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Aimee Leidich April 20, 2011

Determinants of sexual and reproductive rights language: Catholic men's opinions about fertility control in Mexico

By

Aimee Leidich

Master of Public Health

Hubert Department of Global Health

Signature _____

Dr. Roger Rochat, M.D.

Committee Chair

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By: Aimee Leidich

B.A., University of Colorado at Boulder, 2006

Thesis Committee Chair: Dr. Roger Rochat, M.D.

An abstract of a thesis submitted to the Faculty of the
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Abstract

Determinants of sexual and reproductive rights language: Catholic men's opinions about fertility control in Mexico

By Aimee Leidich

Background Exercising sexual and reproductive rights (SRR) can be in conflict with Catholic doctrine, creating potential barriers to reproductive health access. The recent 2007 decriminalization of first trimester abortion in Mexico City was followed by sixteen states amending their constitution to define life as beginning at conception. The Mexican Constitution and ratified international human rights conventions guarantee Mexicans the right to self-determine the timing and spacing of their children however reproductive health policies along with public opinion jump between support for progress and Catholic tradition.

Objective This study identifies factors associated with support for SRR among Catholic men in Mexico. Based on prior research, this study hypothesizes that support for abortion is not independently associated with support for SRR whereas religiosity is inversely associated with support for SRR.

Methods I used a subset of 1,304 men from a nationally representative 2009 survey of 3,000 self-identified Mexican Catholics aged 18 and over. Using logistic regression, we measured relationships between the outcome of interest (support for the right to decide the number and spacing of one's children) and the independent primary variable of interest (support for abortion within 12 weeks gestation) while controlling for demographics, religiosity (frequency of Church practices), and opinions about fertility control and Catholic identity.

Results Most men in Mexico (80.1%) support SRR but only 38.2% support abortion in the first trimester. After adjusting for confounders, support for abortion was not independently associated with support for SRR [aOR1.02(0.73-1.43)]. In turn, those more likely to support SRR include those who believe EC should be available to everyone [aOR1.81(1.30-2.52)], believe sexed should teach all methods of contraception [aOR2.02(1.40-2.92)] and believe someone can continue being a good Catholic after using contraception [aOR1.96 (1.41-2.72)].

Discussion Among Mexican Catholic men, supportive views about fertility control as well as believing contraception does not affect Catholic status are associated with support for SRR. I infer that Mexican Catholic men do not associate SRR with abortion rights but do associate that right with other fertility control strategies because their role in contraception education and use is more direct than their role in abortion.

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Acknowledgements

I am forever grateful for the hard work, optimism, and kind words of Dr. Roger Rochat whose unending support has been the driver of not only this project but many other Rollins accomplishments. The GEMMA Fund vision of abortion as a social justice issue deserving of research and public attention motivated much of this work. I would also like to thank Roula AbiSamra, Ruth Dawson, and Maria Presley for their invaluable friendship and collaboration during our time in Mexico. Un montón de gracias to the Population Council Mexico City team and the rest of the Mexico National Pro-Choice Alliance who provided the inspiration and experience to make this project possible. A special thank you to Kate Wilson for providing edits and always making me feel like my hard work was important and to Pat Kilgo and Paul Weiss for making biostatistics exciting. I owe my deepest gratitude to my family and close friends for their never ending encouragement and company through the journey of life.

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Chapter 1: Introduction

Since the 1970s, Mexico has ratified Human Rights conventions as well as amended the Mexican constitution to guarantee couples the right to self-determine the timing and spacing of their children which in theory includes choosing abortion. Interventions, government policies and human judgments are rarely this inclusive in their perception of sexual and reproductive rights (SRR). In 2007, Mexico as a lay state legalized abortion during the first trimester in Mexico City. Following this legislation, Mexico as a Catholic state redefined life as starting at conception in 18 state constitutions thus further criminalizing the procedure. Many Mexicans identify as Catholic from a cultural standpoint however behaviors that occur behind closed doors are far from pious. Still, government policy more often than not reflects restrictive and often harmful sexual and reproductive health policy. This disconnect between private life and public policy not only perpetuates discriminatory reproductive health service provision but denies the right of men and women to responsibly enjoy their sexuality.

Many global studies assess the relationship between religiosity and sexual and reproductive health (SRH) behaviors among women. Fewer explore this relationship among men, and none investigate this relationship and its association to SRH attitudes or rights. An analysis of where Mexican Catholics stand on the issue of sexual and reproductive rights (SRR) are needed to determine which past and future SRH policies best represent the direct beliefs and actions of the public. Similarly, an analysis of support for rights can help to determine the effectiveness of rights language in garnering public support for abortion and other reproductive health issues. To provide evidence for SRR, this study seeks to analyze the factors associated with support for SRR among Catholic men in Mexico by asking the following questions:

- What factors are associated with Catholic men's support for SRR in Mexico?
- Is support for abortion among Mexican Catholic men independently associated with support for SRR?
- Does religiosity influence Catholic men's support for SRR?

Based on prior research, I hypothesize that support for abortion is not independently associated with support for SRR. Those who are more religious often hold less progressive SRH attitudes therefore I also hypothesize that religiosity is inversely associated with support for SRR while support for broader fertility control is positively associated as demonstrated in the conceptual framework (Figure 1).

Chapter 2: Comprehensive Review of the Literature

2.1 *Sexual and Reproductive Health and Religion*

Studies investigating the relationship between sexual behavior and religiosity generally show high religiosity to have a protective effect in delaying sexual debut and reducing the number of lifetime sexual partners. In contrast, high religiosity is also associated with poorer control of undesired fertility and STIs. Measurements of religiosity in these studies vary. Some differentiate between intrinsic (personal) religiosity and external (public) religiosity (Gold, Sheftel et al. 2010) (Roberts 2006) (Nonnemaker, McNeely et al. 2003) (Zaleski and Schiaffino 2000) whereas others summarize multiple dimensions of one's lifestyle to encompass the multidimensionality of religion (Miller and Gur 2002) (Lefkowitz, Gillen et al. 2004) (Faulkner 1966).

The use of intrinsic versus extrinsic religious motivation is derived from Allport and Ross's Religious Orientation Score which defines intrinsic religious motivation as "the degree to which religious attitudes and behavior proceed from a personal and internal locus and this represents a central motivating force in individual decision-making." In contrast, extrinsic religious motivation is defined as the "degree to which religion is pursued as the result of external social influences" (Holder, DuRant et al. 2000). From these definitions, religiosity is described as originating from within the individual as well as the outside influences of others. Extrinsic religious motivation was found to be more indicative of sexual conservatism when compared to intrinsic religious motivation in that those who have less of a spiritual connection and more of a practical connection to religion are more likely to follow conservative sexual norms. (Zaleski and Schiaffino 2000). When studying intrinsic and extrinsic religiosity in tandem, high intrinsic and extrinsic religiosity has a protective effect on individual sexual behaviors such as number of partners and age at sexual debut but

a harmful effect on intra-relationship behaviors that require communication such as contraception use and negotiating safer sex.

Among 231 Freshman at a US Catholic University, Zaleski et al. found that students with higher intrinsic and extrinsic religious affiliation were less likely to be sexually active (Zaleski and Schiaffino 2000). Similarly, in Gold et al's study of 572 American female adolescents aged 13-21, those with high religiosity (both intrinsic and extrinsic) were less likely to have had sexual intercourse (OR 0.23, CI95% 0.14-0.39) or to have had more than three lifetime sexual partners (OR 0.38, CI95% 0.21-0.68)(Gold, Sheftel et al. 2010). In contrast, Zaleski found that highly intrinsically and extrinsically religious individuals were less likely to negotiate condom use during sexual intercourse (Zaleski and Schiaffino 2000).

Other studies that categorize religiosity on more than two levels found similar results. Miller and Gur surveyed the sexual and religious behaviors of 3,356 adolescents across North Carolina using the following religiosity categories: personal devotion (personal connection to God); personal conservatism (rigid or literal adherence to creed of religious denomination); and institutional conservatism (fundamentalism of religious denomination) (Miller and Gur 2002). More inclusive, Lefkowitz assessed the association between sexual initiation and religiosity among 220 US University students measuring the following characteristics: identity (religious group affiliation), behavior (frequency of attendance), attitudes (importance of religion in daily life), perception (religion's negative sanctions against sexual behaviors) and practice (extent to which individuals adhere to their religion's sanctions against sexual behavior) (Lefkowitz, Gillen et al. 2004).

