(IN)VISIBILITIES

“I am not ‘macho’ but...”

Male contraceptive pills and the unequal distribution of reproductive responsibilities in India and Mexico

NOSÓTRICOS TIK-TANK

GENDER INEQUALITIES /SERIES/


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Nosótricos Tik-Tank

Nosótricos Tik-Tank is a Mexican research organisation established two years ago by young professionals to conduct social research for development. Concerned about the way social problems and solutions were commonly framed in the country, we decided to establish a new approach that accounts for different ways of knowing.

The team at Nosótricos is conscious about how dominant visions shape forms of knowledge and uneven power relations. We believe that theories based on Western frameworks and contexts are insufficient to capture local perspectives. Our research therefore aims to understand the concepts through which communities interpret their everyday lives.

The present study focuses on gender inequalities in reproductive responsibilities and is based on self-financed research. This report is the first installment in the Gender Inequalities Series, part of Nosótricos research publication ***(IN)VISIBILITIES.***

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Acronyms

Intrauterine device	**IUD**
Male contraceptive pills	**MCP**
Mexican National Population Council	**CONAPO**
Organization for Economic Co-operation and Development	**OECD**
Sexually transmitted infection	**STI**
Sexual and reproductive health	**SRH**
Sexual and reproductive health and rights	**SRHR**
United Nations	**UN**
World Health Organization	**WHO**

Summary

Male contraceptive pills (MCP) have been identified as a potential method for balancing reproductive responsibilities. Available studies exploring levels of acceptability towards MCP in men tend to be based on consumption behavior. Data on the sociocultural factors and structural gender inequalities behind discourses of acceptability, however, is limited, particularly with cross-cultural perspectives. This research therefore aims to determine to what extent the use of MCP may challenge, or reinforce, gender inequalities in reproductive responsibilities. To assess men's attitudes and discourses, we conducted 24 semi-structured interviews, 2 focus groups, and 1 participant observation in Mexico City and New Delhi. Our analysis suggests that, while several men express favorable views towards MCP, acceptability does not necessarily translate into changes in attitudes regarding reproductive responsibilities. Rather, discourses around male contraception, and MCP specifically, generally uphold existing gender inequalities in sexual behavior.

Photo by: Zenia Taluja

La posibilidad de tener en el mercado píldoras anticonceptivas masculinas (MCP por sus siglas en inglés) se ha identificado como una forma de balancear las desigualdades de género en términos de responsabilidades reproductivas. Si bien existen estudios que exploran el nivel de aceptación hacia dichas píldoras, la mayoría se basa en conductas de consumo, ignorado la importancia de factores socioculturales y desigualdades estructurales de género que pueden esconderse detrás de los discursos. Esta investigación tiene como objetivo determinar en qué medida el uso de MCP puede desafiar o reforzar las desigualdades de género en las responsabilidades reproductivas. Para evaluar las actitudes y discursos de los hombres, realizamos 24 entrevistas semiestructuradas, 2 grupos focales y 1 observación participante en las ciudades de México y Nueva Delhi.

Nuestro análisis sugiere que, si bien varios hombres expresan opiniones positivas hacia usar píldoras anticonceptivas, la aceptación de éstas no necesariamente se traduce en un balance en las responsabilidades reproductivas. Por el contrario, los discursos sobre las píldoras anticonceptivas masculinas generalmente desvelan, y en ocasiones refuerzan las desigualdades de género existentes en el comportamiento sexual.

पुरुष गर्भनरिोधक गोलयिां (MCP) को प्रजनन जमि्मेदारयिों को संतुलति करने के लिए एक संभावति वधिि के रूप में पहचाना गया है। पुरुषों में MCP के प्रतसि्वीकार्यता के स्तर का पता लगाने के लिए उपलब्ध अध्ययन उपभोग के व्यवहार पर आधारति होते हैं। हालांकि, सामाजकि-सांस्कृतकि कारकों और संरचनात्मक लगि असमानताओं पर डेटा स्वीकार्यता के प्रवचनों के पीछे है, हालांकि, वशिेष रूप से क्रॉस-सांस्कृतकि परप्रिेक्ष्य में सीमति है। इस शोध का उद्देश्य यह नर्धिारति करना है कि MCP का उपयोग कसि हद तक प्रजनन जमि्मेदारयिों में लैंगकि असमानताओं को चुनौती या सुदृढ़ कर सकता है। पुरुषों के दृष्टकिोण का आकलन करने के लिए, हमने मैक्सकिो सटिी और नई दल्लिी में 24 अर्ध-संरचति साक्षात्कार, 2 फ़ोकस समूह, और 1पक्षीय अवलोकन कएि। हमारे वशि्लेषण से पता चलता है कि, जबकि कई पुरुष MCP के प्रतअिनुकूल वचिार व्यक्त करते हैं, स्वीकार्यता जरूरी नही कि प्रजनन जमि्मेदारयिों के बारे में दृष्टकिोण में परविर्तन हो। इसके बजाय, पुरुष गर्भनरिोधक के आसपास प्रवचन देता है, और वशिेष रूप से MCP, यौन व्यवहार में मौजूदा लैंगकि असमानताओं को बनाए रखता है

Researchers' reflection

Patricia Robles Muñiz

"Realizar esta investigación fue una oportunidad única para acercarme a la visión masculina de la sexualidad y, con ello, afrontar los discursos patriarcales que, aunque invisibles, llevamos internalizados. Fue sorprendente descubrir los significados que construyen la realidad de los hombres acerca de la sexualidad: una realidad machista centrada en el cumplimiento de placer y expectativas masculinas. Además, llevar a cabo este estudio en India y México me hizo ver, por un lado, cómo las desigualdades en las responsabilidades reproductivas atraviesan fronteras, nivel de estudios e incluso edades. Pero por el otro, fui testigo de cómo las inquietudes globales se pueden movilizar para generar cambios a mayor escala, ya que así fue como intereses similares nos unieron a mí y mis colegas de India para poder materializar esta investigación. Ahora más que nunca estoy convencida que estudiar la sexualidad y cómo ejercemos la misma es uno de los pocos temas que realmente revela las construcciones sociales (la vida política, social y religiosa) que llevamos con nosotros inconscientemente.

Conducting this study was a unique opportunity to approach male understandings of sexuality and, in turn, to grapple with invisible yet internalized patriarchal discourses. I was surprised to discover the meanings that constitute men's reality concerning sexuality: a sexist reality focused on the fulfillment of male pleasure and expectations. Additionally, carrying out this research in India and Mexico helped me realize, on one hand, how gender inequalities in reproductive responsibilities traverse boundaries of nationality, education, and even age. On the other hand, I bared witness to how these global concerns can be mobilized to drive large scale changes. Our shared interests brought my colleagues from India and I together to bring this study into fruition. Now more than ever, I am convinced that studying sexuality and how we exercise it is one of the few topics that truly reveals the social constructions (the political, social and religious life) that we carry with us unconsciously."

Zenia Taluja

Speaking to demographically diverse men about their sexual lives and understanding of contraceptives, revealed an incomplete knowledge regarding contraception that has for long been circulated within the population which still maintains an eerie silence around the topic of sex. Alongside this, what caught my attention was the existing duality in one's attitude towards *'sex, protection and reproduction'*. I use the term 'existing dualities' because, to my surprise, the young and the old, the educated and the uneducated, the rich and the poor, all seemed to be caught between the patriarchal narrative which each of them have learnt and the feminist discourse which they have been introduced to. There were instances when the men, talking to me, a female researcher, said *"Don't mind but..."*, *"I am not being a male chauvinist"*, *"It is not like I am not for feminism but..."*, thereby carefully treading between their feelings and what is considered to be righteous in the feminist discourse.

Their view of the contraceptive pills, shaped by the 'liberal' social forces, as an empowering tool only for women who can exercise their agency over their reproductive life and thus are also responsible for the same, revealed a certain kind of politics of reproduction. This made me realise how the feminist discourse, which, while inducing a fear, was also being capitalized by men as well as the larger medical and state forces which still assert the norms of the past but in the language of a progressive society. These forces produce a knowledge and anxiety related to the terminology of the pill, especially through the medium of patriarchally situated consumer advertisements which celebrates a man's masculinity in the strength of his libido (condom ads) and the woman's responsibility of her own sexual experience (pill ads), which become enough to justify the 'choice' of contraceptive by and for each gender. Examining the narrative of reproductive life in a society, thus became an interesting avenue to understand how something so personal to the human experience and the body, replicates and reinforces the socio-cultural environment; an observation mapped by the research conducted.

Shreya B.

