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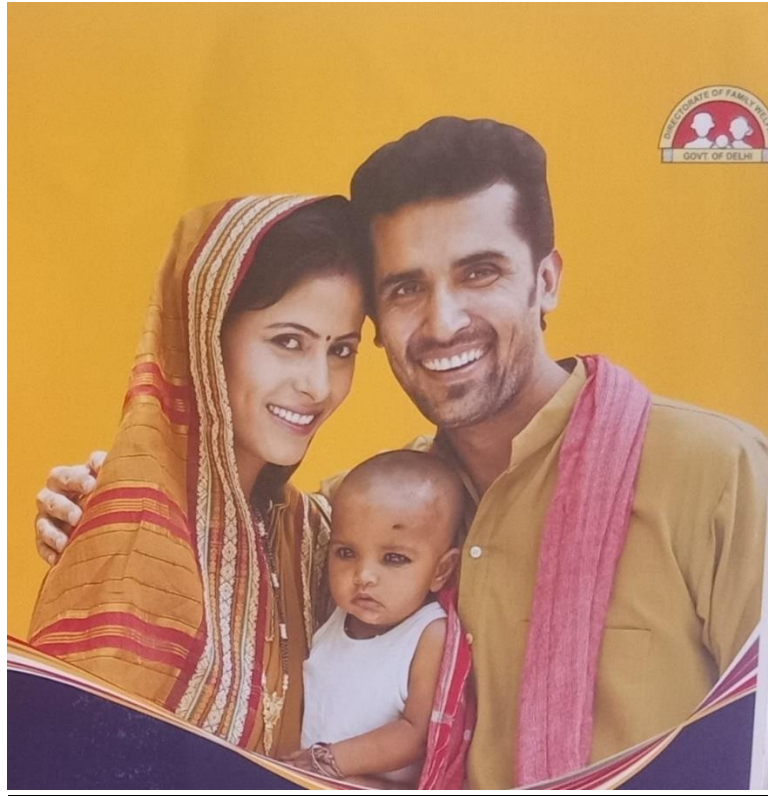
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Taali Do Haath Se Bajti Hai (It Takes Two to Tango): Exploring Men's Involvement in Antenatal Care in India



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submitted for the qualification of

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Institute of Development Studies
University of Sussex

¹ Source: This picture has been taken from a poster in the health clinic where I did my fieldwork. While this thesis is on men's involvement in antenatal care, I have chosen a photo which shows a couple with their child. This is because reproduction is a highly gendered and relational issue and while the lack of research on men in reproduction needs to be addressed, the role of mothers and relationalities between the couple must not be forgotten.

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List of abbreviations

ASHA Accredited Social Health Activist

ANM Auxiliary Nurse Midwife

AWW Anganwadi Worker

ANC Antenatal Care

CHW Community Health Worker

CHC Community Health Centre

C-REC Research Ethics Committee

CSMM Critical Studies of Men and Masculinities

HIV Human Immunodeficiency Virus

ICDS Integrated Child Development Service

ICPD International Conference on Population and Development

IMR Infant Mortality Rate

IMY Indira Mahila Yojana

IPHS Indian Public Health Standards

JSY Janani Suraksha Yojana

JSSK Janani Shishu Suraksha Karyakram

LMIC Low- and- Middle-Income Countries

MDG Millennium Development Goals

MMR Maternal Mortality Ratio

MPHW Multipurpose Health Worker

MoHFW Ministry of Health and Family Welfare

NGO Non-Governmental Organisation

NICU Neonatal Intensive Care Unit

NHRM National Rural Health Mission

NHM National Health Mission

NHP National Health Portal

OBC Other Backward Castes

PMMSY Pradhan Mantri Matritva Sahyog Yojana

PMSMY Pradhan Mantri Surakshit Matritva Yojana

PUHC Primary Urban Health Centre

PHC Primary Health Centre

RMP Rural Medical Practitioner

RCH Reproductive Child Health

RMNCH+A Reproductive, Maternal, Newborn, Child, and Adolescent Health

SC Sub-Centre

SC Scheduled Castes

SDG Sustainable Development Goals

ST Scheduled Tribes

SRQ Sub-Research Question

UK United Kingdom

UNICEF United Nations Children's Emergency Fund

USA United States of America

WHO World Health Organization

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Summary

This PhD thesis explores the concept of men's involvement in antenatal care in India, asking: **In what ways is men's involvement in antenatal care conceptualised, experienced, and operationalised in an informal settlement of Delhi?** To answer this question, I use the Critical Studies of Men and Masculinities (CSMM) framework, which has emerged as a popular tool within the feminist literature to study men's lives. The research for this thesis was conducted in Rajaji Nagar, an urban informal settlement in South-East Delhi, spread over a period of 12 months from July 2019 to August 2020. It began with in-person fieldwork in Rajaji Nagar, although this ceased in March 2020 due to the COVID-19 pandemic. Thereafter, some research (interviews with policy practitioners) was conducted online.

My findings suggest that there is an all-encompassing exclusion of men from the Indian State's³ policies on maternal reproductive health.⁴ This exclusion can be attributed to four reasons which also intersect with each other: a) maternalist bias of the State in policymaking, b) the cultural significance of reproduction that places the burden of good maternal health outcomes on women, c) a neoliberal approach towards achieving development goals, and d) ignoring the relationality of reproduction processes.

This thesis also argues that community health workers (who are all women) are not very keen to involve and engage with expectant fathers. The reasons behind this lack of engagement include their low benchmark of expectations from local men, their lack of

³ Inspired by Unnithan (2022), I differentiate between using the terms 'State' and 'state' in this thesis. By the State, I mainly refer to a ruling authority in a sovereign territory. Furthermore, I use the word 'state' to denote states (regions) and also when I am differentiating between regional (state) and the national governments.

⁴ Though my thesis' focus is on men's involvement in antenatal care, which is a specific phase/period of reproduction, I will use the terms antenatal care, maternal health, and maternal reproductive health interchangeably. This is because the discourse around these issues is similar, and they fall under the broader umbrella of reproduction. However, I will use the term 'antenatal care' when I am referring to stakeholders such as expectant fathers and community health workers. I will use the terms 'maternal health' or 'maternal reproductive health' when I am discussing the broader policy context.

agency and power to challenge hegemonic masculine norms, a desire to maintain their dominance as authoritative figures on maternal reproductive health in the community, and finally, given their incentive-based incomes, the lack of any financial gains for engaging with men as stakeholders.

Finally, my research with expectant fathers reveals that they leverage their subjectivities to construct and perform their masculinities during expectant fatherhood in different ways. These masculinities are also constructed and performed in relation to their family members, most notably their mothers. However, men's involvement in maternal health does not indicate any radical disruption of gender relations and power dynamics in the household or the community.

Overall, this thesis offers insights into the multiple ways through which men's involvement in maternal health is imagined and operationalised. The exclusion of men from maternal health policymaking and planning by the State is, in practice, reproduced in Rajaji Nagar by the community health workers and the society. While the thesis finds that some men are engaging in antenatal care of their wives in more ways than they are expected to, there are no social, cultural and institutional mechanisms and ecosystems to facilitate their engagement and encourage it further.

Chapter One: Introduction

My doctoral thesis is a qualitative⁵ study of men's involvement in antenatal care in India. The main research question which this thesis aims to answer is: **In what ways is men's involvement in antenatal care conceptualised, experienced, and operationalised in an informal settlement of Delhi?** In this thesis, I use the Critical Studies of Men and Masculinities (CSMM) framework, which has emerged from feminist, gay and queer literature and is a useful approach for researching men, masculinities, and reproduction (Lohan, 2015).

The research for this thesis was conducted in Rajaji Nagar⁶, an urban informal settlement in South-East Delhi and spread over a period of 12 months from July 2019 to August 2020 in Delhi. In-person fieldwork ceased from March 2020 onwards due to the COVID-19 pandemic, and some research was thereafter conducted online. For data collection, I used different methods such as: a) semi-structured interviews, b) ethnographic listening and participant immersion, and c) informal conversations. Overall, I conducted approximately 550 hours of participant immersion, observed 275 antenatal consultations and neonatal immunisation sessions over six months, conducted 22 in-depth semi-structured interviews, 65 informal conversations, and countless *chai pe charchas*⁷ and lunch chats which included expectant

⁵ While my study is a qualitative one, it is also informed by data collection methods that are generally used for long-term ethnographies and anthropological studies. I had planned to do a fully ethnographic study but due to COVID-19, my research was disrupted. I will describe my methods in depth in Chapter Three.

⁶ This is the anonymised name of the settlement and not the actual name. In this thesis, all respondents and their locations have also been anonymised to protect their identities. The anonymisation ensures that none of the data discussed in this thesis can be linked back to the respective respondent.

⁷ *Chai Pe Charcha* (conversations over tea) is a popularised Hindi term which means discussions over tea. In India, tea discussions are considered a useful icebreaker, especially in research. I had several tea conversations and lunches which many of my respondents invited me to; however, I did not really keep a count of the exact numbers. A major chunk of my fieldwork was done during the winter season in Delhi, which demanded that I have tea regularly to keep warm.

and new fathers, community health workers, informal health providers, and policy practitioners and researchers.

The rest of this chapter is organised as follows. In Section 1.1, I provide an overview of the subject and the justification for the study. In Section 1.2, I highlight my personal and academic motivation for the study. In Section 1.3, I highlight the framing of my issue and describe my research questions. In Section 1.4, I give an overview of India's public health system and the maternal health architecture. In Section 1.5, I give a summary of the sequence of remaining chapters.

1.1 Overview and justification of study

Reproduction is a highly gendered process; yet it has mostly been associated with women, given the biological realities of childbirth leading to an essentialisation of their roles as procreators (Sheldon, 1999; Daniels, 2008; Almeling and Waggoner, 2013; Deb, 2015; Mishra and Parasnis, 2018; Parsekar *et al.* 2021; Almeling, 2020; Sivakumar and Manimekalai, 2021). Thus, historically, most of the attention within health systems and academic research has been given to women. The concept of men's involvement in pregnancy and childbirth issues in high-income countries had gained currency in the 1970s and 1980s, when debates around men's presence in labour rooms started emerging (Early, 2001; Premburg and Lundgren, 2006; King, 2017). However, it was only in 1994, when the whole agenda around men's involvement in reproduction issues became popular in the realm of public health and international development, as the International Conference on Population and Development (ICPD) in Cairo recognised that "special efforts should be made to emphasize men's shared responsibility and promote their active involvement in responsible parenthood, sexual and reproductive behaviour, including family planning; maternal and child health; [and] prevention of sexually

transmitted infections, including Human Immunodeficiency Virus” (ICPD, 1994, p. 30).

Ever since, NGOs, organisations and governments have introduced programmes and interventions in different countries (Barua *et al.* 2004; Mullany, Becker and Hindin, 2007; Singh and Ram, 2009; Kululanga *et al.* 2012; Peneza and Maluka, 2018) which have attempted to ‘involve’ men in maternal reproductive health. A common criticism, however, is that these initiatives tend to be instrumental in nature and focus primarily on men’s ‘physical involvement’ in care activities, rather than including their own subjectivities, perceptions, and attitudes towards maternal health (Comrie-Thomson *et al.* 2015; Tokhi *et al.* 2018). These studies primarily use a positivist approach and have an all-encompassing focus on indicators for defining male involvement such as husbands’ attendance at antenatal care meetings, tracking wives’ pregnancy cycles, skilled birth attendance, and husbands’ physical presence during check-ups and deliveries. Over the past couple of decades, there has been an increased academic focus on subjects such as fatherhood, male involvement in maternal health, male infertility, men’s reproductive health, men’s emotions and masculinities, and male contraceptives, which emphasise the importance of engaging with men (Inhorn *et al.* 2009; Inhorn, 2012; Lohan, 2015; Machin, 2015; Law, 2019; Hannah and Gough, 2020; Almeling, 2020; Edgley and Roberts, 2021). Yet, I agree with Inhorn and Dudgeon (2003, p. 41) who argues “the relationship between men’s intentions and desires for conception, pregnancy, childbirth, and fatherhood have been relatively poorly studied and hence are little understood, especially in international contexts”. Inhorn *et al.* (2009) terms men as the “second sex” in reproduction research, thereby indicating a category which has been neglected, constituting an oversight of large proportions.

In the context of medicine, Almeling and Waggoner (2013, p. 836) write: “reproductive

equations are powerful not only in the making of clinical practice but in the production of medical knowledge. The end result is deeply gendered knowledge about reproduction that simultaneously leaves open social and clinical questions about men while reinforcing women's part of the equation through research and medical practice". In her work on anthropological ethnographies of human birth, Kay (1982) argues that men are an extrinsic factor for pregnant women (with other extrinsic factors being food and sleep), which may affect birth outcomes. For instance, patriarchal structures, subordination of women to men and issues such as domestic violence, and inadequate allocation of financial resources for women, have been proven to be detrimental to maternal health (Prata, Tavrow and Upadhyay, 2017). From a biological perspective, scientific evidence suggests that "maternal and foetal health can be at danger from male exposure to toxic and harmful work environments which can transmit toxins to women's bodies and potentially cause miscarriages and fertility issues" (Sheldon, 1999, p. 132). Based upon this evidence, Sheldon (1999) questions the absence of research on men's behaviour during the antenatal period. Her argument holds relevance as, since the 1990s, in high income countries, the concept of preconception care has become prevalent in public health, and this encourages people to prepare their bodies for reproduction (Almeling and Waggoner, 2013, p. 822) by following certain practices and food lifestyles.

However, Almeling and Waggoner (2013, p. 829) also emphasise the need to develop better conceptual linkages between men and the impact of their behaviours and actions on pregnancy outcomes. From a social perspective, I suggest that the antenatal period is an opportune time for men to get involved as the participation of an expectant parent during pregnancy can usually predict higher involvement post-birth (Fontana and Schoenbaum, 2019). Therefore, to be able to strive towards gender-equitable reproduction and future parenting experiences, it is

important to “unsex”⁸ the pregnancy period and focus on ensuring the active involvement of men during the antenatal period.

These arguments clearly highlight the significance of understanding men’s experiences, involvement and subjectivities in pregnancy, childbirth, and reproduction. Building upon these arguments and evidence, I suggest four reasons as to why men should be considered in research related to maternal health, reproduction, and pregnancy issues. One reason is the lack of research on how men perceive and construe their own involvement in reproduction, pregnancy, and childbirth processes rather than looking at them as instrumental beings. A second reason is to understand the impact of men’s reproductive bodies and their antenatal behaviour on maternal and foetal health. Thirdly, to enhance a closer association of reproduction and men and problematise the absence of the category of ‘men in reproduction’ in social science research. Fourth and probably the most important, to advance the agenda of gender equality by deconstructing hegemonic masculinities and unsexing the process of pregnancy.

However, given the historical subordination of women and their struggles to keep control over their bodies and secure reproductive rights, there is a legitimate fear that recognition of men in reproduction research may override women’s autonomy. As Daniels (2008, p. 141) argues, “feminists are now confronted with two seemingly contradictory imperatives. One is that men must be drawn into reproduction and that the differences between men and women be diminished. But the other is that men’s power over reproduction must be limited and women’s unique relationship to procreation be recognized and affirmed”.

⁸ The concept of ‘unsexing’ the pregnancy is drawn from Fontana and Schoenbaum (2019), which is a review of USA laws (for example, parental leave) relating to pregnancy for women and men. Unsexing here refers to the efforts made towards benefitting pregnant women by creating a more equal distribution of care work during pregnancy through supportive laws and benefits.

In the context of India, which has the second largest population, the fifth largest economy, and one of the highest rates of maternal mortality in the world, the issue of men's involvement in reproductive maternal health has attracted less academic attention than in most high-income as well as many low- and middle-income countries. I suggest that this is because women in India have faced historical subjugation and oppression through essentialisation of their role as procreators and, therefore, academic research has mainly prioritised documenting and theorising women's experiences of fertility and reproduction (which is of course justified). Thus, I recognise that the case for researching men's engagement and understanding their experiences in reproduction processes and maternal health in India needs to be framed carefully, keeping the historical specificities, and questions about gender and power relations, in mind. The only discipline that has explored the issue of men's roles in childcare and family in depth (primarily among urban educated families) is that of psychology (Roopnarine *et al.* 1990; Roopnarine *et al.* 1992; Dutta, 2000; Kumari, 2008). Disciplines such as public health, development studies, sociology, anthropology, and gender studies have had a limited focus on this issue as I will discuss in depth in Chapter Two.

Therefore, my thesis aims to address this research gap, and offers an analysis of the different ways in which men's involvement in antenatal care is perceived, understood, and operationalised in India. To do so, I start by analysing the Indian State's approach towards involving men in maternal health and how this approach is operationalised at the primary healthcare level. I also closely examine the attitudes and subjectivities of community health workers⁹ (CHW) in relation to men's roles in antenatal care and corresponding masculinities, which has seldom been researched in India. I examine men's emotions, subjectivities, and

⁹ There are three categories of CHWs which I refer to: (1) Accredited Social Health Activists (ASHA) workers, (2) Anganwadi Workers (AWW), and (3) Auxiliary Nurse Midwives (ANMs); I will describe them later in this chapter.

feelings and how these are leveraged to construct, perform, and navigate their masculinities to guide their decision making in the antenatal period. Finally, my thesis contributes briefly to the methodological literature on engaging with men as there is a paucity of research detailing how to include men in reproduction research (Law, 2019).

1.2 Personal and academic motivation

Prior to pursuing my PhD, I have had varied professional experiences in different capacities with NGOs, consulting firms, political parties, and media outlets. However, it was during my work as an independent journalist in 2015-16, when I reported and wrote extensively on gender and health issues, that the idea of men's involvement in maternal health intrigued me. One such story was about the impact of hiring male health workers on access to and uptake of maternal healthcare services in the state of Odisha (Saha, 2015). I explored this interest further in my master's programme in 2016-17, where my dissertation focused on using intersectionality as a conceptual framework for a maternal health scheme in India. This dissertation was written with the prospect of moving forward for a doctoral degree. When I started my PhD in September 2018, as I scouted the literature, I found that this subject of men's involvement in maternal health was relatively unexplored in India and given my positionality as a male researcher and interest in gender, it was an appropriate issue to focus on for my PhD.

In addition to my academic interest, my personal motivation in part stems from my parents' experience of a reproductive loss. In 1988, my parents lost their six-day-old newborn son due to some health complications, which was compounded by the fact that no doctor was available in the government hospital in the state of West Bengal on the fateful day. Due to the non-provision of the emergency care required for the infant, he did not survive and passed away unfortunately. For me as a privileged Hindu male from India who believes in the cause of feminism and gender justice, this thesis is an important milestone. I say this because this is my

first major academic effort to produce a qualitative study on the lives of men firmly rooted in a feminist design. This thesis has also helped me challenge some of my personal biases and assumptions about Indian society and therefore is of significance to me beyond its professional implications. For instance, I married my girlfriend amidst my fieldwork in November 2019 and given the patriarchal nature of the institution of marriage in India, men are more advantaged. The thesis has helped me to understand some of the constant pressures and challenges faced by women especially around the essentialisation of their roles as child bearers and care givers. My wife and I have had several discussions which link back to some of my discussions in this thesis. I am ever grateful to this thesis and my wife for constantly reminding me of my advantaged identity and privileges which I often took for granted in the past.

1.3 Framing of the issue, questions and objectives

Given the complexity of the issue of men's involvement in maternal reproductive health, I suggest that this issue can be framed and understood as five different interlocking elements (see Figure 1 on p. 21 below), that need to be researched and engaged with. These elements may not be generalisable to other contexts such as higher income neighbourhoods, which are less dependent on the public health system.

- a) **Men's own perspectives, and experiences of antenatal care:** This element focuses on examining expectant fathers' individual subjectivities, masculinities, perspectives on antenatal care, and how they see their own desires, roles, responsibilities, and needs around impending fatherhood.
- b) **Women's perspectives on their husbands' involvement:** Given the biological realities of pregnancy and childbirth, it is imperative that any initiative on men's involvement

should also take cognisance of women's rights and interests. Therefore, it is important to understand women's desires, interests, and perceptions around the idea of their husbands' increased involvement in maternal health processes.

c) Perspectives of community health workers (CHWs) on the idea of men's involvement:

In working class communities, public healthcare delivery is dependent on and influenced by community health workers who are mostly residents of the same communities as their service users. Thus, given their influence and community embeddedness, it is important to understand their perceptions of the gender norms around the role of men in antenatal care.

d) Role of kin members: Given the strong influence of kin members on the reproductive decisions and lives of couples in India, examining the role of kin members, especially mothers and fathers, in influencing men's involvement in antenatal care becomes extremely important.

e) Role of the Indian State: In India (and in most contexts elsewhere), reproduction is highly regulated and influenced by State policies. Multiple scholars and researchers have extensively written on the impact of State policies on women's reproductive lives and bodies in India. In this thesis, I focus on the ways through which State policies influence men's participation in maternal reproductive health.

Framing of The Issue: Men's Involvement in Antenatal Care

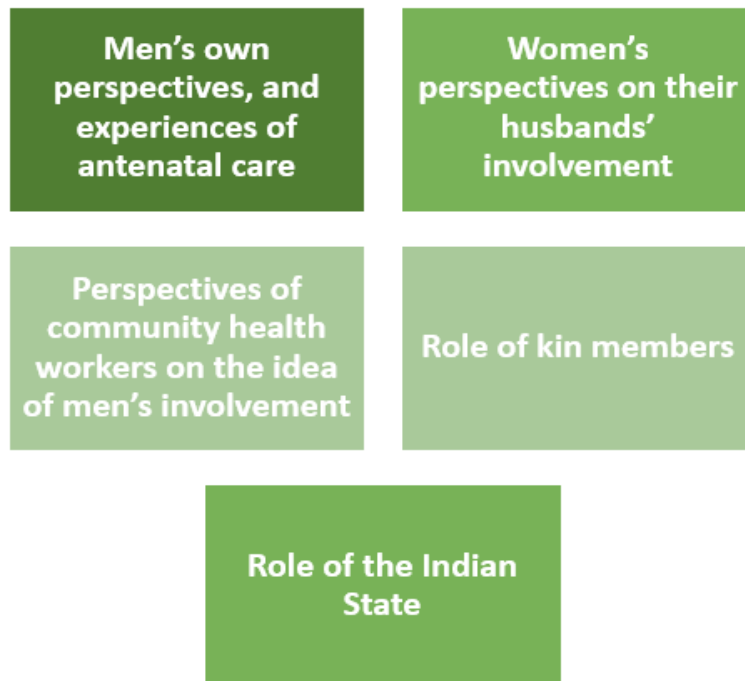


Figure 1 Framing of the issue

Thus, the main research question which shapes this thesis is:

Research question

In what ways is men's involvement in antenatal care conceptualised, experienced, and operationalised in an informal settlement of Delhi?

This research question is further broken down into three sub-questions.

Sub-research question (SRQ) 1: In what ways (and to what extent) does the Indian State

encourage men's participation in maternal health?

SRQ2: What are the perspectives and experiences of community health workers in relation to expectant fathers' involvement in antenatal care, and to what extent do these perspectives limit or encourage men's involvement?

SRQ3: How do expectant fathers construct, perform and navigate multiple masculinities in the realm of antenatal care?

1.4 An overview of India's public health system, maternal health policy, and community health providers

Given that my research is based in a primary urban health centre and focuses on research with health workers and staff, it is important to have a basic understanding of India's public health structure. I have shared a diagram (Figure 2 below), which shows how this system is structured to ensure overall support for Indians.