Among these studies with more inclusive religiosity measurements, Miller et al. found that personal religious devotion, frequent church attendance and institutional

conservatism were all associated with fewer sexual partners in the last year. By religious denomination, Lefkowitz found Catholics to have fewer lifetime partners than Protestants (Miller and Gur 2002; Lefkowitz, Gillen et al. 2004). On the down side, Miller et al. found personal religious conservatism to be associated with higher rates of unprotected intercourse and forced sex (Miller and Gur 2002). Compared to Protestant or Catholic young adults, Leifkowitz found non-religious young adults to be much more confident in their ability to talk to a partner about condom use (Lefkowitz, Gillen et al. 2004). Regardless of the scale used, all of these studies demonstrated an association between religiosity and sexual behavior with harmful outcomes being associated with actions requiring the cooperation of both parties.

While all of these studies investigated religiosity among Americans, it's possible religiosity in Mexico may not reflect similar associations. Two studies researched the relationship between religiosity (behaviors and self-reported importance of religion in life) and fertility of married Mexican-American women in Austin, TX and Los Angeles. The first study found religiosity to have less of an effect on fertility patterns among married Mexican-American women when compared to other Catholics in the US (Alvirez 1973). The second study found no significant change in mean number of children and religiosity among Mexican-American women reared in Mexico (Sabagh and Lopez 1980). Beyond these fertility studies, no research on religiosity and sexual and reproductive health in Mexico was found.

2.2 Sexual and Reproductive Health and Catholicism

Regionally, Latin America houses the largest proportion of Catholics in the world. In South and Central America, 87% and 85%, identify as Catholic, respectively. The next largest regional proportion of Catholics in the world is Europe with 40% (Catholics for a Free Choice 2004). In the most recent census (2000), 76.5% of the Mexican population self-identified as Catholic(Central Intelligence Agency 2008). This majority has declined from 89.7% in 1990 and 96.2% in 1970(Merrill and Miró 1996).

Related to SRH, Catholicism holds a staunchly pro-natalist view of sexual intercourse. In his 1968 Humanae Vitae, Pope John Paul VI made clear that the Catholic Church permits the rhythm method for pregnancy prevention but condemns all other forms of contraception ranging from withdrawal to sterilization as well as pregnancy termination under all circumstances (Pope John Paul VI 25 July 1968).

Despite this institutional denunciation, many Mexican Catholics decide for themselves how to conduct their reproductive lives. In a report by Catholics for a Free Choice that compared global Catholic opinion surveys about sexual and reproductive health, 91% of the 1,048 Mexican Catholics polled agreed that adults should have access to contraception, including the Pill, Depo-Provera, IUDs and condoms and 81% went as far as to support this access being expanded to include adolescents (Catholics for a Free Choice 2004). Similarly, the 2006 National Survey of Demographic Dynamics found that 66% of married Mexican women aged 15-44 were using a modern contraceptive method reflecting the individual secularization of Mexican society (CONAPO 2006; Kane 2008).

In the case of abortion, even though the procedure is largely illegal across Mexico, an estimated 875,000 women had an abortion in 2006, translating into a rate of 33 abortions per

1,000 women aged 15-44 (Juarez, Singh et al. 2008). As a comparison, in the US where abortion is legal the rate was 19.4 abortions per 1,000 women aged 15-44 in 2005 (Guttmacher Institute 2011).

The sad reality of abortion restrictions is that they rarely make the procedure less prevalent but instead make it less safe (Grimes, Benson et al. 2006). Due to a high rate of infections caused by untrained personnel using unsterile instruments and techniques, unsafe abortion accounts for 13% of maternal deaths (about 68,000 women) worldwide (Guttmacher Institute and WHO 2007). In countries where abortion is penalized, the abortion mortality rate is 330 deaths per 100,000 abortions, yet where it is legal that figure drops to less than one in 100,000 (Grimes, Benson et al. 2006). As a region, Latin American has some of the most restrictive abortion laws and more than 95% of abortions are performed under unsafe circumstances (Guttmacher Institute and WHO 2007). In Mexico in 2006 17% of women who had abortions were hospitalized compared to 0.3% in the US (Juarez, Singh et al. 2008).

To address the detriment of unsafe abortion, on April 24, 2007, the Mexico City Legislative Assembly decriminalized first-trimester abortions by redefining "abortion" in the Mexico City Penal Code as the termination of a pregnancy after twelve weeks gestation. Prior to twelve weeks gestation, women are now permitted by law to electively "interrupt" a pregnancy in federally funded hospitals within Mexico City limits. On August 28, 2008, this re-definition withstood a constitutional challenge before the Mexican Supreme Court and thus remains law (GIRE 2011). Between the publication of this ruling and November 2010, eighteen of Mexico's 31 states have enacted restrictive amendments which redefine human life as starting at conception thus further criminalizing abortion despite the negative health

implications (Figure 2, (GIRE 2011)). While the April 2007 ruling was a pro-choice victory in the capital, the resulting backlash in state amendments was largely a policy decision by religious conservative leaders citing the immorality of 'terminating a life.'

To explain the disconnect between government policy, public actions, and health, Bonnie Shepard uses "double discourse" theory which claims that the presence of the Church in Latin America pushes law makers to defend repressive public policies while at the same time, the public privately tolerates contradictory and often illegal mechanisms that expand personal choices related to sexuality (Shepard 2000). In Mexico, this dichotomy is seen in restrictive state amendments despite a high frequency of abortion. A qualitative study analyzing the opinions of eight decision makers in Mexico City concluded that six of the eight decision makers interviewed were in favor of further liberalization of abortion laws however this support was dependent on favorable public opinion(Van Dijk, Lara et al. 2007).

Many studies have been conducted to measure abortion opinion in Mexico, three of which use quantitative methods to measure support for abortion among health care workers and students (Carnevale, Lisker et al. 1998; Vilatela, Morales et al. 1999; Garcia, Lara et al. 2003) and four which quantitatively assess support among the general population (Nuñez-Fernandez, Shrader-Cox et al. 1994; Becker, Garcia et al. 2002; García, Tatum et al. 2004; Palermo, Wilson et al. 2010). The outcome among the latter group measured attitudes toward abortion under an array of hypothetical circumstances in which a woman may need an abortion. All studies demonstrate that 64 – 93% of Mexicans agree with abortion under at least one circumstance and as shown in table 1, support for abortion among the general Mexican population is much stronger among "no fault" abortion circumstances than "at-fault" circumstances.

I define "no-fault[1]" as circumstances under which the public does *not* hold the woman responsible for the circumstances leading to the abortion decision such as risk to the health or life of the woman, fetal abnormalities, etc. The average proportion of Mexicans who support no-fault abortion is 64.6% (Table 1). In contrast, I define "at- fault" abortion as circumstances under which the public *does* hold the woman responsible such as relationship status, contraception failure, financial restraints, etc. The average proportion of Mexicans who support at-fault abortion drops to 13.1%. While these definitions are not meant to concede that a woman is at fault for the pregnancy outcome under circumstances such as failed contraception, the term "no-fault" refers to "the prevailing sense" which in this case is the opinion of the general public. Interesting to note is the higher average support (36%) for abortion when it's the "woman's decision" even though in reality a woman's decision may be driven by "at-fault" circumstances. Referring to more specific circumstances may associate the woman's decision to terminate her pregnancy with irresponsibility and in turn blame therefore phrasing abortion indications more broadly appears to garner additional support (Yam, Dries Daffner et al. 2006).

Beyond abortion indications, these studies of the general Mexican population found the following factors to be associated with general public support for abortion: being male, having medium or high SES, infrequent or rare church attendance, higher education, younger age, Mexico City residence, and supporting Emergency Contraception (Nuñez-Fernandez, Shrader-Cox et al. 1994; Becker, Garcia et al. 2002; García, Tatum et al. 2004; Palermo, Wilson et al. 2010).

[1] Per Miriam-Webster: No-fault (adj) characterized by the absence of a prevailing sense of individual responsibility (as for behavior)

2.3 Sexual and Reproductive Health and Rights

Following the Mexican Revolution in 1917, President Benito Juarez amended the Federal Constitution to remove the legal status of religious organizations. This change barred all Church participation in public affairs and declared Mexico a secular state (Amuchastegui, Cruz et al. 2010). Despite this Constitutional ruling, political party as well as leader affiliation with the Church continues to foment restrictive SRH abortion policies.

The rapid growth of the Mexican population from 15 to 34 million between 1910 and 1960 forced changes in Mexican politics from pro-natalist post-revolution to anti-natalist in 1973 with the enactment of the General Law on Population (Zavala 1990). This law not only expanded family planning services but provided impetus for the fourth article of the Mexican Constitution which declares that: "Men and women are equal before the law. The law will protect the organization and development of the family. All persons have the right to decide in a free, responsible, and informed way on the number and spacing of their children[i]" thus guaranteeing both men and women to self-determined fertility control (República de México Constitución Federal de 1917 ; Alba 1982).