अध्ययन के लिए प्रतिभागियों से संपर्क करते समय, मुझे पुरुषों से एक उत्सुक प्रतिक्रिया के साथ मिला। अपने स्नातक या स्नातकोत्तर कार्यक्रमों के दौरान, मैं लिंग से संबंधित मुद्दों पर चर्चा करते समय पुरुषों पर स्पॉटलाइट के उद्देश्य से कई या किसी भी शोध अध्ययन में नहीं आया था। पुरुष आराम से छाया में दुबके हुए लग रहे थे, परिधीयों से उनके समर्थन का आश्वासन दे रहे थे। इसलिए, जब इस शोध अध्ययन ने उन्हें केंद्र के चरण में खींचने की कोशिश की, तो मुझे एक उत्सुक प्रतिक्रिया के साथ मिला। पुरुष जो अब तक नारीवादी चर्चाओं को सुनकर सहज महसूस करते थे, जो अब एक वाक्य में महिला शारीरिक रचना को तीन बार संदर्भित करते हैं, शोधकर्ता की उनके यौन जीवन के बारे में पूछताछ में असहज लग रहे थे, जो अध्ययन के लिए एक महत्वपूर्ण मानदंड माना जा रहा था। इसके अलावा, ज्ञात "प्लेबॉय" अचानक उनके चेहरे के साथ कुंवारी हो गए, जो कि "सेक्स" शब्द के उल्लेख पर पुजारी अलार्म में उलझे हुए हैं।

कतिपय आख्यानों के आधार पर, एक सांस्कृतिक प्रवचन का उदय हुआ। जबकि पश्चिमी संस्कृतियाँ डर का संचालन करती हैं, जो उनके औषधीय उत्पादों के लिए एक विक्रय बिंदु बन जाता है, भारतीय संस्कृति रासायनिक दवाओं और उपचार के प्रति अविश्वास में निहित है, जिससे लोगों को बुजुर्ग ज्ञान का सहारा लेने के लिए प्रेरित किया जाता है। और यह उनके लिए काम करने लगता है।

While approaching the participants for the study, I was met with a curious reaction from the men. During my undergraduate or postgraduate programmes, I had not come across many or rather any research study that aimed the spotlight at men while discussing issues pertaining to gender. The men seemed to be comfortably lurking in the shadows, assuring their support from the peripheries. So, when this research study sought to draw them to the center stage, I was met with a curious reaction. The men who hitherto seemed comfortable listening to feminist discussions that referenced female anatomy thrice in one sentence, now, seemed uncomfortable at the researcher's inquiry about their sexual life which was supposed to be an important criterion for the study. Furthermore , the known *"playboys"* suddenly became virgins with their faces contorted in priestly alarm upon the mention of the word *"sex."*

Based on certain narratives, a cultural discourse began to emerge. While the Western cultures operate on fear, which becomes a selling point for their medicinal products, the Indian culture is rooted in disbelief toward chemical medicines and remedies, thereby prompting people to resort to elderly wisdom. And it seems to work for them.

J. Alejandro Larios Barrientos

“

Cuando mis compañeras propusieron que hiciéramos una investigación sobre la desigualdad de género en la responsabilidad reproductiva no me pareció un tema tan interesante. Para mí, los temas de salud reproductiva eran algo externo y privado, algo relacionado al campo de la medicina y no al de problemáticas sociales. Sin embargo, durante la investigación, me di cuenta que la falta de importancia que le damos al tema es sólo el reflejo de la ignorancia y ausencia de responsabilidades que los hombres suelen asumir, yo incluído. En mi vida le di poca importancia a tener información acerca del cuerpo de las mujeres, la desigualdad en el uso de anticonceptivos y el entendimiento sobre la reproducción sexual. Debido a que tuve educación sexual en la escuela, estaba confiado de tener toda la información sobre el tema, pero estaba equivocado. La investigación me confrontó con todo lo que creía saber, me desafió a ser más autocrítico sobre cómo trataba y percibía a las mujeres. Me hizo más consciente de que yo solía tener discursos y pensamientos similares a los que reproduce la dominación masculina y ni siquiera me daba cuenta. Me mostró la manera en cómo es sencillo y cómodo para nosotros reproducir el machismo en diversas esferas.

When my colleagues proposed doing a project on gender inequality in reproductive responsibilities, I was not very enthusiastic. Issues regarding reproductive health seemed to me as something external and private, something related to the medical field rather than to social studies. During our research, however, I realized that the lack of importance given to the subject reflects the ignorance and lack of responsibilities men tend to assume, myself included. In my life, I diminished the importance of being informed about women’s bodies, contraception, and reproduction. Having received sexual education in school, I was confident I had enough information, but I was wrong. This study challenged me to be self-critical about how I treat and perceive women. I realized I used to hold discourses and thoughts that similarly reproduce male dominance. In short, I became aware of how easy it is for us, as men, to reproduce gender inequalities in our daily life.

”

María Cerdio Lara

Formar parte de la elaboración de este reporte ha sido una experiencia reveladora. A pesar de considerarme una persona informada respecto a las inequidades de género en México, mi enfoque hasta ahora había permanecido en mujeres y niñas. Esta investigación me obligó a enfrentar los sesgos que tengo arraigados, tal como considerar la salud sexual y reproductiva un tema *"de mujeres"*. Me di cuenta de que cualquier esfuerzo por promover el derecho de las mujeres a decidir sobre sus cuerpos está incompleto si no se incluye a los hombres. Además, tuve la oportunidad de analizar a un nivel profundo la manera en que el discurso y las prácticas institucionales contribuyen a la sedimentación de normas patriarcales. Sin embargo, considerar los casos de India y México en conjunto me permitió apreciar importantes matices, reforzando mi convicción de que las políticas deben ser contextualizadas. Por último, creo que el mayor logro de este reporte es demostrar de manera clara y concreta que los números no cuentan toda la historia – algo que debemos recordar en la era del *"big data"*.

Contributing to the development of this report has been a revealing experience. Although I consider myself a well-informed person regarding gender inequalities in Mexico, so far I had remained firmly focused on women and girls. This research forced me to confront my deeply-ingrained biases, such as considering sexual and reproductive health a *"women's issue"*. I realized that any effort to promote women's autonomy over their bodies is incomplete if men are not included. Additionally, I had the opportunity to analyze in depth the ways in which institutional discourse and practices reinforce patriarchal norms. Yet considering the cases of India and Mexico together allowed me to appreciate important nuances, reinforcing my conviction that policy should be contextualized. Finally, I believe that this report's most significant achievement is demonstrating clearly and concretely that numbers do not tell the whole story – something to keep in mind in the age of *"big data"*.

Abigail E. Morales Peña

“Esta investigación me ayudó a reflexionar y repensar los discursos y prácticas que solemos normalizar acerca de la vida sexual. Tanto mujeres como hombres aceptamos naturalmente que nosotras debemos ser siempre mesuradas y responsables de nuestro cuerpo; los hombres, en contraste, viven pensando que deben de experimentar o explorar más su sexualidad, que debido a su *“naturaleza”* pueden vivir despreocupados por aspectos como la prevención y la salud reproductiva. Lo anterior me llevó a pensar en qué podemos hacer para acercarnos a una sociedad más equitativa. Diría que primero, de manera individual y colectiva, debemos romper las ideas y estigmas que hemos generado no sólo en la familia, sino en toda la sociedad, incluidas las instituciones educativas y de salud que reproducen discursos en los que a mujer lleva la mayor carga de responsabilidad. En segundo lugar, como investigadores sociales debemos empezar a plantear nuevos mensajes que reflejen las injusticias de género en la sexualidad, esto con el fin de generar un cambio paulatino en nuestras prácticas cotidianas y relaciones interpersonales y afectivas.

This study invited me to analyze and re-think the discourses we normalize around sexual life. Both women and men tend to accept that women should be cautious and responsible in the exploration of our bodies. By contrast, men assume that they should experiment more sexually; that, given their *“nature”*, they can live unconcerned with aspects such as prevention and reproductive health. These reflections led me to question: what can we do to approach a more equal society? I would say that, firstly, both individually and collectively, we must overcome the ideas and stigmas we generate within families and throughout society. This includes education and health institutions, which reproduce discourses where women carry the greatest responsibility. Secondly, as social researchers, we must propose new messages that reflect gender inequalities in sexuality, in order to foster gradual changes in our habits and interpersonal and affective relationships.”

Ricardo A. Arenas Hernandez

Como investigadores sociales, llegamos a olvidar que somos parte de nuestro objeto de estudio y que la sociedad que investigamos, es en la que estamos inmersos. Como hombre, me vi enfrentado a través de este proyecto con la visión masculina del mundo, misma que sigue dominando la forma en que nos enfrentamos a hechos de la vida cotidiana, como el discurso que permea en la salud reproductiva. En segundo lugar, como investigador, entendí la riqueza de abordar la visión masculina críticamente, para así abrir nuevos horizontes y espacios que nos lleven a sociedades más equitativas.

