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Pills, Power and Performativity: Negotiating Masculinity in the Emergence of Male Contraceptive Technology

Eleonore Lorijn

The London School of Economics and Political Science (LSE)

Abstract: As we prepare for a new contraceptive revolution centering the male reproductive body, little is known about 21st century men's interest in pursuing hormonal technology. This paper sets out to understand what male hormonal contraception (MHC) means for the performance of masculinity. Specifically, I seek to understand how contraceptive technology might contribute to the emergence and transformation of different masculine identities, and whether these identities will function to enhance or denounce the technology's cultural feasibility and widespread assimilation. Amid the heavily quantitative nature of literature on this topic, I conduct semi-structured interviews to form a more intimate understanding of this relationship. Through thematic analysis, this project reveals a typology of three analytic figures which surface in response to the future existence of MHC: the 'responsible, caring man', the 'lazy man', and the 'independent, heterosexual man'. The ways in which these identities conflict, complement, and interact with each other indicate how masculinities are being negotiated upon a shifting contraceptive landscape. The conclusions derived from my analyses are twofold: Firstly, that the cultural feasibility of MHC in western contexts will simultaneously demand and induce a destabilisation of conventionalised gender performances. Secondly, that the masculinities which emerge from this new frontier of contraception are complex, multiple and fluid. The investigation ends by looking at the wider implications of my findings for policy and practice.
Keywords: Contraceptive technology, masculine identities, gender performativity

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After decades of anticipation, male hormonal contraception (MHC) is approaching commercial viability. Several products are being tested, some of which have already

passed initial clinical trials. Since the birth of the hormonal pill in the 1960s, *women* have borne the burden of contraceptive responsibility: over 12 female contraceptive technologies have been marketed since World War II, yet male contraceptive options remain limited to condoms, vasectomy, and withdrawal (Oudshoorn 2003). Further reinforcing contraceptive inequality is the reality that these three methods account for only 8.9% of all contraception use (UN 2009). MHC has the transformative capacity to alter imbalances in reproductive responsibility and create new practices of gender. Yet despite this potential, little is known about whether men will actually embrace this new technology. This research sets out to understand what MHC means for the performance of masculinity. More specifically, I aim to understand how the arrival of this new contraceptive technology will contribute to the emergence and transformation of different masculine identities, and whether they will function to enhance or denounce its cultural feasibility.

My focus is guided by abundant empirical evidence framing masculinity as central to men's health behaviours.[1] This relationship has so far been researched in relation to seatbelt usage, mental health, alcoholism, violence, vegetable consumption, doctor appointment attendance, sunscreen application, and others (Mahalik et al. 2007). The importance of this research additionally rests upon the historical evidence demonstrating the difficulties of rolling out technologies that conflict with hegemonic masculinity (Oudshoorn 2003). 'Viagra'™ strongly faced this challenge, and it is likely that MHC will, too. To understand this phenomenon, I draw on theories that explicate the co-constitution of technology and gender. Feminist scholarship has increasingly demonstrated how technology design can constitute gender relations (Cockburn 1992; Wajcman 2000). This co-production is paradigmatic within material sociology in that social norms and relationships materialise through technological innovation, and vice versa.[2] Acknowledging the relationality of gender and technology is therefore fundamental to assess the viability of MHC.

In this investigation I draw on existing studies of masculinity and male contraception to situate my proposed research agenda and address various gaps in scholarship. Firstly, little empirical research has looked at whether masculinity is directly associated with men's interest in using MHC (Lacasse, Jackson 2019; Peterson 2019). Secondly, little is known about British or European heterosexual men's approaches to contraception;

[1] WH Courtenay (2000) explored constructions of masculinity and their influence on men's health behaviours. The study used Raewyn Connell's (1995) typology of masculinity to conclude that regardless of educational or socioeconomic background, participants' behaviours were predominantly dependent on their adherence to masculine ideals. This is an interesting dynamic to observe within my research and reinforces the need for effective marketing and health education for MHC as a technology.

[2] Techno-social relationships have been theorised by sociologists such as Bruno Latour (1991), revealing the heterogenous assemblages between non/human entities.

the majority of studies on MHC have been based in the United States over the past 20 years and focus on the 15–19 age bracket (Hamm et al. 2019; Wilson 2018). Finally, social studies of MHC have been predominantly quantitative; most existing research has attempted to correlate socioeconomic indicators such as education level or income with men's willingness to adopt MHC. Whilst it is important to understand social patterns statistically, the reality and nuances of this technology's assimilation are more complex.

This research locates itself within contemporary discussions of masculine identities and explorations of hybrid masculinities, in relation to contraceptive equality. A typology of three figures surfaced in my findings: the 'responsible, caring man', the 'lazy man', and the 'independent, heterosexual man'. These constructions should be understood as analytic tropes rather than as concrete descriptions of individual characters. They are not inflexible, permanent, or isolated. Rather, they are meant to depict the fluidity, conflict, and adaptability of masculinities in relation to MHC and of contraceptive equality more broadly. As stated by Nelly Oudshoorn (2003), assessing hypothetical representations of MHC users is a vital, yet rarely deployed tool used by pharmaceutical or public health industry players. Developing an understanding of the performative tropes which emerge in response to MHC may elucidate and help mitigate the social barriers to its assimilation.

Literature review and theoretical framework

Judith Butler's (1988) concept of gender performativity is fundamental to the theoretical foundation of this investigation. For Butler (1993: 521), gender is enacted and legitimised through ritualised action. She deploys the analogy of actor and script to describe how gendered subjects come into being through the 'recitation' of gender norms. In proposing that gender is a discursive formation that socially produces the sexed body, Butler emphasises corporeality: the body is not merely a 'factic materiality', it is a materiality that 'bears meaning'. This paper heavily relies on the social constructivist insight that gender is a practice, to discuss how masculine performativity, hence maleness itself, could be altered by MHC. My exploration also relies on theoretical and empirical contributions within critical studies of men and masculinities (CSMM). Masculinity refers to ideologies and belief systems that define 'what it means to be a man' within a particular culture (Lacasse, Jackson 2019: 1129). To theorise these ideologies in relation to the male reproductive body, I strongly draw upon the work of Raewyn Connell (1995), who acknowledges the plurality of the male identity. She produced a four-tier hierarchy of masculinity to demonstrate this: *hegemonic* (idealised forms of masculinity constituted by an exclusion of 'women, non-white, non-native-born and homosexuals' (Kimmel 1997: 64)), *complicit*,

marginalised, and *subordinate* (masculinities that are excluded from the hegemonic 'circle of legitimacy' (Connell 2005: 10)). It is important to note that these categories are contextual. A masculinity may be hegemonic in one region or time period but marginal in another. Masculine identities can therefore only be deeply engaged with in the spatiotemporal contexts they are exhibited, and with intersectional power relations, through which race, class, sexuality, and nationality all shape its construction (Strong 2020).