Following this amendment, the Institutional Revolutionary Party (PRI by its Spanish acronym) continued to promote democracy and in turn a mild separation of Church and state. During this time, Presidents Salinas and Zedillo signed the International Conference on Population Development in Cairo in 1994 and ratified the Convention on the Elimination of Discrimination Against Women (CEDAW) in 1981 (Amuchastegui, Cruz et al. 2010). The text of these conventions can be found in Appendix 1, all of which legitimize the right to sexual and reproductive health care in Mexico (UN Committee on the Elimination of Discrimination Against Women 1979; United Nations 1994).

In 2000 Vicente Fox, a member of the National Action Party (PAN by its Spanish acronym) became the first non-PRI candidate to win the Presidency in 71 years. While this defeat of the PRI was politically groundbreaking, the party's close ties to Catholic intellectuals and activists threatened the SRR progress made by previous administrations (Amuchastegui, Cruz et al. 2010). Emergency Contraception was added to the Health Sector list of Essential Medications in 2005 but only after five years of intense disagreements between the National Ministry of Health and the Catholic Church. Similarly, the Archdiocese of Mexico threatened to excommunicate any members of Congress who voted for the Mexico City Abortion Law (Amuchastegui, Cruz et al. 2010). The clash of Catholicism, SRH and politics has created a long battle for SRR advocates in Mexico.

Sexual and Reproductive Health and Men

While Human rights conventions as well as the fourth article of the constitution guarantee SRR to both men and women, society and public health research and programming often exclude men from SRH discourse. This exclusivity may make SRR issues less relevant to men who in many cases are the most influential group in policy formation.

Being that women and not men become pregnant, previous reproductive health epidemiological research concentrates reproductive health research on pregnancy outcomes since the final product of 'successful' reproduction is pregnancy. In reality, the use of contraception before pregnancy determines the outcome of sexual intercourse. In this context, men are necessary for modeling contraceptive and family planning decision making and in turn family planning policy.

The traditional or stereotypical images of men in Mexico pose men as perpetrators. As noted by Marston during his research of gendered communication in Mexico City, the stereotypical man is strong and aggressive and is expected to follow the "approved" masculine model which includes fighting, proving sexual knowledge and expressing opinions (Marston 2004). Similarly, while investigating male sexual attitudes in Oaxaca, Mexico, Matthew Guttman found that male sexuality is considered to be closer to its "natural state" meaning it is more acceptable for men to be more sexually reckless than women (Gutmann 2005). While some men do act as barriers or adversaries in the reproductive process, most are respectful. Men in the latter group are often alienated by negative male-stereotypes and their inadvertent exclusion from public health programming when they should be lauded. These negative impressions suggest men feel disconnected from the responsibility of

controlling unwanted fertility and in turn SRR. No objective analysis of men's opinions about SRR exists.

Men's opinions, as citizens and voters, impact the direction of government policy as well as their own role in reproduction. Understanding men's public opinion can work towards better linking public laws and private values as well as upholding international conventions on the importance of including men in improving SRH. The analysis of Mexican Catholic men's public SRH opinion and associated rights in relation to the modern, Mexican Catholic identity can help to uncover the tangled web of what support for SRR means to this group.

Chapter 3: Manuscript

3.1 Contribution of the Student

My contribution to this project began as part of a Summer 2010 Emory Global Health Institute Multidisciplinary Field Scholars Team in Mexico City where I conducted preliminary analysis of a survey collected the year prior by Population Council and Catholics for a Free Choice. Using the male subset of this dataset, I designed the research question and analysis strategy as well as conducted all background research and statistical analyses for my thesis.

3.2 Abstract

Background Exercising sexual and reproductive rights (SRR) can be in conflict with Catholic doctrine, creating potential barriers to reproductive health access. The recent 2007 decriminalization of first trimester abortion in Mexico City was followed by sixteen states amending their constitution to define life as beginning at conception. The Mexican Constitution and ratified international human rights conventions guarantee Mexicans the right to self-determine the timing and spacing of their children however reproductive health policies along with public opinion jump between support for progress and Catholic tradition.

Objective This study identifies factors associated with support for SRR among Catholic men in Mexico. Based on prior research, this study hypothesizes that support for abortion is not independently associated with support for SRR whereas religiosity is inversely associated with support for SRR.

Methods I used a subset of 1,304 men from a nationally representative 2009 survey of 3,000 self-identified Mexican Catholics aged 18 and over. Using logistic regression, we measured relationships between the outcome of interest (support for the right to decide the number and spacing of one's children) and the independent primary variable of interest (support for abortion within 12 weeks gestation) while controlling for demographics, religiosity (frequency of Church practices), and opinions about fertility control and Catholic identity.

Results Most men in Mexico (80.1%) support SRR but only 38.2% support abortion in the first trimester. After adjusting for confounders, support for abortion was not independently associated with support for SRR [aOR1.02(0.73-1.43)]. In turn, those more likely to support SRR include those who believe EC should be available to everyone [aOR1.81(1.30-2.52)], believe sexed should teach all methods of contraception [aOR2.02(1.40-2.92)] and believe someone can continue being a good Catholic after using contraception [aOR1.96 (1.41-2.72)].

Discussion Among Mexican Catholic men, supportive views about fertility control as well as believing contraception does not affect Catholic status are associated with support for SRR. I infer that Mexican Catholic men do not associate SRR with abortion rights but do associate that right with other fertility control strategies because their role in contraception education and use is more direct than their role in abortion.

3.3 Introduction

According to anthropologist Eric R. Wolf, the Virgin of Guadalupe is a prominent symbol of Mexican Catholicism and society that links family, politics, and religion which may complicate the realization of sexual and reproductive rights in Mexico (Wolf 1958). Since the 1970s, Mexico has ratified Human Rights conventions as well as amended the Mexican constitution to guarantee men and women the right to self-determine the timing and spacing of their children which in theory includes choosing abortion (República de México Constitución Federal de 1917 ; UN Committee on the Elimination of Discrimination Against Women 1979; United Nations 1994). Interventions, government policies and human judgments often side with the Catholic Church in their lack of support for SRR whereas behaviors behind closed doors more reflect the strong tradition of individual rights and growing secularization of Mexican society (Kane 2008). This public-private dichotomy not only perpetuates discriminatory reproductive health service provision but denies the right of men and women to responsibly enjoy their sexuality.

In his 1968 Humanae Vitae, Pope John Paul VI made clear that the Catholic Church permits the rhythm method for pregnancy prevention but condemns all other forms of contraception ranging from withdrawal to sterilization as well as pregnancy termination under all circumstances (Pope John Paul VI 25 July 1968). In Mexico, 76.5% of the population self-identifies as Catholic yet in 2006, 66% of married Catholic women aged 15-44 were using a modern contraceptive method(CONAPO 2006; Central Intelligence Agency 2008) and an estimated 875,000 women had an abortion translating into an abortion rate of 33 abortions per 1,000 women aged 15-44(Juarez, Singh et al. 2008). Mexico as a lay state decriminalized abortion within the Mexico City limits in 2007. Following this legislation,

eighteen of Mexico's 32 states amended their state constitutions to define life as starting at conception thus further criminalizing the procedure and pushing policy further from the lived realities of Mexican women (GIRE 2011). A qualitative study analyzing the opinions of eight decision makers in Mexico City concluded that six of the eight decision makers interviewed were in favor of further liberalization of abortion laws however this support was dependent on favorable public opinion (Van Dijk, Lara et al. 2007).

Many studies have been conducted to measure abortion opinion in Mexico, three of which use quantitative methods to measure support for abortion among health care workers and students (Carnevale, Lisker et al. 1998; Vilatela, Morales et al. 1999; Garcia, Lara et al. 2003) and four which quantitatively assess support among the general population (Nuñez-Fernandez, Shrader-Cox et al. 1994; Becker, Garcia et al. 2002; García, Tatum et al. 2004; Palermo, Wilson et al. 2010). The outcome for studies measuring the general population's attitudes toward abortion under an array of hypothetical circumstances in which a woman may need an abortion. By this measurement, 64 – 93% of Mexicans agreed with abortion under at least one circumstance however this support was much stronger among "no fault" abortion circumstances than "at-fault" circumstances (Nuñez-Fernandez, Shrader-Cox et al. 1994; Becker, Garcia et al. 2002; García, Tatum et al. 2004; Palermo, Wilson et al. 2010). .

