gaps in research on reproductive health and social stigma, followed by a second iterative review after coding to refine interpretation and situate the emerging findings within current academic conversations.

This study employs a digital ethnography/netnography approach to examine the public construction and contestation of narratives surrounding social stigma, gender roles, and challenges in contraceptive access among young people. Digital ethnography was operationalized by collecting naturally occurring online dialogues from YouTube comment sections highly active public spaces where Gen Z women from Indonesia and West Africa, together with broader online audiences, engage in open discussions about perceptions, myths, and stigmas related to contraceptive use. The investigation focuses on how commenters frame reproductive and health responsibilities, how they interpret gender roles and social values, and how these interpretations shape their views on social justice in the governance of women's bodies.

The study relies exclusively on publicly accessible data, and no interaction with users occurred during data collection. In accordance with ethical principles for ethnographic research (Kozinets & Gretzel, 2024), identifiable elements such as usernames and timestamps were removed, and excerpts were paraphrased when necessary to prevent traceability. Given the public availability and non-interventional nature of the data, formal approval from an ethics review board was not required. This approach safeguards participant anonymity while preserving the integrity of the dialogue.

Data were drawn from publicly available digital channels where discussions on stigma, perceptions, and the framing of Gen Z women's roles in contraceptive use and reproductive health are most prevalent. YouTube was selected as the primary research site due to its function as a public forum in which freelancers, consumers, and broader communities debate platform deductions, benefit eligibility, and the ambiguity surrounding "partner" versus "employee" classifications. A total of 200 comments from high-engagement YouTube videos addressing issues of contraceptive responsibility and gender-based discrimination were collected for analysis.

Results

Analysis of the digital corpus reveals three dominant narrative patterns that consistently emerged across both country contexts through selective coding: embodied burden, gendered power dynamics, and systemic critique, as presented in Appendix A1 and Appendix A3. In the Indonesian dataset, narratives of embodied burden are especially pronounced, reflected in intense accounts of side effects from injectable contraceptives ranging from hormonal disturbances and depression to sexual discomfort. One representative paraphrased comment illustrates the layered nature of these experiences: "*Suffering from the three-month contraceptive injection... headaches, increased appetite... feeling*

miserable but my husband insists I keep using it so selfish.” This complaint illustrates how the female body becomes the primary site where contraceptive consequences are absorbed. Meanwhile, the pattern of gendered power dynamics appears strongly in discussions surrounding male ego and resistance to male contraceptive methods. Several users on X (Twitter) directly highlight these double standards. A frequently echoed sentiment notes: *“My husband refuses condoms because they feel less pleasurable, won’t consider a vasectomy... so it has to be me again?”* Such comments reveal how reproductive decision-making is often negotiated unevenly within marital relationships.

In contrast, within the United States context, narrative patterns shift more decisively toward institutional critique and the failures of the medical system. Many comments describe dismissive physician responses to women’s complaints or the lack of adequate informed consent. Representative paraphrased examples include: *“I’m sick of some doctors denying that weight gain is a side effect”* as well as extreme medical experiences, such as an ischemic stroke attributed to hormonal pills: *“I’m 34 and had an ischemic stroke because of the pill.”* These narratives underscore the structural dimensions of reproductive injustice. Despite originating from two vastly different social contexts, the three major patterns appear with striking consistency. Women in both Indonesia and the United States shoulder the physical, emotional, and social burdens of contraception; navigate gendered power relations that position them as the “primary bearers” of responsibility; and confront medical systems that often fail to provide validation, protection, or adequate care. Full representative quotations illustrating these three patterns are presented in Appendix A2.

Fist findings

Embodied Burden

Preliminary analysis indicates that embodied burden is the most dominant theme emerging across the entire netnographic corpus, both from Indonesia and the United States. The majority of comments describe severe physical and psychological experiences related to contraceptive use, ranging from menstrual disruption, weight fluctuation, and prolonged pain to emotional side effects such as depression and anxiety. The following section elaborates on three central clusters within this embodied burden: systemic physiological disruption, life-threatening health complications, and mental health and sexual-function detriments. Furthermore, Table 2 presents a summary of the frequency of the ‘Embodied Burden’ theme across the full netnographic dataset.