The notion of hybrid masculinity is also fundamental to my analysis for conceptualising recent transformations in masculine identities. CSMM theorises the 'hybrid' man as representing the way men navigate modern masculinity by appropriating nonhegemonic practices. Tristan Bridges and C. J. Pascoe (2014: 246) render the hybrid identity as a 'selective incorporation of performances' typically associated with marginalised and subordinated tropes. What emerges from my own findings of interviewing men about MHC is a complex, hybridised masculinity; a masculinity which cares, which shows reproductive agency[3], and which advocates for contraceptive equality. Yet also a masculinity which looks to dominate, which preserves conventional gender roles, and which prioritises its own sexual pleasure. Scholarship on the hybrid man is split between those who regard 'him' as indicative of a new era of gendered identities (Anderson 2009) and those who simply see the emergent identity as another cultural or temporal variation of hegemonic masculinity (Connell, Messerschmidt 2005; Demetriou 2001). Supporting the latter argument, Michael Messner (1993: 725) notes that although 'softer' and more 'sensitive' styles of masculinity are developing in certain social groups, 'this does not necessarily contribute to the emancipation of women; in fact, quite the contrary may be true'.[4] The theoretical debate over masculine hybridity is significant to my research as it concretely emerges in my interview responses. Participants' nominally *progressive* statements about contraceptive responsibility are frequently embedded in comparatively *regressive* and essentialist ideologies surrounding gender roles.

Technology is an extremely significant site of gender negotiations. Contraceptive technology is no exception. Cynthia Cockburn (1992) stresses that gender and technology are co-constructed and claims that, due to historical associations of masculinity with scientific innovation and power, one cannot be fully understood without reference to the other. Thomas Hughes' (1986) composite, non-hyphenated

[3] Note this paper's nuance between reproductive agency and reproductive responsibility. The notion of agency here describes one's capacity to be in control of actions and their consequences. Responsibility is the way in which this agency materialises. Responsibility is inextricably linked to agency, duty and accountability.

[4] Demetriou (2001) contends that what makes hegemonic masculinities so powerful is 'precisely their ability to adapt' (Bridges, Pascoe 2014: 249).

notion of *the sociotechnical* to identify the fusion between technology and society, reinforces this, as does the field of *somatechnics* in demonstrating the inextricable bond between the *soma*, (corporealities), and the *techné* (technologies and techniques through which bodily-being exists). By reminding us of the ways in which gender and embodiment are experienced 'through cultural and discursive technologies' (Randell-Moon 2012: 265), this research looks to understand the new sociotechnical networks which will need to be forged to manage the effects of MHC on masculine embodiment, subjectivity, and sociality.

The avoidance of femininity is another central dynamic underpinning MHC discourse. Anna Van Wersch et al. (2009: 175) revealed that the 'fear of losing connotations of masculinity' was the most predominant barrier expressed by men against using MHC in a US study, due to the feminine connotations of pill-based contraception. In a similar vein, Katherine Jones (2020) writes about the 'Men Too' movement in late twentieth-century Britain, a campaign that sought to legitimise men taking contraceptive responsibility by only printing the movement's logo on beer mats in sports bars and pubs. This affirmative demonstration of manhood 'via an avoidance of femininity' is a priority when analysing masculine identities and MHC (Peterson et al. 2019: 12). Peterson et al.'s (2019: 3) quantitative study of US men reinforces the reality that masculine performativity will play a central role in MHC acceptance. The authors outline three factors determining willingness to pursue MHC; (1) 'if the men believed that other men would too'; (2) 'if their image of a man who would use the contraception was positive'; (3) 'if they rated themselves as less concerned about avoiding effeminate behaviours'. Finally, Lacasse and Jackson (2019: 1128) found that men's belief in 'Power Over Women' and the level of importance associated with their 'Heterosexual Self-Presentation' were correlated with negative sentiments towards the prospect of MHC. Conversely, men who exhibited positive sentiments towards contraceptive technology cared less about such 'masculine norms'.

An intersectional lens illuminates broader structural factors shaping masculine identities and men's relationship with contraception (Crenshaw 1991). William Marsiglio (1993: 22) examined the socioeconomic factors that shape adolescents' attitudes towards contraception use and gender roles across the United States. In the study, lower-class young men often communicated being 'pleased' with unplanned pregnancies, something the authors concluded was due to procreative prowess being strongly equated with 'feeling like a real man'. Layte et al. (2006: 477) provide complementary evidence that less privileged social backgrounds are associated with 'lower likelihoods of using or discussing contraception'. Further studies have suggested that young men who have stronger traditional attitudes about male gender roles are more likely to define their masculinity in terms of sexual promiscuity

and regard contraception as a female responsibility (Hamm et al. 2019). Sociological research on US and European men has demonstrated a positive correlation between age and a lack of willingness to engage in discussions concerning contraceptive methods with sexual partners as a result of habit and stigma (Oudshoorn 2003). Within these intersectional theorisations, the role of religion is also frequently documented as an identity axis that intensifies biologically determinist beliefs.[5] Of further interest to this study is that strong religious beliefs are often associated with adherence to conventional gender roles. Finally, the stereotypically positive correlation between higher income, education, and MHC acceptability (Heinemann et al. 2005) has been nuanced in explorations of US college men who equate 'fun' with casual, unprotected sexual encounters (Hamilton, Armstrong 2009). Privileging associations of whiteness with lower accountability is evident in studies of white college men, who have less regard for the reputational consequences of unsafe or harmful sexual encounters (Wade 2017). This effect is counteracted by age, as Stefanie Mollborn (2017) has found that US university graduates avoid pregnancy for as long as possible to maintain their alignment with expected societal goals, such as career mobility and marriage. These studies all demonstrate the importance of intersectionality to masculine identities and contraception. Referencing Connell, we are reminded that masculinities emerge at the intersection of many other identities which should not be considered in isolation.