This study defines "no-fault[2]" abortion as circumstances under which the public does *not* hold the woman responsible for the circumstances leading to the abortion decision such as risk to the health or life of the woman, fetal abnormalities, etc. The average proportion of Mexicans who supported no-fault abortion in these studies was 64.6%. In contrast, this study defines "at- fault" abortion as circumstances under which the public *does*

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Beyond abortion indications, these studies found the following factors to be associated with support for abortion: being male, having medium or high SES, infrequent or rare church attendance, higher education, younger age, Mexico City residence, and supporting Emergency Contraception (Nuñez-Fernandez, Shrader-Cox et al. 1994; Becker, Garcia et al. 2002; García, Tatum et al. 2004; Palermo, Wilson et al. 2010) The two most recent abortion opinion studies in Mexico took religion into account by controlling for religious denomination and frequency of Church attendance (García, Tatum et al. 2004; Palermo, Wilson et al. 2010) however these two measurements alone have been criticized as failing to capture the multidimensionality of religion (Lefkowitz, Gillen et al. 2004).

Studies outside of Mexico have more thoroughly assessed the relationship between religiosity and sexual behavior. Findings suggest that religiosity has a protective effect on individual sexual behaviors such as number of partners and age at first sex but a harmful effect on intra-relationship behaviors that require two-partner communication such as condom use and negotiating safe sex (Faulkner 1966; Zaleski and Schiaffino 2000; Miller and Gur 2002; Nonnemaker, McNeely et al. 2003; Lefkowitz, Gillen et al. 2004; Roberts 2006; Gold, Sheftel et al. 2010). None of these studies incorporated abortion behaviors or attitudes in their analysis and none directly assessed men.

Being that women and not men become pregnant, previous reproductive health epidemiological research concentrates reproductive health research on pregnancy outcomes since the final product of 'successful' reproduction is pregnancy. In reality, the use of contraception before pregnancy determines the outcome of sexual intercourse. In this context, men are necessary for modeling contraceptive and family planning decision making and in turn family planning policy.

The traditional or stereotypical images of men in Mexico pose men as perpetrators. As noted by Marston during his research of gendered communication in Mexico City, the stereotypical man is strong and aggressive and is expected to follow the "approved" masculine model which includes fighting, proving sexual knowledge and expressing opinions (Marston 2004). Similarly, while investigating male sexual attitudes in Oaxaca, Mexico, Matthew Guttman found that male sexuality is considered to be closer to its "natural state" meaning it is more acceptable for men to be more sexually reckless than women (Gutmann 2005). While some men do act as barriers or adversaries in the reproductive process, most are respectful. Men in the latter group are often alienated by negative male-stereotypes and

their inadvertent exclusion from public health programming when they should be lauded. These negative impressions suggest men feel disconnected from the responsibility of controlling unwanted fertility and in turn SRR. No objective analysis of men's opinions about SRR exists.

Men's opinions, as citizens and voters, impact the direction of government policy as well as their own role in reproduction. Understanding men's public opinion can work towards better linking public laws and private values as well as upholding international conventions on the importance of including men in improving SRH. The analysis of Mexican Catholic men's public SRH opinion and associated rights in relation to the modern, Mexican Catholic identity can help to uncover the tangled web of what support for SRR means to this group.

To develop SRR policies that best represent the direct beliefs and actions of the public, this study seeks to analyze the factors associated with support for SRR among Catholic men in Mexico by asking the following questions:

- What factors are associated with Catholic men's support for SRR in Mexico?
- Is support for abortion among Mexican Catholic men independently associated with support for SRR?
- Does religiosity influence Catholic men's support for SRR?

Multiple logistic regression was conducted to determine which factors were associated with support for SRR as defined by agreeing with the fourth article of the Mexican Constitution guaranteeing every citizen: "the right to freely decide in an informed and responsible

manner, the number and spacing of their children" (República de México Constitución Federal de 1917). The primary variable of interest for this study is support for abortion during the first twelve weeks gestation. Additional covariates include demographics, religiosity (frequency of engagement in seven Catholic practices and behaviors) and opinions about fertility control and Catholic identity. This research shows that among Mexican Catholic men, neither abortion, demographic characteristics nor religiosity are independently associated with support for SRR. In turn, support for fertility control (EC and comprehensive sex education) and agreement that one can be a good catholic and use modern methods are associated with endorsing SRR.

3.4 Methods

Data for this study uses a subset of 1,304 men from a nationally representative survey of 3,000 self-identified Mexican Catholics aged 18 and over collected by Catholics for a Free Choice and Population Council in 2009. Four of the male respondents in the survey were under 18 and therefore dropped from the sample leaving a final sample size of 1,300 respondents. In compliance with Population Council's two-tiered IRB review procedures, this study was exempt from full IRB committee review since it was not conducted among a "vulnerable population" and no identifiers were used. Participation in the survey was voluntary and anonymous and informed consent was obtained as per the Council's ethical guidelines. A multivariable analysis was conducted using logistic regression to examine whether support for SRR was independently associated with support for abortion (primary variable of interest) and if changes in religiosity and opinions about fertility control and Catholic identity explained changes in that support.

The dependent variable, supports SRR, categorized respondents as either in support or against reproductive rights according to their response to the following question:

"The fourth article of the Mexican Constitution states: 'every person has the right to freely decide in an informed and responsible manner, the number and spacing of their children.' Do you agree (support) or disagree (against) with the Mexican state in guaranteeing this right?"

The primary variable of interest for this study, supports abortion, was categorized as someone who supports abortion in the first 12 weeks of pregnancy. Using gestational duration to represent abortion support averts public misinterpretation of unrestricted versus

fully restricted abortion laws as well as avoids blame associated with at-fault abortion circumstances.

Religiosity for this study was a continuous summary variable of the frequency (Frequently = 3, often = 2, not very often= 1, never = 0) respondents engage in the following seven Catholic practices and behaviors:

1) Prayer
2) attends mass
3) helps those less fortunate
4) confession
5) participates in Church community service
6) gives money to the Church
7) attends Church groups

Someone with a religiosity score of 21 engaged in all Church practices and behaviors frequently and therefore was considered the most religious whereas a score of 0 indicated no religious practice or behaviors and therefore the least religious.

Data for this study contained 140 possible covariates. The final candidate covariates were those that pertained to demographics; Catholic identity and behaviors; and opinions about reproduction, contraception, abortion, and legal circumstances of fertility control. Given the sensitive subject matter, men often responded with "I don't know." To adjust for this, all non-demographic covariate variables were made into dummy variables to better reflect the proportion of respondents who were confident in their response. As an example, respondents were asked if they supported abortion to save the life of the woman with possible responses being yes, no and I don't know. The dummy variable for this response was categorized as 1 for yes he supports and 0 for no and I don't know responses. Similarly,

attitude questions offered five levels of responses: strongly agree, somewhat agree, somewhat disagree, disagree and I don't know. These variables were set to 1 if the respondents strongly agreed or strongly disagreed and 0 for all other responses.

Simple logistic regression was used to determine the unadjusted association between the outcome and primary variable of interest and each individual study variable. Alpha for this study was set at .05 therefore a p-value less than .05 designated a statistically significant association. Any missing data lead to a removal of the entire subject from the model for that analysis. Any covariates with variance inflation factors greater than 10 in a linear regression analysis were considered collinear and dropped however none were found in this study. Theoretically all potential confounders are significantly associated with both the primary variable of interest and the outcome in a univariate analysis therefore the variables that met this criteria and were not in the causal pathway between abortion and SRR were included in the final model thus adjusting for confounding.

The final dichotomous independent variables by category were:

Demographics

- residence in Mexico City (versus outside Mexico City)
- age (continuous 18-89)
- Marital status (married or living like married (reference), never married, previously married)
- no kids (versus 1 or more kids)
- employment (employed (reference), student, unemployed)

- Education (low: less than secondary education; medium; completed secondary, preparatory, technical or commercial school (reference), high: some college or higher)

Religiosity (continuous 0-21 point scale)

Fertility control

- believing Emergency Contraception should be widely available to all
- believing sexed should teach all methods of contraception (versus abstinence – only education)

Catholic identity

  - believing you can continue being a good Catholic if you use modern contraception

3.5 Results

Demographic characteristics

Among the 1,300 Catholic men surveyed, most are employed (68.5%), married or living like married (58.8%), completed secondary or preparatory school (50.0%) and have at least one child (63.1%). The mean age of the sample is 38.4 (sd15.6, Min 18, Max 89) and 15.9% of respondents reside in Mexico City (Table 2).

Religiosity

Over half of the sample self-reports that they frequently or often attend mass (67.8%), pray (63.5%), help those less fortunate (59.4%) or confess (50.4%) (Figure 3). The average religiosity score is 10.93 (sd 4.56, Min 0, Max 21) showing the sample to have moderate religiosity (Figure 4).

Fertility Control

The large majority of men in Mexico (80.1%) support the fourth article of the Constitution guaranteeing SRR however only 38.2% support abortion in the first 12 weeks gestation. This proportion is slightly smaller than the proportion that supports the Mexico City abortion law (33.6%) (Table 3).