Table 2. Summary of the frequency of the ‘Embodied Burden’

Thematic Clusters (S-Codes)	ID data (N=212)	USA data (N=418)	Key Manifestations
S1: Irregular Menstruation/ Amenorrhea	High (Explicit in 80% of complaints about injectable contraception)	Moderate	menstruation stops, prolonged bleeding, anemia
S2: Weight Gain/Body Changes	High	High	Body image issues, 40 pound gain, "thick belly"
S3: Mental/Mood Distress (Depression, Anxiety)	Moderate (often called "emotions" or "depression")	Very High (explicitly called "horrible depression")	Affects the stability of the relationship

S4: Sexual Dysfunction (Loss of Libido/Pain)	High (Often tied to male frustration)	Moderate (Often tied to self-perception)	Decreased desire, forced ("forced") intimacy
S5: Severe/Life-Threatening Complications (Stroke, Cysts, etc.)	Moderate	Moderate	Risk of blood clots (stroke), cysts, organ damage, near death

Source: Processed by Researchers (2025)

The intensity of narratives surrounding menstrual disruption and weight gain demonstrates that users interpret these effects not merely as medically explicable biological changes, but as forms of physiological disturbance that destabilize the body's equilibrium and interfere with everyday life. This interpretation aligns with D'Souza et al. (2023), who found that contraceptive experiences are often framed through embodied distress, wherein bodily changes are understood as threats to both physical and social identity (D'Souza et al., 2023). Within the Indonesian corpus, prolonged amenorrhea triggered concerns about bodily "abnormality," whereas among users in the United States, significant weight gain was perceived as a loss of control over one's body. These patterns reinforce the argument of Polis et al. (2018) that long-lasting contraceptive side effects may reduce satisfaction, strain interpersonal relationships, and contribute to discontinuation (Polis et al., 2018). Accordingly, the digital corpus does not merely document complaints; it illustrates how subjective bodily experiences shape risk narratives and influence reproductive decision-making.

Narratives describing severe and life-threatening side effects appeared predominantly in the United States corpus, where several users recounted acute medical events they attributed to hormonal contraceptive use. One user reported experiencing "an ischemic stroke two months ago due to the pill" after 18 years of oral contraceptive use. Other comments detailed episodes of heavy bleeding leading to severe anemia, kidney infections, and the onset of thyroid disorders following Mirena IUD insertion. Meanwhile, narratives from Indonesia also reflected concerns about serious long-term complications, indicating a shared sense of vulnerability despite differing healthcare contexts.

The intensity and variation of these narratives indicate that experiences of extreme side effects are understood not merely as biological risks, but as embodied threats that disrupt users' sense of safety within their own bodies (Schwarz et al., 2019). In the U.S. context, highly medicalized narratives for example, explicit references to an "ischemic stroke" demonstrate how users interpret contraception through a clinical risk framework that aligns with established health literature. Conversely, Indonesian users articulate the same sense of threat through descriptions rooted in everyday experience and non-medical terminology, reflecting a different form of health literacy yet producing comparable levels of anxiety. This pattern is consistent with Polis et al. (2018), who argued that perceptions of severe side effects regardless of their clinical prevalence can diminish trust in contraceptive services and accelerate discontinuation (Polis et al., 2018). Taken together, these findings illustrate that digitally circulating risk narratives actively shape collective understandings of contraceptive safety and may influence reproductive decision-making across both cultural contexts.

