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Reconceiving masculinity and 'men as partners' for ICPD Beyond 2014: Insights from a Mexican HPV study

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Men are poorly integrated into sexual and reproductive health programmes, despite long-standing calls for their inclusion. From the 1994 Cairo International Conference on Population and Development (ICPD) to the Policy Recommendations for the ICPD Beyond 2014, calls for 'rights for all' conflict with implicit, homogenising framing of men as patriarchal roadblocks to women's empowerment. This framing generates ambivalence about providing men's services, leading to emphasis on 'men as partners' supporting women's autonomous reproductive health decision-making rather than attention to both sexes' health needs. We argue that this framing also belies both the global rise of self-consciously non-traditional masculinities, and the fact that people's ostensibly individual sexual and reproductive health practices are profoundly relational. Here, we reimagine the concept of 'partnering' as an analytic for understanding how lived relationships influence both men's and women's sexual and reproductive practice. 'Partnering' in this sense is the context-dependent collaboration through which a range of gendered actors, not limited to male–female dyads, interact to shape health behaviour. We apply this approach to Mexican men's participation in a medical research on human papillomavirus transmission, demonstrating how spouses jointly refashioned male-focused health surveillance into familial health care and a forum for promoting progressive gender norms to their children and the broader society.

Keywords: ICPD; masculinity; men as partners; Mexico

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Introduction

One of the major contributions of the 1994 Cairo International Conference on Population and Development (ICPD) was the shift from an overarching emphasis on population control to a focus on social justice, the promotion of individual sexual and reproductive health rights and the empowerment of women to control their sexual and reproductive lives (Anderson, 2005; Dudgeon & Inhorn, 2004; Mundigo, 2000). This fundamental shift resulted in a strong policy focus on 'women's rights' and 'men's responsibilities' as encapsulated in the 1995 United Nations Population Fund (UNFPA) directive to 'provide boys with a different interpretation of masculinity, replacing the one based on domination to one defined by shared responsibility' (UNFPA, 1995, p. 16).

Although the Cairo ICPD provided the first major policy articulation of 'male responsibility', development efforts to promote male responsibility pre-date this conference. For example, notions of 'irresponsible men' were used to justify Western colonisation of many populations in the global South (Ahmed, 1992). Even Egypt, the

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site of the 1994 ICPD, relied heavily on media campaigns to shame ‘patriarchal peasant men’ into being ‘responsible’ by producing fewer children (Ali, 2000). Such early population control discourses surrounding masculinity framed men’s lack of concern for women’s reproductive health as a key cause of women’s health problems (Mundigo, 2000).

ICPD was thus a watershed moment in promoting women’s reproductive rights over top-down population control and calling for men to be ‘responsible’ by supporting women in their reproductive health behaviours and goals. Yet, men’s own reproductive rights were framed as largely secondary. Indeed, both theoretical and implementation-oriented discussions of the Cairo agenda focused on the difficulty of ensuring men’s rights in ways that did not infringe upon those of women. This was posed as a difficult feat in contexts in which men, as a group, were privileged over women, and where individual men might assert their rights by controlling individual women’s reproductive decisions and behaviours (Callahan, 1996).

Since ICPD, the international health and development communities have continued to express ambivalence about the inclusion of men in agendas for sexual and reproductive rights. In a context of scarce resources and continuing patriarchy, supporters of women’s health have voiced concern that focusing on men might: (1) decrease services available to women; (2) shore up existing gender asymmetries; (3) obscure men’s privileged legal and economic positions in the control of resources and (4) be difficult to execute in infrastructures designed for women’s reproductive health care (Berer, 1996; Dudgeon & Inhorn, 2003, 2004; Frye Helmer, 1996).