Methodology

According to Van Wersch (2009: 6), qualitative research into male contraceptive technologies is 'necessary', as number-driven conclusions often negate contextually or individually-nuanced factors. I decided that my findings would be best presented and interpreted through a qualitative methodology because of the sensitive and exploratory nature of sexual behaviours, identity, and men's sense of self.

I deployed semi-structured interviews as the predominant research method because of its ability to narrow the conversational focus with predetermined question themes whilst maintaining flexibility for the conversation to expand into unanticipated areas (Edwards and Holland, 2013). Eight respondents were selected from my friendship network for my research sample. The existing rapport between myself and the participants facilitated a sense of trust, particularly in relation to intimate questions. The benefits of friendship as a method has been promoted by Lisa Tillmann-Healy (2003),

[5] Not using contraception was frequently supported by the argument that procreation is a miracle outside of human control; a view that researchers have referred to as 'religiously-oriented fatalism' (Hamm et al. 2019: 10).

who writes that prior relationships between respondents and researchers cultivate an environment of openness and minimise a sense of hierarchy. Gender and sexuality were excluding factors for participation: I chose to interview only individuals who identify as men and who engage in heterosexual intimate behaviours. This was done to maintain a tight focus on male identities, and because contraceptive technologies apply to individuals with reproductive capabilities. The ages of the respondents ranged between 20 and 24 years and the nationalities included Chinese, Turkish, and white British, Spanish, French, and Eastern European. Relationship statuses varied between single and short-, medium-, and long-term relationships. All participants are London residents, university-educated, and either completing their education or employed in a highly-skilled sector. The constraints on my research caused by the COVID-19 pandemic prevented me from accounting for wider demographic and cultural factors that may also interact with MHC. Future investigations should therefore be conducted across other axes of identity, such as geography and socioeconomic background, whilst preserving the depth offered by a qualitative approach.

Participants were instructed to assume the administration method of the technology-in-question would be an oral pill. This was to ensure they were considering the same technological object. Gender practices are tightly bound up with features of *particular* technologies; therefore, it is important to isolate what masculinities are specifically associated with the pill given its feminine connotations. The interview questions covered contraceptive awareness, personal sexual behaviours, gender norms, and reproductive agency. The interviews (40–70 minutes long) were conducted one-on-one and in person to further strengthen the reliability of the answers. (Silje Lundgren [2013] emphasises how homosocial competition between male participants in groups can produce exaggerated answers, embarrassment, and mockery). Additionally, I made a conscious choice not to mention the word 'masculinity' in interviews, as this could affect participants' responses. The impact that certain words can have on the 'dialogic constitution of meaning' is intensified in cross-gender research (Galam 2015: 16). My vocabulary was therefore adapted and disarmed to maintain answer validity. Interview recordings were transcribed verbatim with the aid of *Otter.ai* software, which offered an automated frequency analysis of words and synonyms. Quantifying my qualitative research codes was useful when analysing the motifs raised by the respondents.

My research was conducted within a constructivist framework. This approach provides me with the capacity to engage with contraceptive technologies as realities 'created in practice' rather than 'rooted in nature' (Kole 1999: 27). What I mean by this is that MHC is not emancipatory by nature, nor inherently oppressive; it is a relational technology *inscripted* with different cultural meanings by different actors in different contexts (Oudshoorn 2003). I chose to deploy thematic coding for

my analysis as it best suits the aim of the research. Immy Holloway and Les Todres (2003: 15) stress its strength when searching for 'repeated patterns of meaning' across a data set. The technique allowed me to extract the three analytical tropes from the dataset. Anselm Strauss and Juliet Corbin (1998) guided my data coding process by recommending the generation of initial open codes, which I then aligned to a hierarchical coding scheme. I supplemented my open coding with axial coding at this stage of the analysis, which entailed looking at how key themes associate with other subthemes. This method allowed me to understand how the three identified analytic themes interact, complement, or conflict with each other. I was aware of the need to maintain the coherence of the data *within* as well as *between* these themes. To deepen my analysis, I moved beyond the surface-level semantic style of analysis and adopted a latent coding approach to examine the 'underlying ideas, assumptions, conceptualisations and ideologies' of the responses (Braun, Clarke 2006: 13). The coding process of my methodology was cyclical and required a recursive reviewing and refining of my evaluations.

In qualitative research, it is fundamental to consider one's positionality prior to, during, and after fieldwork, to continually reflect on internal biases in the collection and interpretation of data. As a cisgender woman investigating men, I recognise the epistemological and methodological hurdles involved in conducting cross-gender research.[6] Part of the research process was seeking to gain *insiderness* with male participants: a notion in line with the 'insider, outsider' dichotomy often expressed in qualitative cross-cultural research (Dwyer, Buckle 2009). Prior friendship and mindful use of 'non-threatening' language enabled this insiderness (Lefkowich 2019: 4). Moreover, a fundamental challenge of this research is the fact that I am writing about a technology that has not yet come to market. However, producing this research prior to the technology's release is necessary to fulfil my objective of assessing the MHC's cultural feasibility. By developing an understanding of what social barriers stand in the way of its widespread adoption, this paper looks to offer insight into strategies for effectively assimilating MHC.

Ethics-informed considerations were prioritised for the integrity of the research. Interviews were voluntary, conducted with full disclosure of the research aim, and were consensually recorded. Respondents were reminded of their right to withdraw at any point and were guaranteed anonymity with pseudonyms.

[6] My self-reflexivity is strongly influenced by Maya Lefkowich (2019: 1), who emphasises the need for female researchers to produce 'meaningful, credible and safe' research with men.