As social researchers, we tend to forget that we are part of our object of study – we investigate the very society in which we are immersed. This study confronted me, as a man, with the male worldview which continues to define how we navigate daily life. The discourse that permeates reproductive health is but one example. Secondly, as a researcher, I understood the productiveness of approaching male perspectives critically. Only then can we open new horizons and spaces that may lead to more equitable societies.

“I am not ‘macho’ but...”

Introduction

In recent years, gender inequalities have garnered increasing attention across disciplines as social, political, and economic changes expose pervasive and emergent challenges. These transformations have contributed to the development of key policies and interventions that have sought to shift the balance in power. However, too much emphasis has been placed on topics related to *"public"* issues such as labor and education, while research on *"private"* matters such as sexuality and reproduction remains limited.

Yet sex is not only a central part of human experience, but also an immensely powerful lens for social analysis. Our private lives both reflect and shape broader social, cultural, economic and political structures. Understanding sexuality and reproduction is thus crucial to address gender power relations. The effects of the distribution of reproductive responsibilities on women's health and rights clearly illustrate this link. As the international community has long recognized, ensuring women's full participation in society requires shared responsibility for sexual health, family planning, and other aspects of reproductive life (Pizzarossa, 2018).

This report presents research into how the use of male contraceptive pills (MCP) may challenge, or reinforce, gender inequalities in reproductive responsibilities. The possibility of introducing hormonal male contraceptives into the market has been identified as a potential method for balancing reproductive responsibilities (Campo-Engelstein, 2012; Plana, 2017). Most available studies focus on men's attitudes towards the usage of MCP, the chemical feasibility of the product or the health safety for users (Eberhardt, van Wersch & Meikle, 2009; Walker, 2011; Martin, Anderson, Cheng, van der Spuy, Smith & Baird, 2000). Less attention has been paid, however, to the sociocultural factors behind levels of acceptability which are key to fully overcome gender inequalities in reproductive responsibilities (Van Wersch, Eberhardt & Stringer, 2012; Crawford, & Waldby, 1994). Therefore, the present study focuses on analyzing the discourses of Indian and Mexican men regarding contraception and MCP specifically, taking into account the power relations, sociocultural beliefs, normative gender roles and constructions of masculinity which permeate this topic.

We decided to focus on men partly to address their general absence in research on sexual and reproductive health and rights (SRHR). Further, it is important to highlight men's perspectives given that male contraceptives may become increasingly available (Chankapa & Tsering, 2010). Given the pervasiveness of gender inequality in the contexts studied, attending to male perspectives also provided insights into normative – often institutionalized – discourses. Moving from conceptualizing reproduction as a "women's issue" and incorporating both sexes into the analysis is essential, we argue, in order to target the root causes of unequal distribution of responsibilities.

To assess the significance of cultural factors, we conducted studies in two different contexts: India and Mexico, specifically Mexico City and Delhi. Data were collected through qualitative methods including focus groups, semi-structured interviews, and participant observation.

Before launching into our analysis, the text begins with a description of the broader context of SRHR in India and Mexico. We present quantitative data, highlighting how the data fails to reveal the fundamental drivers of practices and attitudes which may be key to understanding gender imbalances. The second section outlines the methodology, including a brief discussion of how the methods and participant selection criteria used align with our research aims. This section also offers potential limitations of this study and how we attempted to address them. The third section examines our results, starting with an analysis of the impact of socio-cultural representations of male and female sexuality on reproductive responsibilities. It then reveals the role that sex education has on participants' knowledge and attitudes towards sex and reproduction. Additionally, it evaluates how social constructions of masculinity relate to decision-making regarding contraceptives. The final section offers key policy recommendations.

1. Background

1.1 India

a) Context

Reducing fertility rates and improving reproductive health outcomes is an urgent priority for the Indian state in order to achieve its social and economic objectives (Ministry of Health and Family Welfare, 2014). Notwithstanding the uneven results of policies and wide regional disparities, India has seen significant fertility reduction since the mid-eighties (Maharatna, 2002). Despite this decline, India is still projected to overtake China as the world's most populous country by 2030 (UN, 2019).

Family planning is hardly a new topic in the Indian government's agenda. As early as 1952, India launched one of the first family planning policies in the world, the National Family Planning Program (Visaria, 1999). Since then, the program has evolved to adopt a range of approaches reflected in different Five Year Plans, some of which have been highly controversial. Nevertheless, the Indian government has continued its efforts to regulate population growth. Today, the official approach is to move away from coercive and demographically-oriented methods towards a focus on reproductive health and rights (Ministry of Health and Family Welfare, 2014).

At the London Summit on Family Planning held in 2012, the country committed to invest USD$2 billion by 2020 for family planning, raising this commitment to USD$3 billion in 2017. The 2020 action plan aims to drive access and quality of family planning services. It emphasizes expanding the range and reach of contraceptive options in an effort to shift away from female sterilization, which in 2016 accounted for three-fourths of contraceptive use in India (Family Planning 2020, 2016). India's goal is to increase modern contraceptive usage to 54.3% and to meet 74% of demand by 2020 (Ibid., 2017).

Family planning policy has become increasingly decentralized, as several Indian states have adopted or are in the process of developing policies of their own. Although states have established *"population policy initiatives"* since at least 1952, these governmental measures were not considered *"official"* (Maharatna, 2002). Since 1997, however, the central government has encouraged state-level family planning policies and district-level action plans as part of its community needs assessment approach. In Delhi, the local government aims to provide family planning services to 430 thousand additional people (Ministry of Health and Family Welfare, 2014). Although they expect to reach the whole population, the main target are women, newly assigning reproductive responsibilities to them.

In terms of sexuality education, lack of political will and strong opposition from both politicians and the public have ensured that no comprehensive program has been implemented in India.

The National Policy on Education stipulates the provision of education on family planning in schools and colleges, the 2000 National Population Policy emphasizes the need for accessible sexual and reproductive health (SRH) information, and the 2003 National Youth Policy advocates for free counselling services for young people (Das, 2014). While these policies reflect support for sexuality education at least on paper, there is a long way to go in terms of implementation.

One of the challenges of providing relevant sexuality education is that some officials and political parties see it as unnecessary and contentious, and are reluctant to advocate for it. Indeed, some opponents regard sex education as incompatible with Indian cultural, moral, and religious values. Such arguments led several states to ban the 2007 Adolescent Education Programme, which included components of sexual and reproductive health. In June 2019, however, the government released a Draft National Education Policy that proposes the inclusion of sex education in the secondary school curriculum. It remains to be seen whether this measure will be adopted.

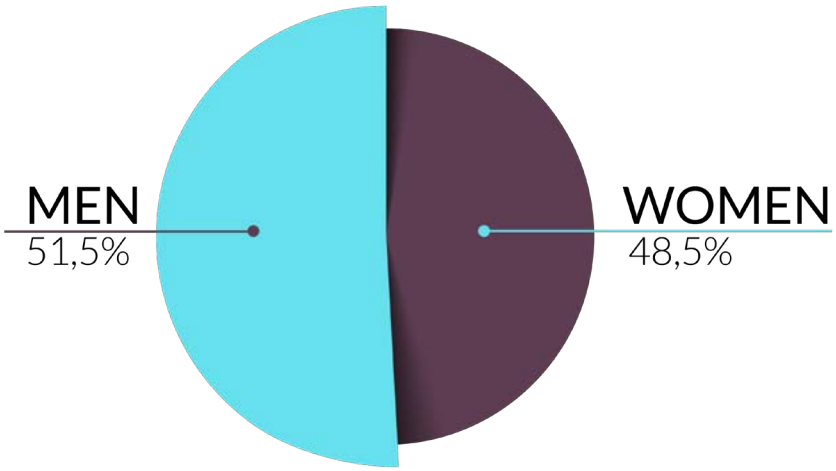
b) Key indicators

The state-led National Family Health Survey monitors a range of health indicators in India, including family planning, reproductive health, sexual behavior, and contraception, among others. Its focus on quantitative data means the survey does not provide in-depth insights into the explanations behind responses. Few questions seek to evaluate attitudes, values and norms. Further, the reliance on quantitative methods is rooted in an assumption of rational behavior, which elides the emotional, intimate and socio-cultural aspects that are key to understand sexual and reproductive life.

Nevertheless, the effort to disaggregate data by sex and the attention to male perspectives in a number of relevant areas is promising.

Both the fertility rate and wanted fertility rate are lower in Delhi than the national average. Although fertility rates have declined throughout the country over the last 10 years, this trend has been especially pronounced in Delhi, dropping from 2.3 to 1.8 children (against 2.7 to 2.2 nationally).