Mental health impacts also emerged as a strong thematic pattern across both corpora, though with differences in intensity and linguistic framing between Indonesia and the United States. In the U.S. corpus, users described experiences of severe depression, anxiety, and extreme mood instability, including statements such as "*horrible horrible depression with birth control*" and reports of feeling "suicidal" after using emergency contraception. Psychological disturbances were likewise present in the Indonesian corpus, though expressed through more everyday phrasing such as "*keep*

getting emotional to my husband” (constant irritability toward one’s husband) or “*depression too*” indicating a perception that hormonal contraception disrupts emotional balance and interpersonal relations. These findings resonate with literature showing that psychological experiences related to contraception are often relational and contextual rather than solely hormonal (D’Souza et al., 2023). When mood changes are perceived as disrupting household harmony or daily functioning, users tend to regard these effects as threats to their overall well-being (Lundin et al., 2017). Consequently, the narrative patterns across both corpora illustrate how perceptions of mental health play a central role in shaping satisfaction, trust, and decisions to continue or discontinue hormonal contraceptive use.

Beyond psychological aspects, the loss of sexual desire (libido) emerges as one of the most consistently reported complaints in both contexts. Indonesian users described that after receiving the three-month contraceptive injection, they experienced “*no desire*” or “*reduced sexual appetite*,” with some portraying sexual encounters as feeling “*forced, unpleasant, and not enjoyable*.” One user even mentioned that her partner complained about the situation by saying he “*felt like he didn’t have a wife*,” illustrating how diminished libido is interpreted within the dynamics of marital life. The loss of sexual desire often generates marital tension when male partners insist on the continuation of the contraceptive method being used. Expressions such as “*my husband told me to continue the injection... he’s being selfish*” depict situations in which reproductive decisions are not fully negotiated and instead become a source of pressure.

These findings indicate that the loss of libido is understood not only as a physiological disturbance that diminishes sexual satisfaction, but also as a threat to the stability of domestic relationships (Cici Krismawati & Nanik Yuliwati, 2023). Reduced sexual desire is perceived as a performative failure within prevailing gender roles (Le Guen et al., 2021), placing women in a dual burden: coping with unwanted bodily changes while simultaneously facing social pressure from their partners. Thus, the decline in libido identified in this study is not merely a clinical side effect, but a social phenomenon that shapes users’ emotional well-being and intimate dynamics

Second findings

Power Dynamics

The findings on bodily burden in the previous section illustrate that the medical and psychological consequences of contraception are shouldered almost entirely by women. Moreover, the results show that these experiences are rooted in gendered power relations that become visible in digital conversations. Narratives from both the Indonesian and U.S. corpora reveal that contraceptive decisions do not stand alone; rather, they are shaped by patriarchal norms, male sexual entitlement, stigma, and culturally embedded definitions of masculinity. This section discusses two primary forms of inequity: the patriarchy of pleasure, which normalizes men’s rejection of condoms, and the masculinity crisis, which renders vasectomy taboo both of which contribute to reproductive coercion within households. Table 3 summarizes the patterns of resistance and stigma against male contraception that emerged across the three digital corpora.

Table 3. summarizes the patterns of resistance and stigma against male contraception

Tema (G-Codes)	Indonesia (Twitter/YouTube ID)	USA (YouTube US)	Rasional Stigmatik Kunci
G1: Pleasure Over Partnership (Condom Refusal)	High	Moderate	"Not so good," prefer "natural feel"

G2: The Threat to Masculinity (Vasectomy Stigma)	High	Moderate	Fear of becoming "less of a man if you have a vasectomy," threat to your "testicle pouch"
G3: Systemic Health Inequities (Men's Safety Priority)	Low (Focus on personal ego)	Very High (Focus on Pharma/FDA)	Male BC study halted due to minor side effects; women suffer for decades
G4: Marital Obligations (Spiritual Support)	Moderate	Low (Focus on individual rights)	A wife must comply with her husband's sexual needs or face relationship conflict.