These concerns have been reflected in ongoing debates about nomenclature. For example, the term ‘men’s responsibility’ promoted in ICPD discourse has been criticised for failing to adequately capture the relational nature of sex and reproduction, and for implying that men act ‘irresponsibly’ by default. Feminists have also criticised the alternative discourse of ‘male involvement’, promoted by the UN, for obscuring historic gender inequalities, including ongoing relationships of male dominance (Corrêa, Maguire, & Figueroa-Perea, 2000; Verme, Wegner, & Jerzowski, 1996). Thus, the terminology of ‘men as partners’ was introduced to acknowledge that: (1) both women and men are involved in reproduction and (2) men may enhance, rather than invariably compromise, women’s health care and empowerment (Becker & Robinson, 1998; Oudshoorn, 2003; Wegner, Landry, Wilkinson, & Tzanis, 1998). Although the ‘men as partners’ approach has gained widespread currency in family-planning circles, this terminology has also been critiqued. ‘Men as partners’ seems to assume and even naturalise heterosexual monogamy, obscuring reproductive and sexual practices occurring outside marital forms of partnership (Greene & Biddlecom, 2000). Furthermore, this paradigm fails to recognise the many disadvantages faced by non-elite men in their attempts to ‘partner’ with women, including the fact that reproductive health services in contexts of economic scarcity focus almost exclusively on women (Collumbien & Hawkes, 2000).

In short, despite a great deal of conceptual work and calls for male inclusion, formal efforts to incorporate men into sexual and reproductive health care have lagged far behind the goals originally outlined in Cairo. Health programmes around the world still tend to leave men out of the reproductive equation – an omission linked in part to stereotypical understandings of men as, at best, ‘bit players’ in reproduction, or at worst, as coercive obstacles to women’s health and empowerment (Almeling & Waggoner, 2013; Basu, 1997; Daniels, 2006).

Unfortunately, the omission of men is also evident in the Policy Recommendations for the ICPD Beyond 2014. This powerful document calls for universal sexual and

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reproductive rights, and it unflinchingly critiques global failures to meet key 1994 goals. Yet, its language of 'universality' is in tension with its focus on women and youth. Rights for women and for youth are frequently mentioned throughout the document, while rights for men are rarely invoked, and are discussed almost exclusively in terms of 'young' or 'older' men. The document clearly calls for the rights for all groups *except adult men*. Thus, counter to the document's stated goal of combating 'entrenched gender discrimination and stereotypes' (ICPD, 2013, p. 2), the policy statement's language reinforces negative caricatures of men as implicitly harmful to women. In so doing, it obscures the ways that both men and women may be affected by gendered systems of inequality and radically underestimates the ways in which men may be involved in transformative social processes, including improvements in sexual and reproductive health in their own societies.

More alarming is the implicit framing of men as the sole perpetrators of direct physical and indirect structural violence against women, children, and the elderly. For example, the document opens with the statement 'Adolescent girls and young women are especially at risk of violence. Up to 50% of sexual assaults are committed against girls under 16; 60 million girls are child brides; and 140 million women and girls have undergone female genital mutilation, which is most often practiced before the age of 15' (ICPD, 2013, p. 1). Such statements do not address men directly, and through this exclusion, suggest that men are uniformly the culprits of the violence described. Although it is true that men are most often the perpetrators of domestic and sexual violence (Heise, Ellsberg, & Gottmoeller, 2002), *women, not men*, are generally the ones who perform and perpetuate rituals of female genital cutting (Gruenbaum, 2001). Furthermore, young men, like young women, may be forced into early marriage, as arranged by both senior men *and senior women* in their families (Hart, 2007; Inhorn, 1996; Joseph, 1993).

Thus, the ICPD Beyond 2014 document obscures more complex realities surrounding each form of harm discussed; these are shaped not only by gender, but by power dynamics based on age, class, ethnicity, nation, and many other factors. Vilifying men as the sole perpetrators of gender injustice does little to unseat complicated systems of patriarchy, men and women's collusion with these systems and the economic and political structures upholding them (Kandiyoti, 1988). Unfortunately, the ICPD Beyond 2014 document seems to reproduce assumptions about both men and women as gendered subjects that are common in development discourse but may oversimplify the lived complexities of patriarchy (Pigg & Adams, 2005).