Figure 2 below (p. 24) represents India's public health system. At the lowest tier are the sub-centres, which cater to a population of 3,000-5,000. However, sub-centres are not present in urban areas like Delhi. A sub-centre is the most peripheral and first contact point between the primary healthcare system and the community. As per the population norms, one sub-centre is established per 5,000 people in plain areas, and per 3,000 people in hilly, tribal or desert areas. A sub-centre provides the interface with the community at the grassroots level, providing all the primary healthcare services. In urban areas such as Delhi, sub-centres are not present, and a primary health centre is the first point of contact. In terms of personnel, the Indian Public Health Standards (IPHS) recommends that two Auxiliary Nurse Midwives (ANM) (one

essential and one desirable) and one Health Worker Male (essential) at every sub-centre. (Ministry of Health and Family Welfare, 2012 (MoHFW)).

The next tier is that of primary health centres (PHCs) which cater to a population of 20,000-30,000. These act as referral units for six sub-centres and refer out cases to Community Health Centres (CHC) and higher order public hospitals located at sub-district and district level. PHCs provide the first level of access to qualified doctors (general practitioners) in rural areas for the sick and those who directly report or who are referred from sub-centres for curative, preventive, and promotional healthcare. In terms of personnel, the recommendation is to have one doctor who is supported by other paramedics and staff (MoHFW, 2012a).

The next tier, the Community Health Centres (CHCs), which constitute the secondary level of healthcare, were designed to provide referral as well as specialist healthcare to the rural population. Indian Public Health Standards (IPHS) for CHCs have been prescribed under the National Rural Health Mission (NRHM) since early 2007 to provide optimal specialised care to the community and achieve and maintain an acceptable standard of quality of care (MoHFW, 2012b). Each CHC should have 30 beds with one operating theatre, labour room, X-ray, and laboratory facilities. The guidelines also suggest that each CHC should have four medical specialists: surgeon, physician, gynaecologist, and paediatrician and 21 paramedical and other staff (Vikaspedia, n.d.).

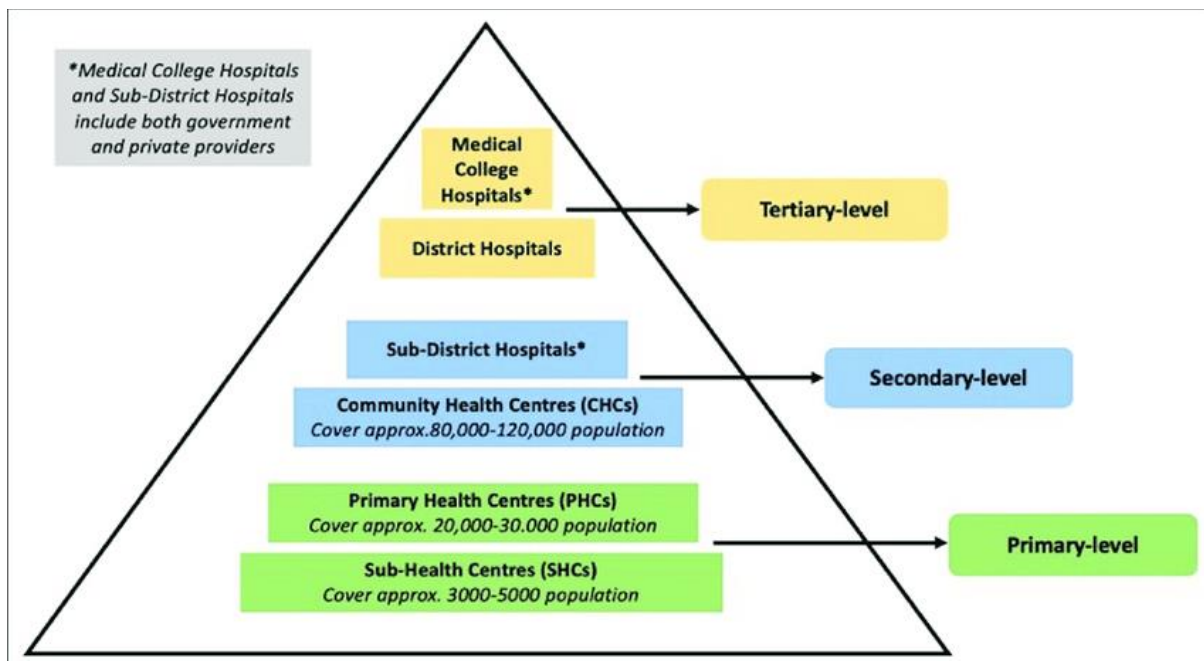


Figure 2 India's public health system structure

(Source: Humphries et al. 2020)

Beyond the CHCs, there are government district hospitals, medical colleges (private and government), and large private hospitals, which offer specialised tertiary care in different regions. In addition to the official public health system, there are also traditional healers and informal practitioners, who fall outside the purview of the health system and official regulations, but they provide various forms of care in rural as well as urban areas. Now, I will give an overview of India's maternal health policies in the next sub-section.

1.4.1 Maternal health in India

Maternal health has been an important policy agenda in India for at least two decades, with a special emphasis on reducing the maternal mortality ratio (MMR). India's MMR has improved from 370/100,000 live births in 2000 to 210 in 2010 to, finally, 145 in 2017, which is the most

recent data available (World Health Organization (WHO), 2019).¹⁰ There has been some improvement in access to antenatal care as well. The percentage of mothers who received at least four antenatal care visits has increased from 51% in 2015-16 to 58% in 2019-20, according to the latest National Family Health Survey (MoHFW, 2022). The number of institutional births has also increased from 79% in 2015-16 to 88% in 2019-20. This improvement has been primarily due to the significant efforts made by successive governments through policies and schemes in the past two decades.

In 1997, India launched the Reproductive Child Health (RCH) initiative which marked the country's in-depth foray into this domain. The attention on maternal health gained further traction in 2005 when the National Rural Health Mission (NRHM) was launched, which included large schemes to improve maternal health outcomes (Ghosh and Ghosh, 2020). For instance, with an objective to reduce maternal mortality rates through institutional deliveries, the government launched the Janani Suraksha Yojana (JSY) – a maternal healthcare scheme under the NRHM and the world's largest conditional cash transfer programme – which incentivises institutional deliveries by paying cash handouts to women for delivering in accredited hospitals. The scheme's launch “coincided with the global interest in the reduction of childhood and maternal mortality because of the Millennium Development Goals (MDG) review process” (Das, 2017, p. 92).

In addition to JSY, the Accredited Social Health Activist (ASHA) community worker programme was also launched in 2005.¹¹ In 2011, the Janani Shishu Suraksha Karyakram (JSSK, Mother Child Protection Program) was launched which provides free and cashless

¹⁰ There are different estimates by different institutions such as the WHO, World Bank, and the Indian Government. However, I have chosen to go with the WHO data here.

¹¹ I will discuss the origins of this programme and given an in-depth overview in Section 1.4

services to pregnant women including normal deliveries, caesarean operations, and treatment for sick newborns (up to 30 days after birth) in public health institutions in urban and rural areas (National Health Portal (NHP), 2015). In 2013, the Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCH+A) strategy was launched which adopted a multidimensional approach to address inequitable distribution of healthcare services for vulnerable population groups and in poor-performing geographies of the country (Taneja *et al.* 2019). In 2017, a previous scheme, Indira Gandhi Matritva Sahyog Yojana (Indira Gandhi Maternity Support Scheme), was relaunched as the Pradhan Mantri Matritva Sahyog Yojana (Prime Minister Maternity Support Scheme). This provides a cash transfer of INR 6,000¹² (around 60 GBP) over three instalments, for all pregnant women aged 19 and above, based on certain conditions such as registration of the pregnancy, attending at least one antenatal care visit, and registration of the birth. Another scheme was launched in 2019, the Pradhan Mantri Surakshit Matritva Yojana (PMSMY, Prime Minister Safe Motherhood Scheme), which aims to provide assured, comprehensive, and quality antenatal care, free of cost and universally to all pregnant women on the 9th of every month (Vikaspedia, n.d.). Under the campaign, a minimum package of antenatal care services is to be provided to the beneficiaries on the ninth day of every month at the clinics to ensure that every pregnant woman receives at least one check-up in the second or third trimester of pregnancy. If ninth day of the month is a Sunday or a holiday, then the clinic should be organised on the next working day.

¹² 1 GBP = approximately 100 INR on 30th July 2022. Therefore 6,000 INR = 60 GBP.



Figure 3 A poster of the PMSMY initiative in the TH20 clinic

(The text in Hindi is exactly what I have explained about this policy initiative in the paragraph above.)

However, despite these achievements and large initiatives, challenges persist as India's public health facilities are in a negligible state and challenges around quality maternal care remain. Das (2017, p. 96) writes, "in context of maternal care, three services—high-quality delivery services, referral services, and life-saving emergency obstetric care services—are still not universally available in all districts". This is particularly important because evidence suggests maternal mortality can be reduced when deliveries are conducted by skilled birth attendants and women have access to emergency obstetric care, given the unpredictable nature of life-threatening complications that can occur at the time of childbirth (Sidney *et al.* 2010). Thus, with public healthcare institutions not being able to provide quality care, women resort to private institutions and traditional medicine practitioners – who can provide care services for money although the quality can be questionable – resulting in high out-of-pocket expenditure. An analysis of government data (Singh, Kumar and Verma, 2016) found that 46.6% of Indian mothers are pushed into poverty due to maternal care expenses which include pre-natal and

post-natal care. The disaggregation of the data revealed that 71.5% of Scheduled Tribes (STs)¹³ women and 49% of Scheduled Castes (SCs)¹⁴ women were pushed into poverty, reinforcing the fact that they are more disadvantaged than other community groups. Therefore, it is evident that despite India's progress in maternal mortality and access to antenatal care, challenges remain which need to be worked upon.

1.4.2 Community health workers

Community health workers (CHW) in India are the backbone of India's public health system. In the context of maternal and newborn health, these workers play a significant role in delivering care services to pregnant women and mothers across 0.6 million villages. Currently, the vast majority of these CHWs are women (Bhatia, 2014). In the context of Rajaji Nagar, my field site, I focus on three cadres of CHWs, all of which are women: a) ASHA workers, b) Anganwadi workers, and c) Auxiliary Nurse Midwives (ANMs), with a dominant focus on the perspectives of ASHA workers as they are the ones most involved in antenatal care. Here, I give an overview of India's different CHW programmes and how India shifted from having male health workers as its dominance workforce to a more women-dominated workforce.¹⁵

Over the last 75 years, several committees and schemes have been established to recommend and implement community health worker programmes in India. Around 1943, prior to India's independence, the Bhore Committee was established by the British colonial government to

¹³ Scheduled Tribes (ST) is an official category for referring to indigenous people of India. They are designated as among India's most socially marginalised and economically backward groups in the country. STs constitute about 8.6% of the country's population.

¹⁴ Scheduled Castes (SC) is an official category for Dalit people, who have been historically considered to be out of the Hindu caste system by upper caste groups. SCs constitute about 16.6% of the country's population.

¹⁵ However, before I move to that discussion, it is important to highlight that while health in India is managed mainly by state governments, the overall guidance, direction, and specific programme-based funding is provided by the national government. Often, many programmes are jointly funded by the national and state governments. In this section, I focus on the overall CHW programmes led by the national government, which were followed by the state governments as a guideline.

suggest and implement healthcare reforms. The committee recommended a sophisticated and formal system of workers with clearly outlined responsibilities and roles to serve the populace. Though most suggestions of the committee were not implemented by the then colonial government, it provided the foundational apparatus for India's public health system for decades to come (Duggal, 1991). In 1962, the national government established the Chadha committee to focus on malaria eradication among the Indian population (NHP, 2015a). Among many of its recommendations, one was "training of personnel engaged in specialized mass campaigns to become multi-purpose workers that so they can continue to follow up the measures required for the maintenance phase as a part of routine health activities" (NHP, 2015a, p. 4). These multipurpose workers had the duties of vital statistics collection, family planning, and malaria vigilance. The guidelines also recommended one male health worker specially for family planning. In 1973, the government further set up the Kartar Singh committee to make recommendations for India's public health system. This committee's prime focus was to conceptualise and outline the roles and responsibilities of multipurpose health workers (MPHW, male and female) workers (NHP, 2015b). In the context of maternal health, the committee's recommendations marked an explicit shift from hiring male health workers to female workers. The committee stated, "it would not be possible for them (male workers) to undertake maternity work for they would not be acceptable to the community in this role" (NHP, 2015b, p. 16). The committee termed MPHW (male) as the grassroots health functionary for the control of communicable diseases including malaria, tuberculosis, leprosy, water-borne diseases, as well as environmental sanitation, detection of disease outbreaks and their control, and health education (NHP, 2015b). Furthermore, in the 1970s, two further cadres of CHWs were introduced by the national government, which focused on having women health workers tasked with implementing specific tasks and achieving certain objectives around maternal child health: one, Anganwadi workers and two, Auxiliary Nurse Midwives (ANMs).

a) Anganwadi Workers, Integrated Child Development Services (ICDS): In 1975, the United Nations Children’s Fund (UNICEF) and the World Bank supported India to launch the ICDS scheme, which aimed to provide maternal and newborn care services to women and children. The programme has evolved and currently offers health, nutrition and hygiene education to mothers, non-formal pre-school education to children aged three to six, supplementary feeding for all children and pregnant and nursing mothers, growth monitoring and promotion, and links to primary healthcare services such as immunisation and vitamin A supplements (Ministry of Women and Child Development, n.d.). Every Anganwadi centre hires two local women, one would be Anganwadi (which means courtyard) worker and another Anganwadi helper (Bhatia, 2014). The Anganwadi worker’s main roles are to manage the centre, survey families, enrol eligible children, conduct pre-school activities, plan, and organise immunisation sessions with the ANM from the primary health centre and make home visits. The helper’s role is mainly supporting the worker and other duties such as bringing children to the centre, cooking food for them and helping in overall maintenance. They receive a monthly fixed honorarium for their duties. Currently, there are around one million Anganwadi workers across the country and around 22,000 in Delhi (Newslick, 2022).

b) Auxiliary Nurse Midwives: The Auxiliary Nurse Midwife (ANM) is the oldest cadre among the CHWs, established in the 1970s. They are trained personnel with 18 months of training on family planning, immunisation, and maternal child health programmes (Scott, Javadi and Gergen, 2018). When the ANM programme was launched, they received two years of training focused primarily on MCH, with midwifery being the focus of nine out of the 24 months of training as they were envisioned to be village-level midwives with “less than full qualifications” (Scott, Javadi and Gergen, 2018, n.p). Within a decade after their introduction,

the role of ANMs was expanded to include a wide range of preventive and curative work at the village level, particularly around family planning and immunisation. With the expansion of their role, ANMs transitioned from temporary to permanent staff within the health system. At the same time, ANMs were also reclassified in the health system, from a nurse-midwife to a female MPW (Scott, Javadi and Gergen, 2018). Currently, there are around 200,000 ANMs in India (Karvande *et al.* 2020).

In addition to introducing these maternal child health oriented CHW programmes, in 1977, the *Swasthya Rakshak* Scheme (Health Saviour Scheme) was launched which aimed to provide overall basic healthcare services to rural Indians. Inspired by China's Barefoot Doctors model, the programme recruited 400,000 male health workers called *Swasthya Rakshaks* spread across multiple states (Bhatia, 2014). This programme, though launched with much fanfare, experienced several problems, including lack of political commitment, resistance from the bureaucracy, administrative lapses, poor resource allocation, and lack of cooperation from the doctors and nurses. Bhatia (2014a, p. 43) writes that an important reason for failure of this programme in 1977 as opined by expert analysis was the selection of males as CHWs, because the men were looking for economic gains from the post, due to pervasive unemployment at that time. Ved. *et al.* (2019, p. 4) also found: "One of the problems earlier [the *Swasthya Rakshak* Scheme] was that every male would [want] to become a [unlicensed] doctor and then would start practicing". Bhatia (2014), however, notes that a major reason for discontinuing this programme was the national government's discomfort towards the protests by *Swasthya Rakshaks* for their rights. In addition to this, due to the growing significance of the maternal child health agenda of the Indian State— as evidenced by the ANM and ICDS programmes — the then government began transitioning to women CHWs from a male-dominated community health workforce (Bhatia, 2014). Eventually, the programme's funding was reduced until the

programme completely came to a halt in 2002 (Press Information Bureau, 2016). However, the MPHW role at the sub-centre level recommended by the Kartar Singh committee in 1973 remained in place.

Even at the time of Census 2001,¹⁶ only 38% of India's community health workforce were women (Anand and Fan, 2016, p. 16). This could be attributed to the fact that until the 1990s, women had to be encouraged to register as CHWs, because they were seen to be less qualified than men, not meant to work outside their homes, and because of early age marriage, among other gender-related issues (Community Health Awareness Research and Action, 1997). This is an interesting paradox as, in the 1990s, there was a political commitment to hire more women as health workers, but not much changed until 2005, when the Accredited Social Health Activist (ASHA) worker programme (discussed in depth after this paragraph) was launched nationally with much fanfare. This transition from predominantly having men as health workers to the feminisation of the health workforce, in addition to the reasons (behind men leaving MPHW roles or showing any interest) discussed above, has reached a point where recruitment and availability of MPHW (male) has declined considerably, leading to some state governments¹⁷ declaring MPHW (male), as a “dying cadre” (MoHFW, 2010, p. 3) and stopping recruitment of men as MPHWS completely. It is pertinent to add that currently, some Indian states still have an official post of MPHWS¹⁸ at the sub-centre level. As per the latest government data in 2019-20, 65.5% of these posts are lying vacant.

¹⁶ Census is held after every 10 years in India. Previous years of Censuses include: 1981, 1991, 2001, 2011. The Census due in 2021 hasn't yet commenced due to the COVID-19 pandemic

¹⁷ As mentioned in a previous footnote, state governments usually follow the overall guideline recommended by the national government and committees.

¹⁸ The official role of MPHW (male) is to mainly focus on activities which are related to disease control programmes, detection and control of epidemic outbreaks, environmental sanitation, safe drinking water, first aid in emergencies like accidents, injuries, burns, treatment of common/minor illnesses, communication and counselling, lifestyle diseases, and logistics and supply management at the sub-centres. In addition, they are supposed to facilitate ANM in MCH, family welfare, and nutrition-related activities (MoHFW, 2010).

1.4.2.1 ASHA workers

In April 2005, the Indian government launched the National Rural Health Mission (NRHM) with the goal of improving the availability of and access to quality healthcare by people, especially for those residing in rural areas, the poor, women, and children (MoHFW, 2005). As I mentioned in the previous section, with an objective to reduce the maternal mortality rate by promoting institutional deliveries, the government of India launched Janani Suraksha Yojana (JSY), a maternal healthcare scheme under the NRHM, which incentivises institutional deliveries by paying cash handouts to women for delivering in accredited hospitals. As part of the NRHM and JSY, the government launched the Accredited Social Health Activists (ASHAs) scheme, who are women CHWs employed by the governments to manage maternal and childcare services in villages.

Originally conceptualised for providing maternal care services, the roles and responsibilities of ASHAs have increased over the years. Termed as “agents of change” (Government of India, 2005, p. 65), they are among the most overworked and underpaid health workers in India despite performing some of the most critical public health functions in challenging geographies and conditions. Their roles and responsibilities include the promotion of institutional deliveries, referrals of pregnant women to the nearest primary health clinics, vaccinations for pregnant women and infants, family planning services, and other activities¹⁹ required from time to time. ASHA workers were also key stakeholders managing the COVID-19 pandemic in India. Their responsibilities in the COVID-19 pandemic included contact tracing, surveillance, awareness

¹⁹ “The ASHA programme guidelines envisage three different roles for ASHAs. First, ASHAs should be a ‘link worker’, a bridge between the rural and vulnerable population within the health service centres. Second, ASHAs are to function as ‘service extension workers’, whereby they are trained and provided with a kit that includes commodities such as condoms, oral contraceptive pills, delivery kits and simple life-saving drugs including cotrimoxazole and chloroquine. Third, they are conceptualised as ‘health activists in the community who will create awareness on health and its social determinants and mobilize the community towards local health planning and increased utilization and accountability of the existing health services’” (Saprii *et al.* 2015, p. 3-4).

and, most recently, door-to-door vaccinations in remote parts of the country (*Times of India*, 2020). However, ASHAs do not receive a permanent fixed salary; rather, they must earn their income through a system of incentives which works on a per use basis. For instance, they receive performance-based incentives for promoting universal immunisation, referrals, and health escort services for Reproductive and Child Health and other healthcare programmes, and for ensuring the construction of toilets (National Health Mission, n.d.). Currently, there are around 1.05 million ASHA workers across India (Ambast, 2021).

1.4.3 Informal and private health providers

Until now, I have given an overview of the history and status of the community health workforce in India. However, India's health sector is highly pluralistic. Due to the poor and often questionable quality of the public health system, Indians often seek care from informal and private health providers. Almost 80% of outpatient and 60% of inpatient care in India is provided by the private health sector (Bader, 2017). Moreover, a significant proportion of informal and private health providers are men, as found in multiple studies (Kumar *et al.* 2007; Das *et al.* 2016; Rao, 2005; Jeffery and Jeffery, 2010) An analysis of official data on registered private rural medical practitioners (RMPs) found that 95% are male (Rao, 2005), with North India reporting the lowest (2%) and South India reporting the highest (11%) numbers of female RMPs relative to male workers.

In Uttar Pradesh, India's most populated state, with a high MMR, women regularly access maternal healthcare from informal and private providers (Sharma and Mukherjee, 2014; Thakur *et al.* 2017) for various reasons. "These practitioners are one of the essential providers of maternal healthcare" (Sharma and Mukherjee, 2014, p. 188). A research study by Jeffery *et al.* (2007, p. 173) found that many families sought the services of unregistered male

practitioners for childbirth and pregnancy care services. “In the early 2000s, male practitioners were called to attend established labours that the labouring women and/ or their female family members and *dais* (traditional birth attendants) considered to be protracted” (Jeffery *et al.* 2007, pp. 173-174). The role and scope of these informal male and private practitioners in relation to maternal care services has been studied to some extent in India by some scholars (George, 2007; Iyengar, Iyengar and Gupta, 2009; Sharma and Mukherjee, 2014; Unnithan, 2019). In Rajaji Nagar, there are several private practitioners and informal providers who offer health services, and I was able to speak with two of them who provided some insights around the prevailing gender norms and practices in maternal care in the community (See Chapter Five).

1.5 Masculinities in India

Masculinities has been a significant area of academic interest among Indian scholars for several decades. This is demonstrated by the fact that researchers from multiple disciplines such as history, sociology, anthropology, gender studies, and political science, have interrogated how Indian men construct, perform and navigate their masculinities across different spheres of life. For instance, significant work has been done in the context of India’s colonial past, where scholars have examined the impact of the colonial rule on masculinities of Indian men varying across class and castes (O’ Hanlon, 1997; Sinha, 1995, 2002; Gupta, 2010; Chakraborty, 2014). Beyond the exploration of masculinities from a colonial and historical lens, the literature in India also examines masculinities and its intersections with various domains such as films (Sen, 2018), Hindu nationalism (Srivastava, 2010; Basu and Sarkar, 2022), South Asian influences (Chopra, Osella and Osella, 2005), Indian culture (Sivakumar and Manimekalai, 2021), and intimate partner violence (Priya *et al.* 2014). These studies of masculinities in India highlight dominant notions of masculinities, predicated around ideas of control, power and dominance, which is in resonance with Connell’s (2005) conceptualisation of hegemonic masculinities. Such notions of masculinities are inspired by heteronormative patriarchal structures that

reinforces the gender hierarchy and maintain the hegemonic power of men and subjugation of women. For instance, in their study on masculinity, son preference and gender-based violence in India, Priya *et al.* (2014) found that men who harbour and internalise hegemonic masculine norms are more likely to have stronger son preference for their families. They also found that these notions of masculinities are correlated with higher intimate partner violence.