Findings and analysis

The 'responsible, caring man'

The 'responsible man' is an archetypal identity that underlay many interview responses. MHC has increasingly become framed within a rhetoric of shared reproductive responsibility – '*men as partners*' (Oudshoorn 2003: 235). Studies have demonstrated that this rhetoric appeals most strongly to men who are younger and more educated, have higher incomes, and have a high awareness of female contraceptive methods (Heinemann et al. 2005; Weinstein, Goebel 1979). The 'responsible man' who shares the risks of sex and is aware of his own reproductive capacity has therefore quickly become a target for MHC pharmaceutical players. Whilst there are many areas of overlap between the 'responsible man' and 'caring man' identities, a key distinction lies in their motivation to pursue MHC. The caring identity prioritises the health and safety of his partner, whilst the responsible agent typically prioritises his own reputation and finances. Both typologies, however, indicate an emerging hybrid masculinity that diverges from the conventional hegemonic image of careless sexual prowess. Responding to aforementioned critiques, we remember that this hybridity is simply another temporal variant of masculinity, and not something fundametally novel. In my own findings, although 100% of the male participants claimed that contraceptive responsibility should be equally shared, their accounts reflected an unequal division of contraceptive labour. Inspired by Arlie Hochschild's (2003) notion of 'emotional labour', I introduce my own notion of *contraceptive labour* to describe the sacrifices and commitments made by women who are in charge of contraception. The term encompasses time invested into researching contraceptive methods, the consumption, insertion, or renewal of said contraception, organising doctor check-ups, the financial costs, and the physical and emotional toll of side effects. Across the respondents, there tended to be a gap between the *intended* contribution to contraceptive labour and the *actual* contribution:

> *Interviewer: Who is responsible for contraception; you or your partner?*
> *Respondent: Definitely both. It should always be a 50/50 split… I'm in charge of the male side of things, and she's in charge of the female side of things.*
> *Interviewer: What entails the 'male side of things'?*
> *Respondent: Well … nothing currently, to be honest, because she's on the pill. So it's been pretty easy for me.* (Marcel, 24, medium-term relationship)[7]

[7] Participant age and relationship statuses are identified to assist the reader's contextualisation and interpretation of opinions.

Whilst Marcel believes that he is equally responsible for contraception, he admits to not taking any responsibility. In the context of contraceptive responsibility, Fiona Socolow (2019: 33) writes that 'intention does not equal behaviour'. The 'commonly observed discrepancy' between principle and action is inadvertently addressed by Spencer:

> *Before Tina [partner] went on the pill, we spoke about how it would affect her body. But doing that doesn't mean you're sharing the responsibility. It just means that there is a conversation regarding responsibility, which I guess is a good first step.* (Spencer, 22, single)

This statement evokes Jones' belief that the term 'shared responsibility' in contraception is a meaningless 'buzzword' (2020: 44). Jones writes that whilst the aforementioned 'Men Too' campaign attempted to 'reimagine masculinity' by idealising emotional expression and shared accountability, there has been little material change in this field, predominantly due to the absence of MHC. On this basis, I illuminate the potential of MHC to create new meanings of gender and bodies by providing men with access to participate in contraceptive labour.

Most participants of this study claimed to have 'high' reproductive agency. However, responses as to whether this trait was *masculine* varied widely:

> *I don't think having high reproductive agency is manly. Football players and rappers who are looked up to don't set a good image. And that sets a precedent. Men are swayed by what their role models do, and you don't hear Jay-Z singing about safe sex.* (Arthur, 22, short-term relationship)

Arthur's comment depicts a reliance on other men's opinions to inform a position on MHC. We are reminded here of Peterson et al.'s (2019) study outlining that men would be more willing to pursue MHC 'if men believed that other men would too'. Particularly in the age of social media, where culturally-situated ideas about what constitutes masculinity are publicised, there is increasing pressure to perform in certain way. A contrasting response for whether a high level of agency was considered to be masculine was expressed by Finley:

> *Responsibility is incredibly manly because it means you're responsible for actively choosing when to be a dad. And I think being a dad is probably the manliest thing you can do.* (Finley, 21, long-term relationship)

Finley's description of reproductive responsibility as '*manly*' on the basis that fatherhood becomes an '*active*' decision, complements the independent and

heterosexual identities of masculinity that are defined by freedom of choice and procreative prowess. This said, the versions of masculinity that prioritise these traits are not universal. Men performing sexually *without* being fertile also conflict with the hegemonic desires to delegate contraceptive responsibility to women and safeguard the reproductive capacity of the male body. Jennifer Randles (2018) has coined the term 'hybrid fatherhood' to describe this discursive reconfiguration of masculine identities around paternal obligation. Nonetheless, with fewer young men in urban spaces seeking to have children in their twenties and thirties for professional and financial reasons, an emphasis on reproductive responsibility could be a significant point of entry for MHC marketability.

Strategically deployed by the pharmaceutical industry, the 'caring man' narrative has underpinned MHC trial advertisements since the 1960s to appeal to men and women wanting to distance themselves from hegemonic associations (Oudshoorn 2003; Ringheim 1996). Expressions of sympathy, selflessness, and compassion conflict with conventional representations of emotionally-detached performances of masculine sexuality. In my findings, the caring identity surfaced through the respondents' motivation to take MHC in order to alleviate the burden on female partners:

> *If it would make a partner feel more comfortable, then I would take it for her. I wouldn't be willing to do it for a stranger, though.* (Spencer)

The pervasiveness of care in my findings as a motive for taking MHC is unsurprisingly supported by quantitative studies suggesting that men in relationships are more open to using contraceptive technology (Eberhardt et al. 2009). A similar dynamic was reinforced by Arthur:

> *Taking the bullet for your partner as a loving gesture is really powerful. I'd have huge respect for someone doing that. Real masculinity in the modern day is more about treating someone well.* (Arthur)