As for abortion indications, the most supported circumstances of the nine in the survey is abortion to save the life of the woman (74.5%) whereas the least supported is failed contraception (23%). When compared to "at-fault" abortion, nearly three times as many Catholic men support "no-fault" abortion and 38.2% of respondents support abortion

within the first 12 weeks of pregnancy, a category under which many of the "at fault" abortion circumstances fall (Figure 5).

Abortion language that refers to the legal status of abortion produces different support then language that refers to specific indications. One-fourth of Catholic men in Mexico agree that "by law, a woman should have the right to abortion whenever she chooses" (Table 3). In contrast, only 7.9% of respondents actually agreed with abortion under all nine of the indications specified in the survey (Figure 5). Similarly, 13% of Mexican Catholic men believe that "by law, abortion should be prohibited under all circumstances" (Table 3) compared to 7.3% who actually disagreed with all nine indications (Figure 5). When asked directly by circumstance, nearly 85% of men sit in between the two extremes ends of abortion support.

Similar proportions of Mexican Catholic men strongly disagree (27.0%) and agree (25.8%) that abortion should be punishable with jail time and the largest proportion of respondents (42.9%) do not believe a woman who has had an abortion should be expelled from the church.

Beyond abortion, other methods of fertility control than abortion are much more accepted by Catholic men. Sexual education that teaches all methods of contraception is supported by 82.6% of Mexican Catholic men and 76% believe Emergency Contraception should be available to anyone wishing to prevent an unplanned pregnancy.

Catholic Identity

Despite low support for unrestricted abortion, 57% of Mexican Catholic men believe a woman can continue being a good Catholic after having an abortion. Similarly, slightly

more (60.2%) believe that someone who supports a woman who has an abortion can continue being a good Catholic. Finally, 74.7% believe someone can use contraception and continue being a good Catholic.

Factors associated with Catholic men's support for SRHR (unadjusted)

Men who live in Mexico City are significantly more likely to support abortion in the first trimester [OR1.80 (CI95%1.3-2.4)] as well as support SRR [1.63(1.07-2.47)] than those who live outside of Mexico City. Support for abortion is significantly univariately associated with having at least some college education [1.44 (1.01-2.06)], being a student [1.68 (1.15-2.45)] and never having been married [1.67 (1.31-2.13)]. The mean religiosity score is slightly higher [Mean 10.71 (sd 4.92) P=0.00024] among men who support abortion than men who support SRR [10.68 (4.57) P = 0.0001] however both have very moderate religiosity.

Men who support abortion in the first twelve weeks are four times more likely to believe Emergency Contraception (EC) should be available to everyone, [4.01 (2.99-5.38)] three times more likely to strongly disagree that abortion should be punishable by jail time [3.28 (2.52-4.28)], and six times more likely to agree with the Mexico City law [5.98(4.63-7.71)].

Men who support SRR are over three times more likely to support sexual education that teaches all forms of contraception [3.17(2.31-4.35)]. A man who supports abortion or SRR is nearly three times as likely to agree someone can continue being a good Catholic if they use contraception, have an abortion, or support someone who has an abortion (Table 4).

Factors associated with Mexican Catholic men's support for SRHR (adjusted)

Once you control for demographic characteristics, there are no identifiable differences between those who do and do not support abortion in the first trimester and their attitudes towards SRR. After adjusting for all confounders, support for abortion is not independently associated with support for SRR [aOR 1.02 (CI95% 0.73-1.43)]. However those who support SRR are around twice as likely to believe EC should be available to everyone [1.81(1.30-2.52)], to believe sex-ed should teach all methods of contraception [2.02(1.40-2.92)] and to believe someone can continue being a good Catholic after using contraception [aOR 1.96 (1.41-2.72)] (Table 5).

3.6 Discussion

International human rights conventions as well as the Mexican Constitution guarantee the right of both men and women to independently decide their reproductive futures which may include deciding to have an abortion. Still, this research shows that among Mexican Catholic men, neither abortion, demographic characteristics nor religiosity are independently associated with support for SRR. In turn, support for fertility control (EC and comprehensive sex education) and agreement that one can be a good catholic and use modern contraception are associated with endorsing SRR.

Mexican Catholic men and Fertility Control

The lack of association between support for SRR and support for abortion in the first trimester indicates that while these men state they support SRR that statement is not indicative of support for all that SRR theoretically entails. Men play distinct roles in fertility control and reproduction compared to women thus they may have different motivations for supporting SRR. Men's involvement in preventing pregnancy through sexual education and the use of male condoms may explain why they associate the contraceptive, and not abortion, components of fertility control with their right to sexuality and reproduction.

The foundation of abortion liberalization lies in women's autonomy therefore abortion advocacy often affects men more as conduits than direct actors. In the case of Mexico, the underlying legal and moral arguments put forth for liberalizing the Mexico City abortion law stressed a woman's right to make her *own* decision with little reference to male involvement (Sánchez Fuentes, Paine et al. 2008). This indirect role in abortion rights discourse may also explain why Mexican Catholic men do not associate abortion support with support for SRR.

Anecdotally, opinions about the moral value of the fetus become increasingly controversial with gestational age just like opinions about acceptable abortion indications become more controversial the further one is from an individual woman's situation (35th Annual NAF Conference 2011). For example, someone may be quick to judge that being single is not an adequate justification for following though with an abortion. In turn, that same person may later find herself unintentionally pregnant without a stable partner and change her mind about lack of support being an acceptable reason to seek an abortion. Because of this double-standard, framing abortion support more holistically such as supporting abortion when it's the couple's decision or when the pregnancy is in the first trimester reduces the amount of external blame associated with misunderstanding.

Catholic identity and fertility control

As demonstrated previously, Catholic adherence to religious doctrine is often subjective. In this study, less than 1/5 of Catholic men agreed with abstinence-only sex education and only 10% strongly agreed that sex was only for procreation as is taught by the Church. Among Mexican Catholic men, how often you attend Church or participate in Church groups may define your religious commitment to your peers but it does not influence your support for SRR. What does influence this support is separating Catholic status from contraceptive use as in someone can continue being a good Catholic even if they do defy the Church ban on contraception. Catholics may comply with the Church publicly but behave and think differently in private. This double discourse in SRR support suggests individual actions speak louder than doctrine in garnering both public and policy maker support for SRR.

Previous advocacy documents rightfully praise the human rights achievements brought forth by the Mexico City abortion policy however until now, no research has existed to analyze the connection between the passage of this right and abortion opinion (Sánchez Fuentes, Paine et al. 2008; Amuchastegui, Cruz et al. 2010). Men's opinions, as citizens and voters, impact the direction of SRH policies as well as their own role in reproduction. How men perceive SRR can influence policy and in turn make states more accountable to guaranteeing those rights. Results from this research can provide evidence for non-discriminatory SRH policies and programming and promote men as partners in reproduction.