Source: Processed by Researchers (2025)

Digital narratives reveal a consistent pattern of complaints regarding the unequal distribution of reproductive responsibility. Women question why they are expected to bear the majority of medical and psychological risks of contraception, while men remain largely exempt from comparable consequences. One of the most dominant rationalizations used by men to avoid involvement in contraception is the claim that contraceptive methods particularly condoms reduce sexual pleasure. Statements such as “don’t want to use condoms because they feel less pleasurable” recur frequently, illustrating how male sexual preference is prioritized over women’s health. These findings demonstrate that contraception functions as a site where gendered power relations are negotiated, often in ways that privilege men’s preferences (Babbar et al., 2025). Complaints about reduced pleasure not only reflect sexual preference but also show how claims of enjoyment are legitimized as acceptable grounds for avoiding reproductive responsibility, whereas women’s physical suffering is minimized as an inevitable consequence (Higgins & Smith, 2016). Within this framework, the female body becomes the primary locus of sacrifice, while the male body remains protected from medical intervention.

This imbalance becomes even more problematic when viewed alongside the previous thematic findings: mood disturbances, depression, and sexual dysfunction experienced by women as side effects of hormonal contraception. When women face adverse effects that impair their ability to engage in sexual intimacy, while husbands continue to demand the continuation of hormonal methods and refuse safer alternatives (such as condoms or vasectomy), the relationship shifts into a form of passive reproductive coercion. Expressions such as “*my husband tells me to keep getting the injection... he’s selfish*” illustrate how domestic pressure can compromise women’s bodily integrity. This highlights that the burden of contraception encompasses not only medical side effects but also relational negotiations marked by structural inequality (Bessett, 2022). When reproductive decisions occur under emotional pressure or reflect the unilateral preferences of male partners, women lose autonomy over choosing the method that is safest for their own bodies (Damte et al., 2024). This phenomenon manifests in men’s reluctance to share contraceptive responsibility, their tendency to minimize women’s discomfort, and their prioritization of sexual convenience over their partner’s health.

Furthermore, although men have the option of using vasectomy as a contraceptive method, it emerges as the most consistent symbol of male resistance. Across Indonesian Twitter/X discourse, women highlight the irony of this situation with sharp sarcasm: men refuse a minor incision to the scrotum, while women undergo repeated invasive procedures and bear risks ranging from hormonal complications to cancer. This contrast reveals that vasectomy is not merely

perceived as a medical intervention, but as a threat to a social order that accords heightened value to the male body (Msoka et al., 2019). Such intense resistance to a low-risk procedure when juxtaposed with the normalization of women's physical suffering produces a form of "moral asymmetry" in which women's health becomes the "price" paid to protect the symbolic integrity of male masculinity (Fleming et al., 2014).

Third findings

Systemic Critique

The findings indicate the presence of strong critiques directed at medical and pharmaceutical structures perceived as perpetuating reproductive injustice. In the U.S. corpus, criticism is explicitly aimed at the pharmaceutical industry, contraceptive research standards, and clinical care practices. In contrast, institutional critique in the Indonesian corpus emerges more implicitly through complaints about an indifferent health system and the limited contraceptive options available to women. This section identifies two recurring forms of systemic critique, elaborated in Table 4: (1) pharmaceutical double standards and medical gaslighting, and (2) digital resistance that fuels the search for alternatives beyond formal institutions.

Table 4. Identifies two recurring forms of systemic critique, elaborated

Systemic Theme	Indonesia	USA
Criticism of the pharmaceutical industry	Hardly appears explicit; focus on individual side effects	Very dominant: Big Pharma, double standards in R&D, bias towards industry
Medical gaslighting	Implicit (doctors underestimate the effects of contraceptive injections)	Explicit: denial of side effects, minimal informed consent
Double standards for male contraception	There are, but they are more geared towards male behaviour	Very strong: critics halt research into male contraceptive pills
Criticism of health services	Complaints about lack of education from midwives/doctors	Systemic criticism: healthcare costs, medical bias, doctor refusal
Focus of discourse	Husband's ego, domestic burden	Pharmaceutical structure, policy, reproductive politics

Source: Processed by Researchers (2025)