India´s population: 1,210, 193, 422



Delhi City´s population: 16, 753, 235

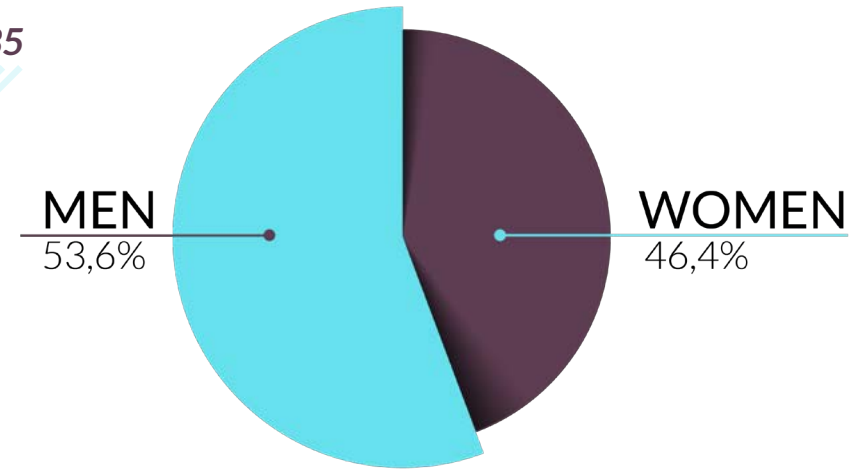


Table 1: Population indicators

INDICATOR	INDIA (COUNTRY)	DELHI CITY
Fertility rate	2.2 children per woman	1.8 children per woman
Wanted fertility rate	1.8 children per woman	1.4 children per woman
Median age at first birth	21 years	-

Source: Government of India (2016). National Family Health Survey (NFHS-4) 2013-2015.

Women become sexually active at a markedly younger age than men, and are also more likely to have had sexual intercourse at the time the survey was conducted. In terms of contraception, both men and women show nearly universal levels of knowledge; however, there is no data on contraceptive use among men. In light of this gap in the data, along with the emphasis on targeting women for contraception in the 2020 National Family Planning action plan, it seems that institutional discourse and practice reinforces the ascription of reproductive responsibility to women. The lack of data on men is especially striking given that they are accounted for in other areas such as fertility preferences.

The most prevalent contraceptive method at national level is female sterilization, even though it has been shown that male sterilization is less invasive and carries fewer health risks (Campo-Engelstein, 2012; Terry & Braun, 2013).

In Delhi, the most common method is non-hormonal contraception, closely followed by female sterilization.

Traditional and hormonal methods show similar rates at both levels, and male sterilization is the least popular method overall. Given that most of these methods are female-focused, these trends reflect how women bear the brunt of responsibility for sexual health and fertility control. At the same time, the survey shows that more than 35% of men support the claim that "contraception is women's business", and it is not clear from the data who chooses the methods used. This gap demonstrates the need for closer scrutiny into decision-making patterns regarding contraception.

Table 2: Sexual well-being among men and women in India (2015-2016)

INDICATOR	WOMEN	MEN
First sexual intercourse (median age)	19.3 years	24.3 years
Knowledge about contraception	97.8%	97.9%
Have used contraception	60.2%	N/A
Had children before first use of contraception	91.0%	-
Never had sex	22.3%	30.6%
Sexually active	48.5.%	47.3%

Source: Government of India (2017). National Family Health Survey (NFHS-4) 2015-2016.

Table 3: Contraceptive use in India and Delhi

INDICATOR	INDIA (COUNTRY)	DELHI CITY
Use contraception regularly	53.5%	54.8%
Most common contraceptive type	Female sterilization	Non-hormonal (including condom)
Female sterilization	67.3%	36.2%
Male sterilization	0.6%	0.4%
Hormonal	8.0%	5.5%
Non-hormonal (including condom)	13.3%	46.5%
Traditional	10.8%	11.5%

Source: Government of India (2017). National Family Health Survey (NFHS-4) 2015-2016.

Table 4: Men's attitudes towards female contraceptive use in India and Delhi

MEN WHO AGREE WITH (%)	INDIA	DELHI
Contraception is women's business and a man should not have to worry about it	37.30%	36.20%
Women who use contraception may become promiscuous	20.30%	20.20%

Source: Government of India (2017). National Family Health Survey (NFHS-4) 2015-2016.

1.2 Mexico

a) Context

Recognizing overpopulation as a key factor in economic and territorial inequality, Mexico enacted its first demographic planning policy in 1974, the General Law of Population (Sánchez, 2012). This policy established the creation of the National Population Council (CONAPO, by its Spanish acronym) to lead implementation efforts. In the years following the General Law of Population, population policy in the country remained largely focused on demographic control. Among other duties, the CONAPO promoted family planning through print media, radio, telenovelas, and public health institutions (Sánchez, 2012). It was not until the National Plan for Family Planning 1977-1979, however, that a coordinated effort developed to encourage family planning and contraceptive use.

In 1995, the Ministry of Health created the Reproductive Health Office to administer a new umbrella program that would fulfil the commitments made at the 1994 International Conference on Population and Development. The resulting Reproductive Health and Family Planning Program 1995-2000 marked Mexico's transition towards a more comprehensive approach focused on women's integral health and social wellbeing (Sesia, 2007). Moreover, the new program states a commitment to extending access to reproductive health information and services to socially and economically disadvantaged groups, such as indigenous populations.

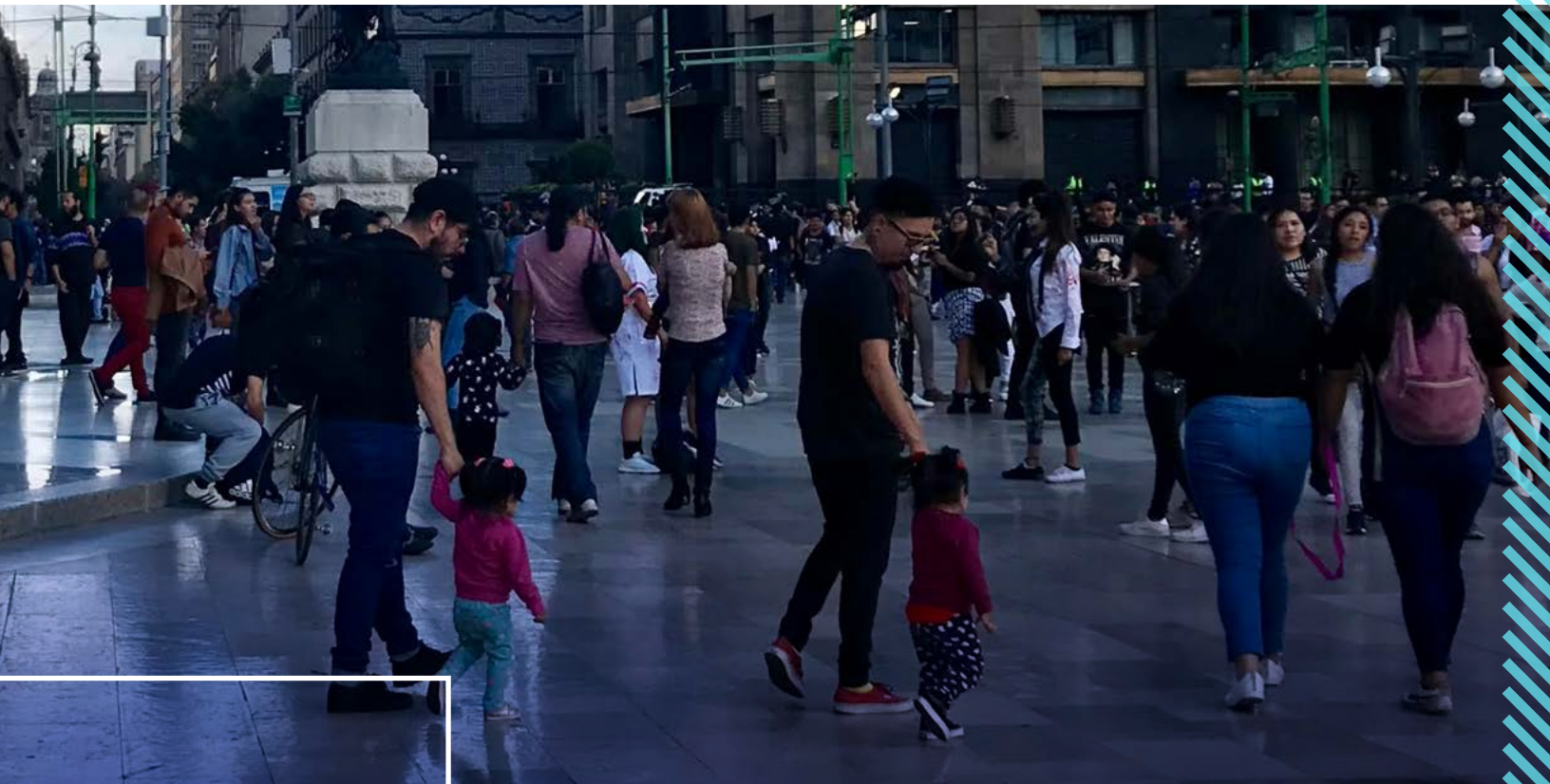
Mexico has made significant progress since the 1970s in improving maternal and child health and in curbing explosive population growth. Population policies have brought a dramatic decrease in the total fertility rate, dropping from 6 children per woman in 1974 to 3.43 in 1990, and 2.1 in 2019 (Allen-Leigh et. al., 2013; CONAPO 2019). These advances, however, have been uneven throughout the country: regions with high levels of poverty contend with maternal and perinatal illnesses, low levels of SRH information, low contraceptive use, high rates of STIs, and inadequate access to health care (Allen-Leig et. al., 2013).