These traditional and dominant masculinities are, however, being challenged in parts of India, with men from different communities – influenced by broader political economy changes or programmatic interventions by NGOs and community organisations – moving away from toxic and hegemonic versions of masculinities (George 2006; Philip 2018; Roy and Das 2014; Burgher and Flood 2018; Das 2019). For instance, in her study of working class men in Mumbai, India, George (2006, p. 49) found that “traditional male authority, which rested on the axes of men’s economic provisioning, control over wives, and violence against women, is eroding in newer social conditions in which women are more autonomous”. This fluidity is leading men to normalise emerging and new forms of masculinities that allow them to claim honour while doing non-traditional gendered actions (George, 2006, p. 35). In another example, an evaluation of a community intervention on gender equality in rural Maharashtra by Roy & Das (2014) found that men renegotiated their masculinities to share their power, leading to an improved status for women in these villages.

Despite these promising studies, one must be cautious and not lose sight of the fact that the emergence of new and non-traditional forms of masculinities does not mean that traditional and dominant forms of masculinities have completely disappeared. In the past few years, due to rising Hindu nationalist politics in India, more virulent and toxic forms of masculinities have taken root among young Hindu men in India (Kinnvall, 2019; Tyagi and Sen, 2019; Das, 2023; Basu and Sarkar, 2022). These virulent and toxic forms of masculinities are being encouraged

and leveraged by Hindu nationalist groups to foment violence against minorities and women in India. This suggests that, in India, a dominant form of masculinities that reinforced gender hierarchies and marginalised women, is still prevalent, yet simultaneously a wide range of masculinities are at play in India, and all these masculinities are in flux.

While this thesis explores men's involvement in maternal health in India, in so doing it also contributes to the broader understanding of masculinities in India, especially in the urban context. In keeping with the literature discussed above, it shows that masculinities among Indian men appear malleable and amenable to change. There has been significant work done on masculinities in urban areas such as by Lohokare (2016), Philip (2018) and Chakraborty, Osrin and Daruwalla (2020), which demonstrate its malleability among young Indian men. My thesis has a distinctive focus on how working-class men in urban informal settlements are constructing and performing their masculinities as expectant fathers and navigating pregnancy and childbirth, a domain that has traditionally been associated with women. As I will discuss in Chapter Six, there are various ways in which some men are re-constructing their masculinities to be able to be involved in antenatal care in India. As suggested above, there are changes happening to masculinities among men across India, yet with little examination of how men feel about their roles as expectant fathers and navigate their masculinities in the realm of antenatal care. My discussion in Chapter Six shows how expectant fathers' masculinities can influence antenatal care patterns but does not lose sight of the prevalence of hegemonic masculine norms in the society that essentialise reproduction as a woman's job.

1.6 Sequence and summaries of chapters

The rest of the thesis is organised into the following chapters.

Chapter Two: Literature review and theoretical framework

This chapter critically reviews and summarises the literature on men's involvement in maternal health, antenatal care, and reproduction globally and identifies the research gaps which this thesis seeks to address. For the review, I draw upon different disciplines and categories of literature such as development studies, anthropology, nursing, midwifery, gender studies, and psychology. I also highlight the theoretical framework for my thesis; that is, a critical studies of men and masculinities (CSMM) approach, which has informed my research design and writing of this thesis.

Chapter Three: Navigating the labyrinths of fieldwork: research methodology, field site and experiences

In this chapter, I outline the research methodology and describe the various data collection methods that I used. I also give an in-depth description of my field site, Rajaji Nagar, and the clinic, where I conducted most of my research. Given that my research was a qualitative study, my first such independent endeavour, I also share my experiences, reflections, and ethical challenges involved in the process of knowledge production. Finally, I discuss the impact of COVID-19 on my research and explain how my research was adapted to accommodate this pandemic.

Chapter Four: 'Woh nahi chahte ki hum andar aaye'²⁰: exploring the Indian State's approach towards men's involvement in maternal health

In this chapter, I examine the Indian State's approach towards men's involvement in maternal health. To do so I examine and analyse the perspectives and experiences of different reproductive maternal health practitioners and researchers who have worked in this field for

²⁰ This translates to: They do not want us to go inside. I will discuss this in-depth in Chapter Four.

several years. I also draw upon my ethnographic observations of everyday antenatal care processes at the TH20 primary healthcare clinic in Rajaji Nagar to give a holistic overview. Finally, I juxtapose these two analyses and offer a broader view of the State's approach.

Chapter Five: Community Health Workers' notions, perceptions and conceptualisations of men's roles in antenatal care

In this chapter, I shift my level of analysis and discuss the individual perspectives of community health workers: ASHAs and Anganwadi workers, and how they perceive and position the idea of men's involvement in antenatal care. Within this analysis, I also outline the prevailing gender norms and practices through which the idea of men's involvement in antenatal care is constituted. I explore their perspectives through three lenses: as local women residents, as government health functionaries and finally as women caring for other women. I also illustrate CHWs' conceptualisations and perceptions of men's involvement in antenatal care as a theoretical concept.

Chapter Six: Men's subjectivities, emotions, and vulnerabilities during expectant fatherhood

This chapter focuses on men's emotions, feelings, vulnerabilities, and subjectivities during the antenatal period and how they leverage these emotions to construct their caring masculinities. I also highlight the relationality of these masculinities and how these are constructed in relation to their kin members (especially their mothers) and household dynamics. Drawing upon my fieldwork conversations with expectant and new fathers, I delve into how these masculinities are constructed, performed, and locally negotiated by expectant fathers to guide their decision making and to engage in the care of their wives and families.

Chapter Seven: Conclusion

In this chapter, I offer my concluding thoughts and arguments.

Chapter Two: Literature review and theoretical framework

In this chapter, I explore and provide an overview of the existing literature and research on men's involvement in reproduction issues. I also highlight the research gaps in these categories of literature and how my thesis aims to address specific gaps in the context of India.

The 1994 International Conference on Population and Development (ICPD) in Cairo, to which India was a signatory, recognised that special efforts and attention must be given to husbands' roles and responsibilities in order to promote their active involvement in responsible parenthood and sexual and reproductive behaviour (ICPD, 1994). This recognition regarding the importance of men's roles was a landmark turning point for the domain of men's involvement in maternal reproductive health in the international development arena. Ever since, academic and policy focus around male involvement in maternal, reproductive, and newborn health has significantly increased, which has manifested in the form of programmes, interventions, and evaluation studies, especially in the non-western world and in low- and middle-income countries (LMICs) where social and cultural norms around engaged expectant fatherhood and male caregiving were not prominent.

However, the situation in western nations and high-income countries such as the United States of America (USA), United Kingdom (UK), Ireland, and especially Nordic countries is quite different. Extensive literature in these contexts (prior to as well as post-ICPD 1994) as compared with LMICs has primarily existed because the debate around men's involvement in reproductive matters (men's presence at birth, in labour rooms and in gynaecological spaces) gained ground a few decades earlier than in most LMICs. For

instance, in the context of the UK, Early (2001, p. 163) writes: “since the 1970s, men have been encouraged to take up an active role in childbirth and, to a lesser extent, pregnancy. This has resulted in fathers becoming participatory in maternity services”. The concept of men’s roles and involvement has been investigated in many disciplines such as gender studies, anthropology, psychology, nursing, middle eastern studies, clinical medicine, and sociology among others, which makes the literature from high-income nations quite diverse.

Based on my review and analysis of these disciplines, I broadly categorise the literature on men and reproduction into three different strands. One, the impact of men’s instrumental involvement on women’s maternal reproductive health (mostly in quantitative and instrumental terms) as discussed in Section 2.1 below. Two, studies on individual men’s masculinities, emotions, subjectivities, and experiences in relation to reproduction processes and fatherhood, discussed in Section 2.2. Three, men’s reproductive bodies, health needs and desires, which is addressed in Section 2.3. Within each strand, I describe and highlight the different studies and evidence that currently exist in HICs as well as LMICs. In Section 2.4, I give an overview of existing literature on men’s involvement in India and highlight the potential research gaps and areas of further inquiry. In this section, I also give an overview of the literature on community health workers and the Indian State, which I refer to and use widely in my thesis. In Section 2.5, I discuss my theoretical framework and conclude the chapter.

2.1 Impact of men’s involvement in maternal health from an instrumental perspective

As I noted above, the 1994 ICPD Cairo conference has been one of the primary catalysts promoting the idea of men’s involvement among public health and international

development sectors because it recognised that special efforts and attention must be given to husbands' roles and responsibilities and their active involvement in responsible parenthood and sexual and reproductive behaviour should be promoted (ICPD, 1994). Ever since the conference's explicit focus on men's roles, there has been an upswell of interest in male involvement in maternal and newborn health (Comrie-Thomson *et al.* 2015). This interest has translated into several research studies, initiatives, and interventions across countries, especially LMICs (Barua *et al.* 2004; Mullany, Becker and Hindin, 2007; Singh and Ram, 2009; Carter, 2010; Kululunga *et al.* 2012; Ganle *et al.* 2016; Peneza and Maluka, 2018; Mwije, 2018, Mkandawire and Hendriks, 2019) which have attempted to 'involve' men in their wives' maternal reproductive health and examined their perceptions regarding antenatal care through a quantitative as well as a qualitative lens.

These studies have had mixed findings. For instance, the study by Mullany, Becker and Hindin (2007) was a randomised controlled trial, which evaluated the impact of involvement of male partners in antenatal health education on maternal healthcare utilisation and birth preparedness in urban Nepal. The study found that women who received education with husbands were more likely to attend a post-partum visit than women who received education alone or women who received no education. In rural central Malawi, Mkandawire and Henriks (2019, n.p.) found "men also play a supportive role in food preparation, helping women access diverse diets during and after pregnancy. They also take up a supportive role in household activities, providing women with assistance in housework and looking after children". However, a crucial study by Ganle *et al.* (2016) in Northern Ghana found that while most women understood the significance of men's involvement, not many women supported an increased role for men, and they expressed negative attitudes towards involving them.

A key critique is that many interventions and studies on men's involvement are rooted in a reductionist and instrumentalist approach that researches the utility of men's involvement and

aims at altering their behaviours without addressing the underlying gender influences or investigating the subjectivities, perceptions and attitudes towards maternal health that drive men's behaviours (Comrie-Thomson *et al.* 2015; Tokhi *et al.* 2018). Such an approach has an overarching focus on men's external actions and behaviours rather than their internal subjectivities, feelings, and emotions towards reproductive processes (Comrie- Thomson *et al.* 2015, p. 182). A systematic review (Galle *et al.* 2021) of 282 quantitative studies on male involvement conducted in different countries found that a significant proportion of studies focused on men's presence at ANC check-ups or Human Immunodeficiency Virus (HIV) testing,²¹ which is a testimony to the overarching focus on implementing instrumental male involvement policies. This review by Galle *et al.* (2021) also resonated with the findings of Comrie Thomson *et al.* (2015) in the sense that most studies included in the review did not collect data directly from men and even fewer studies assessed the potential benefits of male involvement for fathers or mutual perceived support. Thus, while the ICPD 1994 conference led to huge interest in the idea of male involvement in maternal reproductive health, the relative absence of research on men's internal feelings, emotions and subjectivities around their roles remains an important issue.

There is also ambiguity about how male involvement is defined in this literature and evidence base. The review by Galle *et al.* (2021) found that this instrumental focus has resulted in male involvement being defined narrowly by fixed indicators. The review further found that key aspects of male involvement such as communication, decision making and 'feeling supported' were rarely included as male involvement indicators. Pursuant to this, my review, and an analysis of 282 studies on men's involvement by Galle *et al.* (2021), suggest that in most studies, male involvement indicators – be they antenatal care (ANC) attendance,

²¹ There is significant literature on the impact of men's involvement in relation to HIV-infected pregnant women which I will discuss later in this section.

check-ups, skilled attendance²² at birth, or presence during labour – have a ‘medicalisation of birth’ undertone. In other words, a husband’s involvement is mostly examined through the lens of him attending medical check-ups, attending medical institutions, or activities related to medical care (Singh and Ram, 2009; Kululanga *et al.* 2012; Yargawa and Leonardi-Bee, 2015; Penez and Maluka, 2018).

I suggest that a unilateral focus on indicators (or statistics) which measure men’s presence or tasks performed by them conceals the social, cultural, economic, and political realities surrounding reproduction and maternity. For instance, among the Wari community in Brazil, a man’s claim to fatherhood is not determined only through biological conception (Conklin and Morgan, 1996). Rather, post-conception social nurturance must be provided to the foetus through regular sex and semen. This means that, if a woman has sex with another man during pregnancy, this man can also claim fatherhood (1996, p. 685). Therefore, in the Wari community, nurturing a foetus through semen is a marker of male involvement and responsibility, but this is not acknowledged as a form of responsibility and is not measured statistically in the wider literature. Early (2001, p. 163) writes: “there has been an emphasis in the practitioner literature on men taking an active role in labour through greater levels of physical involvement, as getting men to do something practical is thought to be the best way to integrate them in childbirth events”. Singh and Ram (2009) examined the factors influencing male involvement in pregnancy and childbirth in Maharashtra, India. The two indicators used by them focused on husbands’ physical presence and involvement and men’s visits to antenatal care check-ups. However, based on my fieldwork and research - which I will talk about in-depth in further chapters - I find resonance with Ginsburg and Rapp’s (1991, p. 328) arguments

²² The World Health Organization (WHO) advocates for skilled care at every birth. Ensuring quality maternity care services can save the lives of women and newborns. These services require an accredited health professional – such as a midwife, doctor or nurse – who has been educated and trained to proficiency in the skills needed to manage normal (uncomplicated) pregnancies, and childbirth. (WHO, 2016)

that: “physical absence of husbands during childbirth should not be construed as lack of male involvement. Neither men nor women are naturally absent, their segregation is socially constructed and continually renegotiated”. Therefore, my thesis intends to investigate the concept of male involvement beyond the fixation of men being ‘physically present.’ I intend to delve deeper and find out how men navigate pregnancies and construe their own roles and responsibilities as expectant fathers.

Significant research has been conducted on the impact of men’s involvement in maternal health for HIV-infected pregnant women and preventing mother-to-child transmission.²³ I found that most research is concentrated in the African region due to the wide prevalence of HIV in African countries. For instance, Msuya *et al.* (2008) investigate the implications of men’s involvement in antenatal HIV preventive programmes in Tanzania. Aluisio *et al.* (2011, p. 76) investigate “the relationship between male involvement in prevention of mother-to-child HIV transmission services and infant HIV acquisition and mortality in Nairobi, Kenya”. Another study in Kenya (Farquhar *et al.* 2004) found that antenatal couple counselling has a positive effect on preventing HIV transmission. Furthermore, there are some systematic reviews. Triulzi *et al.* (2019) analyse the effectiveness of interventions involving men living with HIV-positive pregnant women, whereas Morfaw *et al.* (2013) review the existing studies and interventions to summarise the factors facilitating men’s involvement in prevention programmes relating to mother-to-child transmission of HIV. While discussing the findings of these studies in depth is beyond the scope of my thesis, broadly, these studies argue that men’s involvement in the

²³ The HIV burden and scale of the issue is much larger in African countries than India which is why there is a plethora of research, initiatives, and programmes at the intersection of HIV and maternal health in those countries. Although HIV is still a problem in India, it has not really been a problem in the context of pregnant women getting infected. Thus, I do give an overview of the literature on men’s involvement in HIV-infected women’s antenatal care in this section but do not delve deeper into or engage with it any further in this thesis.

maternal health of HIV positive women has a positive impact on uptake of antenatal care services and eventually health outcomes.

2.2 Men's masculinities, subjectivities, and experiences of fatherhood

Although many studies have an instrumental perspective on men's involvement in maternal health and study the issue through a quantitative lens, I now examine studies on men's masculinities, emotions, and subjectivities in relation to expectant fatherhood and fatherhood in general. This literature has emerged from disciplines such as anthropology, gender studies, sociology, nursing, and medicine. My review of the literature suggests that a significant amount of research has been conducted in high-income and western countries at the intersection of men, fatherhood, and masculinities (Foster, 2003; Williams, 2009; Ivry, 2009; Inhorn, Chavkin and Navarro, 2009; Hadley and Hanley, 2011; Deeney *et al.* 2012; Brandth, 2014; Farstad and Stefansen, 2015; Johnsen *et al.* 2016; Rice *et al.* 2017; Hamm *et al.* 2019; Law, 2019). However, the term 'male involvement' or 'men's involvement' may not necessarily have been used in every study.²⁴ These studies also cover a vast range of men belonging to diverse backgrounds: low-income families, homeless families, rural residents, and upper class men in cities. I highlight a few studies here.

Williams (2009) explores the commonalities and differences between white and African-Caribbean working class fathers in the UK through the Connell's (1995) framework of masculinities. The study provides evidence that masculinities of African-Caribbean fathers are changing, and fathers are resisting hegemonic masculine norms to spend time with their children. It also emphasises the importance of reorienting health and social care services to meet these fathers' needs (Williams, 2009). In Northern Ireland, Deeney *et al.* (2012) also used the lens of masculinities to explore the gendered experiences of fathers

²⁴ I suggest that this is because these terms are rooted in a development studies perspective, but the absence of these terms should not be construed as a lack of literature in this domain.

whose newborn children were admitted in a Neonatal Intensive Care Unit (NICU) setting. The study found that these men constructed new masculinities and identities during birth, but over time, they acknowledged women as the main caregivers. They also mentioned encountering resistance and challenges from their partners and health professionals during this process of forging new identities and masculinities. More recently, Baldwin *et al.* (2019) examined the experiences, mental health and wellbeing needs of first-time fathers in the UK. A major finding of this study was that men expressed their desires to be supported as expectant fathers during the perinatal period. A key commonality among these studies was that fathers from multiple ethnicities and backgrounds are expressing their desires to move away from traditional gender norms and have an increased involvement in childcare and fatherhood. Thus, these desires and needs should be supported by social care, health, and State services to facilitate newly emerging conceptions of fatherhood as well as encouraging gender-equal parenting norms.

In the Nordic region, which is known for its progressive policies and gender equality agendas, Brandth (2014) explores the constructions of rural masculinities through fathering practices in Norway and examines the potential for development of alternative rural masculinities among men through the experiences of fathering. His study found that there is an increasing involvement in childcare by these fathers in rural Norway, which indicates an incremental shift towards more egalitarian practices of parenting. In a cross-country study of British and Swedish fathers, Plantin, Mannson and Kearney (2003, p. 3) argue that “men’s practices as fathers are shifting toward more involvement in childcare and household labor and that this process can be assisted by structural changes and social policy initiative”. Johnsen *et al.* (2016) investigate the experiences of first-time expectant fathers in Finland, Sweden, and Denmark and found that fathers were interested to engage and participate in pregnancy processes, but the approaches of healthcare professionals can affect their

experiences of feeling excluded or included as fathers. In the context of Iceland, Farstad and Stefansen (2015) assess the narratives and practices around involved fatherhood in the country. Their study found that the concept of involved fatherhood is not homogeneous; rather, it needs to be further deconstructed and explored contextually in terms of its potential and limitations for egalitarian parenting.

Therefore, as I highlighted, there is a vast range of studies on men and fatherhood from different standpoints and perspectives in the North American and European regions. However, it would be incorrect to suggest that such research is only concentrated in western and high-income nations. Indeed, a chunk of these studies are Europe and North American-centric, but a sizeable amount of work has also been done on men in other countries as well. I would like to highlight an important monograph 'Globalized Fatherhood' (Inhorn, Chavkin and Navarro, 2009) which offers compelling insights on men, masculinities, and experiences of fatherhood from different countries. From the East Asian region, Lam and Yeoh (2015) explore the changing fathering practices in Indonesia and found that amid the rapid feminisation of labour migration, fathers are increasingly showing affinity towards changing their everyday gendered roles through incremental steps, even though large institutional and societal changes are much slower. Thao (2015) documents the experiences of stay-at-home fathers in rural Vietnam where mothers migrate to the capital city of Hanoi for better economic opportunities. He found that while fathers are involving themselves in care work and domestic tasks and prioritising children's interests over masculine pride, some fathers consider this as a stop-gap measure and aspire to return this role to their wives when they return home (Thao, 2015). Treymane (2015) analyses the different faces of fatherhood among Iranian fathers in the context of the changing political order following the 1979 Iranian revolution. She found that considering the changing behaviour of children due to globalisation, Iranian fathers have resorted to renegotiating their

fatherhood ideals to ensure that they remain in control and avoid facing flak for failing to maintain their authority over children (Treymane, 2015). Going towards Latin America, Olavarria (2003) writes about how fathers are undertaking caregiving and childcare in Chile, but these practices are not disrupting care dynamics and gender norms radically. More recently, a doctoral thesis (Powis, 2020) explored the subjectivities and experiences of expectant fathers in Senegal and found that men are indeed involved in antenatal care and parenthood. However, the thesis further argued that local understandings of involvement and fatherhood differed significantly from those propagated by the global health and international development agenda.

Although all these studies have been conducted in varied contexts and have different departure points, a common theme is persistent among them; that is, fathers across the world are responding to different challenges and situations and reconstructing their masculinities to adopt new forms of fatherhood. However, this restructuring of their masculinities and roles is not necessarily translating into a radical upending of gender norms and practices and overall social and cultural change remains a slow work in progress.

Despite the vast literature on men, masculinities, and fatherhood, my review suggests that there is still a research gap regarding understanding men's experiences during the antenatal and pregnancy period (Eddy and Fife, 2021) and men's roles as expectant fathers are still under-researched, especially through a cultural lens. Almeling and Waggoner (2013, p. 832) write: "While men's reproductive contributions are seen as significant when it comes to conception and equal to women's when it comes to genetics, their role in pregnancy is understood as negligible. Among those working in preconception care,²⁵ there was little

²⁵ Preconception care is defined as a set of interventions that aim to identify and modify biomedical, behavioural, and social risks to the woman's health or pregnancy outcomes through prevention and management. (Department

discussion of men in this stage of the reproductive process”. I suggest that understanding men’s lives during the pregnancy period is particularly important as they transition from being husbands to being fathers (applicable for first-time fathers mainly). Thus, this period is a crucial window for engaging with men to advance the idea of gender equality in reproduction work, which is why researching men’s lives during this period is critical.

The above studies show that men from diverse backgrounds, classes, ethnicities, and income levels have varied experiences as expectant fathers, new fathers, caregivers, procreators, and husbands. As I discussed, in many cases, expectant fathers are also creating their own meanings and conceptualisations of fatherhood as well as navigating their reproductive lives (Olavarria, 2003; Williams, 2009; Deeney *et al.* 2012; Lam and Yuoh, 2015). Drawing inspiration from these studies, I research men's experiences in antenatal care in an informal settlement in Delhi to understand the distinct cultural ways in which working class men are navigating expectant fatherhood (see Chapter Six).