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3.8 Tables & Figures

Figure 1. Conceptual Framework

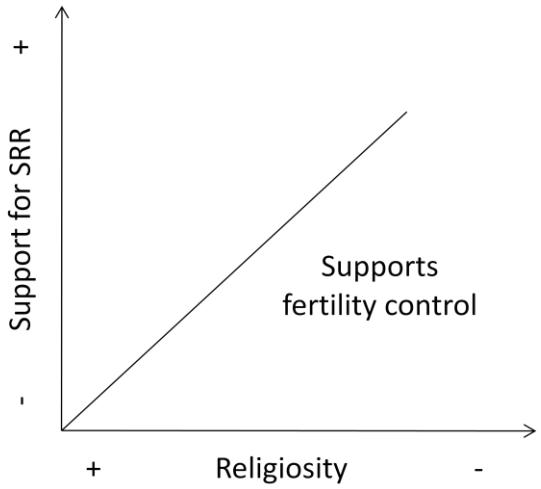

Figure 2. Abortion legislation by state in Mexico, 2010

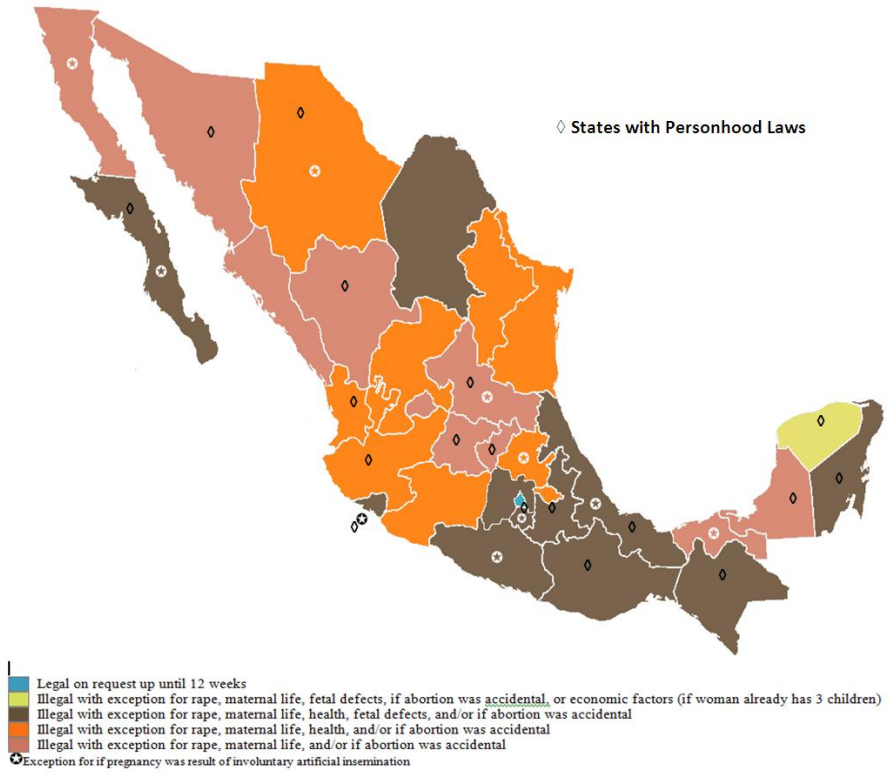

Table 1. Proportion of Mexicans in the general population who support abortion by no-fault and at-fault circumstances. Adapted from (Yam, Dries Daffner et al. 2006).

			No-fault					At-fault			
Author(s)/ year published	**Sample population**	**How support for abortion is defined in study**	**a.**	**b.**	**c.**	**d.**	**e.**	**f.**	**g.**	**h.**	**i.**
Palermo et al. 2010	Women in Tlaxcala ≥ 18	Agreement with the practice of abortion	7	55	84	79	58	n/a	13	4	25
	Men in Tlaxcala ≥ 18		10	50	83	79	52	n/a	10	4	25
Garcia et al 2004	Men & women aged 15-65	Belief that abortion should be legal	21	64	82	76	53	11	17	11	10
Becker et al. 2002	Men & women aged 15-24	Support for legal abortion	n/a	70	83	77	50	11	19	13	20
Nunez-FErnandez et al. 1994	Men aged 15-69	Support for right to abortion	n/a	60	70	n/a	61	n/a	33	11	66
	Women aged 15-69		n/a	56	63	n/a	69	n/a	26	9	70

Abortion indications (average % for group)

a. Under no circumstances (12.7%)

No-fault circumstances (64.6%)

b. Rape (59.2%)
c. Risk to the woman's life (77.5%)
d. Risk to woman's health (77.8%
e. Fetal malformations (57.2%)

At-fault circumstances (13.1%)

f. Contraceptive failure (11%)
g. Financial hardship (19.7%)
h. Woman is single (8.7%)
i. Woman's request (36%)

Figure 3. Self reported religiosity behavior among Mexican Catholic adult males. Mexico, 2009 (n=1,300)

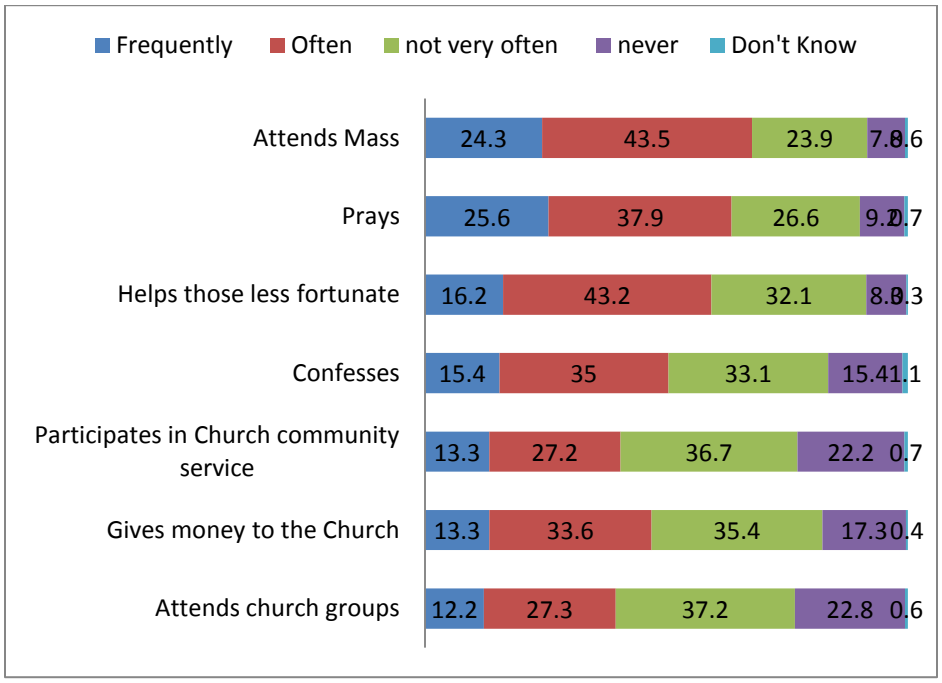

Figure 4. Percent distribution of religiosity score among Mexican Catholic adult males. Mexico, 2009. (n=1,263)

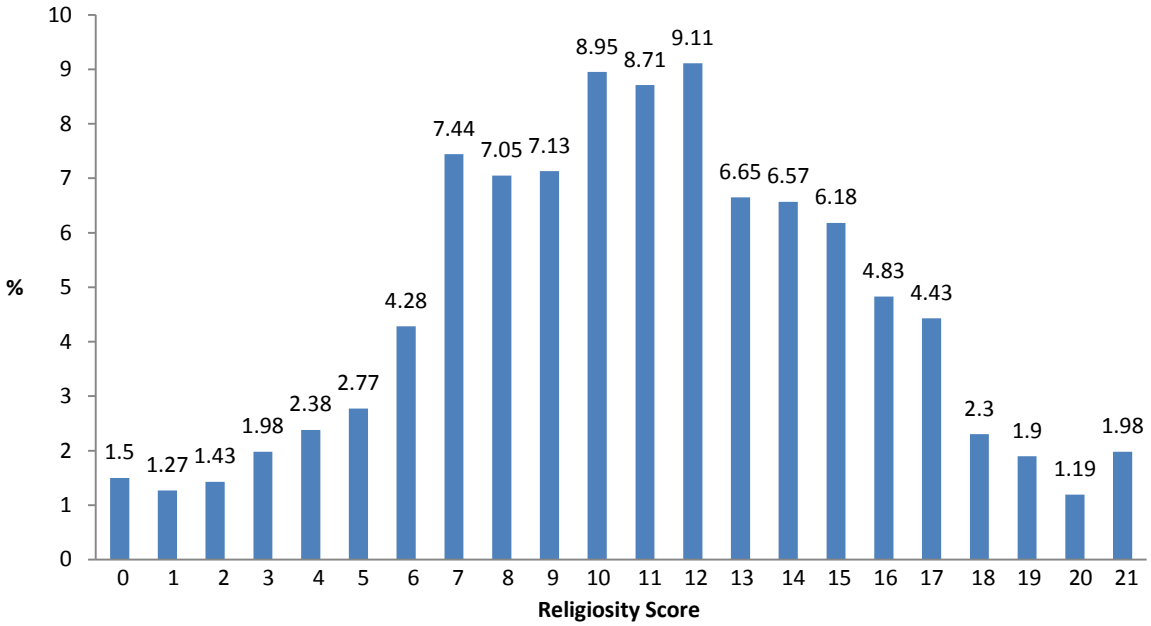

Figure 5. Circumstances under which adult Mexican Catholic males approve of abortion. Mexico, 2009. (n=1,300)