Beyond territorial inequalities, Mexico has the highest adolescent fertility rate in the OCDE with 66.2 births per 1000 women aged 15-19 (OCDE, 2019). It is the only member country in which the mean age of women at childbirth has decreased since 1970. The issue persists in spite of an increased focus on adolescents in health and population policy. For instance, the Health Sector Program 2013-2018 emphasized the need for providing adequate SRH services to adolescents. In this vein, the National Strategy for the Prevention of Teenage Pregnancy launched in 2015 aims to guarantee access to contraceptives and adolescent-friendly services in health-care clinics, among other measures (Castro, et al., 2018, ENAPEA, 2015).

These policies are a step in the right direction: the WHO (2012) asserts that adolescents require access to high quality, age-appropriate, and culturally relevant SRH services. However, the lack of a meaningful reduction in adolescent pregnancies suggests that current approaches are insufficient.

Additionally, there is little evidence that public SRH services incorporate a gender lens, despite the commitments enshrined in the 1995 Program. The Federal and Mexico City governments acknowledge that women are socially assigned greater responsibility. Yet they have not taken meaningful action to promote a more equitable distribution and, instead, tend to reinforce existing inequalities. For instance, the National Survey on Demographic Dynamics (ENADID) currently collects information on men's sexual and reproductive lives only indirectly, since all questions on this topic address women exclusively. The CONAPO justifies this strategy on the basis that *"it is women who experience pregnancy and remember every detail best"* (CONAPO, 2017:145).

Women have also been subjected to coercive measures. Among other concerns, several reports have emerged of women who have been forced directly or indirectly to have an IUD inserted (El Universal, 2015; La Silla Rota, 2019). Some indigenous women claim that they had an IUD inserted without having received information in their language (La Silla Rota, 2019; Rivas, Nazar, Estrada, Zapata & Mariaca, 2009). Others have stated that they were forced to receive a contraceptive injection to collect state benefits under PROSPERA (El Universal, 2015; La Silla Rota, 2019). Similarly, several female prisons have made conjugal visits conditional upon receiving contraceptive injections (Animal Político, 2017). In Mexico City, women have reported that some abortion clinics use the incentive of an earlier discharge to compel patients to get an IUD (Animal Político, 2017a). These cases show the extent to which women are made responsible for SRH, even at an institutional level.

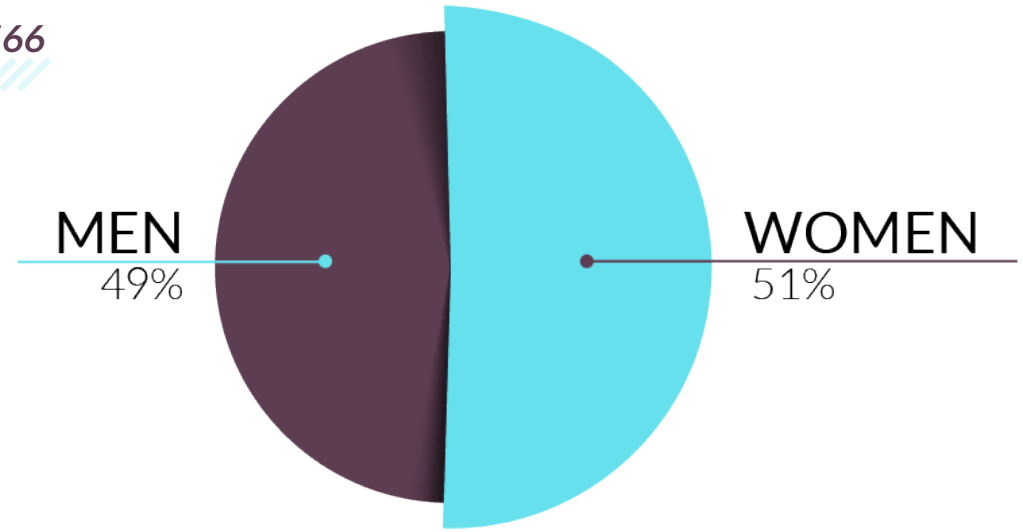


b) Key Indicators

In contrast with India's Family Health Survey, the Mexican data on sexual and reproductive life is not disaggregated by sex and only reflects views collected from women. Bearing this limitation in mind, here we use the data to provide an overview of the situation in the country, rather than a precise description.

At 2.1 children per woman, the average fertility rate in Mexico is comparable to that in India. The rate is also similar at city level, with 1.3 children in Mexico City against 1.8 in Delhi. As is common for urban contexts, fertility is lower than the country average in both cases.

Mexico´s population: 124, 994, 566



Mexico city´s population: 8, 738, 086

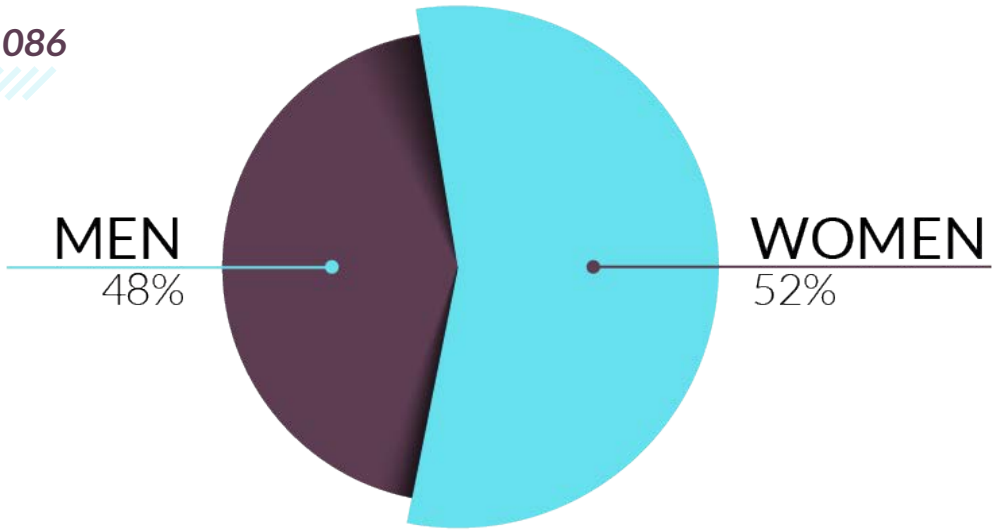


Table 5: Population indicators

INDICATOR	MEXICO (COUNTRY)	MEXICO CITY
Fertility rate	2.1	1.3
Wanted fertility rate	N/A	N/A
Median age at first birth	N/A	N/A

Source: Encuesta Nacional de la Dinámica Demográfica (ENADID), 2019

Despite nearly universal knowledge about contraception, only 69.2% have used some form of protection. Among these, nearly all had children before the first use, although the rate is much less dramatic than in India. While Mexico City shows higher prevalence of contraceptive use, the rate still lies far below levels of information.

In terms of methods, the most popular type of contraception in Mexico and Mexico City is female sterilization which, as already mentioned above, is riskier than male sterilization. However, the usage rate is considerably lower than in India, while male sterilization and hormonal and non-hormonal contraception are more common. In Mexico City, female sterilization and non-hormonal contraception are used with similar frequency and, unlike in Delhi, traditional methods are less common than the country average.

The only section in the survey that offers a gendered lens concerns women who have had more children than they wanted, representing 14.2% of all women with children. Of these women, 18.5% listed their partner's desire for more children as their key motive.

Table 6: Women's sexual well-being in Mexico and Mexico City

INDICATOR	MEXICO	MEXICO CITY
First sexual intercourse (median age)*	17.6	17.9
Knowledge about contraception**	98.6%	99.8%
Have used contraception**	69.2%	72.4%
Had children before first use of contraception*	68.9%	49.4%
Never had sex**	18.1%	N/A
Sexually active*	52.3.%	51.1%

Source: *Encuesta Nacional de la Dinámica Demográfica (ENADID), 2015;
**Encuesta Nacional de la Dinámica Demográfica (ENADID), 2019.