Arthur's answer offers many significant insights. His '*respect*' for men who care for their partner exemplifies a renegotiation of traditional hegemony – from one that is individualist to one that values compassion. Moreover, rather than explicitly distancing himself from the typified hegemonic masculine traits, he looked to associate himself with his own definition of '*real masculinity*' to justify his nonhegemonic position. This is meaningful for my research as it reasserts the potential that MHC has to redefine gendered identities. However, I recognise that whilst well-intentioned,

this renegotiation is not entirely devoid of hegemonic ideology.[8] Arthur's mention of '*real masculinity*' necessarily implies a 'non-real' masculinity against which it is defined. Whilst normative constraints of what constitutes masculinity are shifting, this comment indicates how these shifts are still able to sustain systems of inequality and existing ideologies of what constitutes manlihood. Arthur's claim that taking MHC for one's partner is '*powerful*', comparing the act to '*taking a bullet*', is therefore noteworthy. These language choices are significant because they inject projections of strength and force into a statement premised on nonhegemonic associations of care. Protective imagery arose in other interviews:

> *If [MHC] existed for me to take, I wouldn't hesitate. Monica [partner] was scared because her aunt died of a blood clot [from the pill]. If [MHC] was available for me, I would have taken the hit for us before Monica got her IUD.* (Finley)

> *Girls would love it if I took [MHC]. They'd think 'wow, this guy is saving me from all the painful side effects'. I'd be like a pill-popping hero! If I were a girl, I'd find that attractive.* (Jamal, 22, single)

Finley's willingness to '*take the hit*' and Jamal's perception of being a '*hero*' and '*saving*' women from taking the contraceptive pill echo Arthur's desire to establish a masculine position of strength through *care*. Douglas Holt and Craig Thompson (2004: 425) explain how in light of women gaining more sexual and socioeconomic independence, men have sought to symbolically reaffirm their manhood and protector status through material 'props' (e.g. tool kits), a phenomenon the authors call 'the pursuit of heroic masculinity in everyday consumption'. I regard this idea as an interesting way of interpreting the symbolic value of MHC and understanding what the use of MHC could mean for the performance of masculinity. It also struck me that Jamal did not problematise his self-identification with femininity; he even positions himself *as* the female to support his claim: '*if I were a girl*'. Steven Arxer (2011) depicts an analogous practice: he illuminates men's adoption of feminine identifications, yet their simultaneous maintenance of dominance. In one instance, the men Arxer observed recognised the strategic value of demonstrating care and emotional sensitivity and used this to attain greater sexual interest from women. In a similar vein, the instrumental value of care is echoed in Jamal's belief that taking MHC would be considered '*attractive*' for girls and as something that could support his sexual prowess – an aspect of conventional masculinity which is intensified by

[8] The concept of hegemonic ideology reminds us that hegemony, by definition, is a process that operates through the transfer of a dominant ideology.

his single status. The work of Hirose and Pih is instructive here (2010: 202), as they reinforce how 'feminised elements [of behaviour] can work as a type of cultural capital for hegemonic masculinity'.

Furthermore, non-altruistic components, such as expectations of reciprocity or material gain, also surfaced from the motive of *care* in men's willingness to take MHC:

> *I'd take it to help her… if she really genuinely appreciated the physical sacrifices I'd be making for her.* (Dmitri)

> *As well as the burden I would be alleviating off Sara [partner] there would have to be tangible material benefits for me. If [MHC] isn't cheaper or has less side effects than the female pill, then it's a no go.* (Marcel)

These responses present a conditionality that undermines the rhetoric of protection and care. The level of appreciation expected from the female partner demonstrates the asymmetrical power dynamics present in the masculine sexual script and reminds us how selective the incorporation of marginalised and subordinate masculine characteristics can be. My findings of the 'caring, responsible man' contradict Lacasse and Jackson (2019: 1128), who write in their study that men's positive sentiments towards MHC are wholly 'unrelated to masculine norms'. My analysis suggests that men's acceptance of MHC is *extremely* contingent upon masculine norms – the norms are just *different* from the conventional hegemony Lacasse and Jackson were writing about. As indicated by Hirose and Pih (2010), masculine hegemony remains an ongoing symbolic and material process of construction. The way such hegemony materialises is contingent upon the spatiotemporal resources available to preserve it. Whilst indications of hybrid masculinity through care signal a shift in the hegemonic identity, this shift may also appropriate alternative masculinities as means to reproduce existing gendered systems of power and privilege.

The 'lazy man'

The belief that female bodies are closer to nature and should therefore serve as passive sites of contraceptive intervention has been encouraged throughout history. Biological determinists continue to frame male contraception as being 'against nature', since it overturns women's naturally ordained role (Laird 1994). This essentialism has been used to justify the delay in MHC development according to Oudshoorn (2003: 8), who challenges whether the technology's absence is truly down to 'male *bodies*' or 'male *bias*'. However, in the present day, this essentialism takes a different form. The narrative underlying the MHC delay has shifted from a biological one to a behavioural one. Men as future users of MHC are associated with unreliability, inattentiveness, and

untrustworthiness. The image of the 'lazy man' persists and weakens the legitimacy of MHC. This was evidenced in response to the interview question '*what do you think an obstacle will be for MHC assimilation?*'

> *Laziness! No question. It will be difficult for a lot of men to realise the duty is now on them. If there were a pill which meant you were 'good to go' for the next 72 hours, it would be much more popular… but scientists haven't gotten that far.* (Finley)

> *Looking at myself and my friends, I think laziness. And laziness gets stronger with age… Men have been relying on women for forever, so a lot will see popping [ingesting] something daily as an unreasonable effort.* (Spencer)

Finley and Spencer illuminate laziness as a key barrier for widespread MHC adoption. Spencer also introduces the signifance of age as a factor for MHC uptake, which aligns with US studies correlating a decline in MHC acceptability with older age; a pattern tightly linked to traditional perceptions of gender norms (Okigbo et al. 2018). Hamm et al. (2019: 11) also acknowledge the prevalence of laziness in relation to men's dissatisfaction with male contraception options: condoms are largely considered disruptive and vasectomies are expensive. Interestingly, the authors stress that men appear to 'use' this dissatisfaction 'to *avoid* responsibility for contraception'. Since contraception has so integrally been aligned with femininity, the authors suggest that men rely on the expectation that this will continue. I recognise the strategic deployment of the 'lazy man' image in my own findings. Considering that all the participants are independently living in London and are either employed in highly-skilled jobs or finishing higher education, the use of self-deprecatory language when questioned about pursuing MHC seemed theatrical:

> *It's much too proactive for me... I'm so silly and forgetful. I know I would just forget [to take MHC] and be so dumb about it.* (Finley)