2.3 Men’s reproductive health, desires and needs

The third strand of literature is focused on men’s reproductive bodies and health. More specifically, I refer to a foregrounding of men’s reproductive lives, their own health, and the associated politics (or lack of) around it.

A recent book ‘GUYnaecology’ (Almeling, 2020) examines the reasons behind the omission of research on men’s reproductive health and bodies, despite the expansive literature on men and masculinities in social sciences. She argues that the production of biomedical knowledge led to an asymmetry where links between women’s health and pregnancies kept emerging, leading to further areas of research, while men’s exclusion from reproductive health kept on increasing (Grainger, 2021).²⁶ This asymmetry has also

of Health, New York, n.d.).

²⁶ I was not able to access the book online or as a hard copy, so I relied on a review (Grainger, 2021) of the book

extended to social sciences wherein histories of women's reproductive rights, experiences of pregnancy and motherhood, and other related subjects have been more widely researched, while equivalent stories for men are relatively under-researched – though this has undergone significant change in the past few years (Grainger, 2021).

In an edited volume '*Reconceiving the second sex: Men, Masculinity and Reproduction*' (Inhorn *et al.* 2009), Inhorn (2009, p. 253-278) highlights Egyptian and Lebanese men's experiences of 'varicocelelectomy', a genital surgical procedure for men who experience reproductive difficulties. Another chapter by Tjørnhøj-Thomsen (2009, p. 246) in the same book examines how male infertility affects notions of masculinities and fatherhood in a Danish context and found that men handled childlessness more smoothly than their partners because in "everyday life and social interaction men are not—and do not let themselves be—affected by their childlessness to the same degree as women". In the same book, Goldberg (2009) explores the cultural notions and silence around male infertility in an Israeli Jewish setting and found that men's infertility challenges their masculinities, which must be renegotiated in institutions.

Through a biographical book '*The Male Pill*', Oudshoorn (2000) examines the history of hormonal contraceptives for men and explores the reasons as to why there is no male pill despite the technical feasibility of male contraceptives in the 1970s. Broadly, she found that recruiting men for contraceptive research and trials proved to be difficult as men were, traditionally, never involved much in contraceptive clinical trials. Enrolling men in contraceptive research required major shifts in the mechanisms and processes of medical institutions (where were mainly designed for women) which hindered men's engagement

to highlight the book's findings.

in these trials (Oudshoorn, 2000). Daniels' (2008, p. 4) book 'Exposing Men: The Science and Politics of Male Reproduction' examines "how ideals of masculinities have skewed the science of male reproductive health and our understanding of men's relation to reproduction, and how such understandings have led to a profound neglect of male reproductive health".

In addition to these popular edited volumes and books, there are individual research studies and papers as well, which examine men's reproductive bodies, desires, health, and the politics around them. In the context of UK, Sheldon's (1999) article "focuses on the regulation of liability for congenital disability and foetal protection legislation and policies, in order to uncover the perceived understandings of male and female reproductivity which have informed the law in this area. It argues that these understandings are predicated upon a particular vision of men's and women's bodies and of a gendered division of labour following the birth of a child" (Sheldon, 1999, p. 129). Kotelchuck (2022) explores the impact of fatherhood on men's own health during antenatal and perinatal periods and finds that there are mainly six pathways²⁷ which influence expectant fathers' as well as their partners' and infants' health. Law (2019) investigates men's perceptions of reproductive timings²⁸ among unmarried White British, African-Caribbean, and Asian men currently living in the UK.²⁹ Thus, there is quite a bit of research on men's reproductive bodies and health; however, this is not an area of focus for me in this thesis.

²⁷ These six pathways are: 1. Men's physical health status during the perinatal period (pregnancy and early parenthood) 2. Changes in fathers' physical health during the perinatal period: Impact of Fatherhood on Men's Physical Health 3. Changes in fathers' mental health during the perinatal period: Impact of Fatherhood on Men's Mental Health 4. Changes in fathers' social health and wellbeing during the perinatal period: Impact of Fatherhood on Men's Social Well-being 5. Men's psychological maturation of paternal generativity: Men's Improved Capacity for Parenthood and Fatherhood 6. Men's life course development of fatherhood. For more details, see Kotelchuck (2022)

²⁸ Reproductive timings refers to the time when people think they should conceive a child.

²⁹ This research is still ongoing as it is a part of a doctoral thesis and thus, I do not have access to its findings.

2.4 A review of the literature on men's involvement in India

In India, there has been limited interest among researchers on specifically investigating men's experiences of and interest in maternal health, antenatal care, and reproductive health. Within the realm of reproduction, there have been a few research studies which explore men's participation in family planning and contraception issues, but this has not translated into researching men's experiences and subjectivities during the pregnancy period. The only discipline that has explored the issue of urban educated men's roles in childcare and family in depth is that of psychology (Roopnarine *et al.* 1992; Roopnarine *et al.* 2000; Dutta, 2000; Kumari, 2008).

Though these studies are mostly conducted via the lens of family dynamics rather than understanding and promoting the idea of men's involvement in health issues, a common argument among these studies is that the role of Indian fathers has been much understated. Solely applying a patriarchal lens may mask the ideological and structural shifts in family roles as well as the attempts made by men to engage in decisions regarding morally intelligible fathering – the caring and responsible aspects of fathering (Roopnarine *et al.* 2013, p. 227). The study also found that “Indian men are beginning to develop a better understanding of the psychological aspects of becoming a parent, showing levels of interest in participating in prenatal visits and being present at the birth of their infants” (Roopnarine *et al.* 2013, p. 231).

Thus, these findings suggest a missed opportunity for social science researchers, especially those in gender studies, public health, anthropology, and development, who have not explored the role of men in maternal health and antenatal care in depth. In these disciplines, however, there are a few exceptions. Studies by Bhalerao *et al.* (1984), Jayalakshmi *et al.* (2002), Saha *et al.* (2007), Char, Saavala and Kulmala (2009), Singh and Ram (2009) and

Chattopadhyay (2012) have explored male involvement in family planning, female sterilisation, antenatal care, and maternal health in different contexts and have offered some good insights. For instance, a quantitative study by Singh and Ram (2009) of 1,000 husbands and 400 wives in Ahmednagar district of Maharashtra found that 81% of men reported that they accompanied their wives for antenatal check-ups. The same percentage was 77% as reported by women. 52% of men were present during the delivery of their youngest child, the same percentage as was reported by wives (Singh and Ram, 2009, p. 94). A study by Bhalerao *et al.* (1984) in the city of Mumbai – which is one of the oldest studies in India on this issue – found that the involvement of husbands in antenatal care counselling has a substantial positive impact on the frequency of antenatal care among uneducated and low socio-economic groups. Another evaluation of an intervention by Hazra, Khan and Mondal (2019) examined the impact of providing information on maternal child behaviours to husbands' mobile phones and found that providing knowledge to them enhances their knowledge and potentially increases their wives' access to proper antenatal care. Moreover, a well-known study in India is the 'Men in Maternity' intervention and study (Caleb-Varkey *et al.* 2004) that was conducted over a year across public health hospitals in Delhi. The study investigated the feasibility, acceptability, and cost of a new, more comprehensive model of maternity care that encouraged husbands' participation in their wives' antenatal and postpartum care. It found that when men accompanied their wives to the clinics and participated actively in the intervention, notable changes were observed in family planning knowledge and behaviours of both stakeholders (Caleb-Varkey *et al.* 2004).

In addition, recent studies explore indigenous and *Adivasis*³⁰ men's involvement in maternal health. For instance, in an evaluation of a male engagement intervention in the state of Odisha, Fotso, Higgins-Steele and Mohanty (2015) found that hiring male health

³⁰ Adivasis refer to people belonging to the indigenous communities of India.

workers can make a difference in access to maternal health services as they educate other men about these issues and help them take decisions. Jungari and Paswan (2019) and Nair *et al.* (2021) in Maharashtra examined the participation of husbands in their wives' antenatal care and community perspectives on the role of men in utilising maternal health services among tribals in India. Jungari and Paswan's (2019, p. 1) quantitative analysis found "an increase in husbands' education level increased the wives' utilization of antenatal care services. Husbands who were poor were 22% less likely than husbands in the rich category to report the utilization of antenatal care by their wives. Women having husbands who had at least some knowledge of pregnancy, childbirth, and postpartum complications were more likely to utilize all maternal health services". The qualitative study by Nair *et al.* (2021, p. 769) found that factors such as "poor knowledge, fear of loss of wages, community gendered practices and attitudes of healthcare providers impacted men's engagement in maternal health".

Thus, the evidence on male involvement in maternal health in India is still emerging. However, a key limitation is that most of these studies are based on structured questionnaires and quantitative survey methods, and provide limited insights on individual subjectivities, experiences and perceptions of expectant fathers and husbands. They are mostly rooted in an instrumental approach, which I referred to in Section 2.2, that positions men (husbands and expectant fathers) as means to an end (achieving good maternal reproductive health outcomes) without giving much accordence to their own subjectivities, desires, and emotions as they transition to fatherhood. Gutmann (1997, p. 385) writes that there is a need to view "men as men" and tend to their reproductive capacities and desires, which will in turn, lead to their own happiness and ensure better maternal health outcomes for their wives.

Moreover, despite the above-discussed studies, these issues have not been investigated in a sustained manner. For instance, in the context of western nations and the Middle East region, there are researchers (Inhorn, 2012; Hearn, 2004; Galle, 2021; Law, 2019; Almeling, 2020) who have consistently worked on men's involvement over years and decades and have researched several areas of inquiry; whereas in India, the studies done by researchers are mostly on a one-off basis. Thus, in India's context, historically, there has been a lack of in-depth qualitative and ethnographic studies that use a robust theoretical and conceptual framework to understand men's masculinities, emotions, vulnerabilities, and subjectivities in the realm of reproduction. Such studies can provide rich and thick descriptions of processes and factors constructing and influencing men's involvement and roles and leverage them for programmatic actions.

The situation has been changing, however, over the past few years, where there is an emerging interest in undertaking in-depth qualitative and ethnographic research on men, masculinities, and fatherhood. One key study by Burgher and Flood (2018) of urban educated fathers in Mizoram, a state in North-Eastern India, found the prevalence of a new child-oriented 'family man' masculinity, where fathers are increasingly involved in caregiving and childcare. However, they also add that these men may not be motivated by notions of gender equality and are part of an arrangement that ultimately still sees mothers perform the bulk of parenting. These findings "highlight the potential agency of these fathers to forge social change, even if change is slow, incremental, and constituted of everyday practices that hardly seem revolutionary" (Burgher and Flood, 2018, p. 219). Apart from independent researchers, some non-profit organisations have actively focused on researching the role of men in family planning, reproductive and maternal health, abortions, contraception, and sexual health. For instance, the International Centre for Research in Women (ICRW), a prominent research organisation in India, has a significant focus on understanding men's experiences

and roles in reproductive health. In 2018, they conducted a study (Kedia *et al.* 2018) which explored male involvement in pre-marital abortions in Delhi, the first such study in India. The study argues that while popular discourse and perceptions tend to paint unmarried men in premarital relations as oversexed, exploitative, and irresponsible, “increasing numbers of men are showing up with their partners for abortions. They sought information about pregnancy kits, abortion pills, clinics and, wherever needed, purchased medication, reached the clinics, spoke to doctors, accompanied their partners to the clinics and paid for the abortion” (Kedia *et al.* 2018, p. 9). More recently, ICRW launched Couple Engage, a portfolio of studies and projects which focused on understanding perspectives of men as well as women in family planning. The project aims to develop a series of approaches and strategies for effectively engaging men and couples in family planning (Seth *et al.* 2020).

Thus, although the body of literature on men and reproduction is slowly increasing, there are limited studies which examine men’s perspectives, subjectivities, and masculinities during the pregnancy and antenatal care period in India as well as globally to some extent.

2.4.1 A brief overview of the literature on the Indian State, reproduction, and community health workers

Till now I have discussed and highlighted the literature specifically on men’s involvement in reproductive maternal care and fatherhood. However, in addition to this specific literature, I have also engaged with a wide array of literature on reproduction in India, community health workers, and the Indian State’s role in, and influence on, reproductive politics. I refer and apply some of the conceptual findings and discussions in these works to expand my discussions on ASHA workers (see Chapter Five) and the State’s approach towards men’s involvement in maternal reproductive health (see Chapter Four).

Most of the work done on ASHA workers in India explore their experiences, subjectivities, frustrations, and identities vis a vis their work for the health system and the State. I draw upon the work by Roalkvam (2014) who explores the relationship between expectant mothers and ASHA workers in India and provides insights on the ways through which citizenship in neoliberal reform is enacted in the context of India's maternal health policymaking and planning. Her other work (Roalkvam and Mishra, 2014; Nordfeldt and Roalkvam, 2010) focuses on understanding the everyday work of these ASHA workers through varied perspectives. In addition, Ved *et al.* (2019) and Saprii *et al.* (2015) have done critical research on ASHA workers in terms of the ASHA programme's origins, motivations, impact on maternal health outcomes, and challenges faced by these workers.

Unnithan's ethnographic work (2005; 2010; 2015; 2019; 2022) over 18 years with the maternal health system and CHWs in Rajasthan has informed this thesis immensely. For instance, her book (Unnithan, 2019) examines how social and economic inequalities are produced and sustained in discursive and on-the-ground contexts of family-making, how authoritative knowledge and power in the domain of childbirth is exercised across a landscape of development institutions, how maternal health becomes a category of citizenship, how health-seeking is socially and emotionally determined and political in nature, how the health sector operates as a biopolitical system, and how diverse moral claims over the fertile, infertile and reproductive body-self are asserted, contested and often realised. More recently, a book chapter by Unnithan (2022) offers an analysis of India's conflicted reproductive governance, where she argues that despite the State's shift towards a more rights-based approach in policy documents, the target-oriented approach to reproductive maternal health continues.

I also draw upon a historical analysis of the Indian State's approach towards involving men in family planning (Balasubramanian, 2018). Through a historical and archival analysis of public documents, Balasubramanian (2018) traces the history of India's family planning

programme in the 1960s and 1970s, and in its unconventional focus on men's bodies for reproductive governance and population control in post-colonial India.

For discussing the State's perspectives and approach towards men's involvement, I draw upon Strepputat and Hansen's (2001) edited volume on ethnographic work on State processes. Other works which inform my thesis include (Kielmann, 2002; Hacking, 1982) who emphasise the significance of health statistics and numbers as tools to compare different countries on the global stage.

Thus, while there is significant work on the Indian State's regulations and policies around reproduction, there are limited studies which examine the State's approach towards men in maternal reproductive health in the current context. Therefore, Chapter Four of this thesis is an attempt to address this specific gap in the literature.

2.5 Theoretical framework

In this section, I discuss the theoretical framework which has informed my research design and analysis.

Multiple scholars have highlighted the lack of methodological literature and theoretical frameworks for studying men's experiences of reproduction (Culley, Hudson and Lohan, 2013; Lohan, 2015; Law, 2019). As reproduction is a highly gendered process, it is important to use a suitable theoretical framework to study men and their involvement in antenatal care from a feminist lens. For my research, I find resonance with the critical studies of men and masculinities (CSMM) framework, which has emerged from feminist, gay and queer literature and is a useful approach for researching men and reproduction (Lohan, 2015).

Whitehead and Barrett (2001, p. 15) write that CSMM emerged as a field of sociological inquiry in the 1950s in the USA. In their book on men and masculinities, they outline three different theoretical waves of CSMM. The first wave focused on the male role performance and costs associated with them attempting to assert dominant masculine expectations. The second wave around the 1980s focused on the centrality of male power to dominant ways of being a man (2001, p. 15). It also saw the emergence of Connell's (1987) theories of the gender order and hegemonic masculinity. The third wave of CSMM drew influence from feminist post-structuralism and looked at "how men's sense of identity is validated through dominant discursive practices of self, and how this identity work connects with (gender) power and resistance" (Whitehead and Barrett 2001, p. 15). Hearn (2019) writes that in the past 20 years, this field of inquiry has further blossomed and expanded significantly. "What is really transforming CSMM is the fact that research and publishing on men and masculinities have become more geographically widespread, more dispersed, more comparative, inter- national, transnational, postcolonial, decolonializing, globally "Southern" (Connell 2008), global, globalized, and globalizing" (Hearn, 2019, p. 57).

The framework which I use in my research builds upon Lohan's (2007, p. 494) work. She writes that CSMM is guided by three feminist conceptual elements (see Figure 4 below on p. 61). **First, seeing gender as socially constructed.** This principle of CSMM is to recognise that men "have gender too" (Annandale and Riska, 2009, p. 123), holding a mirror to the male gaze and researching the gendered constructions of men's lives alongside those of women's (Lohan, 2007). **Second, hegemonic masculinity.** The concept of hegemonic masculinity (Connell, 1987) is one of the most prominent concepts in the study of men and masculinities. It is the most dominant ideal against which other types of masculinities are performed and measured. A CSMM approach to studying hegemonic masculinity refers to interrogating and analysing local forms of hegemonic masculinities

and how these are being challenged and negotiated in diverse ways. **Third, challenging gender power relations** (2007, p. 494). The third key principle to CSMM is acknowledging and challenging gender power relations; that is, the subordinated position of women vis-à-vis men and their greater control over resources in the society. In Hearn's (2004) words, it is to theorise men's lives in a way which does not exclude men's structural positioning with women and femininities.

I am also interested in applying a new sub-strand of CSMM to my work, which puts a focus on men's caring and nurturing and has emerged from the European region and is termed as caring masculinities (Elliott, 2016). Elliott (2016, p. 252) suggests "caring masculinities can be seen as masculine identities that exclude domination and embrace the affective, relational, emotional, and inter-dependent qualities of care identified by feminist theorists of care". Caring masculinities is increasingly being applied in different studies on fatherhood globally such as Germany (Joshi, 2021) and New Zealand and Scotland (Baines *et al.* 2015).

Figure 4 below shows the CSMM framework and its three main conceptual elements which I will apply in this thesis to discuss my findings and analyses. I will examine men's involvement in antenatal care by considering them as reproductive beings within the broader gendered context of Rajaji Nagar and India. I will also investigate and elucidate how local versions of hegemonic masculinities are challenged, encouraged, and negotiated during antenatal care by expectant fathers, the Indian State, the public health system, and CHWs (as applicable to each stakeholder). Finally, my thesis is rooted in a feminist design that recognises the structural dimensions of gender relations and will analyse men's involvement in a way that does not exclude women's disadvantageous position in the society as well as the household.

Theoretical Framework: Critical Studies of Men and Masculinities (CSMM) (Lohan, 2015)

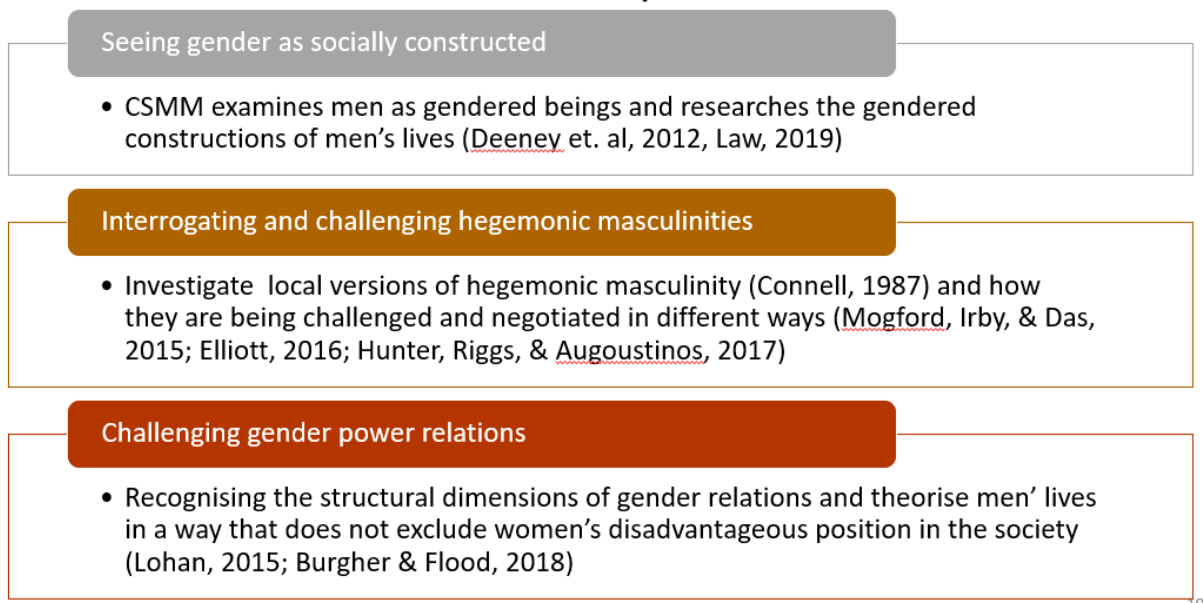


Figure 4 Critical Studies of Men and Masculinities Framework

I am aware of two studies in the realm of reproduction, fatherhood and maternal care which have actively used CSMM as a framework for research and analysis. A study by Deeney *et al.* (2012) investigated the experiences of men fathering babies admitted in the neonatal care unit in Ireland and another study by Law (2019) used the CSMM framework to examine men's intentions and perceptions regarding reproductive timings in the UK.

I apply this framework to understand men's subjectivities and understandings of antenatal care and analyse their positioning within the reproductive domain (see Chapter Six). I also employ this framework to examine the perspectives of CHWs and the health system on men's roles and involvement (see Chapters Four and Five). In other words, I theorise men's experiences and perceptions in Rajaji Nagar in a way which acknowledges them as the second sex in reproduction research (Inhorn, 2012) but does not exclude their structural positioning with women and femininities (Hearn, 2004) in the Indian context.

In India, the usage of CSMM as a framework for researching men is still nascent. A recent edited volume by Chowdhury and Baset (2018) includes essays on men working and researching feminist issues in India. However, the volume is mainly about highlighting the contributions and experiences of male researchers and activists doing feminist research and activism. Many other NGOs, researchers, and academics have been involved in interventions around engaging men and boys in gender justice, although very few of them focus on reproduction. A review of the literature on these interventions suggests that while they might not have used CSMM as a term specifically, their approaches resonate with the CSMM framework.

Chapter Three: Navigating the labyrinths of fieldwork: methodology, processes, and reflection

In this chapter, I discuss my research methodology for this thesis. I start by giving an overview of my methodology, data collection and analysis (Section 3.1). The next section, 3.2, describes my field location and the Rajaji Nagar community in depth. Next, I move on to discussing ethnographic research and my experiences and challenges in doing ethnography in Delhi (Section 3.3). This is followed by a discussion of the ethical challenges and issues involved in this research. Finally, I outline the impact of COVID-19 on my research and the subsequent decisions that were taken.

3.1 Overview of research methodology, data collection, and analysis

I conducted my field research in Rajaji Nagar, an informal settlement in South-East Delhi, between August 2019 and October 2020 (online after March 2020 due to the COVID-19 pandemic). Rajaji Nagar has an estimated population of 1 million and primarily consists of working class migrants belonging to Muslim and different Hindu caste backgrounds from the neighbouring states of Haryana, Rajasthan, and Uttar Pradesh. Having lived and worked in this community for three years (2011-14) as part of a teaching fellowship in a government school, I have an understanding of the developmental challenges faced by the community such as unemployment, lack of sewage disposal systems, lack of sanitation facilities, and scarcity of clean drinking water.

This thesis is shaped by a primary research question and three sub-research questions:

Research question

In what ways is men's involvement in antenatal care conceptualised, experienced, and operationalised in an informal settlement of Delhi?