Netnographic findings show that one of the most salient forms of systemic critique in the U.S. corpus concerns the double standards embedded in contraceptive research and development. As summarized in Table 4, comments such as "Men's birth control pill has stopped many studies... Meanwhile, women's birth control is still ongoing despite harmful side effects" highlight how trials for male contraceptives are frequently halted in response to relatively mild side effects such as mood changes or depressive symptoms while women have long endured comparable, and often far more severe, consequences. This critique exposes a broader dynamic in which science, technology, and gender intersect. When studies on male contraception are terminated due to side effects that parallel those experienced by women for decades, it illustrates how men's bodies are positioned as the benchmark of comfort and safety within medical research agendas. Conversely, women's bodies are treated as experimental terrains expected to tolerate higher levels of risk in the name of advancing reproductive technologies (Abbe & Roxby, 2020). This paradox reinforces the argument that gender bias is embedded not only in contraceptive use experiences but also in the very production of scientific knowledge.

Systemic critiques within the U.S. corpus also extend to biases in clinical practice, particularly the phenomenon of *medical gaslighting* (Khan et al., 2024). When women's complaints

are dismissed or invalidated, the consequences reach beyond delayed diagnosis; the legitimacy of their embodied experiences is itself called into question. This dynamic reinforces *epistemic inequality*, in which women's accounts are deemed less credible than clinical assumptions shaped largely by male-centered perspectives (Mickiewicz, 2025). Over time, such patterns erode women's trust in healthcare services and widen the gap between contraceptive products and the actual needs of users. In this sense, medical gaslighting does not merely reflect the biases of individual providers but also exposes the structural conditions that continue to position women's bodies as objects of intervention rather than authoritative sources of knowledge about their own health (Khan et al., 2024).

Discussion

The netnographic findings of this study strongly affirm core arguments within Feminist Theory, as articulated by Disch and Hawkesworth (2016), that the burden of contraception is not a biological inevitability but a socially constructed outcome of patriarchal systems that normalize a *gendered division of reproductive labor* (Disch & Hawkesworth, 2016). Data from Indonesia and the United States reveal a consistent pattern in which women's bodies are positioned as the primary site of fertility control, while men's bodies remain comparatively untouched by reproductive interventions. Women's suffering ranging from weight gain, depression, loss of libido, and chronic pain to the risk of stroke is treated as a "natural consequence" of contraceptive use. In contrast, men's discomfort is framed as a legitimate justification for withdrawing from contraceptive trials or refusing vasectomy. This threshold asymmetry in risk tolerance underscores how patriarchal norms establish a double standard: women's pain is normalized and made negotiable, while men's discomfort is elevated as an absolute limit (Fleming et al., 2014).

From an Islamic perspective, these findings contradict the principles of *maqāṣid al-syari'ah*, particularly the imperative of protecting life (*hiḍḍ al-naḥs*), as the health risks borne by women are no longer proportional to the intended goals of safeguarding family welfare (Oraby, 2024; Sinulingga et al., 2025). Moreover, unilateral decision-making practices where men refuse condoms or vasectomy while pressuring their wives to use hormonal methods are fundamentally misaligned with the values of *syūrā* (consultation) and *musyārahah* (partnership), which mandate deliberation and equality in family matters.

The netnographic findings unexpectedly generated a new theoretical model, referred to here as the *Islamic Feminist Reproductive Framework*. As illustrated in Figure 1, this framework emerges from the integration of *maqāṣid al-syari'ah* with feminist critiques of the uneven distribution of reproductive labor. The model is constructed through the convergence of three foundational components: Feminist Theory, *maqāṣid al-syari'ah*, and women's digital expressions. Feminist Theory elucidates the patriarchal structures that position contraception as a predominantly female burden, producing a gendered division of reproductive labor and a threshold asymmetry in the tolerance for suffering. *Maqāṣid al-syari'ah* reinforces this critique through the principles of *hiḍḍ al-naḥs* and *hiḍḍ al-naḥs*, which emphasize that the physical and psychological harms induced by contraceptive use violate the ethical imperative of protecting life, and that reproductive decision-making must be grounded in consultation (*syūrā*) and partnership (*musyārahah*). The resulting practice of "digital lamentation" observed in the netnographic corpus then functions as an epistemic mechanism that transforms individual experiences into collective social critique. The interaction of these three components culminates in the formulation of the *Islamic Feminist Reproductive Framework*.