Emergent masculinities, companionate responsibility, and partnering

In an attempt to counter unproductive framings of men as sole and inevitable sources of harm, a number of researchers have recently called for more attention to men's experiences of sexuality and reproduction in a variety of global settings (Barker & Das, 2004; Culley, Hudson, & Lohan, 2013; Dudgeon & Inhorn, 2003; Hawkes & Hart, 2000). Their call is part of a greater move within gender studies to incorporate men, masculinity and fatherhood into discussions of gender systems and dynamics (Inhorn, Chavkin, & Navarro, 2014; Whitehead, 2002), including in discussions of development (Cleaver, 2002). Around the globe today, many men are engaged in self-conscious critiques of local gender norms, which may serve to unseat some of the more pernicious forms of patriarchy described above (e.g., Inhorn, 2012; Wentzell, 2013b).

Furthermore, many men are demonstrating their desire to share the responsibility for reproduction and parenting with wives, and to utilise the full panoply of reproductive and

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sexual technologies, from condoms to assisted conception (Gutmann, 2007; Inhorn, 2003; Inhorn, Tjornhoj-Thomsen, Goldberg, & la Cour Mosegaard, 2009). Indeed, in many global sites, new forms of masculinity are becoming increasingly apparent (e.g., Ashcraft & Flores, 2003; Falabella, 1997; Thompson, 1985). These 'emergent masculinities', as we have called them (Inhorn, 2012; Inhorn & Wentzell, 2011), often involve new notions of conjugality, centred on love, commitment, nurturance and care: what we would describe as 'companionate responsibility'.

Emergent masculinities and companionate responsibility have been shaped by a number of global forces. First, women's political participation and feminist movements in many societies have encouraged more egalitarian gender relations in both the public and private spheres (Connell, 1990; Gutmann, 1996). The rise of companionate marriage, which privileges emotional bonds over economic and social reproduction, has been co-produced with these political shifts (Padilla, Hirsch, Munoz-Laboy, Sember, & Parker, 2007; Wardlow & Hirsch, 2006). This companionate ideal has reached global audiences through the media (Altman, 2001), as well as through the spread of global protestant movements, which call for men to become more faithful, sober and attentive to the family (Martin, 2013; Tuzin, 1997; Williams, 2001). In addition, secular self-help groups aimed at men often rely on quasi-religious 'conversion' narratives to assist men in revising their ways of being (Amuchástegui, 2009; Brandes, 2002; Irvine & Klocke, 2001). On a more structural level, legal codes, including reforms of personal status laws governing marriage, divorce, custody and inheritance, are increasingly incorporating notions of gender equity, facilitating the practice of these emerging ideals and linking them to popular ideas of social modernity (Aboim, 2009).

Having said this, emergent masculinities are being adopted in the context of global economic and structural downturns, which have made many men less able to live up to the economic and social expectations associated with companionate responsibility. Amid a global economic crisis and increasing economic inequality, men worldwide are facing decreased earning power despite increasing educational attainment and fewer options in shrinking and increasingly feminised labour markets (Amit & Dyck, 2012; Mills, 2003). Exclusion from previously expected social roles leads some men, especially those disadvantaged by local racial, class or other systems of inequality, to develop masculinities centred around generating status through violence (e.g., Bourgois, 2003; Mendenhall, 2013). Furthermore, in some regions of the world, ongoing and emergent forms of religious fundamentalism have served to reinforce sharply defined gender roles and to assert traditionally hegemonic forms of masculinity as ideal (Corrêa, Petchesky, & Parker, 2008). Clearly, patriarchy still persists around the world, with men disproportionately occupying positions of political and economic power (Spar, 2013). However, over time, 'traditional' masculinities linked to overt, patriarchal dominance are becoming less desirable in sites where companionate responsibility has become the new hegemonic norm. In such settings, men excluded from 'traditional' sources of male power may be especially likely to adopt new, emergent forms of masculinity, in which companionate responsibility is essential to being seen as both a good man and a good conjugal partner (Hansen, 2012; Ranson, 2001).

From 'men as partners' to partnering

The role of men as partners to women has been clearly acknowledged in post-ICPD development discourse. Yet, the terminology of 'men as partners' has been used explicitly to describe men in a 'supportive' capacity, and not as co-equals with women, who are

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assigned primary responsibility as autonomous individuals in reproductive decision-making. Clearly, women can be powerful reproductive actors. But, generally, they do not act completely alone. Not only are male partners involved but so are other actors, including friends, relatives, neighbours, co-religionists and health care professionals (Basu, 1997; Montgomery, 2012; Rapp, 2000). Failing to account for this collaborative context is counterproductive to meeting the goal of enhanced gender equality in ICPD Beyond 2014 (Bojin, 2013; Edström, 2010).