Sub-research question (SRQ) 1: In what ways (and to what extent) does the Indian State encourage men's participation in maternal health?

SRQ2: What are the perspectives and experiences of community health workers in relation to men's involvement in antenatal care, and to what extent do these perspectives limit or encourage men's involvement?

SRQ3: How do expectant fathers construct, perform and navigate multiple masculinities in the realm of antenatal care?

To answer these questions, I used a qualitative ethnographic approach for data collection and chose a primary urban health centre (PUHC) in Rajaji Nagar as a focused research site. Rajaji Nagar has a total of four PUHCs, but I purposively chose a PUHC³¹ in lane number TH20, popularly referred as TH20 dispensary³² due to ease of transport access and the fact that this clinic has the largest target population (around 100,000) among all PUHCs in Rajaji Nagar. I started fieldwork through participant observation (Dewalt and Dewalt, 2002; Schensul, 1999). I immersed myself in the clinic through daily visits and built a rapport with the clinic's staff, initiating conversations and spending time by just hanging around the clinic, which I will describe in depth in Section 3.3.

³¹ I had official permission from the Department of Health, Government of Delhi for researching primary health clinics in the entire South Delhi district. I could have researched in all clinics but given my ethnographic approach, I chose to focus on one PUHC.

³² From here on, I will refer to this PUHC as the TH20 clinic or just the clinic.

Using this immersion as a base to establish myself in the clinic and Rajaji Nagar, I used different qualitative data collection methods: a) semi-structured and unstructured interviews, b) ethnographic listening and participant immersion, c) informal conversations, and d) *chai pe charchas* (conversations over tea). The following table (Table 1) summarises the different methods used for investigating the different research questions.

Table 1: Summary of data collection³³

Research question	Methods used for data collection to answer this question	Key stakeholders
SRQ1	Eight semi-structured interviews (online and offline), one focus group discussion, 550 hours of participant observations, and active listening in 275 antenatal care consultations	Maternal and reproductive health researchers and practitioners, and TH20 clinic staff
SRQ2	Seven semi-structured and unstructured interviews, 550 hours of participant observations over six months (this includes antenatal care consultations, immunisation sessions for infants, and monthly trainings for ASHAs and Anganwadi workers), 30 informal	ASHA workers, Anganwadi workers, ANMs, informal health providers, and pregnant women

³³ Given this is the only table in this thesis, I have not added a list of tables at the beginning.

	conversations and numerous casual <i>chai pe charchas</i> (tea chats)	
SRQ3	Seven semi-structured interviews, 35 informal conversations, and casual hanging out with expectant fathers	Expectant fathers and expectant mothers

I will now briefly describe each of these methods and the rationale for them.

My perspectives on interviews are inspired by Kvale (1996, p. 14) who writes that the “*interview* is an inter-change of views between two persons conversing about a theme of mutual interest”. Therefore, during my fieldwork, I adopted Kvale’s (1996, p. 14) “researcher as traveller” approach, wherein my “fieldwork will be a journey that will lead to a tale [PhD thesis in this context] to be told upon returning home [to the university]”. In Rajaji Nagar, I conducted seven interviews with expectant fathers and eight with community health workers. These interviews gave me insights into wider social norms, values, and practices surrounding pregnancy and childbirth, especially through the ways in which expectant fathers recounted and experienced issues during the antenatal care period and the varied perspectives of CHWs on men’s roles in these issues. These interviews were not one-off interviews; rather, I had repeated meetings with the same respondents and interviewed them over several weeks. Repeat interviews with the same individual are counted as one interview.

For example, I interviewed an ASHA worker three times: for 43 minutes (planned and semi-structured), 15 minutes (unplanned and unstructured), and 10 minutes (unplanned and unstructured); but I have included that information as one interview (although her responses are dated accordingly).

Ethnographic and participant observations involved listening to antenatal consultations between women and the healthcare staff, observing and recording the clinic's dynamics vis-à-vis their engagement with expectant fathers and husbands who accompany their wives on ANC check-up days, attending monthly training events for ASHA workers and vaccinations for infants and children, and so on, which I will discuss in detail in Section 3.3. Additionally, I had several informal conversations with expectant fathers and health workers. Swain and Spire (2020, n.p.) “view informal conversations as opportunities to add “context” and “authenticity” to data and argue that they can unlock otherwise missed opportunities to expand and enrich data”. These conversations happened with expectant fathers while they waited for their wives to finish their consultations, with ASHA workers as they waited for their files to be approved by their supervisors, with Anganwadi workers as they waited for children's midday meals to arrive and with health clinic staff after the clinic's closing hours. Many of these conversations also happened when I accompanied ASHA workers on their daily work journeys to households and Anganwadi centres for neonatal vaccinations.

While the fieldwork in Rajaji Nagar focused on health workers' perspectives and men's individual experiences and perceptions around antenatal care, I interviewed eight policy practitioners in Delhi who work with different organisations and institutions in the domain of maternal reproductive health at the state and national level. These respondents included demographers, gynaecologists, midwives, and gender researchers who have worked on

maternal reproductive health issues for several years. They came from seven organisations, four of which are headed by upper caste, upper class men and focus on researching or working with men's involvement in maternal reproductive health. These interviews with practitioners and researchers were conducted in the offices of different organisations and on online platforms such as Zoom, and Microsoft Teams following the COVID-19 pandemic. The fieldwork in these different locations produced data and knowledge in a sense that Merry (2005) termed "de-territorialized ethnography". These interviews inform Chapter Six which goes beyond multi-sited interviews to capture the intra-national flow of ideas in the reproductive maternal health domain (Unnithan, 2019, p .23). The concept of "de-territorialized ethnography" (Merry, 2005) applies here as these policy practitioners have worked in this domain for several years and are part of governmental committees and programmes; their ideas and inputs usually are considered for implementation by ministries and government departments.

Overall, I conducted approximately 550 hours of participant immersion, observed 275 antenatal consultations and four neonatal immunisation sessions in the clinic over six months, conducted 22 in-depth semi-structured and unstructured) interviews, one focus group discussion, initiated 65 informal and casual conversations, and numerous *chai pe charchas* (tea chats) which included expectant and new fathers, expectant mothers, ASHAs, Anganwadi workers, ANMs, informal health providers, and policy practitioners and researchers. In March 2020, my field ethnography was disrupted due to the COVID-19 pandemic and lockdowns. After March 2020, I mainly conducted interviews with policy practitioners online and took the decision to cease in-person data collection completely. I will discuss the impact of COVID-19 on my research in Section 3.4.

While data collection was ongoing, I started the process of preliminary data analysis four months into my fieldwork because I wanted my research to be reflexive and iterative. After the first three months of fieldwork (August to November 2019), I did a weekly review of my field notes and interview transcripts, analysed the emerging themes and patterns, and considered whether any new strands of inquiry were emerging in addition to those which I had in my talking points guide. As I found the emerging themes and patterns, I wrote descriptions of these themes (and how they differed or resonated with the original talking points guide I had) and shared them with my supervisors during monthly meetings. At that point, I knew that I had a few more months to collect data, after which I intended to start the analysis in a fully-fledged manner. However, as described in the previous section, after the COVID-19 pandemic struck, I could not do any in-person fieldwork. Thus, from May 2020 onwards, I focused on doing some additional online interviews with policy researchers and practitioners and the analysis of my empirical data.

3.2 Field site: An overview of the social, cultural, economic and political context

As I trace the journey of my PhD admission applications in early 2018, to doing my fieldwork in Delhi, I remember that I explored multiple locations for fieldwork before settling on Rajaji Nagar in the end. Initially, I chose the states of Assam and Jharkhand in my PhD proposal applications, both home to significant indigenous populations. This was primarily influenced by the fact many existing studies on men's involvement in maternal health in India have been conducted among indigenous populations.

However, over the course of my first year of PhD work, I realised that rather than focusing on indigenous populations, I should do my fieldwork at an easily accessible location and decided on Rajaji Nagar because this is more familiar to me, as I worked in this community for three years as part of a teaching fellowship (with a non-profit organisation) in a government-funded

primary level school. Thus, I would be able to quickly immerse myself in fieldwork without being too awed. In many cases where researchers go to a field site for the first time, it usually takes a few weeks or months to get acquainted or comfortable with the local context, culture, transport, and weather which I was already well versed with. In hindsight, my hypothesis proved right, and I realised that I was not awed by Rajaji Nagar, which allowed me to focus on the actual research questions from the very start of fieldwork.

Rajaji Nagar is spread over an area of five square kilometres with an estimated population of 0.6 million.³⁴ It is estimated that Rajaji Nagar as a settlement started emerging in 1979 – on what was previously agricultural land.³⁵ The colony's population has grown exponentially since then due to migrants from North Indian states of Haryana, Rajasthan, Uttar Pradesh, and Bihar, who come to Delhi for mostly informal jobs. Being an informal settlement, the structure of the houses is quite varied and haphazard. For instance, there were homes that were made of bricks and not painted or cemented (See Figure 5 below). There were also homes that were slightly better off with plastered, painted walls and entrances. Some houses are unfinished, or have broken doors or windows and residents clearly cannot afford to maintain these buildings. These different homes are juxtaposed against each other, without designated 'richer' or 'poorer' areas.

³⁴ While there is indeed a reference which confirms this population estimate, that document has the community's actual name. Therefore, adding the reference here would lead to non-anonymisation which would be against the ethics guidelines.

³⁵ Same issue as footnote 31.



Figure 5 The community of Rajaji Nagar

In terms of religious demographics, my fieldwork suggested that Rajaji Nagar consists of mainly Hindus and Muslims with a negligible proportion of Sikhs and Christians. Unlike the rest of Delhi city, where there are designated Muslim areas with almost 100% Muslim populated regions, Rajaji Nagar has a scattered composition. Barring a few *galis* (lanes) which are populated by *kasais* (butchers) – a term used for Muslims engaged in meat businesses – and immediate areas around mosques, there are no segregated Hindu and Muslim sections in the settlement. Hindus and Muslims’ residences are scattered unevenly in blocks and lanes. Hindu people belonging to all castes are scattered across Rajaji Nagar; however, conversations with my respondents indicated that Rajaji Nagar has a significant population of Telis, a community classified by the Indian government as Other Backward Castes (OBC).

Given my research is on men’s experiences of antenatal care, it is important to have an overview of the gender norms and practices in the community. While I will delve into this further in Chapter 5 from the perspectives of community health workers, here I would like to

give a brief overview based on my previous experience in the community. As mentioned above, I worked in Rajaji Nagar during a teaching fellowship. My role entailed working as a classroom teacher in a low-income government school of Delhi in an all-girls class. During this time, I gained an understanding of the local gender norms and practices within households. Having worked with 30 young girls in a class for around two years, I witnessed a range of social and cultural norms in the community that disadvantaged girls. Several students in my class belonged to families that had three to four female siblings and one male sibling. This meant that families kept having children till a son was born, thereby, reflecting the strong son preference among households. The subjugated position of girls was also visible through the fact that often, the male sibling attended a private school, whereas the girls were sent to the government school (which was free to attend) where I taught. The prevalence of gender norms was also visible in families where mothers of these children were mainly confined to household work and tasks, whereas the fathers were expected to be the main financial providers of their families.

For children in government schools, and especially girls, access to education was also negatively affected by these gender norms as well as the lack of basic infrastructure and facilities as I will describe now. Development challenges galore exist in Rajaji Nagar with the issue of piped water and access to clean drinking water being a highly political and emotive priority given the informality of the settlement.³⁶ Water mafias control the supply and distribution of water in the community as is the case in most informal and unauthorised settlements of Delhi (See Birkinshaw, 2018). This leads to an unequal distribution and access

³⁶ An informal settlement in Delhi is a settlement which cannot be used for official purposes such as mortgaging for a loan and providing collaterals. Here you can expand the construction of houses without any due permission from municipal authorities. Due to the sheer numbers of people living in these settlements, most of them do have access to government schemes and programs. The sizes of these settlements vary significantly but Rajaji Nagar is the largest informal settlement in Delhi. These settlements are also known as *Jhuggi Jhopdi* colonies and resettlement clusters and are spread all over the city.

to water, restricting availability of water to erratic and short time windows. During my teaching days, often, many parents came to the school around 11am/12noon (the school timings were from 8am-1pm) and requested that their daughters leave school early because they needed extra support for carrying more water cans and storing water as the next water supply date was not clear. Thus, the young girls of Rajaji Nagar often faced challenges that affected their access to education, but not their motivation to study and succeed.

Another significant challenge faced by people living or working in Rajaji Nagar is that of transportation, especially due to the dilapidated condition of roads and the time taken to travel to and from the main connecting road. The medic in charge of the clinic where I did my research termed Rajaji Nagar a “hard-to-reach” community due to dilapidated roads and poor infrastructure, which often hindered access to emergency maternal healthcare. The settlement is spread over more than 15 blocks with unsystematic naming of lanes and roads (due to the informality of the settlement). There are five different routes which can be used to enter the settlement and the routes depend on which block you want to go to.³⁷ Only two of these are just about suitable for cars due to the bad condition of the roads and sewerage systems. Due to the bad design and planning of these systems, these sewer lanes overflow many times which make these side canals invisible, and hard to differentiate from the roads, making them risky. The most common way to travel into Rajaji Nagar is to take a shared e-rickshaw or auto-rickshaw, with a fare of 15 Indian rupees per person.³⁸ These rides are often heavily crowded with more than seven customers crammed into an auto-rickshaw during peak hours and a ride could take anything between 10 minutes to 1-1.5 hours depending upon the traffic in congested lanes. I used to go into Rajaji Nagar every day around 9.30-10am which was the office rush

³⁷ The houses and lanes are mostly numbered in a haphazard manner and do not follow a fixed convention and are not numbered in a systematic manner. There are some houses that are not even numbered. This is due to the informality of the settlement.

³⁸ 15 INR roughly equals 0.15 GBP. This is as of June 2022.

hour time, and if lucky, it took me 20 minutes to reach the clinic from outside. There were days when the lanes were so congested that I had to abandon my rickshaw and walk to the clinic (which was about two kilometres from the main road). Thus, the amount of time it took me to reach my field site from the main road was equal or often more than the time needed to reach the main road from my residence in Delhi.

Economically, even though Rajaji Nagar is an informal settlement, it consists of diverse economic groups ranging from extremely poor families to middle class families, with an overwhelming proportion of working class families. It is not uncommon for families to own cars and vehicles despite the deplorable condition of the roads.³⁹ This is because it is an informal settlement, so buying a house is much cheaper than in a formal settlement and area, making it attractive for middle class and lower-middle class families to stay here and invest in vehicles. There are limited economic opportunities in Rajaji Nagar, and residents pursued a heterogeneous array of jobs outside the community. There were gendered differences in the types of paid work undertaken by men and women, which are reflective of the larger gendered nature of professions in India. The men of the community worked as autorickshaw drivers, factory workers, drivers for upper class households of Delhi and corporate firms, shop assistants, small-time textile traders, etc., professions that are socially and culturally assumed to be for men. Over the past three to four years, however, there has been an incremental shift in terms of the nature of jobs, where the slightly more educated men (those educated till Grade 11/12 and college dropouts) are working with online food delivery apps such as Zomato, Swiggy and Foodpanda⁴⁰ as well as app-based taxi aggregators such as Uber and Ola.⁴¹ This

³⁹ Parking is a huge issue in Rajaji Nagar due to the informality of the settlement. Thus, people who own cars usually park them a bit further from their houses wherever space is available.

⁴⁰ These apps are like Deliveroo and Uber Eats in the UK.

⁴¹ Ola is an online cab company in India like Uber.

shift can be attributed to the rise in internet-based businesses in India over the past decade.⁴² Some of the expectant fathers I spoke were working with these food app companies, others were small time traders and marketing executives with companies. In terms of women's employment, I found that the labour force participation of middle-aged and elder women is quite low.⁴³ With the exception of ASHA, Anganwadi workers and some schoolteachers very few women⁴⁴ of this age bracket actually engaged in any form of paid work. However, given the increasing aspirations among the youth, young women are pursuing paid work opportunities outside of these categories such as clerical jobs, sales assistants in shops, ticketing agents in railways, and office assistants and receptionists, which I came to know about during my fieldwork conversations. These economic opportunities also have social and cultural implications. For instance, many coaching and training centers have sprung up in Rajaji Nagar which prepare candidates for job interviews by imparting rapid English language trainings. These training programs have led to more increased interactions between young men and women as they attend these centres together in batches. Furthermore, during fieldwork I found that there has also been a perceived increase in consensual romantic relationships, leading to love marriages⁴⁵, which is looked down upon by the wider community (I will also discuss this further in Chapter 5 in context of the correlation of marriages with men's involvement). During my time in the field, I also witnessed young couples travelling in autorickshaws together.

Within the community, the lines between public and private spaces are blurred as residents live literally side by side, and neighbours witness and take part in each other's intimate lives, which is quite common in informal settlements across India (See Unnithan, 2019). Daily domestic

⁴² The increase in access to internet also has implications for men's involvement in antenatal care, which I will discuss in-depth in Chapter 6.

⁴³ I did not do any survey or have access to statistics. It is just based on my observation.

⁴⁴ This mainly refers to women who live in Rajaji Nagar.

⁴⁵ This refers to marriages where a couple chooses their own life partner rather than their parents finding a prospective partner for them through matrimonial networks and social media.

and personal tasks such as washing clothes, combing children's hair, teaching children, and eating food are often done in full view of each other. During my fieldwork, I often witnessed new mothers breastfeeding their babies by putting their sarees⁴⁶ over themselves, something that one would not see in high income communities. I also witnessed women sitting with their children in the immediate area outside their house and teaching them. Furthermore, the houses are so close that one can often overhear fights or arguments in nearby houses, thereby limiting the privacy of families. These particularities are very different to the community I live in Delhi where houses are bigger, further apart and, consequently, the lines between the private and the public are more clearly defined.

Despite the informality of Rajaji Nagar, the community has access to most government services and institutions such as primary and secondary schools, proper electricity connections, primary healthcare institutions, public distribution system⁴⁷ (PDS) shops, and government pharmacies. Rajaji Nagar has four primary urban health centres (PUHC), three Delhi state government dispensaries,⁴⁸ six *Mohalla* (neighbourhood) government clinics and another central government-funded dispensary. In addition, there are about a dozen small private hospitals and hundreds of informal and private practitioners spread across the community who provide healthcare services. In the immediate areas outside Rajaji Nagar, there are two major hospitals: Morena Hospital and Ashfaq Hospital, which provide secondary as well as tertiary healthcare services. I purposively chose to focus on a PUHC due to ease of transport access in *gali* no. 20, popularly referred to as TH20 dispensary. This TH20 clinic has the largest target population

⁴⁶ A saree is an item of Indian clothing worn by women.

⁴⁷ PDS shops are centres run by the government that provide rice, lentils and grains for very low prices to those below the poverty line.

⁴⁸ The term "dispensary" refers to health clinics which primarily focus on dispensing free medicines under government schemes and support. However, dispensary is in common parlance in Rajaji Nagar, and is also used as a term for the primary health clinics. This is because, for several residents, the clinic is primarily a place where free medicines are given, rather than free care per say.

(around 100,000) among all PUHCs in Rajaji Nagar. The staff of the PUHC (hereby referred to as the clinic subsequently) includes a female doctor who was the in-charge,⁴⁹ another male doctor who is the co-in-charge, four auxiliary nurse midwives (ANMs), one pharmacist (female), one receptionist (female), one data entry operator (male) and one helper (male). There are around 30 ASHA workers attached to the clinic, but they are not full-time staff as ASHA workers are supposed to be volunteer health workers. A brief diagram (Figure 6) explaining the clinic's staff structure is shared below.

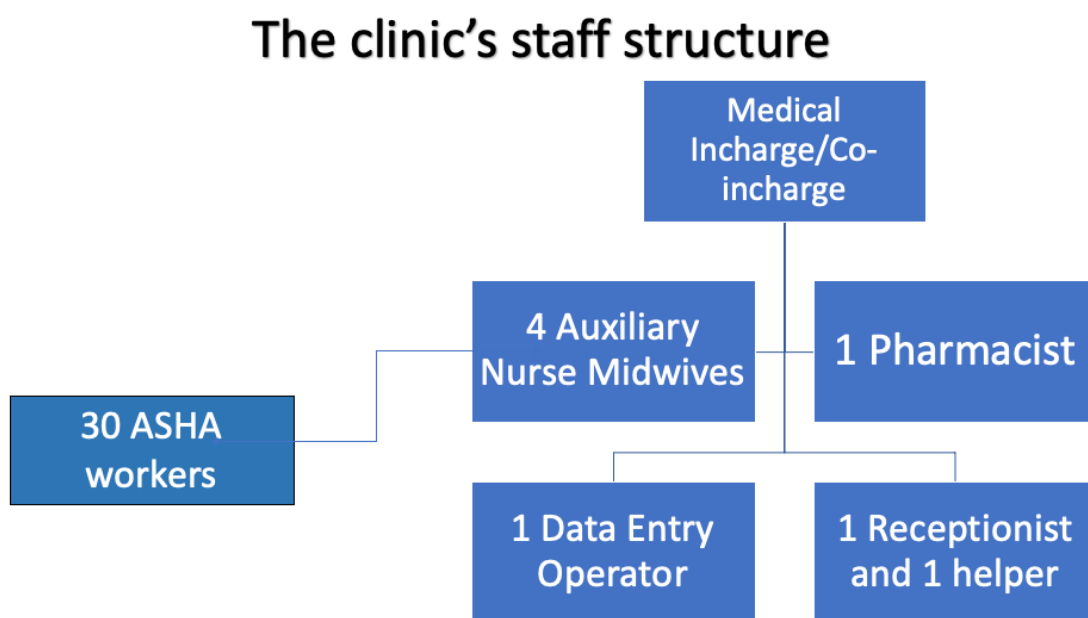


Figure 6 The TH20 clinic's hierarchy

3.3 Qualitative fieldwork processes: experiences, reflections, and challenges

Till now, I have given an overview of the research site, which is also the site of knowledge production, as well as an overall summary of the quantum and diverse forms of data collected. However, in addition to discussing these, it is equally important to describe the processes that

⁴⁹ I visited the clinic recently in October 2022 and came to know that the female doctor was transferred to another PUHC in Delhi. The clinic's in-charge is now a male doctor.

shaped this knowledge production and my experiences, reflections, and challenges during these processes.

As I mentioned earlier, this thesis is a qualitative study informed by ethnographic insights and inputs. However, when I started the fieldwork for this thesis, I had planned to do a fully ethnographic study but was unable to do so due to the COVID-19 pandemic. Thus, I describe my fieldwork experiences and processes through an ‘ethnographic’ lens. However, within academic literature, the term ‘ethnography’ is a contested one. From being an approach itself to being used as a term for a finished knowledge product, ethnography has different interpretations and meanings according to different disciplines (Smith, 2014). In my case, I interpret ethnography as an approach for my qualitative study where a researcher conducts research by observing the daily interactions and practices of respondents in their own setting. This interpretation resonates with that of Hammersley and Atkinson (2007, p. 4) who write: “collecting data in ‘natural’ settings, in other words in those that have not been specifically set up for research purposes (such as experiments or formal interviews) also gives a distinctive character to ethnographic work”. Thus, as I mentioned earlier, I used participant observation as a tool to start my fieldwork and using this as a base, I moved onto other methods.