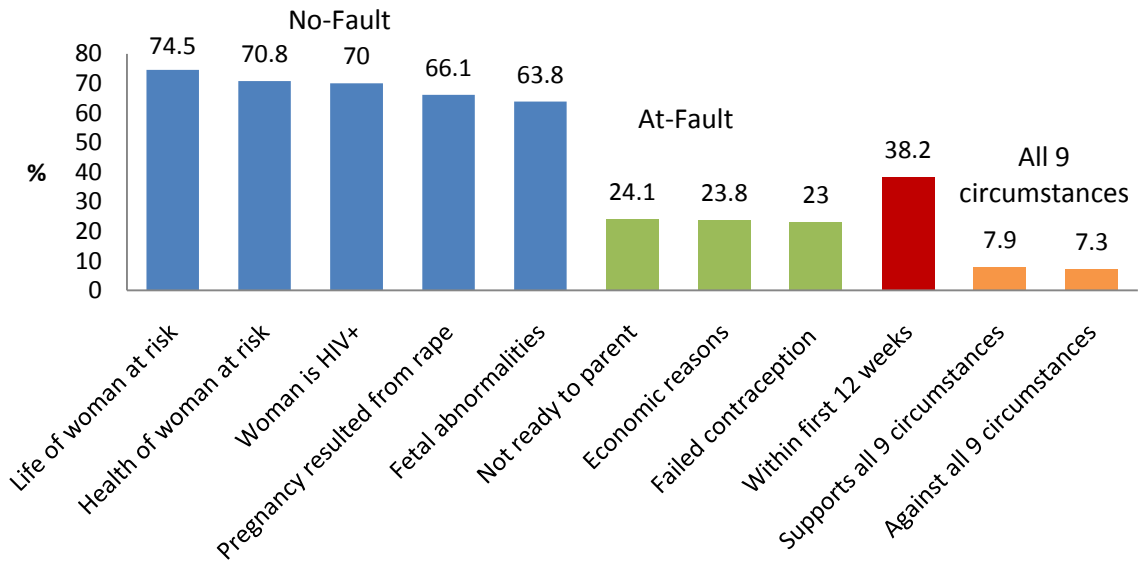

Table 2. Characteristics of study participants, Mexico 2009 (n = 1,300)

	n	%
Residence in Mexico City	206	15.9
Education		
Low	478	38.1
Medium	628	50.0
High	149	11.9
Employment		
Employed	891	68.5
Student	124	9.54
unemployed	285	21.9
No kids	480	36.9
Marital Status		
Married or living like	759	58.8
married	422	32.7
Single	111	8.6
Previously married		
Age	1300	38.4 (sd15.6) Min 18; Max 89
Religiosity	1263	10.93 (sd4.6) Min 0; Max 21

Table 3 Opinions about fertility control among Mexican Catholic adult males, Mexico, 2009 (n=1,300)

	n	%
Supports SRR	**1040**	**80.1**
Supports abortion in the first 12 weeks	**481**	**38.2**
By law, abortion should be		
Unrestricted	325	25
Permitted under some circumstances	754	58
Entirely prohibited	169	13
Abortion should be punishable by jail time		
Strongly disagrees	327	27
Somewhat disagrees	89	7.4
Somewhat agrees	215	17.8
Strongly agrees	312	25.8
Don't know	267	22.1
Agrees with Mexico City abortion Law	**429**	**33.6**
Believes EC should be available to everyone	**920**	**70.8**
Those who have an abortion should be expelled from the Church		
Yes	**260**	**20.3**
Depends	**416**	**32.4**
No	**551**	**42.9**
Don't Know	**57**	**4.4**
Sex is only for procreation		
Strongly disagrees	**331**	**25.5**
Somewhat disagrees	**458**	**35.2**
Somewhat agrees	**351**	**27**
Strongly agrees	**128**	**10**
Don't know	**32**	**2.5**
Believes someone can continue being a good Catholic if they	**955**	**74.7**
Use contraception	**726**	**57**
Have an abortion	**770**	**60.2**
Support someone who has an abortion		
Believes Sexed should teach		
All methods of contraception	**1056**	**82.6**
Only abstinence	**223**	**17.4**

Table 4. Univariate analysis of factors associated with supporting abortion during the first 12 weeks gestation and supporting Sexual and Reproductive Rights among Mexican Catholic Men. Mexico, 2009

	Unadjusted odds of supporting abortion OR (95%CI)	Unadjusted odds of supporting SRR OR (95%CI)
Supports abortion in the first 12 weeks ₮	n/a	1.44(1.08-1.93)*
Demographics		
Residence in Mexico City ₮	1.80 (1.3-2.4) *	1.63(1.07-2.47)*
Education ₮		
Low	0.63 (0.49-0.81)*	0.76(0.57-1.02)
Medium	Reference	Reference
High	1.44 (1.01-2.06)*	0.93(0.59-1.46)
Employment ₮		
Employed	Reference	
Student	1.68 (1.15-2.45)*	1.09(0.67-1.79)
unemployed	0.80 (0.60-1.06)	0.77(0.56-1.06)
No kids ₮	1.82 (1.44-2.29)*	1.28 (0.96- 1.71)
Marital Status ₮		
Married or living like married	Reference	Reference
Single	1.67 (1.31-2.13)*	1.35 (0.99-1.85)
Previously married	1.16 (0.77-1.76)	0.78 (0.49 - 1.25)
Age ₮	Mean 37.4 (14.9) P=0.0444*	Mean 38.15 (15.4) P=0.0853
Religiosity ₮		
	Mean 10.71 (4.92) P=0.00024*	Mean 10.68 (4.57) P = 0.0001*
Fertility Control		
Believes sexed should teach all methods of contraception ₮	1.77(1.29-2.45)*	3.17(2.31-4.35)*
Believes EC should be available to everyone ₮	4.01 (2.99-5.38)*	2.66(1.99 - 3.57)*
Abortion should be punishable by jail time	3.28 (2.52-4.28)*	2.27(1.56-3.30)*
Strongly disagrees		
Agrees with Mexico City abortion Law	5.98(4.63-7.71)*	1.34(0.99-1.82)
Catholic Identity		
Believes someone can continue being a good Catholic if they		
Use contraception ₮	2.17 (1.63-2.89)*	2.67 (1.99 - 3.57)*
Have an abortion	3.10(2.43-3.97)*	3.10 (2.43-3.97)*
Support someone who has an abortion	2.81(2.19-3.60)*	2.65 (2.00-3.51)*
Women who have an abortion should NOT be expelled from the Church	1.59(1.27 - 2.00)*	1.97(1.47-2.65)*

***= significant at .05 ₮ = included in the model**

Table 5. Multivariable analysis of factors associated with supporting sexual and reproductive rights among Mexican Catholic men. Mexico, 2009. (n=1,179)

	B (error)	B (error)	B (error)	B (error)	B (error)	OR (CI95%)
Supports abortion	0.18 (0.07) *	0.28 (0.16)	0.30 (0.16)	0.10 (0.17)	0.02 (0.17)	**1.02 (0.73-1.43)**
Demographics						
Residence in Mexico City		0.60 (0.25)*	0.44 (0.26)	0.48 (0.26)	0.47 (0.26)	**1.60 (0.96-2.68)**
Age		-0.002 (0.005)	-0.002 (0.005)	0.0001 (0.005)	0.00005 (0.005)	**1.00 (0.99-1.01)**
Low education		-0.15 (0.16)	-0.14 (0.16)	-0.06 (0.17)	-0.06 (0.17)	**0.93 (0.67-1.30)**
High education		-0.15 (0.24)	-0.15 (0.25)	-0.23 (0.25)	-0.24 (0.25)	**0.79 (0.48-1.29)**
Student		-0.19 (0.18)	-0.15 (0.18)	-0.14 (0.19)	-0.10 (0.19)	**0.91 (0.63-1.31)**
unemployed		-0.10 (0.31)	-0.07 (0.31)	-0.003 (0.31)	0.004 (0.32)	**1.00 (0.54-1.87)**
No kids		0.16 (0.25)	0.16 (0.25)	0.13 (0.26)	0.11 (0.26)	**1.11 (0.67-1.86)**
Never married		0.36 (0.27)	0.29 (0.27)	0.10 (0.28)	0.07 (0.28)	**1.07 (0.62-1.86)**
Previously married		-0.24 (0.25)	-0.24 (0.25)	-0.23 (0.26)	-0.26 (0.26)	**0.77 (0.46-1.28)**
Religiosity						
			-0.05 (0.02) *	-0.04 (0.02)	-0.03 (0.02)	**0.97 (0.94-1.01)**
Fertility control						
Believes EC should be available to everyone				0.65 (0.17)*	0.59 (0.17)	**1.81 (1.30-2.52)***
Believes sexed should teach all methods of contraception				0.82 (0.18)*	0.70 (0.19)	**2.02 (1.40-2.92)***
Catholic identity						
Believes someone can continue being a good Catholic if they use contraception					0.67 (0.17)	**1.96 (1.41-2.72)***

***= significant at .05**

Chapter 4: Conclusion, Recommendations and Limitations

Being that the presence and actions of both men and women are required for reproduction, progressive advocacy in sexual and reproductive health programming and policy must find a place for men in the sexual decision making process. This realization not only upholds the right of both men and women to enjoy their sexuality free of undesired fertility and blame but encourages men to evolve their space as partners in reproduction.