Here, we propose a new approach to the idea of 'partnering' as a way to understand the context-dependent social interactions through which women *and men* make reproductive health care decisions in collaboration. Rather than focusing on women as the central actors in reproductive health and male partners as supplemental, 'partnering' is a context-dependent interaction performed by gendered actors in ways that are intimately shaped by local social contexts (involving politics, economics, age distributions and the like). A broadly interactional conception of partnering also accounts for the ways in which local gender norms are changing in ways that may significantly shape social interactions surrounding sexual and reproductive health. Partnering in this sense is also not limited to the male–female dyad since even seemingly individual reproductive health activities are always embedded within a complex range of social relationships, including often invisible relationships with the (usually) male authority figures in positions of legislative, economic, medical, religious and other forms of social power. Although some partners may strive to live out egalitarian gender ideals, partnering is power laden, not power neutral. It is an analytic rather than a prescriptive approach, which can be used to understand how men and women act proactively to undermine local systems of patriarchy, or act in ways that reproduce those systems.

This new paradigm of partnering can help to meet previous calls to include men in reproductive and sexual health research and practice. By shedding light on the daily life ways that people practice partnership – including but not limited to those in which participants seek gender equality – a partnering approach may reveal new ways to destabilise gendered hierarchies, not only within conjugal dyads but also in social life more generally. We thus see a new paradigm of partnering as a useful analytic for understanding the realities of reproductive health practice involving both men and women within their local communities. Partnering in this sense is a way of seeing how interactions surrounding reproductive health reflect, reinforce and unsettle gendered hierarchy, revealing productive possibilities for collaborative reproductive relations.

To illustrate the utility of this partnering approach, we now turn to a case study of Mexican men's participation in an international research project regarding sexually transmitted infection (STI). By applying this analytic, rather than a prescriptive, understanding of partnership, we show how some participants undergoing ostensibly individual health surveillance collaborated with their wives to frame medical study participation as a joint endeavour. We discuss the ways that some couples used study experiences to their own ends, seeking to promote familial health, critique 'traditional' Mexican masculinity (*machismo*), and spur related improvements in gendered health practice on the societal level. Our analysis of their efforts highlights the shared social consequences and possibilities emerging from medical experiences aimed at a single sex, as well as the ways that people work together to relate such effects to local debates about ideal gender norms and relations.

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Mexican couples partnering through the HIM study

Study site and methods

From 2010–2013, the first author did anthropological fieldwork to assess the social consequences of Mexican spouses' involvement with the Human Papillomavirus in Men, or HIM, study, a multinational, observational, longitudinal medical research study tracing the 'natural history' of human papillomavirus (HPV) occurrence in men (Giuliano et al., 2006). HPV is the world's most common STI. It is usually asymptomatic, although some viral types can cause genital warts or cancers, including cervical cancer. In Mexico, cervical cancer is a major cause of morbidity and mortality, and HPV is becoming better known as its cause through recent educational and vaccination campaigns (de Sanjose et al., 2010; Secretaria de Salud, 2010).

The Mexican arm of the HIM study is based in Cuernavaca, a large and growing city near the nation's capital. Mexican HIM participants undergo 10 biannual clinic visits, which include the collection of anogenital skin, blood and urine samples for STI testing, the completion of computer-assisted sexual and health questionnaires and the receipt of prior test results. These participants were recruited from the pool of patients and workers at a government health service that offers care to all formally employed Mexican workers, as well as from large local businesses and research institutes. Participants were mostly lower to upper middle class men, who were literate, employed and able to access cost-free government health care. Since Mexican HIM participants are not compensated beyond receiving free STI treatment and medical check-ups, those likely to participate were men interested in health care and/or medical research. HIM participation offered the opportunity to access additional preventive care and medical testing, and in doing so, enacted the 'modern' health care and gender practices being promoted within the local health care system.