I started my research in August 2019 after seeking official permission⁵⁰ from the Directorate of Health Services, Government of Delhi, to conduct research (Annexure 5). I started fieldwork by visiting TH20, the health clinic⁵¹ I had identified for my research, daily and acquainting myself with the clinic’s environment and daily activities. Within a few days, the clinic’s staff responded to my presence and started interacting with me on a regular basis and often inquired about my research. The clinic’s then in-charge, a middle-aged female doctor, invited me to

⁵⁰ This is in addition to the official ethical permission from Ethics Review Committee at the University of Sussex.

⁵¹ There was no separate permission required from the clinic’s in-charge. They only required me to have permission from the Directorate of Health Services, Delhi.

attend the monthly training day for ASHA workers, which enabled me to meet them individually and make acquaintances. This monthly training day proved to be extremely useful as it enabled me to meet ASHA workers together and speak to them on a regular basis, as given their busy schedules, it was challenging to communicate with them.⁵² This monthly training is like a refresher course which provides guidance to ASHAs on what to focus on in their everyday work, for which they are also paid a small financial incentive. Although all ASHAs were well versed with their tasks, new training circulars and new concepts were often also introduced to improve their service delivery. This day was also a sort of get together for all ASHAs as they discussed each other's work, gossiped about people, and shared their anxieties and concerns regarding their lives.

⁵² Although the clinic has 30 ASHA workers registered with them as I mentioned earlier, rather than having a large sample size, I chose to focus on a few specific ASHAs with whom I had a good rapport and then explored their perspectives on men's involvement and antenatal care in depth through interviews.



Figure 7 An ASHA monthly training in progress

Of six working days weekly at the clinic, there were mainly two days when men⁵³ (new fathers or expectant fathers) attended the clinic: Wednesdays (dedicated immunisation day for newborns) and Thursdays (antenatal care (ANC)⁵⁴ check-ups). Usually, I went to the clinic three to four times a week, but the most important day would be Thursday, which was the weekly ANC day, and was when I approached expectant fathers and had conversations with them. An average ANC check-up day runs from 10am to 1pm but husbands and pregnant

⁵³ While men did attend the clinic on other days, these two days were solely for maternal newborn care services so on other days, men mostly came for generic treatment for other ailments or diseases.

⁵⁴ Hereon, I will use the term 'ANC check-up day' when I am referring to the clinic's dedicated day for antenatal care. In other cases, I will use the full term 'antenatal care' when I am referring to conversations around antenatal care in general.

women start to queue up around 8am because usually there is a heavy rush. This day is dedicated for antenatal care appointments, immunisations for pregnant women, providing iron, folic and other tablets to boost pregnant mothers' health, and the review of pregnant women's medical reports and checking of their vitals. On this day, there would be a crowd of 40-50 women, assisted by their designated ASHA workers.⁵⁵ Some women were accompanied by their husbands, mothers-in-law, or other relatives. ANC check-up days were an opportune time to meet and chat with husbands. In addition, on ANC check-up days, many ASHA workers come and bring the women registered under them.

There is a five-step process of seeking care on an ANC check-up day. Step One is registration at the counter. A woman (or her husband) must go to the reception counter, get her name registered and her notebook stamped.⁵⁶

⁵⁵ Designated ASHA workers bring women 'clients' to the clinic as their remuneration is determined on a per user basis. For every scheduled visit by a pregnant woman, the ASHA receives an incentive.

⁵⁶ Every care seeker at the clinic must bring a notebook, which acts as a record book for all her prescriptions and check-ups. The stamp is of that date which is mostly a bureaucratic procedure.



Figure 8 The clinic's reception

(The reception area of the clinic where I used to sit for observing Step One of the ANC check-ups processes.)

Step Two involves waiting in the queue to meet the doctor and ANMs. Usually, the queue is long and entails an average waiting time of at least 30 mins to more than an hour. Step Three involves the checking of vitals such as blood pressure, weight, and heart rate. Before meeting the ANM, a pregnant woman needs to get her weight checked by an ASHA worker, which will be written on her notebook. This helps to determine whether a woman is underweight or overweight, and whether she needs additional support or medical intervention.⁵⁷ Step Four involves a consultation with the ANM, who documents a pregnant woman's details (new registrant or already in the system, month of pregnancy, any prior abortions or miscarriages, and contact details). The woman is then given vaccinations if scheduled as per her pregnancy

⁵⁷ Being overweight can cause pregnancy complications but of all the pregnant women I saw, no one was overweight.

timeline and health supplements (iron, folic acid, calcium tablets). Pregnant women are advised to attend the clinic for an antenatal care consultation once every month.⁵⁸ Step Five involves meeting the doctor in charge: following the consultation with ANM, some women prefer to meet the doctor in-charge for any queries or doubts. Steps Four and Five are usually interchangeable depending on different women's priorities and processes of crowd management by the clinic staff. The picture below highlights the locations of each step within the clinic. It also shows the crowded nature of ANC check-up days, and within these spaces, the predominance of women (discussed further in Chapter Four).

⁵⁸ The World Health Organization recommends a minimum of four antenatal visits during a pregnancy. Most women who came to the clinic usually attended the ANC day in their third or fourth month (based on my observations of ANC consultations), so most women would visit the TH20 clinic a maximum of four times.



Figure 9 ANC check-up day at the clinic.

(Each of the care seeking steps and their respective locations are marked with numbers)

The other two days on which I would visit the clinic were not fixed and would depend upon my plans or the clinic's operations. The weekly ANC check-up day would usually be the densest data collection day, as I observed and witnessed consultations, spoke with expectant fathers, and conversed with ASHA workers. On ANC check-up days, I usually reached the

clinic by 9am, where there would already be a huge queue of women (some with their husbands and mothers-in-law). Most of these times, I had to squeeze my way in to reach the inside due to the large number of people.

In my observations, I found that redundant bureaucratic hurdles often led to women being turned away from the clinic. For instance, two months into my fieldwork, I came to know that the clinic had run out of official registers which were used for documenting the name. Therefore, the receptionist asked the care seekers to buy a small notebook or a copy which the clinic staff could use to write their overall observations and prescriptions. These notebooks cost around INR 5- INR 10 (around 5 pence to 10 pence in GBP terms), but often many women did not have the money to buy them, and thus they returned to their homes and said that they would come back next week.

Within the clinic, there were two major sites of knowledge production, which I constantly shifted between. One, observing consultations between pregnant women and ANMs in the ANM room. Two, conversing with expectant fathers waiting outside the clinic. In the picture above, label number 4 was where the consultations happened in a room. While the ANM room was a dominant space in the sense that this was where the business of maternal health and reproductive services took place, the area outside the clinic, where expectant fathers waited, was another key site of interest for me. There were some days where I focused on one space exclusively but other days, I divided my time between these two sites of knowledge production.

The ANM room was a small sized room which could fit four to five seated people. I sat near a corner besides two ANMs who managed the consultations. A woman would come in, answer some questions, would be given an injection (if due as per her pregnancy schedule), would be

given some medicines and general advice, and then sent off. I share a conversation below.

“ANM: Rani, what is your name?”

Woman 1: Vimla Kumari.

ANM: Kitna mahine⁸⁹roduce? (How many months pregnant are you?)

Woman 1: Five or six, I think.

ANM: What number child is this?

Woman 1: 3rd child.

ANM: [She gives a tetanus toxoid (TT) injection.] Ghar jaake thandi sikai kar lena, dard⁸⁹roduco jaega.” (Apply a cold press when you go home, the injection pain will go away.)

ANM: Baccha hospital mei karna, ghar pe mat karna. (Deliver your baby in the hospital, not at home.)

Woman 1: [No response. Woman 1 gets up and leaves the room.]

(ANM Room, TH20 clinic, 29th August 2019)

I observed and listened to around 275 such consultations over six months, which had several commonalities such as the length of each conversation (three to four minutes), dominance of the ANM in leading the conversation, and the content of the consultations (mostly providing free iron and folic tablets, and advice on basic care). Of these 275 consultations, no more than six women asked follow-up questions and the rest just listened to the ANM silently. Furthermore, only in three cases were the husbands of these women involved (called by the

ANM to clarify some questions). In about a dozen cases, their mothers-in-law accompanied them but overall, most expectant mothers were alone.

While listening to these observations and consultations gave me in-depth insights around maternal care and related issues, being a male researcher, I often felt out of place or just awkward in this predominantly women's site, especially in the ANM room, which was an all-women's space. To mitigate those feelings, when I listened to consultations between pregnant women and the clinic's staff in that room, I always lowered my head and did not make direct eye contact with anyone. I focused on listening to them and writing my field notes as I did not feel comfortable making eye contact during such sensitive conversations. Drawing upon his research on women's issues, Kumar (2018) writes that when male ethnographers attempt to collect information over women's personal and bodily aspects, they should focus on ethnographic listening rather than observing. Although he writes this in the context of male researchers hiring female research assistants to record events for them to listen to, I focused on listening and making sense of the noises in the consultation room rather than using my eyes to observe and do meaning-making.

The second major site of knowledge production was the immediate area outside the clinic's main space (but technically part of the clinic). This was the area where expectant fathers, who had accompanied their wives for the ANC check-ups, waited. I position these expectant fathers in the liminal space as while they were in the clinic's area per se, they were quite not there in the antenatal care system. When I observed these men, I saw them waiting alone, fiddling with their mobile phones, or just sitting on the stairs of the clinic waiting for their wives to finish their check-ups. Usually, it would take anything between one to two hours for a woman to complete her check-up, and thus this waiting time gave me a good window to approach expectant fathers. Due to the sensitivity of the subject and it being my maiden foray into

ethnographic research, I was initially hesitant to approach them, but I overcame my fears and started conversing with them.

Devanik: Namaste! My name is Devanik, I am a researcher from London, UK working on understanding men's roles in maternal health involvement. Could I speak with you briefly?

Once they said yes, I moved on to explaining my research further and initiating further conversations. As I introduced myself, I made sure to wear my Sussex identity card as it gave me a sense of legitimacy so that I could be taken seriously. I noticed that whenever I conversed with them, they always looked at my identity card hanging around my neck. Surprisingly, none of the fathers ever explicitly refused to speak, although in many cases, they just gave one-word answers or stayed silent. After a few such instances, I thought it would be prudent to use a different technique. Thus, I designed and printed brief pamphlets (shown below in Figure 10) in Hindi, the locally spoken language in Rajaji Nagar, which I tried sharing when I approached expectant fathers. However, after trying it for a couple of weeks with a few men, it did not work as I had imagined it to. Somehow, they were more hesitant to speak when I used this strategy. I removed this strategy and resorted to my old method of approaching directly and speaking to them. Therefore, from this experience, I realised that it might be better to approach men directly and speak about the issue, rather than using a printed pamphlet as it could invariably introduce power dynamics between the researcher and the respondents.

गर्भावस्था में पुरुषों की भागीदारी



क्या आपका जल्द ही नवजात बच्चा होने वाला है? अगर हाँ, फिर मातृ स्वास्थ्य में पतियों की भूमिका को समझने के लिए आपकी राय मूल्यवान है.

क्या आप इस बातचीत के लिए 30-40 मिनट निकाल सकते हैं?

यह देवानिक साहा द्वारा किया गया एक अध्ययन/survey है, जो लंदन के ससेक्स विश्वविद्यालय में एक पीएचडी छात्र है।

Figure 10 The recruitment poster for expectant fathers

(Translation of the text: Men's involvement in pregnancy. Are you expecting a new child soon? If yes, then your perspectives on understanding the role of fathers in maternal health are valuable.)

In the context of researching men's roles in reproduction, Law (2019, p. 2) writes: "while there has been some discussion of the reasons for men's relative absence in reproduction

research, there has been much less in the way of published methodological literature addressing how to engage men in such research”. Based on my above-mentioned experience in Rajaji Nagar, I have primarily three reflections on engaging with men in reproduction-related research.

Firstly, I found that men who are higher up in the economic ladder (within the working class) are more likely to speak and share their experiences of being expectant fathers. I suggest this is because men in higher economic quintiles are more confident and willing to talk to strangers due to their economic backgrounds. For instance, many of the men I interviewed were in customer-oriented employment such as restaurants, marketing, and food delivery services where they would have to interact with customers from higher income groups. When I approached men who were less educated and less financially affluent than the ones who spoke to me, they were hesitant and not willing to talk. My inference that relatively well-positioned men were more engaged in speaking to me about my research was also corroborated by Mohammad Zubair, an informal health provider in Rajaji Nagar, whom I interviewed. He told me that men from poor backgrounds and professions such as rickshaw pullers, vegetable sellers, daily wage labourers, and rag pickers, are apprehensive to talk to doctors, nurses and ANMs due to power dynamics and class issues and hence, they are not visibly involved in the antenatal care of their wives. Therefore, this thesis is particularly focused on the perspectives of men who belonged to higher income, education, and class quintiles within working class families in Rajaji Nagar.

Secondly, my experiences suggest that it might be easier to recruit technologically savvy working class men in customer-oriented roles for research than those who are involved in daily labour and manual work professions. This also meant that these semi-skilled working class men were quite willing to open up to me and share their experiences of expectant

fatherhood. Some of them told me that they had never discussed these issues with anyone else and that they felt comfortable in sharing their emotions and feelings. For instance, Amit Sharma, a 28-year-old expectant father, shared an experience of reproductive loss where his child had a neonatal death due to health complications and he held himself responsible for it. When I asked him, why did you share this with me in our first conversation, he said, *“Because I felt like you are a good person and I feel comfortable”*. Though I did not ask him why he described me as a “good person”, my inference is that probably I was the first one to speak to him about his deceased child and his experience as an expectant father, which led him to say this.

Thirdly, I suggest that semi-skilled expectant fathers in Rajaji Nagar are willing to be participants in co-constructing research narratives and knowledge on men’s involvement in antenatal care. Though the findings of my thesis and my reflections may not be generalised, they do offer promising insights and hope for future researchers who wish to engage with men on such subjects in similar contexts.

While these processes of data collection in the clinic were significant, my research and knowledge production were not limited to the spatial confines of the clinic, especially around engaging with the community health workers (ASHAs and Anganwadi worker (AWWs)). As I mentioned earlier, the clinic was a helpful site to meet and get acquainted with the ASHA workers, but my rapport with them was built outside the clinic. Within the focus group of seven ASHA and three AWWs, there were two ASHAs, with whom I developed a special rapport. I learnt a lot about their work and about the maternal healthcare processes in poor communities by accompanying them on their work journeys. Most of these work journeys were their trips to local Anganwadi centres where they assisted the ANMs to give vaccinations (and observed those for newborns and infants). Most of these journeys with ASHA workers were initiated by ASHAs themselves when they met me at the clinic.

“Rita Verma (ASHA worker): Namaste Sir ji, challenge aaj hammare sath anganwadi ? (Hello Sir. Would you like to come join us at the Anganwadi for vaccinations?)

Devanik: Sure, I will join you.”

Many times, when these vaccinations ended, they often invited me to their homes to have tea and biscuits. One ASHA worker who was involved in religious events and programmes often sent me invitations to attend them, which I politely declined. I had lunch twice at her home as the clinic closed around 1pm and it would take me time to reach my home and thus, she offered a lunch at her place countless times. However, negotiating and managing these relationships challenged some of my own habits and beliefs. For instance, many of these ASHAs were older ASHAs aged around 50-55 years, but I used to call them *Didi* rather than an *aunty* (a generic term used by young people to address women of that age group) because of the popularisation of the term ‘ASHA *Didi*’. They always addressed me as Devanik Sir or Sir ji, even though I was at least 15-20 years younger than them. Most of them had strong political views which were in opposition to mine, but I always maintained a diplomatic stance by responding with “Hmm, hmmm” and not speaking much on those issues.

These ASHA workers also introduced me to Anganwadi workers – who are part of the ICDS programme, and who were not directly involved with the clinic administratively – with whom I developed a rapport by sitting and chatting with them in their Anganwadi centres. I often observed some of the work processes of these centres; for instance, measuring the weight and height of newborn infants to check for anomalies. I also observed four immunisation sessions for newborn babies and young kids (0-3 years) conducted by the ANM at these Anganwadis.

A significant part of the CHWs' time involved collating statistics and numbers relating to the activities performed, which was crucial to their income and incentives (more applicable for ASHA workers as they received an incentive-based income). The ASHAs and Anganwadi workers also gave me a glimpse of how this is done. For instance, Figure 11 below shows Rita Verma, an ASHA worker, and Anjali Bantwal, an Anganwadi worker, jointly measure the height of a five-month-old infant.



Figure 11 CHWs Rita Verma and Anjali Bantwal measuring the height of an infant.

After taking the measurement, they entered this information in a mobile application (Figure 12 below), which is used to track child health outcomes.

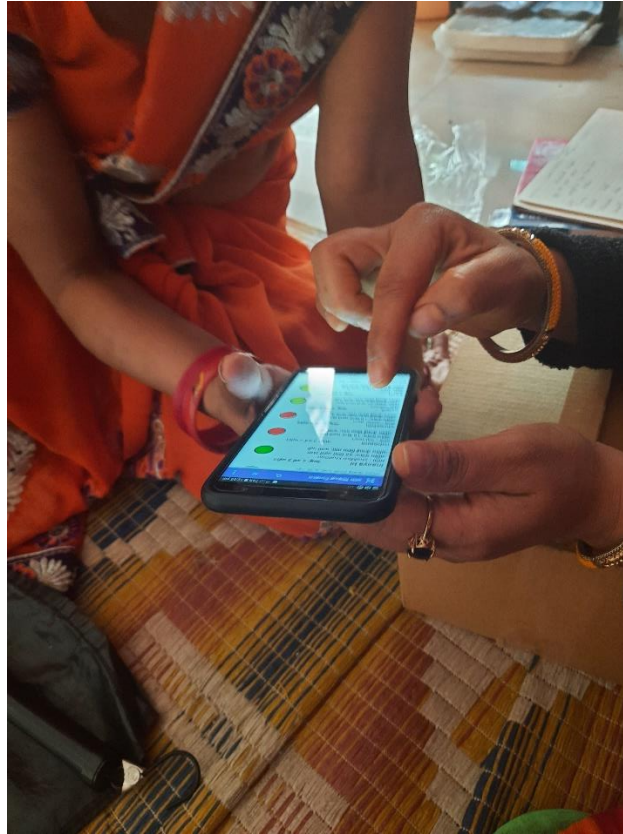


Figure 12 Both CHWs entering the information on the mobile app

Apart from discussing my research and sharing their everyday health work, these CHWs were quite inquisitive about my background, family, and marriage. These discussions also extended to politics, caste issues and local developmental issues. Here again, one Anganwadi worker, Draupadi Devi, inquired about my caste and which community I came from, which was a bit challenging to manoeuvre around. Once she heard that I was an upper caste Hindu, she often focused on some upper caste Hindu-related issues which are quite prevalent in India (mainly debates around affirmative action). However, as compared with the ASHAs, my conversations with these AWWs remained confined to the Anganwadi centres, as I conversed with them primarily in the centres and did not visit their homes.

In addition to producing data for my research questions, these fieldwork experiences also

problematised my academic understandings of qualitative research methods. When I reflected upon my fieldwork experiences alongside reading methodological literature, in hindsight, I realised that the term ‘participant observation’ has a limited scope and does not fully capture the complexities involved during ethnographic research. The term ‘observation’ subsumes other activities that are done by a researcher such as personal interactions, listening to conversations, helping people fill in forms, doing daily activities in the field site, among others. For instance, on 8th November 2019, a non-ANC check-up day, all the ASHAs were called to the clinic to fill in some forms regarding an educational training programme provided for them. As the form had to be completed in English, one ASHA approached me for help which I readily agreed to. Eventually, I ended up filling in the forms for around 15 ASHAs, which helped me to get acquainted with them. An unintended consequence of this activity was that because the form required the completion of demographic details, it gave me a clear idea of the religious and caste composition of ASHAs.

Thus, instead of participant observation, I prefer the term ‘participant immersion’ which I interpret as immersing myself in a certain context for the purpose of doing research. I agree with Gerard-Forsey (2010, p. 563) who writes: “a significant enough portion of ethnographic writing is based more upon what was heard in the field than what is seen there. And often what is reported as the ‘seen’ are in fact observations of people conversing, singing, listening, speechmaking – noisemaking”. For example, while I ‘hung out’ at the clinic every day as a researcher and used my eyes as an instrument to witness the daily processes and interactions, as described above there were times when I deliberately avoided using my eyes and invested a significant effort in using my ears and listening to the interactions and conversations that happened among the participants, which was documented in my field notes. In addition to listening and observing antenatal consultations between pregnant women (Step Four of the care

seeking process on ANC check-up days as described earlier) and with the clinic staff in a systematic manner over several weeks, much more of the listening was unstructured. In Moerman's (1988, p. 8) words, such data can be termed as "droppings of talks", which informed my understanding and added additional insights to the more formal interviewing and conversations in my fieldwork.

On non-ANC check-up days, which were mostly unstructured in terms of data collection in the first few months, I had several informal conversations with the health clinic staff and expectant fathers (discussed above in Section 3.1). When I reflected on these conversations and experiences later, I realised that there are three main advantages of using informal conversations: 1) they are non-performative: an informal conversation often might elicit more data than a structured or a planned interview as the respondent is in a relatively relaxed position as compared with a planned and structured interview where they might feel performative and focus on giving the 'right answers', 2) they can be free flowing and give new avenues for research and new findings not thought of previously, and 3) they help mitigate the power dynamics between the researcher and researched to a certain extent. These informal conversations started as introductory conversations between respondents, and eventually turned into deep discussions about the research questions.

There is a reasoning which suggests that informal conversations are the same as ethnographic interviews (Bernard, 2011, p. 57). However, I distinguish between the terms 'ethnographic interviews' and 'informal conversations' and suggest that the key difference is that informal conversations are random, unplanned, without any set agenda and can happen anywhere and anytime. Another key feature of informal conversations was the fact that during these conversations, I did not audio record these conversations or write notes during the midst of

discussions. I mostly wrote down these conversations from memory immediately in my field diary after they ended.

3.4 Data management and analysis process

My PhD data is stored on OneDrive, a cloud storage platform provided by IDS (See Figure 13 below). This data includes audio recordings of all interviews, focus group discussions and transcriptions of these interviews. During research, I kept a field diary where I wrote my participant observation notes, informal conversations, and *Chai Pe Charcha*⁵⁹ notes. As far as possible I sought to transcribe and translate interviews from Hindi to English on the days of the interviews.