To this end, this study recommends the following action items to improve the involvement of men in SRH:

1. Move away from the female contraceptive culture and allow the entrance of more male-initiated hormonal birth control methods
2. Expand family planning research and interventions to highlight the couple as the reproductive unit
3. Encourage men to be allies in Sexual and Reproductive Health advocacy by posing fertility, reproduction and its regulation as cooperative tasks
4. Encourage men to accompany their partners to abortion counseling and procedure appointments
5. Engage men to be partners as well as fathers to also create positive role-models for boys

Conservative religious traditions have not always supported scientific advancements to control fertility or the individual Catholic's autonomy to decide privately his/her reproduction. As shown by this research, institutional opposition to contraception does not necessarily translate into individual objection -- to identify as Catholic or religious does not necessarily indicate sexual conservatism. Religion is a fundamental component of many

peoples lives and therefore cannot be divorced from the issue of SRH. To this end, this study recommends the following action items to expand the support for SRH:

6. Ally with progressive religious groups to promote SRH
7. Treat SRH as a health issue primarily and a social issue secondarily
8. Engage the media in a rights-based-approach to health that reflects the lived realities of the public, including religiosity

Sexual intercourse is intimate and personal. The misunderstandings that inevitably accompany this secrecy often lead to shame and in turn blame. Sexual and reproductive health language and policy is limited to what is researchable and what a certain group of people agree on thus further complicating the objectivity of the issue. Abortion and reproduction always have and perhaps always will be an ideological battle but it is the responsibility of public health professionals and policy makers to look holistically at the issues so as to keep sexuality healthy and abortion safe.

Limitations

One limitation of this study is the use of close-ended "frequency" of religious practice responses to describe religiosity. This measurement can be subjective since someone who attends mass twice a month may consider that rarely whereas another person may consider bimonthly Church attendance to be frequent. I considered separating religious practices by intrinsic (more spiritual) and extrinsic (ritual and traditional) behaviors to describe religiosity as in previous literature (Zaleski and Schiaffino 2000; Nonnemaker, McNeely et al. 2003; Roberts 2006; Gold, Sheftel et al. 2010). However intrinsic religious motivation entails more internal (and therefore less tangible) actions, whereas this dataset

provided measurements on more practice and therefore external religious behaviors. By only capturing more externally religious individuals, I could not probe the intrinsic dimension of Catholic men.

While this was the first ever rigorous research study to attempt to dissect the meaning of SRR among Catholic men in Mexico, unanswered questions remain. Firstly, there is no measurement of sexual and reproductive health behaviors or personal experiences with abortion. Without practice measures this study could not assess the more direct implications of these opinions on actual health outcomes. Secondly, respondent's understanding of the concept of SRR may be superficial. To many, the idea of SRR may not exist beyond theory. To address these limitations, more qualitative work on men's views about abortion, religion and SRR is warranted.

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Appendix

1. International Conference on Population Development (ICPD) Cairo, 1994 Programme of Action (United Nations 1994)

1.1 Chapter VII, Reproductive Rights and Reproductive Health

A. *Reproductive rights and reproductive health.* Reproductive health is a state of complete physical, mental and social well-being in all matters relating to the reproductive system and to its functions and processes. It implies that people have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this is the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility, which are not against the law, and the right of access to health-care services that will enable women to go safely through pregnancy and childbirth. Reproductive health care also includes sexual health, the purpose of which is the enhancement of life and personal relations.

Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other relevant UN consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. They also include the right of all to make decisions concerning reproduction free of discrimination, coercion and violence. Full attention should be given to promoting mutually respectful and equitable gender relations and particularly to meeting the educational and service needs of adolescents to enable them to deal in a positive and responsible way with their sexuality.

All countries are called upon to strive to make reproductive health accessible through the primary health-care system to all individuals of appropriate age as soon as possible and no later than 2105. Such care should include, *inter alia*: family planning counselling, information, education, communication and services; education and services for prenatal care, safe delivery and post-natal care, especially breast-feeding and infant and women's health care; prevention and treatment of infertility; abortion as specified in paragraph 8.25; treatment of reproductive tract infections, sexually transmitted diseases (STDs) and other reproductive health conditions; and information, education and counselling on human sexuality, reproductive health and responsible parenthood.

Reproductive health-care programmes should be designed to serve the needs of women, including adolescents, and must involve women in the leadership, planning, decision-making, management, implementation, organization and evaluation of services. Innovative programmes must be developed to make information, counselling and services for reproductive health accessible to adolescents and adult men. Such programmes must both educate and enable men to share more equally in family planning, domestic and child-rearing responsibilities and to accept major responsibility for the prevention of STDs.

B. *Family planning.* Actions are recommended to help couples and individuals meet their reproductive goals; to prevent unwanted pregnancies and reduce the incidence of high-risk pregnancies and morbidity and mortality; to make quality services affordable, acceptable and accessible to all who need and want them; to improve the quality of advice, information, education, communication, counselling and services; to increase the participation and sharing of responsibility of men in the actual practice of family planning; and to promote breast-feeding to enhance birth spacing. The text emphasizes that Governments and the international community should use the full means at their disposal to support the principle of voluntary choice in family planning. As part of the effort to meet unmet needs, all countries are asked to identify and remove all major remaining barriers to the use of family planning services. Governments are urged to provide a climate that is favourable to good-quality public and private family planning and reproductive health information and services through all possible channels. The international community is urged to move, on an immediate basis, to establish an efficient coordination system and global, regional and subregional facilities for the procurement of contraceptives and other commodities essential to reproductive health programmes of developing countries and countries with economies in transition.

C. *STDs and HIV prevention.* Section C recommends actions designed to prevent, reduce the incidence of and provide treatment for STDs, including HIV/AIDS, and the complications of STDs such as infertility. Such actions include: increasing efforts in reproductive health programmes to prevent, detect and treat STDs and other reproductive tract infections; providing specialized training to all health-care providers in the prevention and detection of, and counselling on, STDs, especially infections in women and youth; making information, counselling for responsible sexual behaviour and effective prevention of STDs and HIV integral components of all reproductive and sexual health services; and promoting and distributing high-quality condoms as integral components of all reproductive health-care services.

D. *Human sexuality and gender relations.* The objective is twofold: to promote the adequate development of responsible sexuality that permits relations of equity and mutual respect between the genders; and to ensure that women and men have access to information, education and services needed to achieve good sexual health and exercise their reproductive rights and responsibilities. Recommended actions include giving support to integral sexual education and services for young people, with the support and guidance of their parents and in line with the Convention on the Rights of the Child, that stress male responsibility for their own sexual health and fertility and that help them exercise those responsibilities. Educational efforts should begin within the family unit, but must also reach adults, in particular men, through non-formal education and a variety of community-based activities. Educational programmes should also encourage and support active and open discussion of the need to protect women, youth and children from abuse, including sexual abuse, exploitation, trafficking and violence. Governments and communities are advised to take steps urgently to stop the practice of female genital mutilation and protect women and girls from all similar unnecessary and dangerous practices.

E. *Adolescents.* Adolescent sexual and reproductive health issues, including unwanted pregnancy, unsafe abortion (as defined by the World Health Organization), and STDs and

HIV/AIDS, are addressed through the promotion of responsible and healthy reproductive and sexual behaviour, including voluntary abstinence, and the provision of appropriate services and counselling specifically suitable for that age group. A substantial reduction in all adolescent pregnancies is also sought. The text stresses that countries must ensure that programmes and attitudes of health-care providers do not restrict adolescents' access to the services and information they need. These services must safeguard the right of adolescents to privacy, confidentiality, respect and informed consent, while respecting cultural values and religious beliefs as well as the rights, duties and responsibilities of parents. Countries, with the support of the international community, should protect and promote the rights of adolescents to reproductive health education, information and care, and greatly reduce the number of adolescent pregnancies. Governments are urged, in collaboration with NGOs, to establish appropriate mechanisms to respond to the special needs of adolescents.

2. Convention on the Elimination of all forms of Discrimination Against Women (CEDAW). Adopted by the UN General Assembly in 1979 (UN Committee on the Elimination of Discrimination Against Women 1979)

2.1 Article 12

1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning.

2. Notwithstanding the provisions of paragraph I of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.

2.3 Article 16

1. States Parties shall take all appropriate measures to eliminate discrimination against women in all matters relating to marriage and family relations and in particular shall ensure, on a basis of equality of men and women:
(a) The same right to enter into marriage;

(b) The same right freely to choose a spouse and to enter into marriage only with their free and full consent;

(c) The same rights and responsibilities during marriage and at its dissolution;

(d) The same rights and responsibilities as parents, irrespective of their marital status, in matters relating to their children; in all cases the interests of the children shall be paramount;

(e) The same rights to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise these rights;

(f) The same rights and responsibilities with regard to guardianship, wardship, trusteeship and adoption of children, or similar institutions where these concepts exist in national legislation; in all cases the interests of the children shall be paramount;

(g) The same personal rights as husband and wife, including the right to choose a family name, a profession and an occupation;

(h) The same rights for both spouses in respect of the ownership, acquisition, management, administration, enjoyment and disposition of property, whether free of charge or for a valuable consideration.