This framework asserts that reproductive justice can only be achieved when two core principles gender equality and *hiḍḍ al-naḥs* are simultaneously embedded in contraceptive governance. Within this model, contraceptive decision-making must be grounded in the principle of "*minimizing*

harm and maximizing shared decision-making” which entails reducing both the physical and psychological burdens on women while ensuring consultation and partnership as ethical mechanisms of reproductive deliberation. Accordingly, women’s suffering resulting from contraceptive use is not understood as an individual failure, but as a form of structural suffering produced by patriarchal norms and institutional biases in reproductive health. Within digital spaces, women’s testimonies expressed through “*sambat*” practices operate as a mode of epistemic resistance, transforming personal experiences into collective knowledge that challenges existing power structures.

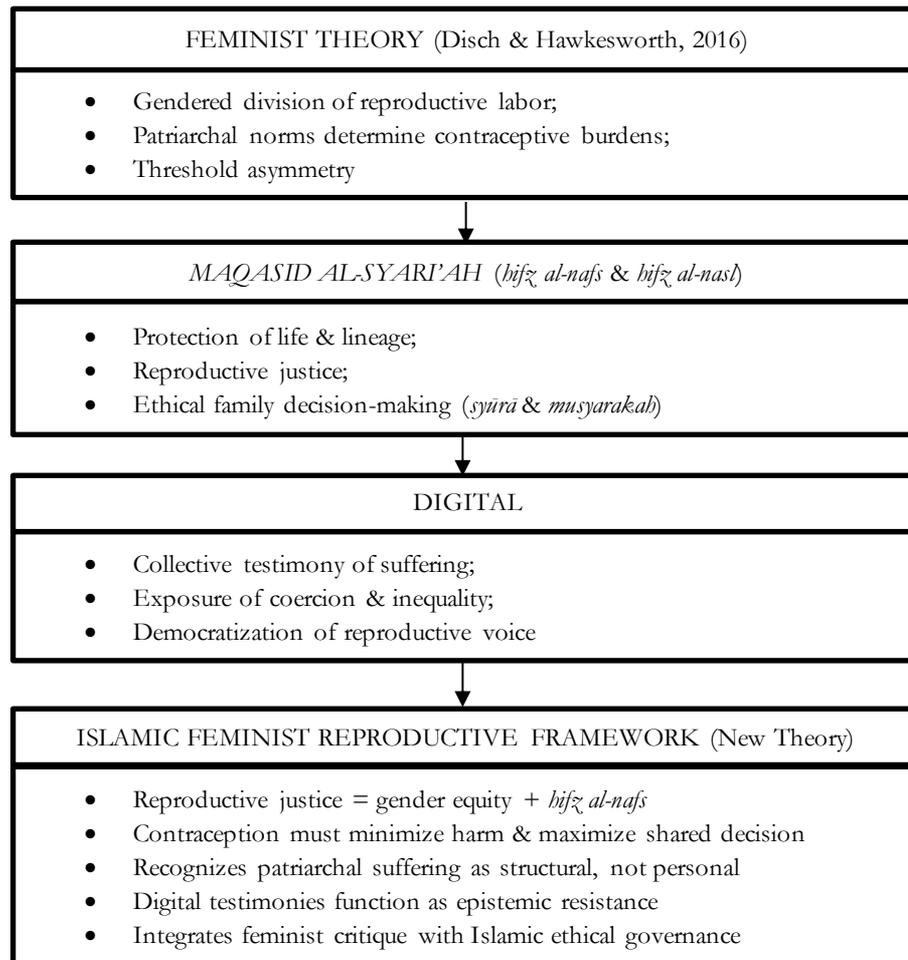


Figure 1. Islamic Feminist Reproductive Framework

Conclusion

This study identifies three dominant narrative patterns that consistently emerge in conversations among women in Indonesia and the United States: embodied burden, relational power asymmetry, and systemic critique of health and pharmaceutical institutions. Together, these patterns reveal that contraceptive experiences are not merely biological side-effect concerns but multilayered burdens manifested through bodily suffering, power negotiation within relationships, and structural failures in delivering responsive and equitable healthcare. Despite substantial differences in social, cultural, and healthcare infrastructures between the two countries, the digital narratives demonstrate a shared reality: women remain the primary actors bearing the physical, emotional, and social consequences of contraceptive use. These cross-national findings underscore that contraceptive burdens are structural in nature, transcending cultural and geographical boundaries.

These findings affirm that the disproportionate contraceptive burden borne by women is not merely a biological inevitability, but the outcome of patriarchal social arrangements that have long normalized unequal divisions of reproductive labor. Within this structure, women's bodies are treated as the primary sites for managing fertility, while men's bodies remain largely exempt from medical intervention. This inequality is most visible in what can be described as threshold asymmetry: women's physical and psychological suffering