> *Not sure if I'd take it because I'd be all over the place and Miranda [partner] is so organised. I'm so not.* (Oscar, 24, short-term relationship)

> *It would be a huge chore, you know. I can't imagine having to think about something that important every day. It's too much thought; too big a risk.* (Dmitri, 24, single)

The extent of self-doubt in the interview responses surprised me, as it seemed inconsistent with participants' expressions of control, intelligence, and awareness throughout the interviews. Whilst at first glance these responses appear to contradict hegemonic masculinity, on closer examination they may not. In western portrayals, men are frequently cast as being more active, capable, assertive, and creative than women; yet, it is also more culturally sanctioned for them to be impractical, careless, and child-like (the corollary of which may be unreliability in interpersonal relationships). Under this conception, men are ill-suited to care work and perceived as better-suited to more individualistic forms of achievement. Conversely, women who are careful, prudent, and patient are denied these more dynamic traits and considered better-suited to under-valued, unprestigious forms of labour. This dichtomony reinforces the behavioural essentialism in justifications of existing gender relations, particularly in the division of labour. Oudshoorn (2003: 203) claims that the depiction of future MHC users as unreliable 'simultaneously *reproduces* and *contests*' hegemonic cultural representations of masculinity. Whilst unreliability is a character weakness not admitted by men in professional contexts, it corresponds to the hegemonic view of masculinity that emphasises men's 'disinterest' in contraception matters. The 'lazy man' image therefore legitimises the contraception domain as female, both directly and indirectly.

The participants' self-removal from contraceptive labour mirrors Ashcraft's (2020) concept of 'domestic dodging'. I draw upon the contributions of Cristen Dalessandro et al. (2019) to further this understanding. Their investigation assesses the 'strategic silence' of US college men in suggesting or providing contraception during one-time sexual encounters with women. The research concludes that men's silence and self-depiction of being lazy, forgetful, and unreliable is *tactical,* in that it subtly, and conveniently, enables men to pursue condom-free sex by placing the onus of pregnancy and STI prevention entirely on women. Dalessandro et al.'s concept of strategic silence adds insight to my findings, as well as to broader theorisations of masculinities, by revealing the manner in which men may use a contraceptive reliance on women as a demonstration of power in intimacy. Butler's notion of performativity is strongly drawn upon here to remind us how different identities of masculinity can be deployed deliberately.

Further shaping the 'lazy man' construction were fatalist accounts of why certain participants would not take the MHC. Reluctance was largely blamed on women's monopoly over fertility control and the historical limitations in male contraceptive technologies:

> *It's too late. If something had been invented decades ago for us [men] then there would be a fair chance of contraception gender roles being less concrete. But we're too far gone for any male pill to be fully integrated into society now.* (Arthur)

Taking the pill is just part of being female but it would be an active effort for us. We [men] haven't had something invented for ages, and now that something pops up we suddenly have to take it? (Oscar)

Arthur's and Oscar's responses spotlight how women have historically been the focus of pharmaceutical contraceptive development, which has limited men from taking up a proactive role (Campo-Englestein 2011). The health industry and media campaigns perpetuate this sense of male laziness in relation to contraception with 'health messages' stating that men are both 'incapable of change' and 'passive victims swayed by forces beyond their control' (Wilson 2018: 259). We see here the curious contradiction between agency and passivity that recurs in constructions of masculinity. As much as MHC could be considered culturally infeasible for being *too active* for men, MHC marketing could also capitalise upon the lazy identity by pitching it as an easier option compared to condoms and withdrawal.

Women also play a distinct role in the essentialist arguments present in male contraceptive discourse. Actual or anticipated endorsement from female partners is crucial to MHC's cultural feasibility. This was evidenced in participants' interview responses such as '*No way would Phoebe* [partner] *trust me*', '*Sophie* [partner] *doesn't believe I'd take it everyday*'. These reactions complement Susan Walker's (2011: 2) study, which concluded that 42% of male and female respondents said that men would be '*incapable*' of taking the male pill. Attributing laziness and unreliability to the essence of the reproductive man works against the numerous efforts of men who do feel that contraceptive labour should be equal. The pressure to conform to conventional gendered behaviours and reputations has been shown to discourage 'full involvement' in contraceptive labour (Van Wersch et al. 2009: 1129). The 'lazy man' identity highlights how the cultural acceptability of MHC will depend upon both men and women mutually adjusting certain gendered identities. MHC uptake will demand a culture that looks beyond essentialist conceptualisations of masculinity.

The 'independent, heterosexual man'

Through a frequency analysis of interview codes, '*independence*' and '*control*' emerged as dominant motives across all participants. This finding demonstrates the importance of independence and power in relation to MHC and masculinity. In response to the question '*why would someone take MHC?*', Pedro replied:

I imagine many guys would feel empowered by taking it. Taking it makes you in charge of your own body and actions. (Pedro, 22, long-term relationship)

Pedro's mention of '*empowerment*' here is significant. Drawing upon Naila Kabeer's (2001) tripartite conceptualisation,[9] empowerment is theorised as a relative term that necessarily implies prior *dis*empowerment. Pedro's statement can be interpreted as an indication that certain men may feel powerless as a result of the current contraceptive asymmetry between men and women. This perception positions MHC as a tool through which men can reclaim their autonomy. In a similar vein, Lisa Campo-Engelstein (2011) suggests that limited contraceptive options and men's subsequent dependence on female partners can leave them feeling emasculated. As well as reaffirming the relationality between gender and technology, this theme of power and control allows us to conceptualise the impact that an absence (or future presence) of MHC has on masculine performativity. The motif of independence took many forms throughout the interviews including reclaiming control, financial risk protection, a desire to pioneer, and a sense of freedom:

> *There is a huge attraction to being careless and free, as a guy. [MHC] would cut any sense of dependence on girls, which a lot of men want to seem macho and independent.* (Dmitri)

Dmitri's response echoes the point that hegemonic masculinity is 'overwhelmingly defined' as an attempt to distance oneself from anything feminine (McCreary 1994: 517). Oudshoorn (2003: 15) explains that this rejection of the feminine underpins contraception's 'exclusion' from the hegemonic identity. The image of the 'independent man' therefore emerges as a complementary means to facilitate this distancing.