A subset of these study participants and their spouses were recruited into the present ethnographic study of male–female couples' experiences of men's HIM participation. Thirty-one couples participated, as well as comparative groups of 10 male HIM participants and wives of 12 HIM participants interviewed alone. Participants' age ranged from 20 to 60 years, with most being in their 30s to 50s. They were mostly married with children, reflecting the broader adult population. The anthropological study included three annual rounds of semi-structured Spanish language interviews with the first author. (Study methods also included clinical observation and daily life participant observation with some of the participants, but data from these methods are not discussed here.) The HIM study staff recruited participants and then scheduled interviews for the anthropologist. Interviews, which tended to last from 45 to 60 minutes, took place in private areas at the HIM site and were audio recorded with participants' permission. All participants signed informed consent forms, and they were told that their decisions regarding participation in the anthropological study would not impact their HIM study eligibility or treatment. The research protocol was approved by the author's home institution and the Mexican institution housing the HIM study.

The anthropological study's longitudinal design was intended to reveal relationships over time between participants' ongoing study and daily life experiences. Interviews were organised in light of best practices in the qualitative research of intimate topics, including ordering questions from least to most intimate, demonstrating confidentiality, establishing rapport and avoiding assumptions (Herdt & Lindenbaum, 1992; Parker, Barbosa, & Aggleton, 2000). Initial interviews collected participants' life, health and romantic histories, and they elicited discussion of their HIM study experiences to date, including

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reasons for enrolment. Subsequent interviews gathered data on participants' changing experiences and ideas over time, addressing participants' understandings of the HIM study, as well as their marital, health and other key life experiences that had occurred since the prior interview. Interview schedules were personalised based on previous interview content to capture changes over time regarding specific participant experiences. Couples' interviews were also intended to generate data on the ways that spouses interacted to debate and present shared experiences. Questions were posed broadly as well as to specific individuals in order to elicit spousal communication while mediating imbalances – such as 'scene stealing' by one partner – that may occur in couples' interviews (Arksey, 1996).

Findings

While the HIM study focused on the male body itself, a large group of anthropological study participants and their spouses conceptualised the HIM study as a joint undertaking. They viewed the study in terms of not only their own health but also the health of their families and society more broadly. Thus, HIM participants and spouses often cast men's study experiences as 'shared' events through which they lived out joint identities as couples and worked towards shared goals. This began with their decision to enrol. Husbands generally decided to join in consultation with their wives, and wives often heard of the HIM study first, suggesting it to their husbands. Even couples in which one partner felt less inclined towards research participation usually came to frame the experience as one that highlighted unity. For example, a 71-year-old industrial salesman, speaking of his wife, said that joining the HIM study 'was her suggestion; I agreed'. Laughing, he added, 'Really, it's her who pulled me by the ear'. However, he had become deeply invested in the project, and both he and his wife hoped that a proposed women's version of the HIM study would soon be initiated. When asked why, the man's wife, who was a 56-year-old photographer, responded, 'Because we started something, and we have to finish it. He's finishing, and they invited us as a couple'. Since study recruitment materials focused solely on men – partly by discussing the harm that male 'carriers' can cause to their female partners – this wife's interpretation reflected the couple's joint view that sexual health was a shared concern.

While there was no formal role for women in the HIM study, spouses often shared the research experience by attending the medical visits together. Many couples explicitly framed going to appointments together as a way to demonstrate emotional and sexual openness and compatibility. A 36-year-old nurse discussed how her jokes had put her husband at ease during the unfamiliar anogenital sampling undertaken during his first HIM visit. Working as a bartender, the 50-year-old husband noted how he also accompanied his wife to her gynaecological appointments, even looking through 'the little camera' that the doctor inserted into her vagina. She noted, 'We're really compatible; there aren't many taboos between him and me'.

Similarly, when asked to describe his clinical visits, a 36-year-old hospital lab technician's first statement was 'She accompanied me'. His wife, a 39-year-old office worker, described the decision as a shared one, noting, 'He asked me to accompany him, and I was interested in knowing about it'. They believed that sharing this experience had also helped them to deal with his positive HPV diagnosis. He said, 'That positive [result] alarmed me, and when I discussed it with my wife she was worried. But we kept going to the study visits and they explained that, of the bad news to get, it wasn't that bad'. The couple's fears were allayed by conversations with medical staff in which they learned that

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his strain of HPV was not carcinogenic. Furthermore, the husband described discussions with some of his work colleagues who had received similar diagnoses. In a way that strengthened their romantic and social bonds, the spouses partnered with each other and with their peers to convert the HIM study experience into a shared educational forum for making sense of positive results.