Table 7: Contraceptive use in Mexico and Mexico City

INDICATOR	MEXICO (COUNTRY)	MEXICO CITY
Use contraception regularly*	75.5%	78.6%
Most common contraceptive type**	Female sterilization	Female sterilization
Female sterilization**	48.5%	39.3%
Male sterilization**	2.7%	3.6%
Hormonal**	15.6%	18.0%
Non-hormonal (including condom)**	29.3%	37.0%
Traditional**	3.9%	2.1%

Source: *Encuesta Nacional de la Dinámica Demográfica (ENADID), 2015;
**Encuesta Nacional de la Dinámica Demográfica (ENADID), 2019.

2. Methodology

2.1 Objective and methods

This study explores to what extent the use of male contraceptive pills (MCP) may challenge or reinforce gender inequalities in reproductive responsibilities.

To achieve this aim, four key questions guided our research:

1. What discourses guide men's reproductive responsibilities?
2. What are men's social representations about: reproduction, female sexuality and male sexuality ?
3. What is the male perspective on contraceptives, specifically on MCP?
4. What meanings, factors and feelings motivate men to accept or reject the use of MCP?

Recognizing that several studies regarding reproductive health and the use of contraceptives do not account for contextual factors (Van Wersch, Eberhardt & Stringer, 2012), we sought to highlight the importance of culture. Research was conducted in Delhi and Mexico City to contrast two different cultural relations to reproduction, sexuality, and contraception, among other aspects.

These locations were selected because, on the one hand, both belong to the *"Global South"* and share historical legacies of colonization, weak democratic governance, gender inequality, ongoing industrialization and urbanization, and similar youth population size. On the other hand, their stark cultural differences bring into sharp relief the influence of this factor in defining the distribution of reproductive responsibilities. For example, although both are family driven societies, Mexico and India have different kinship patterns, most notably the prevalence of arranged marriages in the latter.

Finally, the two cities were easily accessible given that the researchers who motivated the study are based there.

Qualitative research was conducted to deeply understand the meanings that Indian and Mexican men ascribe to reproductive responsibilities and their attitude towards MCP. The data collection methods used were (i) focus groups, (ii) semi-structured interviews, and (iii) participant observation; distributed as follows:

LOCATION	SS-INTERVIEWS	FOCUS GROUP	P. OBSERVATION
NEW DELHI	12	1	--
MEXICO CITY	13	1	1
TOTAL	25	2	1

The target study population were men between the ages of 17 to 62. All respondents participated voluntarily and anonymity was guaranteed through a consent form. Participants were recruited through snowball sampling.

Data were collected in Delhi and Mexico City from May to July 2018.

Focus groups

Focus groups were used to understand collective views on reproductive responsibilities, as well as the processes whereby meanings beyond acceptance/rejection of MCP are constructed (Bloor, 2001). They were also helpful to identify opposite perspectives, given that focus group dynamics simulate social interaction by contrasting the participant's positions and experiences (Barbour, 2008; Howitt, 2016).

The sample included two focus groups, one in India and one in Mexico, each conformed by 6-10 participants recruited using the following selection criteria:

- ***Aged 18-24***
- ***Currently studying at university***
- ***Sexually active***
- ***Half of the group with stable sexual relationships; the other half with casual sexual relationships***

We targeted sexually active young men to capture perspectives based on real experiences, rather than on hypothetical situations or expectations. Meanwhile, we recruited men in both stable and casual sexual relationships to allow for comparisons, based on research carried out by Eberhardt, Van Wersch & Meikle (2009), and Van Wersch, Eberhardt, Stringer (2012) where relationship status determined levels of acceptability towards MCP.

Given that focus groups analyze active participation in the construction of meanings (Howitt, 2016), we considered that university students were more suitable for this method compared to other research participants. Young students are accustomed to constructing collective realities within the classroom, and talk more openly about perceived "sensitive topics".

Focus groups took place in open areas near University of Delhi and the National Autonomous University of Mexico. Evidence shows that the physical environment influences group dynamics (Puchta & Potter, 2004). We therefore decided to moderate focus groups in places that participants were familiar with. The choice of using university spaces was based on the perception participants would feel more relaxed and open to talk in a liberal environment. Additionally, focus groups were held in the afternoon to avoid crowds and distractions.

Semi-structured interviews

We conducted 24 semi-structured interviews to foster comfortable environments where sensitive topics can be openly discussed (Bloor, 2001; Barbour, 2008). Using this method allowed us to observe individual behaviors and to collect more personal or intimate data (Hennink et.al., 2010).

A variety of profiles divided by age, education level, and socioeconomic status were included in the sample. Detailed information about respondents is shown in Annex 1.

Participatory observation

Participatory observation was conducted over a three-day period in a Public Health Center in Mexico City to capture institutional discourses on family planning and fertility control in a natural environment (Gray, 2002).

The objective was to observe:

1. *How is information on reproductive health given?*
2. *What is the discourse promoted?*
3. *Who facilitates this information?*
4. *Who is the target for this information?*
5. *Who comes into the Center to ask for information?*

To gain an understanding of these dynamics, a Mexican female researcher conducted covert observations within the Center. During the first visit, she acted as a patient of the Health Center to observe how family planning information was distributed. The second and third observations were conducted as a visitor seeking information on contraception.

2.2 Data collection and analysis

Following standard qualitative research practice, focus groups and interviews were conducted using a general topic guide (Berg, 2004). Nevertheless, the questions were adapted and refined based on feedback from data collection and according to the research method.

The guide explored 6 general dimensions:

1. *Relationships and their changes over time*
2. *Personal reproductive life*
3. *Sexuality*
4. *Contraceptives (knowledge, usage, attitudes, preferences)*
5. *Responsibilities in reproductive life*
6. *MCP*

Interviews and focus groups were audio-recorded and notes were taken during the conversations. Audio and written notes were also recorded as often as possible during the participatory observation. Since the analysis was based on field notes and audios, transcripts were not necessary. Audios were reviewed at least twice.

Using these notes, we generated central concepts around the topic such as representations of masculinity, contraceptives, sexuality and men's relationship with their bodies, etc. The analysis afforded a deeper understanding of notions underlying acceptance or rejection of MCP.

To ensure confidentiality, the analysis and supporting materials were anonymized through codes related to profile characteristics (Annex 1). For instance, *"Int22,Mex,29y,HG"* represents: Interview 22, from Mexico City, 29-year-old male, education level high-school. Every quote featured in this report will use these codes.

2.3 Limitations

Although we sought to include men from a variety of backgrounds, difficulties of access led us to focus this study on an urban sample. It is likely that the findings would have been different had we focused on rural populations. Additionally, we do not account for women's perspectives since this was beyond the scope of the research. As argued above, focusing exclusively on men allowed us to address a gap in the literature, to shed light on normative discourses, and to understand men's decision-making regarding contraception in depth. Another limitation of the study was that the involvement of female researchers may have hindered free expression for some men, despite efforts to create an open and respectful environment. However, the analysis suggests that group discussions mitigated this effect to an extent and helped participants engage less self-consciously. One more limitation was that participatory observation was conducted in a single Public Health Centre in Mexico due to time constraints. As such, these data do not offer a broader picture of institutional dynamics in India and Mexico. A further limitation was that the nature of the topic did not allow us to examine behavior in a natural environment. Nevertheless, the methodology selected was suited to the aim of understanding men's attitudes, representations, and discourses.

3. Findings

1 Women in both India and Mexico bear greater reproductive responsibilities than men. This unequal distribution is rooted in socio-cultural understandings of male and female sexuality.

Men perceive themselves as pleasure-driven subjects whose *"animalistic"* pursuit of sex precedes rationality and intimacy, and are therefore unfit to regulate their sexual conduct. The significance of pleasure in male sexual subjectivity is couched in biological terms: for the men studied, the first ejaculation represents a source of unprecedented levels of pleasure and marks male sexual maturity. A young man in Mexico reflected: *"...you learn how to do it watching porn, you do that [masturbation]. when you are a teenager. I do not think women masturbate as we do... to be honest, I do not think women can even imagine how often men do that. My sister used to be worried because of her period, but for us being a teenager is super enjoyable."*

By contrast, pleasure is absent in men's understandings of female sexuality and sexual maturation. Male discourses about women foreground sexual restraint and responsibility. For example, one Indian participant argued that *"[men] are animals and women are not... they can think before having sex, but the brain of men just stops working. Women's brains work differently, they cannot be very horny."* Women's sexual behavior is construed by men as a rational choice ultimately driven by either emotional attachments: *"they have sex with you to demonstrate their love"*; or, especially in India, the desire to have children: **"**... *women know it's important for their partners to have children, to have a family and it's a way to consolidate the relationship."*

Additionally, women are perceived to be naturally disposed to assume SRH responsibilities. Like male pleasure, women's responsibility is traced to biological sexual maturation, manifested at menarche. Men understand menstruation as entailing new health duties such as periodic gynecological examinations. Consequently, women are believed to be more conscious of managing fertility and protecting their sexual health.