> *I like the idea of being in total control. I like knowing that I won't be taken for a ride by someone who wants a baby and paternity cash. I'd feel secure knowing I was totally covered.* (Oscar)

Oscar's desire to have '*total control*' contributes to the 'independent man' typology and lends weight to Amanda Wilson's (2018) contention that the male pill should be framed within a context of power in order to appeal to the majority of men. What I also found interesting was that among the six out of eight participants who mentioned managing risk exposure, five framed it within a context of monetary cost. From both Arthur's and Oscar's comments, we recognise that to neutralise MHC's feminine connotations, male contraceptive technology should be perceived as something which *frees* men from reliance on women, unwanted pregnancies, and the financial obligation of unwanted children. Across the participant group, MHC uptake

[9] Empowerment is a process that concerns resources, agency, and achievements.

appeared to depend on whether the individuals subscribed to masculinities predicated on autonomy *without* responsibility (as women take up burden of contraception for them), or autonomy that entails *greater* responsibility (men who see autonomy and responsibility as inter-linked). A similar rhetoric of independence and power has been used in the commercial marketing of 'Viagra'™. Even today, 'Viagra'™ advertisements deploy the modernist rhetoric that the drug provides men with the capacity to reclaim their masculine sexual power and be in control of their bodies. Oudshoorn (2003: 236) explains how, generally, a lot more effort is invested in managing male sensitivities and preserving their sense of strength 'to avoid making men feel embarrassed, insecure or stupid'. This reinforces the idea that the future viability of any male contraceptive technology will heavily depend on marketing strategies that pay heed to these sensitivities.

My findings also reveal that MHC assimilation will rely on cultural representations of masculinity that signify its male users as independent, brave, and pioneering subjects. I draw upon Cockburn (1992), who insists that technology, hegemonic masculinity, and industrial capitalism are all 'linked symbolically' by 'themes of control and domination' (Lohan, Faulker 2004: 322), a contention that underpins Judy Wajcman's (2000) reference to new technology as a 'masculinised culture'. In line with these theorisations, interview responses included words and phrases such as '*bravery*', '*revolutionary*', '*being part of something new*', '*heroic effort*', and '*leading the herd*', all of which indicate the appeal of the perceived pioneering independence:

> *I'd be scared of side effects… but… I could tell my grandchildren that I was one of the first people to ever take it [MHC]. By that time, it will be as common as paracetamol. First man on the moon, versus first man on the pill.* (Spencer)

Spencer's response indicates a negotiation between current and new identities of masculinity that may emerge from MHC. Comparing his future-user-self to the '*first man on the moon*' reiterates the enduring connections between hegemonic forms of masculinity and revolutionary technology.[10] Spencer's pride to represent a pioneer in the contraceptive field further exemplifies this. However, the image of the 'independent man' is in tension with his apprehension of the technology's potential 'side effects', a nonhegemonic indication of fear or worry. To this end, whilst MHC assimilation will indeed rely on cultural representations of masculine control and bravery for marketable purposes, Spencer's expression of caution reinforces that the masculinities produced for and by the technology will emerge as complex, multiple, and fluid.

[10] Space metaphors by MHC trial participants have frequently been documented in other studies. See 'Astronauts in the Sperm World' (Oudshoorn 2004).

Furthermore, heterosexuality and female conquest are 'irrevocably tied' to hegemonic performativity (Kimmel 2003: 58). Hegemonic performativity is a concept which combines Connell's framework of masculine hierarchy and Butler's approach to gender. This practice-based theorisation demonstrates the centricity of public performance to masculine identities: we understand that masculinities are homosocial experiences 'performed for' and 'judged by' other men (Kimmel 2008: 47). The one-to-one interview settings restricted my ability to assess homosocial group dynamics. Nonetheless, I observed that the participants displayed a strong consciousness of what taking the MHC would look like to other men during our conversations:

I am definitely open to taking it… but would I tell my guy-friends about it? Probably not. (Arthur)

I would worry about the stigma associated with it… I'd be opening myself up to even more jokes from mates. (Jamal)

Both responses expose the social pressures tied to performing masculinity in a certain way, a reality which underpins Michael Kimmel's (2008: 66) claim that 'the stakes of perceived sissydom [for men] are enormous'. Jamal's mention of stigma is also important. Bethany Johnson (2018) claims that men are more likely to internalise public stigma relative to the contextual critera which define manliness. Avoiding public stigma is important for gaining a sense of belonging, which cannot be extended to 'those who fail to perform the illusion of gender' (Butler 1988: 522). The heterosexual performance was also indicated through sexual prowess which surfaced as a motif in interview responses:

Taking a pill like that would be a total flex. It literally means 'I can have sex right now'. I mean – that's cool. (Oscar)

Remember when boys were 'cool' if they had condom rings imprinted into their wallets at school? Even though they were virgins. In the same way, [MHC] will be a display of opportunity and sexual expertise. Even if it's just a bluff. (Finley)

Oscar and Finley portray a desire to conform to an image of masculinity that privileges sexual promiscuity. Cross-cultural studies have demonstrated the social value of sexual prowess to establish positions of masculinity (Silberschmidt 2001; Odimegwu et al. 2013). In these studies, having multiple sexual partners garners homosocial respect and admiration. And, as asserted by Finley, the 'masculine capital' obtained by this heterosexual performance is so significant that it is sometimes bluffed

(Peterson 2019: 13). Masculine capital was also presented as being obtained through physical appearance:

> *We live in a world where appearance matters a lot… guys flaunt their muscles and diets on Instagram. The type of physical side effects which come from [MHC] will hugely affect its popularity.* (Pedro)

> *Will [MHC] cause weight gain or acne? I wouldn't want that.* (Spencer)

An increasing focus on bodily aesthetics and exaggerated hypermasculine corporealities is characteristic of the emergent hybrid masculinity (Messner 2007). Pedro and Spencer reveal how men may become less accepting of MHC if the technology turns out to have negative physical side effects. In addition to a focus on public performances, the participants' consideration of physicality extended to private performances as well, including sexual virility and sperm production:

> *I wouldn't take it if a side effect was lower libido. Nothing is worth sacrificing my sex drive.* (Jamal)

The biological goal of MHC is to temporarily block or denature sperm cells. To achieve this, synthetic hormones and other steroid combinations are being developed to target men's testosterone levels,[11] which play an important function in libido and sperm production. In light of this knowledge, certain recipients demonstrated reluctance. Sperm production surfaced as a key point of discussion:

> *Would it stop my sperm production? I wouldn't want that at all. How emasculating to have zero swimmers [sperm cells].* (Oscar)

> *If I'd be shooting blanks, I don't want it.* (Arthur)

The conversations indicated that the respondents were concerned about the influence of MHC on their semen; a social emblem of masculinity. However, according to Wilson (2018), men often have little idea about the biology or health of their ejaculate and premise many of their perceptions on unrealistic pornographic performances. Arthur expresses his concern on this topic by emasculating the MHC through humour; '*shooting blanks*' is a colloquial term for when your semen does not contain sperm. His tone and disposition revealed a discomfort and embarrassment

[11] NHS.inform 2021.

when discussing the prospect of having less or impacted ejaculate. As the cultural significance of sperm on masculinity is more ideological than anything else, Wilson (2018: 260) maintains that the visible impact of MHC on semen should be considered 'a priority for clinical trials' in order to maximise cultural acceptance by independent, heterosexual users.

Conclusions and implications

This paper set out to explore what MHC may mean for the performance of masculinity. More specifically, I want to understand how contraceptive technology will contribute to the transformation and emergence of different masculine identities, and whether they will function to enhance or denounce its cultural feasibility. Through thematic analysis, this project revealed a typology of three analytic figures which surfaced in response to MHC: the 'responsible, caring man', the 'lazy man', and the 'independent, heterosexual man'. The ways in which these identities overlap, complement, and conflict each other indicate how masculinities are being negotiated in response to this new contraceptive frontier.

My conclusion is twofold. Firstly, the cultural feasibility of MHC in western contexts will simultaneously demand and induce the destabilisation of conventionalised gender performances. The 'lazy man' analysis is a strong example of an identity which *demands* such change. The dominant cultural narrative framing reproductive men as unreliable and uninterested in contraception is a huge impediment not only to MHC success but to gender equality as a whole. Confronting this identity entails looking beyond essentialist conceptualisations of masculinity and demanding accountability for sexually privileged and/or harmful behaviours. Conversely, the 'responsible, caring man' illustrations in relation to MHC signify the identities that will likely strengthen *in response to* MHC. My interviews revealed an emerging masculinity which looks to partake in the equalisation of contraceptive labour – albeit for different motives. Ranging from a desire to alleviate female partners' contraception side effects, to wanting increased protection over personal financial risk, there appeared to be recurrent displays of compassion, selflessness, and agency. The increasing relevance of these characteristics suggests a shift away from the typified hegemonic performativity that prioritises sexual prowess and should be strongly considered by MHC public health and marketing campaigns.

My second conclusion is that the masculinities emerging from this new frontier of contraception are complex, multiple, and fluid. Despite its capacity to transform contraceptive equality, my findings show that the technology may reinforce existing scripts of masculine performativity by offering a new site where hegemonic or hybrid performances can be enacted (Butler 1990). Hybrid masculinity emerges within this

analysis in response to MHC and is heavily critiqued by scholars who regard its appropriation of alternative identities as means to reproduce gendered systems of power. In particular, the 'independent, heterosexual man' narrative elucidated how MHC may preserve certain aspects of the hegemonic ideology by facilitating manipulative or individualist behaviours. As with all of the identities, however, there are many areas of overlap and conflict. The *independent* desire for '*control*' and '*power*' may support MHC's viability and beneficially reduce the *lazy* reliance on women, yet may also affect the *caring* motive to encourage the autonomy of women to make their own contraceptive decisions. In a similar vein, the technology's masculine appeal for '*pioneering*' and '*brave*' men may conflict with its unmasculine potential side effects of lower sex drive and sperm production – features indicated as significant to male heterosexual performance.

In light of my conclusions, I maintain that both MHC and the masculine identity require mutual adjustment moving forward. MHC's feasibility cannot solely be ascribed to biological efficacy, nor can it be exclusively reliant on social assimilation. New somatechnical networks will need to be forged to manage the effects that the technology may have on masculine and feminine embodiment, subjectivity, and sociality. Just as men's culturally-situated ideas about contraception and gender roles require disruption, the development of MHC itself – including its physical side effects, administration methods, and marketing strategies – will need to be spotlighted. This point was particularly evident in the 'independent, heterosexual man' analysis, where men's increasing focus on bodily aesthetics and sperm quality, combined with the feminine association of the pill, were central factors determining MHC use. For these reasons, Peterson et al. (2019: 29) call for more research to be made on identity construction to inform the viability of MHC. For them, located understandings of masculinities are 'fundamental' to 'future contraceptive public health policy'.

My theoretical and empirical findings reveal that social relations of technology are, in themselves, gendered relations. As such, the effective implementation of technology is crucial in shaping how these relations are reinforced or challenged by societies. It is clear that MHC in particular is a contested site of gender politics; the mere prospect of its commercial existence is enough to fuel polarised opinions on contraceptive labour and gender ideology. For this reason, I am fascinated by the space that MHC could create for identity negotiation. By offering such space and an ability to reconceptualise care, health, responsibility, or equality, MHC directly empowers its user because it provides an opportunity for men to perform masculinities *differently*. This, to me, is what makes MHC a meaningful technology, and one which has the potential to transform practices of gender and reproductive bodies in the future.

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Eleonore Lorijn obtained a Master of Science in 'Gender, Policy and Inequalities' with Distinction at the London School of Economics and Political Science (LSE). During her time at LSE she was awarded a Fellowship for her contributions to a co-authored Harvard-LSE paper on colonial legacies of African cities. Eleonore's interest in gender policy and research, particularly regarding reproductive health, was founded during her upbringing in the Middle East. Most recently Eleonore served as a United Nations UK Delegate to the 66th Commission on the Status of Women, 2022. Author can be contacted via genderteam@soc.cas.cz.