Some spouses who did not necessarily begin the study with shared ideals of communication and coupling described how the HIM study experience had had wide-ranging, non-medical effects on their relationships. A 47-year-old construction worker married to a 41-year-old direct-sales vendor explained that their participation 'united us more' as a couple. He reported joining the HIM study because he blamed his infidelity for his wife's abnormal Pap smears. When his test results confirmed that he was positive for HPV, he said, 'I felt guilty. You feel like "Swallow me up, Earth!" You don't want to touch her or see her, because you feel guilty'. However, both this man and his wife described how the study had changed his way of being a man. He explained, 'There was increasing closeness between us, because I stopped wandering in the street and withdrew more from alcohol, which was one of the causes of me stepping out. We started to go out more as a couple'. His wife said that their relationship had improved dramatically, and that now 'we're always together…. We spend more time together to the point that now people tell me, you're always going with him'! Thus, while some participants incorporated HIM study experiences into their ongoing expressions of companionate marriage, others used their HIM study participation to alter their performances of gender and marital intimacy.

In keeping with their focus on sexual health as a familial rather than individual concern, couples frequently discussed HIM study participation as a way to care for their children. Men sometimes linked this to the dominant ideal of caring responsibility. For example, a 47-year-old hospital warehouse worker noted that he joined the study 'principally for my health, well-being. First mine, then my family's. If I'm healthy, I can work, support them, have a good relationship with my partner'. His statement demonstrates his conception of the intimate relationship between his individual bodily health and the financial and emotional well-being of his family. Both women and men stressed that good parenting involved maintaining their own health, modelling a healthy marriage and a positive lifestyle and thus being present as caregivers as their children grew into adulthood.

Notions of good parenting also involved providing health education to one's children. Participants frequently described the HIM study as an informational resource, which would help them to educate their children about sexuality and health. For example, a 33-year-old hospital clerical worker regretted that his male relatives had taken him to a prostitute for his first sexual experience. He said that he intended to teach his son about sexual health quite differently, as part of a broader attempt to model being a good man. He planned to tell his son about the HIM study because 'a real man cares for himself and his partner'. He said that 'in our culture it's not really a given that the Mexican man understands health'. Thus, he hoped to transmit an 'open mind' to his son, thereby modelling sexual hygiene and self-care as part of masculinity. In some cases, fathers deliberately brought their older boys with them to HIM visits, in an explicit effort to model caring masculinities, teach anti-macho values of self-care, and further solidify family closeness. For example, one father of three sons explained, 'Normally, here for a man to let someone touch his intimate parts, it's very difficult. And well, I got used to it; now I see it as something normal'. He explained that he teaches his sons this attitude by bringing them to his appointments and engaging in a light-hearted way about the clinical

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procedures so that they see the process. He noted: '[You] go with the doctor: "Okay, I'm going to take some samples", and like that, between jokes, we transmit all that [health orientation] to our sons'.

Many participants also saw their involvement in the HIM study as supporting societal shifts towards non-traditional gender roles. As one man put it: 'I'm against machismo, and my wife knows that very well, and if we can help with that, well, let's do it'. Similarly, the father discussed previously noted that his work with his sons in the clinic reflected a familial commitment to eradicating machismo in their home. Noting that he had been part of the 'long process' of enhancing gender equity in Mexico, he said that he had taught his sons that 'here in the house there aren't machos. Here the machos are those that work, that make the food, wash, mop. That's what men are here in this house'. He said that he and his wife strove to teach their sons the following: 'We all have the same rights. It's not that by being born a woman, you're born as lesser'.