2 *Stereotypes of female sexuality and intrinsic responsibility create a dichotomy between "righteous" and "promiscuous" women that carries a strong moral burden.*

The righteous woman, perceived as such in light of her reproductive and emotional potential, is considered suitable for stable relationships. By contrast, the promiscuous woman is identified by her capacity for pleasure and is valued primarily as a sexual object. This *"masculine"* relationship to her sexuality renders her undesirable for emotional intimacy or serious relationships, as the following men describe:

"I'm not a ´macho´, I've been sexually with women who had sex with more than 10 men... but... I'm not going to go with a woman like that either, it's one of those that you enjoy but not the one you take to your house." (FG, Mexico)

***"Sex means fun for us! You do not need to have a girlfriend for having sex...but my girlfriend, she is different. I can have fun with many girls here, but it does not mean I will take them seriously. They are easy girls, not for having a formal relationship."*(Int20, Mex, 14y, ES)**

While there exists a general understanding of what characterizes a promiscuous woman, men of different age groups use the term differently. For young men, any woman who enjoys sex and her sexuality is promiscuous. A man who equally enjoys sex does not bear the same stigma, as it is understood as a natural behavior. Meanwhile, older men tend to use the term only in reference to women involved in sex work.

This dichotomy carries significant implications, as it seems to contribute to sexual risk taking by determining contraceptive choice. The most significant difference between respondents with stable partners and those without was that the former do not use any kind of sexual protection, other than contraceptive pills in some cases. By contrast, men were more prone to use protection, and to take responsibility themselves, when having sex with *"promiscuous"* women.

"*Now, when we have sex with our wife, we tend to not use condoms, copper T, maladi. Because she is our property. But if we do such a thing (sex) with someone else, we'll have to do it...safe and secure."(Int4, India, 35y, BA).*

3

Some existing policies in both countries fail to integrate socio-cultural representations of female and male sexuality, while institutional discourses and actions seem to reinforce gendered assumptions.

Public data on sexual and reproductive life in Mexico does not account for male perspectives, based on the assumption that women best remember the number of partners, the methods used, and the number of children desired (CONAPO, 2017). Participant observation conducted in a Public Health Center also revealed that information on contraceptives and related services are primarily targeted towards women. A female employee in the clinic stated: *"... during my training I was instructed to show this information and offer contraception to women aged 16-39. I was not told to show it to men, neither was it forbidden, but it was women aged 16-39 who were emphasized."*

In India, only girls and young women receive formal sex education, while boys and men are reliant on informal sources. Additionally, teachings in public schools are largely focused on menstrual health, while boys' specific needs and realities are not addressed.

4

Inadequate sex education and reliance on women for sexual protection contribute to a lack of knowledge about contraception among men. This perpetuates unequal gender dynamics and patriarchal practices which place the burden of reproductive responsibilities and sexual health on women.

Men in both contexts studied lack basic knowledge about contraceptives and show limited understanding of female reproductive biology. This was especially evident among young men in Mexico City, despite being the segment with most formal sex education out of all the research sample. A Mexican informant stated that the morning-after pill is *"obviously an abortion… that's why they're called contraceptives, for not to conceive, so it is a kind of abortion."* In India, boys and young men are entirely excluded from sex education in schools, yet participants were better informed than their Mexican counterparts.

Observations gathered for this research indicate that this disparity stems in part from the stigmatization of ignorance on this topic in Mexico. During group discussions, participants in Mexico hesitated to ask questions and instead boasted their *"knowledge"*. By contrast, young men in India freely expressed doubt and confusion. This suggests that sex education as is currently imparted in Mexico is generating stigmas without truly improving awareness, as sex education becomes a marker for socioeconomic status, modernity, and urbanness. The association of sex with masculinity creates additional pressures for men which compels them to showcase their knowledge among peers, spreading misinformation as a result.

The dearth of quality sex education in both contexts was reflected by men's reliance on female partners for information. Throughout this research, men who had been in stable relationships appeared to be more well-informed, while those who had not referenced sexual partners as their main source of knowledge.

Men's lack of knowledge about sexual and reproductive health, as well as female biology, has direct implications for the distribution of responsibilities. Misinformation guides decision-making about contraception in ways that assign a greater burden on women. One young man in Mexico argued that female condoms were inconvenient because *"if the woman has to pee, she has to take it off and then we need to buy a new one to put it on again; therefore, it is better for women to take pills."* Additionally, the perception that women are more knowledgeable serves to justify delegating responsibility to them, which in turn discourages men to seek out information.

5 Gendered discourses and norms around sexually transmitted infection (STIs) and pregnancy serve to offload reproductive responsibilities on women.

Men perceive themselves with more social, moral and even economic privileges than women. They align themselves with normative gender roles and in doing so, they point out that women are impacted more negatively when contracting STIs or when faced with an unwanted pregnancy. Since, according to participants, women suffer the worst consequences of not using protection/contraception, they should be responsible for prevention.

"The woman should be asked first if she wants to have a child or not because she has to carry it for 9 months. Technically, the man has barely any responsibility. It's entirely on the woman."(FG, India)

In both India and Mexico, a patriarchal discourse which places higher moral, social, economic and biological burdens on women is pervasive, particularly in terms of unwanted pregnancies. In the best case scenario, men understand their responsibility just as economic providers. However, they are aware that they can easily evade responsibility in moral, social and biological terms.

"I do not care a lot for contraceptives because at the end if you have a kid, it is worse for women. You can run away if you want! But they cannot. Even when you decide to help your girlfriend with the baby, you can help her with money, but never with having the baby." (Int20, Mex, 14y, ES)

When talking about STIs, participants consider themselves less vulnerable than women. Based on the righteous/promiscuous dichotomy, they can control when to use contraceptives and when not to. In turn, as a young informant in India put it, "women can never rely on men as they are sex animals".

***"In our society, an unmarried pregnant woman would be raised fingers at and the boy won't even be in picture...so the girl should take protection...the boy will never be practical and will always be in seventh heaven...this comes from the family and the societal atmosphere...The girl should use protection rather than getting herself in trouble."*(Int12, Ind, 58y, BA)**

6

Men's perceptions of and decision-making around contraceptives reveal an egocentric understanding of sexuality. While women are responsible for using contraception, men exercise considerable control over the choice of method and family planning.

In each case country, men's discussions around contraceptives are centered on its effect on themselves. When outlining their criteria for choosing a contraceptive method, participants focused on its effects on their bodies, as well as comfort and convenience– few considered their partners' perspectives. In particular, they evaluated methods in terms of the opportunities for personal pleasure they offered. An Indian participant observed that his friends prefer withdrawal over condoms because *"they do not need to have latex covering the pleasure."* These responses suggest that SRH is not understood as a shared responsibility.

Data from this study showed that interrupted intercourse is the preferred contraceptive method for men in stable relationships. Although at the start of the interview they reported using condoms, by the end they admitted their preference for interrupted intercourse. Explanations such as *"men feel more [without using protection] and do not run as many risks"* suggest that the cost-benefit analysis underlying their choice accounts for their own wellbeing only. These insights into men's rationales reflect the importance of using qualitative analysis to complement and complicate quantitative data on contraceptive usage.

"I know I have said condoms are not good because you cannot feel that much, but people must take care of themselves, condoms prevent pregnancy and disease... ok to be honest, I used to use withdrawal as my regular method. I tried once, then again and again... I just noticed it was the best method, we did not get pregnant, never! I used it for 8 years and it was very effective. I know that it is not responsible, but it was the best method. You can feel everything, you do not need to take anything." **(Int13, Mex, 27y, uni)**

In the case of India, men with stable relationships highlighted the role of community and family on decisions regarding contraceptive choice and family planning. Although this social influence should not be overlooked, ultimately men have authority over fertility control. One young father noted that *"men are responsible for having kids because we are the ones who earn. I have to figure out the expenses of the child otherwise people can just keep having kids as they please."*

7

In both Mexico and India, sexuality lies at the core of constructions of masculinity, with implications for acceptability towards MCP.

Despite their distinct understandings of sexuality, respondents in both locations identified sexual potency as intrinsic to their personhood. It is not surprising, then, that the possible effects of MCP in this regard were the most significant source of concern. Both groups worried about their sexual capacities being affected, particularly by lower testosterone levels. Indeed, the emotion most commonly expressed by participants was fear.

"If we base it on basic biology, if it's not letting the sperm reach, it means it's reducing the power... or even if there are no side effects, I would still be paranoid. Mentally. Like if anything happens after taking the pill, I would think it's because of the pill." (FG, India)

A central aspect of male identity in India is the perpetuation of family lineages, therefore it is not surprising that infertility was the most frequently cited fear in this context. As one informant put it, *"A sane thinking man would say 'give me something that does not jeopardize my chances of having a child'"* (Int10, Ind, 62y ,HS). Infertility caused by MCP use would put a man's masculinity into question and carry both social and religious consequences. For men in India, then, MCP constitute a potential threat to social relations, status, and family honor.