ranging from depression and menstrual disruption to increased risk of stroke is often framed as normal or tolerable, whereas even minor discomforts experienced by men, such as reduced sexual pleasure or mild side effects, become grounds for rejecting participation in contraception. Thus, contraceptive injustice is a structural problem produced by gendered norms, rather than a matter of individual preference or purely biological response to contraceptive methods.

Theoretically, this study offers an important contribution through the formulation of the Islamic Feminist Reproductive Framework, a new conceptual model emerging from the integration of Feminist Theory, the principles of *maqāṣid al-ṣyārī'ah*, and the digital narratives articulated by women in online spaces. This framework asserts that reproductive justice can only be achieved through the combined pursuit of gender equality and *hifẓ al-nafs* the protection of life as a foundational Islamic ethical principle requiring the minimization of physical and psychological harm. Practically, the findings underscore the urgent need for a paradigm shift in contraceptive policy and service delivery. Family planning programs must be redesigned to actively involve men, rather than positioning women as the primary targets of intervention. Health services should also undertake structural corrections to address medical bias and forms of medical gaslighting that have historically undermined women's experiential legitimacy and obstructed the provision of safe, gender-responsive care. Furthermore, reproductive education should be grounded in the values of partnership (*musyārahah*) and deliberation (*syūrā*), ensuring that contraceptive decision-making is no longer a unilateral burden but a shared process that respects bodily integrity, safety, and the well-being of both partners. This approach is expected to foster a more equitable and humane distribution of reproductive responsibility one that aligns with Islamic ethical principles.

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Appendix A1. Data Collection Matrix

Data Set	Platform / Source	Context	Language	Initial Total Comments	Total Replies	Total Data Points
ID-1	YouTube (3 Month Injectable Birth Control)	Side effects, couple conflict	Indonesia	162	N/A	162
ID-2	Twitter/X (Gender Burden)	Social criticism, male ego	Indonesia	33	17	50 [User Query]
US-1	YouTube (Birth Control)	Side effects, systemic criticism	English	418	N/A	418 [User Query]
Total	3 sources	Comparative Netnography	Mixed language	613	17	630