Many spouses saw themselves as partners in a health project that could contribute to changing gender norms by encouraging Mexican men to seek preventive health care. Along these lines, participants frequently saw participation as a way to help others, by fomenting a 'culture of prevention' in Mexico, in which both men and women were equally focused on care. A 43-year-old unemployed man said that he had 'become a messenger' for the HIM study, telling others about it, because 'it's scary to see people who don't protect themselves'. A 36-year-old wife and a 39-year-old husband who worked in the same dental office discussed their own process of adapting to sexual health testing as a trajectory that Mexican society should follow. He said that his first check-up was 'embarrassing but necessary. One has to adapt'. She added, 'He told me he was ashamed, and I told him not to be. This needs to be part of our culture. Like the Pap smear; it didn't use to be normal, but now it is'.

Discussion

These findings illustrate how some HIM study participants and their spouses reconfigured male-focused sexual health surveillance as a collective experience, in their effort to support both conjugal and familial health, promote companionate responsibility as an ideal in their households, and model non-traditional forms of masculinity to their children and to the broader society. Many couples lived out companionate responsibility through their study participation, practicing joint decision-making regarding study enrolment, and communicating about and sometimes going together for sexual health testing. In these ways, many believed that the HIM study further 'united' them, demonstrating their sexual openness and emotional closeness. Framing their bodily health as a familial rather than individual resource, these men and women also enacted responsible care for their children through their engagement with the HIM study.

The 'culture of prevention' that participants sought to model for their families and society entailed a specific vision of gender in which men would view preventive health care as a support for, rather than a threat to, desirable masculinity. Masculinity is a fraught topic in Mexico. Heated public and private debates simultaneously criticise and naturalise the persistent stereotype of *machismo*. This stereotype is the idea that Mexican men, as the progeny of coerced reproduction between conquistadors and indigenous women, are predisposed to emotional closure, drunken carousing, and sex-obsessed womanising (McKee Irwin, 2003; Paz, [1961] 1985). Recent research shows that men in urban central Mexico are keenly aware of this stereotype, even attributing personal behaviours they see as undesirable to it. However, Mexican men today also frequently seek to perform 'non-

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macho' masculinities, which emphasise emotional commitment to family and fathering (Gutmann, 1996; Ramirez, 2009; Wentzell, 2013a).

Many participants in the present study articulated current critiques of machismo, using HIM study experiences as a venue for performing and promoting anti-macho behaviours. Spouses also framed these non-macho men as models, not just for their own children but also for a broader Mexican society. Together, men and women in the study often articulated progressive gender norms, which they hoped would enable men to participate in preventive health care. Such prevention, they argued, would contribute to the modernisation of social health in Mexico overall. Having said this, HIM participants did not always articulate 'non-traditional' ways of being men, and even those that did often combined these views with practices reflecting more traditional gendered behaviours and identities. For example, many participants still expected men to be in charge of family breadwinning and decision-making. As a result, families were more likely to have a male rather than female parent working outside of the home.

Overall, spouses used the HIM study as a forum for performing aspects of the locally emergent norms for masculinity, femininity and marriage that emphasise increasing gender equity and focus especially on the need to 'modernise' men, while maintaining certain pre-existing aspects of patriarchy such as understandings of men as providers. Many men, in collaboration with their wives, sought to deliberately enact these new gender norms through their medical research–related practices. New framings of manhood, along with strong notions of conjugal love, commitment and sacrifice, were prominent in couples' narratives as they framed men's HIM study participation as a way for spouses to enact and model companionate responsibility.

While we intend this analysis to model the analytic approach to partnering that we formulate in this article, these ethnographic findings are subject to the clear limitation that they address the specific experiences of one particular population and sexual health setting. Given Mexican HIM study participants' reasons for enrolling, this population likely displays a 'healthy user effect', a sampling bias in which those likely to follow health recommendations are also most likely to enrol in research studies (Shrank, Patrick, & Brookhart, 2011). The subgroup that agreed to participate in anthropological research with their spouses was probably similarly likely to hold gender norms that they felt willing to discuss with a researcher. However, this bias does not affect the anthropological aim of investigating how people might incorporate sexual health experiences into performances of gender. The fact that the present study focuses on one 'healthy user' group does suggest that participants in the broader HIM study or people experiencing other forms of sexual health testing and treatment might respond differently by keeping specific experiences private or partnering with others to incorporate health experiences into diverse gender ideologies.