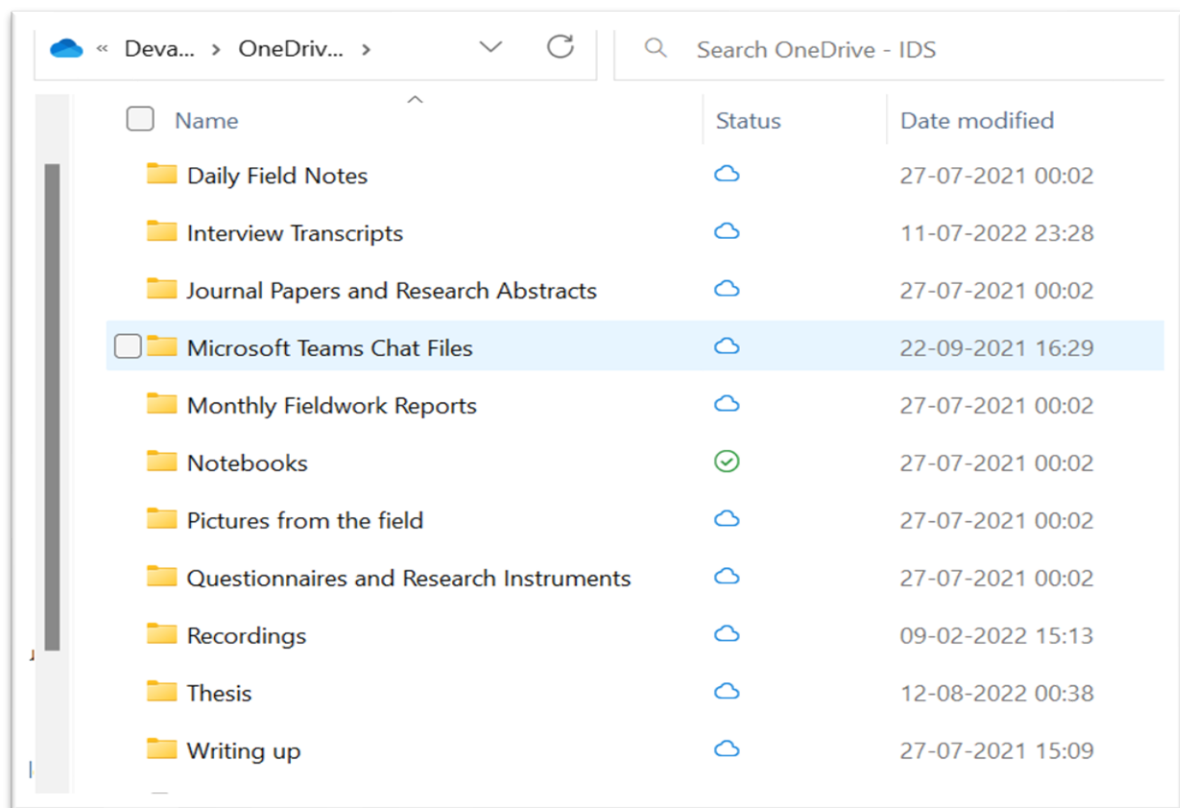


Figure 13 My One Drive folder

Given the diversity of my research methods and sources of data (transcripts, field diaries and

⁵⁹ As informal conversations, *Chai Pe Charcha* chats were not audio recorded, I mostly wrote them from memory once these conversations ended.

pictures), this filing approach was efficient and convenient. I started the process of preliminary data analysis four months into my fieldwork because I wanted my research to be reflexive and iterative. After the first three months of fieldwork (August to November 2019), I started doing a monthly review of my field notes and interview transcripts, analysing the emerging themes and patterns, and considering whether any new strands of inquiry were emerging in addition to those in my talking points guide. Taking my research questions as a frame of reference, I followed an inductive analysis process (Thomas, 2006) to analyse the data. While I extensively reviewed my interview transcripts and field notes, I often returned to the audio recordings and listened to them again to interrogate themes further. For some respondents, such as expectant fathers and ASHA workers, I frequently referred to my field diary and post-interview notes for data triangulation. This triangulation helped to enrich the discussions and analysis. For example, while I interviewed many CHWs, I supplemented my analysis of their perspectives gained through interviews with field observations of their everyday activities at the clinic. I also spoke to respondents multiple times to explore different issues and themes that needed more clarification. Further to this, I wrote descriptions of these themes (and how they differed or resonated with the original talking points guide I had) and shared these ideas with my supervisors during monthly meetings (December 2019 to March 2020).

Once I had descriptions of the themes, I worked on crystallising these themes to develop broad analytical findings in relation to my research questions. A key aspect of this process was the critical engagement with the literature on masculinities, reproduction, men's involvement in maternal reproductive health and gender justice (See Chapter 2) to expand my discussions and analyses. This engagement also enabled me to establish my thesis' empirical and theoretical contributions to the literature on men's involvement, masculinities and maternal health. Eventually, I used these analytical arguments and findings to draft my empirical chapters (Chapter 4, 5 and 6) in connection to the relevant research questions and finalise my thesis.

3.5 Ethical issues and positionality

In the previous section, I shared my reflections on the ethnographic research and processes. In this section, I focus a little more in depth on the ethical issues that I encountered in the field.

My research was approved by the Research Ethics Committee (C-REC) at the University of Sussex, UK (Application No: ER1/DS447/2 (Annexure 4). In addition, I procured permission for fieldwork from the Department of Health, Government of Delhi (Annexure 5). Research ethics procedures are important to ensure that the research process does not infringe upon the rights of respondents and keeps their safety and interests paramount. My position on research ethics resonates with what Hammersley and Atkinson (2007, p. 219) term “ethical situationalism”, which refers to “what is and is not legitimate action on the part of researchers is necessarily a matter of judgement in context and depends on assessment of the relative benefits and costs of pursuing research in various ways. This point of view usually places particular emphasis on the avoidance of serious harm to participants and insists on the legitimacy of research and the likelihood that offence to someone cannot be avoided. It leaves open to judgement the issue of what the benefits and costs of particular research strategies are in particular cases, and how these should be weighed”. This difference between C-REC approval and in-situation assessment of the costs and benefits is evident in the process I followed for seeking informed consent from research participants. While the C-REC committee required submitting sample consent sheets and forms as part of their ethics application, my ethics application also included a process for recording consent verbally if required due to the social and cultural background of Rajaji Nagar respondents. However, before (and after as well in many cases) every planned interview as well as informal conversations, I made it clear that none of the research participants’ demographical and personal information would be used and everything would be anonymised so that they could not be traced back to the respondent at all.

I also made it clear that people did not have to answer and that they could withdraw from the conversation at any point with no negative repercussions. Also, I always wore my Sussex identity card during my research as it always ensured that my identity as a researcher was always foregrounded. This was particularly important during many of my informal conversations, which happened as I walked and chatted with them.

During fieldwork, I constantly reminded myself that I did not want to impose unintentional pressure on prospective fathers, health workers or others giving interviews. For example, during her research on marriage practices in Sri Lanka, Abeyasekera (2017) gained access to respondents through her friends and social circles. During her research, she realised “many women respondents simply agreed to speak to her as they could not refuse their friend”; that is, Abeyasekera’s friend’s aunt (2017, p. 5). Similarly, there arose a situation in the beginning weeks of my fieldwork, when the doctor in-charge of the clinic introduced me to the ASHA workers, and I did not immediately jump into asking questions or requesting interviews. I adopted a cautious approach because given my positionality as an upper class researcher being introduced by the in-charge, some ASHA workers might have said yes to my interview requests only because of the power dynamics involved and an obligation to obey the in-charge’s ‘instructions’. Thus, I exercised caution and spent the next few weeks building a rapport with ASHAs, and only scheduling interviews after this and after speaking to them explicitly about my research.

My upper class background gave me undue privilege which I tried to mitigate during fieldwork. In India, there is a common tendency to treat upper class people with higher deference and respect as they are considered more powerful and worthy of respect. For instance, on ANC check-up days, when I arrived at the clinic, the clinic would be fully packed (as women queued in advance) with no place to sit. I usually sat with the receptionist and thus, when I arrived, the

receptionist would ask other women to get up and make space for me. For the first couple of times, I did not protest much and chose to sit. This was a suggestion given by someone who suggested that when you first go into a community, you should not refuse the efforts they make for you outright, even if you may not agree with some of those efforts. Eventually as I established a rapport with the staff, I politely declined the offer and ensured that no one left their seat for me.

While these issues were handled in real time in the field, in hindsight – during analysis and writing of this thesis – I realised the privileges of being an upper caste Hindu and how that influenced my data collection. In some cases, my respondents, especially CHWs, inquired about my caste and once they came to know that I am a Hindu, especially upper caste, they opened up more and interacted in much more depth. Some CHWs made some disparaging remarks and comments regarding Muslims – as I will highlight in Chapter Five – leading me to hypothesise that had I been a Muslim, their responses might have differed to the ones they gave me at the time. Thus, my social identity helped my data collection and did not create any hindrance, which I acknowledge as a privilege here.

3.6 Impact of COVID-19 on fieldwork and research

On 24th March 2020, the Covid-19 pandemic led to a nationwide lockdown being announced in India. This was considered the world's harshest lockdown (*The Guardian*, 2020) leading India to a standstill for several weeks. Around April 2020, when most countries had introduced lockdowns, the University of Sussex also barred in-person fieldwork for several months and mandated PhD students and staff to do research online only.

Thus, this lockdown and the ensuing pandemic disrupted some of proposed research ideas which I had planned to do post-March 2020. In addition to my existing research activities, I had planned to explore two further strands of inquiry. One, interviewing some expectant

mothers to understand their perspectives on men's involvement. I had, in fact, been in touch with three women who were ready to share their experiences, but the unexpected COVID-19 pandemic disrupted those plans. Two, I planned to do some fieldwork in gynaecology wards and labour rooms of major hospitals near Rajaji Nagar. Although the second plan was more exploratory in nature, I felt that the first plan of interviewing some expectant mothers would have strengthened my analysis of the issue. Due to the social and cultural norms of Rajaji Nagar around young men messaging and speaking with young married women, it would have been inappropriate to speak to them online or over the phone. The COVID-19 pandemic was an extraordinary situation with a nationwide lockdown, which made it impossible to do any such interviews with them. Instead, I focused on the existing themes that strongly emerged from my field data. Nonetheless, this can be an aspect of future research, where the perspectives of expectant mothers on the involvement of their husbands can be explored in depth.

Around December 2020, the University of Sussex revised their fieldwork guidelines for PhDs and researchers, suggesting that they would consider resumption of fieldwork, but each case was to be treated differently as each country was at different stages of the pandemic and a revised ethical application was to be submitted if one wanted to resume in-person fieldwork. However, around this time, when the UK restrictions were removed, India (and Delhi) was still reporting a high number of positive cases. I really wanted to go back to the field for a while not just for the sake of collecting data but also to motivate myself. However, given that the health workers were mostly middle-aged women, it would have been unethical to put them at risk (when the COVID-19 vaccination campaign hadn't started in India) just for the sake of collecting data for my research. Furthermore, multiple news reports, academic articles, and my own interactions with the ASHAs showed that the burden of the COVID-19 fight fell on the shoulders of these CHWs. Thus, due to these two compelling reasons, I felt it would be inappropriate to go back to the clinic with the aim of pursuing 'research at all costs'. Hence, I

continued to focus on analysis and writing for a few more months. Around March 2021, when the situation seemed stable in Delhi in terms of cases and the work pressure on ASHAs had reduced (and all of them were fully vaccinated as priority groups), I thought of going back to the field again. I realised that I had this constant urge to collect more data and my unfinished plans were compelling me to go back again. However, I had just started to plan some fieldwork in the later part of March 2021, when the devastating second COVID-19 wave struck India suddenly, which left millions of Indians in dire circumstances and in a situation of severe panic and desperation, as oxygen supplies and hospital admissions were put under extreme pressure (Pandey, 2021). Due to the severity of this extraordinary situation, I joined many volunteer groups and helped people to coordinate responses for affected people. The enormity of the situation and the ensuing deaths and personal trauma of losing some acquaintances led me to take the eventual decision of ceasing in-person fieldwork completely and focus solely on writing and analysis.

Chapter Four: "*Wo nahi chahte ki hum andar aaye*"⁶⁰: Exploring the Indian State's approach towards men's involvement in maternal health policies and programmes

Introduction

I start the discussion of my empirical findings with this chapter, which will examine in what ways (or to what extent) the Indian State engages with expectant fathers towards achieving good maternal reproductive health outcomes. While there is wide literature on how the State is defined and perceived (Oppenheimer, 1985; Nandy, 1989; Hasan, 2000), I concur with Hansen and Stepputat's (2001, p. 12) conceptualisation of the State, which they suggest is a "dispersed ensemble of institutional practices and techniques of governance".

As discussed in Chapter One, maternal health has been a priority area for the Indian State, which was also a signatory to the 1994 International Conference for Population and Development at Cairo, that recognised the need to engage with men in maternal, reproductive, and newborn health. Thus, examining the Indian State's approach towards men's involvement becomes imperative in this context.

The question which this chapter seeks to answer is:

In what ways (and to what extent) does the Indian State encourage men's participation in maternal health?

I will answer this question through multi-pronged stepwise analysis. First, I will start by discussing the perspectives of maternal reproductive health practitioners and policy researchers

⁶⁰ Translation: "They [the CHWs] do not want us [husbands] to come inside [the primary health clinic in Rajaji Nagar]." This is a quote from an expectant father who shared his view regarding the attitudes of the clinic's staff towards them on antenatal check-up days. I have chosen this quote because this broadly reflect the Indian State's attitudes towards expectant fathers which I will explore in more detail in the chapter.

who have worked in this domain – and in Delhi – for several years. As I mentioned in Chapter Three, these researchers (and their affiliated organisations) actively engage with different state governments as well as the national government on these issues. Therefore, their perspectives and experiences inform my analysis in Section 4.1, where I discuss the Indian State’s approach towards the idea of engaging with men as equal partners in maternal reproductive health. I also draw upon the broader literature on India’s social policy programming, maternal health policymaking, and its eventual impact on the agenda of men’s involvement.

In the next section, given the ethnographic approach of my research, I shift my focus to the primary health system and discuss the various ways in which the Indian State’s approach towards men’s involvement is operationalised at the primary healthcare level. This section is informed by my field observations at the TH20 clinic in Rajaji Nagar. I would like to add that this section is mainly based on my observations and inferences, rather than individual perspectives of health workers and staff (which I will explore in depth in Chapter Five and Chapter Six). In Section 4.3, building upon my discussions in 4.1 and 4.2, I provide a holistic analysis and discussion of the State’s approach towards men in maternal health. Finally in Section 4.4, I offer my concluding remarks.

4.1 How does the Indian State perceive the role of men in maternal reproductive health?

Across contexts and cultures globally, existing research and academic literature indicates that reproduction is essentialised as a women’s issue with limited focus on men’s roles and involvement (Ongolly and Bukachi, 2019; Albuja, *et al.* 2019; Davis *et al.* 2018; Vermeulen *et al.* 2016) due to social, cultural and gender norms.

To explore this line of inquiry further, I interviewed 10 policy practitioners and researchers regarding the Indian State’s attitude towards the idea of men’s involvement in maternal health.

In India, State policies and programmes in the realm of maternal and reproductive health mirror the widely prevalent cultural view that reproduction-related matters are solely women's issues. Stalin, a 46-year-old male Chief Executive Officer of a reproductive health advocacy organisation in Delhi explains that, to date, the emphasis in maternal reproductive health has been on women:

“Just like the society, most of the health system, including government officials, government, and private hospitals, they think from a woman's problem, and we can address it by a policy intervention at women. They are the target audiences and whatever best required for them needs to be done. And policy wise, it has come out of medical reasons. Reducing maternal mortality, infant mortality, neonatal mortality, etc. So, when you see it from a narrow angle, you don't see men contributing too much. We are seeing where they [women] can deliver the children, what sort of support do they [women] get. Everything is being focused on the woman. If you step a little back and look at the family planning programme, it is always focused on women. That's because thinking is based on the management point of view. That gives the best bang for the buck. That's what we will do. Bring the women in the labour room, do institutional deliveries, incentivise her for tetanus injections, and medical check-ups. So that's how it is being looked at. Therefore, people have never thought about what men can do and if there is any role for that.”

(Stalin, NGO office, 10th November 2019)

Stuti, a female researcher with a women's research organisation which works actively with men in this domain, agreed. Stuti has also led studies and initiatives which work with men and boys exclusively on sexual and reproductive health. She said:

“Packaging of services, communication around the schemes, is that it is only for

women. I think that language has to change. Thus, antenatal care visit is important for a couple because a man is supposed to be a father, he has to take care of his wife. It has to be about couples and not necessarily women's health. Sexual and Reproductive Health Rights is always packaged from a woman's health perspective. The entire onus is on women, which has to be changed."

(Stuti Pal, female researcher, NGO office, 11th March 2020)

Stalin and Stuti both agree that the reproductive maternal health services and schemes are focused disproportionately on women, and in so doing, these systems and institutions reinforce the cultural significance of reproduction in women's lives by using Indian men's cultural and social exclusion in reproduction as a conceptual justification. Stuti stresses that the focus should be on the couple, rather than the woman exclusively.

I also spoke to Ritwik, a male demographer and researcher with a reproductive health organisation, who compared his decade-old and recent observations of public hospitals in Delhi:

"Antenatal care, I still feel, in the hospital, the ambience, the infrastructure, the support system, the staff [are] all very much focused with the end users and their support person is female. You will see men are not so welcomed in the hospital. It was in 2003-04, it is still the same today in government hospitals, public health centres, you will see the waiting area. Women will ask husband to wait outside and when their names come, they will go. This is indicative of, this is not your business. The most important is the ANC card, pregnancy stamp; men and women are not explained properly. All these issues really important that men are there."

(Ritwik Chatterjee, NGO Office, 8th November 2019)

Ritwik recounts that in 2003-04, the hospitals did not welcome men (of all income levels), and the health staff (who were mostly female) were mostly dismissive of their presence. This created an exclusionary environment for men, and this, as the above quotes by Stalin and Stuti show, holds true even today. It is also pertinent to note that, in addition to men's exclusion, important logistical issues such as ANC check-up cards, pregnancy guidelines and so on are not explained to expectant mothers in detail. This is an important issue which I will come back to later in this section.

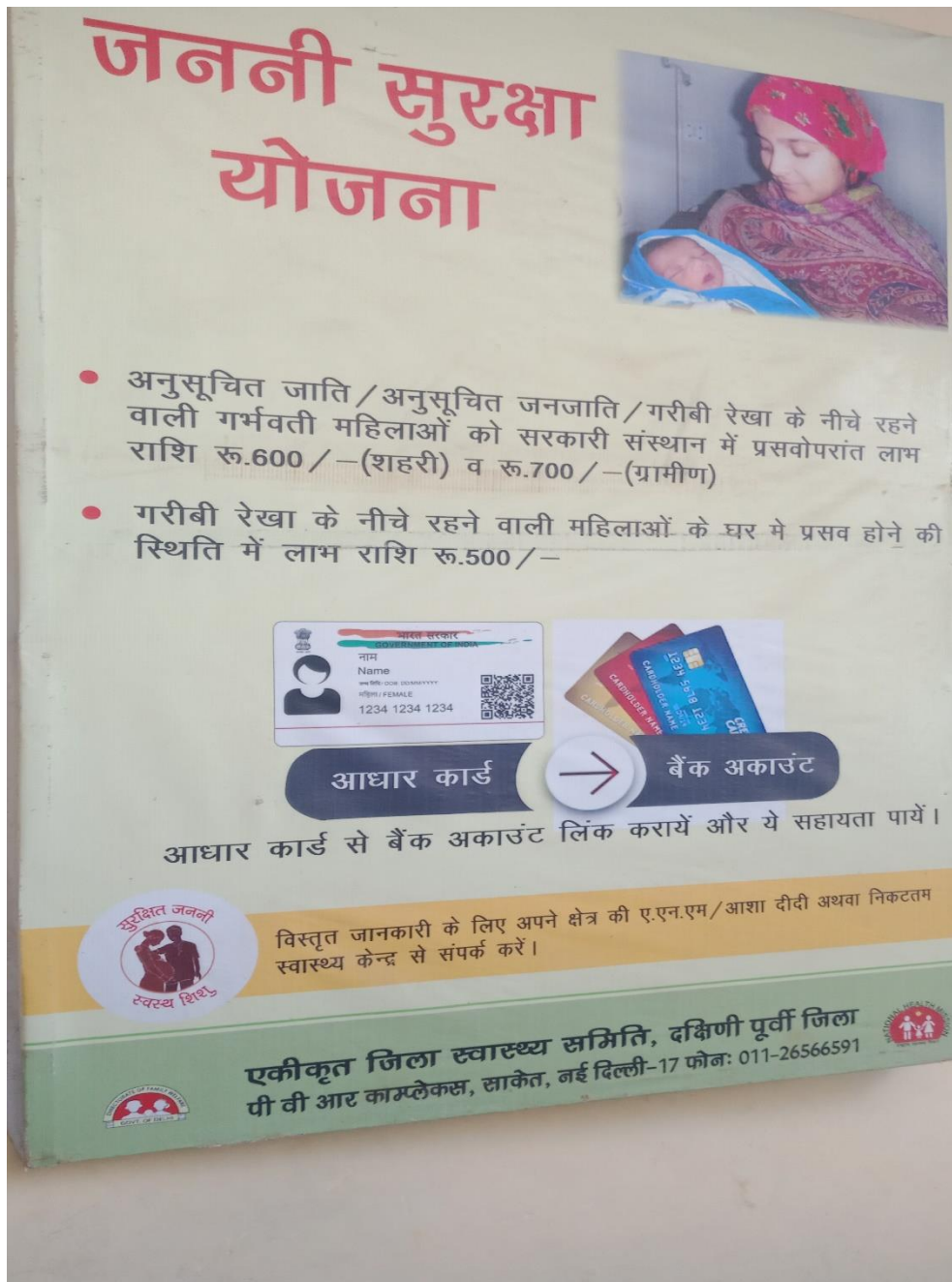


Figure 14 A poster for the Janani Suraksha Yojana (JSY) Scheme

Ritwik also added that these social and gender norms are also reinforced and reproduced by mass media and television:

“How many movies you have seen that men are inside the delivery room. 90% of men

are waiting outside the delivery room. Midwives/nurses open the door and not the whole body comes out. Only their head comes out and say hey listen! you have a daughter/you have a son. Their main role is to hear this from a distance. How many movies you have seen where men are given a prominent role? Men are waiting and not seeing the pain the women are bearing.”

(Ritwik Chatterjee, NGO Office, 8th November 2019)

All three respondents (Stalin, Stuti, and Ritwik) highlight the culturally influenced exclusion of men and the prioritisation of women in reproductive maternal health policy. Stalin analyses it from a developmental and top-down policy perspective, Stuti highlights the programmatic view, and Ritwik emphasises the exclusion of men from antenatal care at an operational level and everyday operations. All other practitioner and researchers (a total of 10) I interviewed and had conversations with, had a similar view around the State's approach towards men in maternal and reproductive health policymaking.

However, the cultural essentialisation of reproduction cannot alone explain this overarching policy and programmatic focus on women. Spain (1993, p. 139) writes: “single institutions do not operate in isolation to ‘cause’ gender stratification. Precedence may be attributed to one institution or another, but institutions reinforce one another”. This argument holds true in the Indian context because there is not just one single institution; rather, the paradigm in maternal health policies is an overarching focus on women, and which ignores the presence and potential participation of men in maternal care. A review of women-related social policies in India (Krishnan, 2022) highlights that the Indian State has a maternalist bias where the State pays overarching attention to women as mothers (Nangia, 2018). This argument is reinforced by other academics who argue that the State adopts a gendered familialism ideology (Palriwala

and Neetha, 2011), where it tends to conjoin caregiving of children with the female body (Nandy and Banerjee, 2017). Even Unnithan (2019, p. 17) posits that women and maternity has been at the forefront of India's policy discourse on reproductive health since independence and more profoundly after the new millennium (due to the Millennium Development Goals (MDGs) discourse) and this deployment of maternalist frames has manifested into a near total reliance on women's bodies and lives for reproductive governance.