Appendix A2. Illustrative Netnographic Citations based on Thematic Clusters

Indonesian Quotations (ID Data) – Physical Burdens and Gendered Conflict

1. Physical and Psychological Burden: *“I’m suffering from the 3-month contraceptive injection, no menstruation for years, frequent headaches, fatigue, dizziness, increased appetite, bloating, decreased sexual desire... while my husband’s libido is high. Sometimes I have sex even though it feels uncomfortable and not pleasurable. Yes, I’m depressed too... it’s sad, but my husband keeps telling me to get the injections... so selfish.”*
2. Severe Complications: *“Because of the 3-month contraceptive injection I’ve been using all this time, I now have a 10.5 cm fibroid and must undergo a hysterectomy because my menstruation became irregular.”*
3. Critique of Male Ego: *“I once complained about how birth control might be causing my acne... Then I told my husband I wanted to stop using it. His answer? Then I should be ready to get pregnant again. He refuses condoms because they ‘don’t feel good,’ and he won’t get a vasectomy because he says it makes him ‘not a real man.’ So it has to be me, right? Funny.”*
4. Call for Partnership: *“A message to husbands: don’t be selfish! Your wife has already sacrificed so much during pregnancy and after childbirth. Her hormones and body are a mess. Using condoms won’t diminish your manhood.”*
5. Prioritization of Male Pleasure: *“Back then, women were told to use birth control so they wouldn’t give birth too often, and they stayed quiet even though the side effects were terrible. Now when men are asked to get a vasectomy so their wives don’t get pregnant during sex, suddenly they complain loudly? Is your ego that fragile?”*

USA Quotations (US Data) - Institutional Criticism and Extreme Risks

1. Depression and Extreme Risk: *"Horrible horrible depression with birth control. I get migraines so I can't take estrogen-based pills. Lots of bleeding and cramping continuously when I had a copper IUD. Developed thyroid issues and depression with mirena."*
2. Life-Threatening Complications: *"I'm 34 yrs old and had an ischemic stroke 2 months ago due to the pill"*
3. Pharmaceutical Double Standards: *"Men's birth control pill, has stopped many studies, due to concerns and complaints about side effects. Meanwhile, women's birth control is still ongoing, even after the fact, knowing"*

the harmful side effects caused by taking synthetic hormones. Let that sink in."

4. Medical Gaslighting: *"I'm sick of some doctors denying that weight gain is a side effect"*
5. Traumatic IUD Experience: *"IUD was the worst for me- so painful, for so long! Until I finally insisted they remove it early. Informed consent is a must."*

Appendix A3. Comprehensive Thematic Coding Scheme

Level Three: Theoretical Framework	Second Level: Thematic Clusters	First Level: Netnographic Explicit Code
I. Physical and Medical Burden (Embodied Burden) (Feminist Theory: Exploitation of Body)	S1: Menstrual Cycle Dysfunction	Amenorrhea (no menstruation), prolonged spotting/bleeding, anemia
	S2: Metabolic Changes & Body Image	Weight Gain (drastic increase in weight, weight becomes wow), Thick Stomach, Obesity
	S3: Severe Health Consequences	Stroke/Blood Clot, Cyst/Myoma/Need Hysterectomy, Kidney Failure
	S4: Sexual Dysfunction	Loss of libido, forced sex (unpleasant), pain during intercourse
II. Gender Power Relations (Power Dynamics) (Feminist Theory: Reproductive Coercion)	G1: Masculinity Resistance	Vasectomy Refusal (Fear of 'not being a man'), Condom Refusal ('Not feeling good'/Ego Pleasure)
	G2: Double Reproductive Burden	Bearing the Cost of Pregnancy and Birth Control, Husband is Selfish/Forces Wife to Use Birth Control
(Islamic Justice: Syūrā/Musyarakah Failure)	G3: Men's Well-Being Priorities	Menstrual Delay Pills for 'Inner Support', Wife Called Ugly for Being Fat
III. Institutional Criticism (Systemic Critique) (Feminist Theory & Policy Analysis)	I1: Pharmaceutical Research Bias	Male BC Fails Due to Side Effects, Females Suffer More Severe/Long-Lasting
	I2: Failure of Medical Services	Medical Gaslighting (Doctor Blaming Patient), Lack of Informed Consent, IUD Trauma
	I3: Alternative Demands	FAM/Natural Method, Permanent Sterilization Option