Conclusion

In conclusion, this example from Mexico highlights the need for a broader conception of partnering. To more faithfully reflect the ways in which both women and men support each other's gendered health care practices, it is necessary to move beyond static notions of 'women's rights' and 'men's responsibilities'. Understanding partnering as a relational practice that happens among women and men within and beyond conjugal dyads – and is often supported by relatives, friends, physicians and others – can help researchers to map the many ways in which partnerships shape people's engagement in health care. Partnering is a useful analytic for understanding the lived collaborations between men

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and women in places like Mexico, where husbands and wives are self-consciously improving their sexual and reproductive health practices in ways that are also refashioning existing gender norms.

Since stereotypes of traditional masculinity in Mexico focus heavily on virility and fertility, men's use of reproductive and sexual health services has proven to be a key arena for the enactment of companionate responsibility (Gutmann, 2007; Huerta Rojas, 2007; Wentzell, 2013b). The case of HIM study participation in Mexico demonstrates that in cultural contexts in which companionate responsibility has become part of emergent masculinities, male-focused sexual and reproductive health interventions may allow men to put progressive gender norms into practice. More significantly, this example highlights the collaborative nature of men's and women's participation, even in a reproductive health intervention aimed at individual men. These spouses understood medical participation as a form of partnership done in the best interests of both familial and social health. While only men received HPV testing in the HIM study, spouses often discussed their shared involvement, framing both study participation and sexual health more generally as a joint project through which they could live out desired gender norms, teach these norms to their children and support a local 'culture of prevention', linking emergent masculinities to new forms of self-care and health research.

These findings model application of the partnering analytic presented here in a specific context and are generalisable only to similar social groups in cultural settings where companionate responsibility is becoming a normative ideal. Given local critiques of machismo and the HIM study's focus on men, spouses in this case partnered primarily to assert 'modern' masculinities and relationships; however, partners might assert different kinds of masculinities, femininities and social relationships through other sexual health experiences in different settings. A value-neutral analytic of partnering can be used to identify the varied ways that people work together to perform diverse gender norms through health practice, including both progressive norms that further ICPD goals and patriarchal norms that may confound them. Overall, this approach is helpful for identifying the unanticipated ways that targets of medical intervention and their social circles might make use of that experience to perform locally salient forms of gender.

Furthermore, while the case presented here focuses on male–female spouses, this conception of partnering need not be limited to married couples. It can be productive for understanding non-conjugal male–female relationships, same-sex romantic partnerships and familial partnerships, such as those that men enact with their children in attempts to influence youthful practices of gender, sex and reproductive health. It is also productive for understanding the influence of other relationships often left out of policy discussions of sexual and reproductive health, such as partnerships between friends, religious communities and more abstract policy-makers and service providers. Finally, this approach can also shed light on non-human actors as partners. People interact with technologies, including sexual health technologies such as the HPV test and the gynaecological speculum (Clarke & Montini, 1993; Clarke & Casper, 1996). If non-human actors are seen as inanimate 'partners', then the notion of partnering may be expanded to include human–technology interactions that are conducive to achieving optimal sexual and reproductive health.

Overall, an expanded, non-prescriptive analytic of partnering can facilitate a broader investigation of sexual and reproductive health programmes' collective consequences. The notion of 'men as partners' initially entered policy discourse amid debates about whether men could be included in women's health interventions in ways that would promote equality despite patriarchy. Yet, as our case study shows, the targets of health

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interventions might incorporate others into their experiences regardless of programme designers' intentions. A shift to a broader understanding of 'partnering' is thus needed to accurately understand men's and women's personal and interactional reproductive and sexual health experiences. This approach can be applied to existing health interventions, enabling health care providers and policy-makers to understand the gendered ends to which people are using health programmes. Programme designers could then work with care recipients and their partners to revise programme elements and support health interventions that further the gender equity being espoused in ICPD Beyond 2014.

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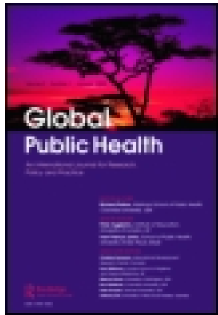

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Reconceiving masculinity and 'men as partners' for ICPD Beyond 2014: Insights from a Mexican HPV study

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