Mexican men placed greater emphasis on sexual desire and performance, which they considered as ways to express their masculine self. Men's strong identification with their sexual pleasure helps explain the widespread anxiety over impotence or low libido. This anxiety is both interior *("without libido, what is your virile side?")* and exterior *("[taking the pill] would strip you of your role of a man in society")*. Men also focused their concerns on physical markers of manliness or hegemonic masculinity, such as muscles, facial hair, and voice pitch.

***"...testosterone gives you everything as a man...it governs you completely...so when [MCP] reduce it you lose that [maleness]."* (FG, Mexico)**

***"... reducing libido is the most negative aspect of the MCP because if you do not have testosterone, which is your man side?"* (Int 23, Mex, 26y, BD)**

8

Male contraceptive pills do not appear to balance the gendered distribution of reproductive responsibilities. Despite expressing willingness to participate more equally, men's motivations for using or not MCP disclose a certain continuity with patriarchal norms.

Participants in both Mexico and India perceived MCP as a source of control over their sexual relationships not previously held, particularly in terms of preventing pregnancy. However, the content of men's considerations varied markedly across cultures.

Unmarried men in India emphasized the consequences for social cohesion in terms of a destabilization of the institution of marriage. Having direct control over fertility, without relying on women, would help avoid the social stigma that an unwanted pregnancy would bring: *"I'd definitely use them. There won't be any allegations. As in, if I don't take the pills and the lady gets pregnant, then it becomes a matter of dishonor, right?"*(Int4, India, 35y).

By contrast, in Mexico the control afforded by MCP was valued for preventing women from *"deceiving"* men and *"tying them down"* with children: *"[women] are excellent cheaters, so If we can have a contraceptive for us, you will be sure that the baby is not yours."* (FG, Mex).

At the same time, men who rejected MCP in both locations largely referred to their dangerous potential to (1) reduce their masculinity, or (2) increase women's promiscuity.

One participant in India expressed concern that *"when these pills come, the amount of sex will increase. Right now there are boundaries for girls like what if I get pregnant or what if I bring dishonor to my family. With these pills, nobody will know." (Int4, India, 35y).*

Few respondents questioned the consequences MCP might carry for their partners. Although some acknowledged that the pill would allow men to share the responsibility for fertility control and preventing STIs, no participants in either Mexico or India considered further implications for their partner's wellbeing. Further, they did not demonstrate awareness that several side effects they feared are currently experienced by women using female contraceptive pills.

The prevalence of sexist notions among both men who had a favorable view of MCP and those who rejected them demonstrates that levels of acceptability are insufficient to assess the effects of MCP on gender equality. These findings highlight the importance of accounting for the discourses that motivate decision-making around contraception when assessing gender imbalances in reproductive responsibilities.

4. Recommendations

The persistence of patriarchal discourses and norms noted throughout this study indicate that these issues have not been sufficiently addressed by efforts to promote SRHR. However, we have identified interrelated approaches to drive changes in the gendered distribution of responsibilities. These actions need to engage multiple levels, from governments to local civil society and the private sector, to develop a more comprehensive strategy and deliver enduring results.

Integrate a gendered lens throughout the SRHR policy-making process to address the unequal distribution of responsibilities.

- Governments need to take leadership in providing a legislative framework and institutional practices that do not reproduce harmful gender norms, such as overcoming the view that SRHR are a *"women's issue"*.
- Policies should create mechanisms to facilitate men and boys' participation in policy research, design, implementation and evaluation processes to encourage engagement with SRH and guarantee relevance.
- To address specific needs and barriers to uptake, policies and programs should be implemented within a rights-based framework that accounts for intersecting inequalities of gender, age, class and race/ethnicity, among others.

Ensure accessible, quality, culturally relevant sex education.

- Training and support for educators that stresses a gender lens is critical to ensure that gender inequitable norms are not perpetuated in schools.
- Collaboration across multiple sectors is necessary to reach girls and boys via various touchpoints and facilitate scalability. Policies and programs can leverage digital technologies to promote engagement and accessibility. In areas where technology use is not widespread, strategies need to include a range of media channels and involve community leaders.
- To foster ownership, strategies must seek to involve adolescents themselves in defining the content and shape of education programs, as well as promote peer-to-peer learning.
- Lessons should be focused on encouraging critical reflection about inequitable gender dynamics in decision-making about contraception and family planning. Additionally, it is important to foster discussion about contraceptive methods that are currently being tested such as MCP, to ensure that they are understood and normalized from a young age.

Complement advertising for MCP and other male contraceptives with messaging that promotes gender-equitable discourses and behaviors.

- Communications materials distributed by both public and private entities should aim to raise awareness about harmful sociocultural gender norms regarding sexual and reproductive behavior. Messaging that stresses their effect on human rights as well as health outcomes is key.
- Actors involved in marketing contraceptives need to address men's concerns and misconceptions about MCP and other male-centric options, while being careful not to reinforce discourses that masculinize pleasure and feminize SRH.
- If MCP or other male contraceptives enter the market, culturally-sensitive and context-specific strategies are needed to promote uptake, by accounting for local needs, beliefs and priorities.

Promote rights-based state health services that consistently apply a gender lens.

- Health systems must provide comprehensive services that account for gender-specific needs, risks, concerns and challenges in relation to SRH.
- Targeted capacity-building efforts are required to improve the gender sensitivity of SRH service provision. These efforts should include specialized training; and issuance and enforcement of codes of conduct on the perpetration of gendered violence, such as coercive insertion of IUDs.
- Information provision and data collection about SRHR need to target men as well as women. In particular, male contraception should be promoted in ways that foster positive masculinities, destigmatize issues such as infertility, and address misconceptions to encourage utilization.

Ensure that SRHR policies and programs are supported by contextualized and mixed-method research.

- While policy-making should routinely incorporate both quantitative and qualitative data, this is especially relevant in the case of SRHR. Beyond contraceptive usage rates and population indicators, sexual and reproductive life involves emotions, discourses, and other aspects that qualitative research is particularly suited to understand.
- It is important to promote research that accounts for contextual specificities (both between and within countries) to ensure that policies and programs will be locally appropriate, as well as shed light on the aspects that act as risk factors and barriers for SRHR.
- Future research on MCP and other forms of male contraception needs to expand its scope to include different contexts and profiles. For instance, more evidence is needed on rural communities and men of different ages, as well as studies that involve both men and women.

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Annexes

Annex 1: Data Tables

INDIA: Participant profiles

CODE	AGE	RELATIONSHIP STATUS	EDUCATION LEVEL
Int1, Ind, 25y, Ba	25	Married	Bachelor of Arts
Int2, Ind, 25y, Ba	25	Married	Bachelor of Arts
Int3, Ind, 34y,ES	34	Married	Elementary School
Int4, Ind, 35y,Ba	35	Married	Bachelor of Arts
Int5, Ind, 23y, Ba	23	Casual Relationship	Bachelor's in Journalism
Int6, Ind, 24y, Msc	24	In a relationship	Master's degree
Int7, Ind, 24y, Msc	24	In a relationship	Master's degree
Int8 Ind, 23y, Msc	23	In a relationship	Master's degree
Int9 Ind, 28y, ES	28	Divorced (no kids)	Middle School
IInt10, Ind, 62y, HS	62	Married (2 kids)	High School
Int11, Ind, 24y, Msc	24	Casual Relationship	Currently enrolled in Master's program
Int12,Ind, 58y,BA	58	Married	Bachelor of Arts

MEXICO: Participant profiles

CODE	AGE	RELATIONSHIP STATUS	EDUCATION LEVEL
Int13, Mex, 27y, Uni	27	Has finished relationship 4 months ago	Current undergraduate
Int14, Mex, 24y,HS	24	In a relationship	High School
Int15, Mex, 60y, MD	60	Divorced (2 kids)	Master's Degree
Int16, Mex, 53y,ES	53	Married (2 kids)	Elementary School
Int17, Mex, 46y,NE	46	Married	Non-educated
Int18, Mex, 28y, HS	28	Single	High School
Int19,Mex, 17y, ES	17	Single	Elementary School (nini)
Int20, Mex, 14y, ES	14	Casual sex	Elementary School
Int21, Mex, 36y, MD	36	Married (no kids)	Master's Degree
Int22, Mex,29y, HG	29	Single	Current undergraduate
Int23, Mex,26y, BD	26	In a relationship	Bachelor's Degree
Int24, Mex, 30y, BD	30	Divorced (no kids)	Bachelor's Degree
In25, Mex, 29y, BD	29	Single	High School

(IN)VISIBILITIES

NOSÓTRICOS
TIK-TANK

GENDER
INEQUALITIES
/SERIES/