Using the case studies of two women-oriented policies⁶¹ (one on maternal health and institutional deliveries, another on empowering women at the grassroots), Nangia (2018) argues that the reasons for India's maternalist bias in policy programming – which has significantly increased in the past few years – are twofold. One, the prioritisation of maternal health (more specifically the reduction of maternal mortality) as an international development agenda for adult women especially after the introduction and immense popularisation of the MDGs (which has had a significant impact on India's social policy programmes) as compared with other fields such as paid work, political participation, or higher education. Two, social policy thinking in India conflates gender with poverty, treating it as a single dimension of social stratification, which leads to efforts to address gender by solving poverty and to arguments for women-specific programmes for educational, economic, and political empowerment (Nangia, 2018, p. 1). Due to these two factors, India's social provisioning is uncommonly attentive to adult women, and is almost exclusively focused on their pregnancies and maternal roles as

⁶¹ The first case study is Janani Suraksha Yojana (JSY, Maternity Protection Scheme); this is a conditional cash transfer programme which provides incentives to women for delivering in an institution. The second case study is Indira Mahila Yojana (IMY, Indira Women's Scheme). This scheme was launched in 1995 which aimed to empower women through (i) generating awareness amongst women by disseminating information and knowledge to bring about an attitudinal change; (ii) helping women achieve economic strength through micro-level income generating activities; and (iii) establishing convergence of various services such as literacy, health, non-formal education, rural development, water supply, and entrepreneurship (NITI Aayog, 2021)

healthier pregnancies and healthier children are considered as means to achieving developmental aims of the State. This overarching attention has only risen in the past few years, in the form of numerous programmes for maternal health and nutrition (Nangia, 2018), which solely focus on women.

Nangia's arguments regarding the impact of international agendas on policymaking and implementation also emerged in my research. Stalin (quoted on p. 100 above) stated that maternal reproductive health programmes in India are target-oriented (institutional deliveries, provision of incentives for injections, check-ups, and so on) which are driven by a management point of view to give 'best bang for the buck' (optimal usage of low resources) to achieve development goals (MDGs earlier, and now Sustainable Development Goals (SDGs)) such as reducing maternal mortality, neonatal mortality, and fertility rates. Although no other respondent highlighted this aspect, Stalin's assertions are corroborated by Unnithan's (2022) work, which argues that a target-based approach rooted in neoliberalism continues to dominate maternal reproductive health policymaking. She writes that when India's first Reproductive Child Health (RCH) programmes (1997-2002, 2003-05) were introduced, they had an explicit mention of how their strategic orientation needed to be consistent with the MDGs and other national population-related policies of India (Unnithan, 2022), thereby clearly linking the Indian State's emphasis on achievable targets with international agendas. In addition, this approach is rooted in neoliberalism that aims to optimise low resources to achieve the maximum output, as Stalin had suggested. For instance, despite multiple contraceptive methods available for family planning, Unnithan's (2022, p. 128) analysis suggests that the State's continued and overarching focus on sterilisation is attributed to the fact that other contraceptive methods⁶² require far more resources and money, and thus are not cost effective. On the

⁶² Other contraceptive methods such as the copper T intrauterine device require administering and counselling

contrary, sterilisation requires “little surgical time, involves minimal discomfort and the client is discharged 2–4 hours after surgery” (Government of India, 2007, cited in Unnithan, 2022, p. 127).⁶³ I will further delve into the influence of a neoliberal approach on men’s involvement in Section 4.3.

From these discussions, two clear reasons behind men’s exclusion and erasure from maternal and reproductive health policymaking emerge. One, the cultural essentialisation of reproduction in Indian women’s lives, which are mirrored in the State’s policies. Two, the maternalist bias in India’s social policy programming. Juxtaposing these two factors, I suggest that the Indian State appears to re-inscribe biological motherhood and discourage men’s participation in maternal care and subsequent caregiving post pregnancy (Nandy and Ghosh, 2018). This has led to an overarching focus on women’s bodies and lives as sites of reproductive governance and neglecting the role of men as expectant fathers. This sustained policy and programmatic focus on women’s bodies and lives enables the State to move towards achieving their target MDGs (prior to 2015) and SDGs, while being careful to avoid disrupting the existing culturally and socially influenced maternal reproductive health policies.

However, it must be noted that contrary to the current scenario, in the past, the Indian State did engage actively with the idea of working with men to achieve reproductive health goals, mainly in the context of family planning. Through a historical and archival analysis of public documents, Balasubramanian (2018) traces the history of India’s family planning programme in the 1950s, 1960s and 1970s and its unconventional focus on men’s bodies for reproductive governance and population control in post-colonial India. In 1952, India was the first country

by a trained paramedic (Unnithan, 2022).

⁶³ There are other studies which explore the role of neoliberalism in reproductive politics of India (See Simon-Kumar, 2007 and Sreenivas, 2021)

globally to introduce a national family planning programme as the government of the day wanted to limit population growth with international aid assistance. To prioritise the reduction of family sizes, they sought the assistance of American social scientific experts and communication scientists, who studied India's social and cultural history and recommended that the best approach would be to influence men and convince them to use contraception (Balasubramanian, 2018) These scientists believed that as “men were the patriarch breadwinners and primary decision makers within their families” (Balasubramanian, 2018, p. 48), they were an appropriate choice for reproductive interventions rather than women, who had limited bargaining power and control. Figure 14 below shows one of the posters that was used to encourage men to use *Nirodh* (a word for condoms).

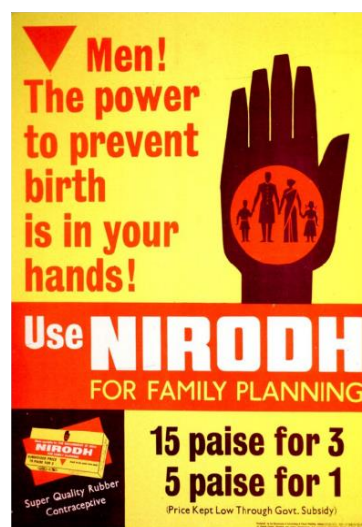


Figure 15 Nirodh poster

(Source: National Library of Medicine, n.d.)

Therefore, the Indian government deployed mass communication campaigns which projected controlling childbearing as a “rational economic thought” that would save unnecessary costs (Balasubramanian, 2018, p. 47). The government tried various ways to convince men to undergo sterilisation: financial incentives, free household items, peer-to-peer convincing,

engaging with village leaders and *panchayats*.⁶⁴ A criticism of this approach was that it reinforced the gender stereotypes of men being rational and economically driven, and of women being confined to household duties and incapable of taking ‘rational’ decisions (Balasubramanian, 2018, p. 40).

The agenda to promote male sterilisations achieved some success which can be evidenced by the fact that the proportion of female sterilisations fell from 46% in 1974-75 to around 25% in 1976-77 due to the rise in male sterilisations (Green, 2018). However, the uptake of sterilisations by men was marred by the Emergency period⁶⁵ in India, during which many men were coerced and forced to undergo vasectomies and as a result, the idea of male vasectomy became a political hot potato, leading the State to stop focusing on male sterilisations. During this period, around 6.2 million men were forcibly sterilised with thousands of them dying due to botched operations (Biswas, 2014). This turbulent period completely switched the State’s focus from men’s bodies to women’s for sterilisations; due to this, female sterilisations accounted for 80% of all sterilisations in 1977-78, then increased to 91.8% in 1989-90 and stood at around 93% in 2018 (Green, 2018).

⁶⁴ A *panchayat* refers to a village council, which is the most basic tier of governance in India.

⁶⁵ The Emergency period was between 1975-77 and is considered one of the most controversial and dark political periods of India. The decision to enact it was led by the then Prime Minister Indira Gandhi, who declared “Emergency in India citing threats to the security and safety of the nation”. During this period, most democratic rights and civil liberties of the populace were curbed. For a detailed understanding, see Dutt (1976), Morris-Jones (1975), and Prakash (2019).



Figure 16 A poster for a male sterilisation camp in 2018 which was at the TH20 clinic

(This poster demonstrates that male involvement in family planning is mostly perceived as being open to sterilisation. The headline translates as: “Men are making their new identities by taking up family planning and increasing their pride/honour. However, family planning was not the focus of my research at all”)

Echoing these family planning policies from the 1950s to the 1970s, and as shown in Figure 15, India’s experiments around engaging with men have tended to focus on family planning and men’s sterilisation. The State has not sought to involve men in antenatal care, where its main policies on maternal health (such as the Indira Gandhi Maternity Support Scheme, the Janani Suraksha Yojana, the Janani Shishu Karyakram, the Reproductive Maternal Newborn Child Health Initiative, and the Prime Minister Maternity Support Scheme, among others) make no mention of men, indicating a complete absence of men as expectant fathers.

However, in 2016, a new move was introduced by India’s health ministry which allowed birth

companions to accompany pregnant women in labour rooms. Though this move was conceptualised as a low-cost approach to address India's maternal mortality, it also led to allowing husbands to accompany their wives in labour rooms in some cases. Thus, I discuss this move and the challenges and opportunities around it in the next section.

4.1.1 Men as birth companions? An examination and discussion of India's labour room guidelines

To promote the participation of men in delivery and childbirth and subsequently in antenatal care, allowing them in labour rooms and during deliveries has been a key entry point towards encouraging their involvement in many countries. For example, Early (2001) traces how the emerging presence of men during childbirth and deliveries in the 1960s in UK heralded the start of the 'new dad' image, to the extent that it has now become an expectation for fathers to be present during childbirth. Premburg and Lundgren (2006) highlight a similar trajectory of men's involvement in pregnancy and childbirth in Sweden in the 1970s, which led to the creation of an ecosystem to support men's participation (childbirth education classes, peer discussions, allowing men in antenatal consultations, and so on).

Although limited academic literature exists on men's desires and experiences of participating in deliveries and childbirth in India, I scouted different media platforms such as national newspapers, community forums, YouTube, Facebook, and Instagram and found that over the past decade, there has been an increasing demand among men of all classes for being present in labour rooms (*Times of India*, 2015; YouTube, n.d.). This demand is also visible, to some extent, in government hospitals across India which are mostly accessed by working class and lower income families such as those living in Rajaji Nagar. My brief review of these platforms

suggests that this topic has generated significant interest among citizens, although this interest is more likely to be present among upper class families. I present a snapshot of these platforms and the debates on them now.

On Quora⁶⁶, which is a popular community forum worldwide, I searched for these debates using a string search of key words (men's involvement, labour rooms, husbands and India). I found around 15 discussion threads spread across the past few years which debated the presence of husbands in labour rooms in India from diverse perspectives (such as husbands, doctors, pregnant women, and social workers). Most of these discussion threads revolved around how and why husbands are (or are not) allowed in labour rooms, although there is no major consensus among these posts. I did the same on YouTube and found some videos by different stakeholders discussing whether a husband should be present inside labour rooms (as seen in Figure 16). There are some video blogs being made by expectant fathers on how they felt while waiting for their partner or their experience in the labour room.

⁶⁶ Due to the ethical considerations around using Quora for research, the C-REC at University of Sussex advised me to share my findings from the discussions but not use a screenshot of the conversations as it will violate ethical regulations and guidelines.

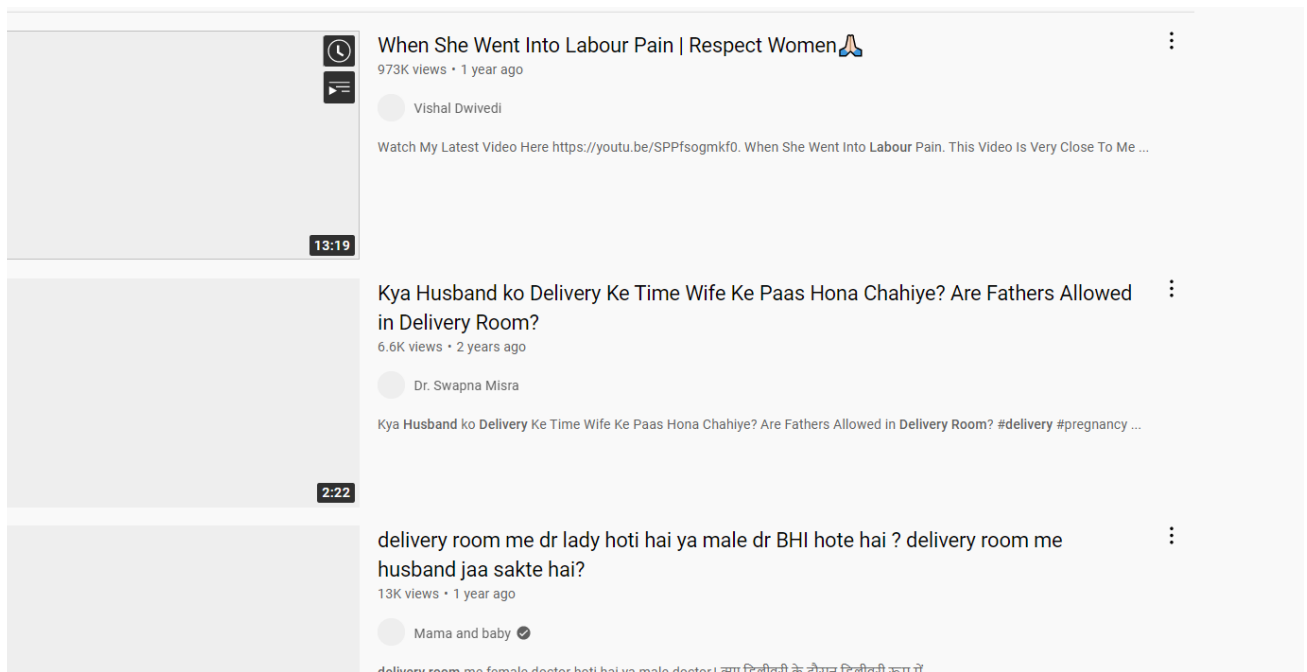


Figure 17 Discussions on YouTube

(Translation of the third YouTube video in the screenshot: Do delivery rooms have a female or a male doctor? Can husbands go into delivery rooms?)

There is a flurry of Indian blogs (which have varied opinions) by medical professionals (Pandharkar, 2020), doctors (Practo, 2018) and even pregnant women (Mompreso, 2020) who share their perspectives on, or experience of, having husbands as birth companions. Furthermore, an article by *Times of India* (2015), a leading national daily in India, reported that in the city of Kanpur in the state of Uttar Pradesh in 2015, expectant fathers were increasingly wanting to be in the labour room to witness the birth of their child. However, the article also reported that gynaecologists and medical professionals were, at the time, largely not in favour of this, as the following quote from the article suggests:

"A lot of young husbands request to be in the operating room either to watch their child being born or just to support their wives. Though it is legally allowed, I don't allow them

because it may after all not be all that a good experience for them. And that can cause disruption in the operation for us and increase our problems.”

(Gynaecologist, Government Hospital in Kanpur, Times of India, 2015, n.p.)

Nonetheless, building upon these existing discussions on social media, videos, and blogs, I suggest that there is an emerging demand – even though the overall proportion of the population may be low – among expectant fathers of all classes to be present during childbirth. It is in the light of these emerging interests and discussions, that a policy guideline introduced by the health ministry in 2016 becomes relevant and important to discuss.

In October 2016, the Ministry of Health and Family Welfare (MoHFW) released a Labour Rooms guideline document which suggested that a pregnant woman should be allowed one “birth companion of her choice” for her social and emotional comfort (MoHFW, 2016). The Indian government’s guidelines in the policy document do not give details about who this “birth companion” could be or should be. In another official notification, however, the central government guidelines specify that “the birth companion must be a female relative and preferably one who has undergone the process of labour. In facilities where privacy protocols are followed in the labour room, the husband of the pregnant woman can be allowed as a birth companion” (Press Information Bureau (PIB), 2016a, n.p).⁶⁷ Although the guidelines also mention that: “In facilities where privacy protocols are followed in the labour room, the husband of the pregnant woman can be allowed as a birth companion” (PIB, 2016a), the Indian State’s maternalist bias is at play as the terms “*preferably one who has undergone the process of labour*” indicate an experienced mother should ideally be a companion and not someone who does not have the experience of birthing, reinforcing the cultural importance of

⁶⁷ Not much is available on why this was allowed only in 2016.

motherhood. Furthermore, this initiative is also reflective of Stalin (quoted on p. 100), Nangia (2018), and Unnithan's (2022) arguments regarding the emphasis on women and the target-oriented approach of the State to achieve developmental goals using a neoliberal rationale. The 2016 notification stated:

*“In an innovative move aimed at reduction in Maternal Mortality Ratio and Infant Mortality Rate, the Ministry of Health and Family Welfare has taken a significant decision to allow birth companions during delivery in public health facilities. While several measures have been taken up by the Ministry over the years aimed in reduction in MMR [Maternal Mortality Rate] and IMR [Infant Mortality Rate], this step signifies India's commitment under SDGs to further accelerate initiatives with specific focus on quality parameters of the interventions. The **presence of a female relative during labour** is a **low-cost intervention** [emphasis added by me] that has proved to be beneficial to the women in labour.”*

(PIB, 2016a, n.p.)

Even this move to allow men into the labour room was underscored by references suggesting that women were better positioned to be pregnant women's labour room companions, and was introduced with an objective to achieve development goals with minimum usage of resources ('low-cost intervention') which is a neoliberal rationale, rather than with an interest in encouraging men's involvement in maternal health.

Due to contradictions and ambiguity within official government documents and of course, the prevailing cultural norms around men's roles in maternal health, expectant fathers are mostly not allowed inside labour rooms and only a select few high-end private hospitals and some

state government hospitals currently allow men to be present in the labour room.

Most Indian states (with exceptions) still do not allow husbands as companions in birth rooms. Kerala, India's most literate state and a state with high social and economic indicators, allowed husbands as companions in 2018 (Gopinathan, 2018). Also in 2018, officials from the School of Public Health in Chandigarh,⁶⁸ a union territory in India, wrote to the state health department requesting permission to allow fathers-to-be or other family members inside the labour rooms, to provide the patients with emotional support. These guidelines and efforts are in line with the World Health Organization (WHO) which recommends that a woman has the right to be with a companion who makes her feel at ease, as having a supportive companion improves the childbirth experience (WHO, 1996). However, in high-income countries, where the debate around fathers in labour rooms gained prominence much earlier than in India, it was mainly due to a demand from men who wanted to be present at the births of their children rather than from an improving health outcomes rationale (See Early, 2001; King, 2017).

I spoke to several respondents (expectant fathers, CHWs, and policy practitioners) regarding their experiences and perspectives on men in labour rooms. I start by sharing a quote from Dr Kavita, who is a trained midwife and the dean of a university nursing department, and she was part of the central government committee which framed the Labour Room guidelines.

“During the meeting on guidelines, I said we should allow men, but other members said that he will leave his wife and may be more interested to see other women. When the decision was taken to allow a companion, it was decided to go slow. First, we should

⁶⁸ Chandigarh is a union territory in India, which is governed by the central government directly and does not fall under any state government jurisdiction.

allow mothers-in-law and see how it goes. The word ‘companion’ has not been officially clearly defined [and] that’s why. Changes happen slowly. But it is a good development that people have accepted and acknowledged that we need to have men. Furthermore, among uneducated men, there is low awareness. In private hospitals, there are exclusive rooms, hence husbands are allowed in some hospitals. For e.g., FORTIS⁶⁹ allows. In government hospitals, the number of deliveries is more, so they do not allow.”

(Dr Kavita, Her university office, 17th February 2020)

As is evident in this quote, it was because of the committee’s opposing views on allowing men that the term ‘companion’ has deliberately been made ambiguous and left to the discretion of the hospitals to allow or not allow men. More importantly, as Dr Kavita argues, the acknowledgement that we need to include men is itself a welcoming sign. However, in the same conversation, she also highlighted the pitfalls of allowing men inside, given the fact that in general, the society is not attuned towards men attending childbirths and being present inside labour rooms, and that many hospitals’ facilities will have several women in labour without private rooms, making it hard to ensure their privacy if men act as birth companions.

“Men are not tuned to behaving in a labour room. He will not behave/cross the line as men are not trained to behave like that. There is a lot of talk about women’s empowerment but no talk of men to facilitate/allow that empowerment. If we allow them in labour rooms, he will open the curtains and other women will have a problem. It will have privacy issues. Therefore, hospitals do not allow men as men are not trained to do it.”

⁶⁹ FORTIS is a high-end and affluent hospital chain across India.

(Dr Kavita, Her university office, 17th February 2020)

Her comments suggest that while having official guidelines is one thing, allowing men inside a labour room is challenging for other pregnant women. Dr Kavita believes that men are not accustomed to ‘behaving’ inside a labour room and other women may have a problem with outsider men inside the room. She suggests the lack of behavioural training and gender conditioning as reasons why men are not/should not be allowed in labour rooms. Similarly, countries such as Italy and Iran have found that there is a strong need for training men and providing them with anticipatory guidance on what to expect during labour, which helps to reduce anxiety among the women during childbirth (Salehi, Fahami and Beigi, 2016; Tarlazzi *et al.* 2015).

In addition to Dr Kavita, I also spoke to Dr Debarati, a physician gynaecologist who has worked in the public and private sector in reproductive health for over 25 years. She managed a private gynaecology practice in an area close to Rajaji Nagar and drew upon her experiences there. She suggests training and involving men at every stage and then allowing their presence in labour rooms.

“I don’t know whether the women would be ready. It takes away a lot from the woman. I have seen men who cannot handle the sight of blood and gore. You have already one person who is very important. It is not a pleasant experience. So, either, men are involved at every stage through classes and sessions on what to expect. If you let them in the last stage, then it’s not easy.”

(Dr Debarati, NGO office, 10th November 2019)

Dr Debarati argues that men need to be involved at every stage of pregnancy on what to expect and how to experience it, otherwise just allowing them inside labour rooms in the last stage will be difficult for them. She argues that until and unless men are involved at every stage of the process, it will be tough for them to handle the sight of childbirth with blood and gore. The concerns around men fainting and panicking in labour rooms, as well as the negative impacts on fathers of attending childbirth have been discussed in other contexts as well (White, 2007; Odent, 2008; Etheridge and Slade, 2017; Van Vulpen *et al.* 2021). For instance, the study by Etheridge and Slade (2017) found that men who attended childbirth experienced extreme distress and the study recommended maternity services to better attend to the needs of fathers. White (2007) found that some fathers experienced symptoms of post-traumatic stress disorder after childbirth. Thus, the concerns highlighted by Dr Debarati are not unfounded.

In addition to these concerns, the structural arrangements in labour rooms with the associated lack of privacy for women is a key issue that has been found in different contexts. At present, any widespread encouragement of men as birth companions would mean that labouring women would be subjected to the presence of men (other than their own husbands) and their gazes. Again, there is minimal evidence on the perspectives of pregnant women on this, but a story shared by Dr Kavita offers some insights and challenges associated with having non-kin men around. She mentioned that being the Dean, she allowed the nursing school to hire male nurses for gynaecology wards and support for deliveries in labour rooms. Other management committee members were not supportive of the idea, but she implemented it. However, eventually Dr Kavita found that pregnant women were not comfortable and got anxious on seeing male nurses in the wards, which was not conducive during childbirth as anxiety and discomfort among women may cause complications. Therefore, she had to rethink her decision and not let male nurses in the labour room. Her experiment and subsequent experience show

that even though health systems and structures may implement gender-transformative ideas which involve men in antenatal care, unless local gender beliefs and norms are transformed and unless hospitals have appropriate physical infrastructure to enable this, it will be difficult to have such interventions and implement them. More importantly, irrespective of hospital, non-profit organisation or individual objectives to promote men's involvement in maternal health, a feminist approach should be used to design and implement a particular policy which prioritises the interests of pregnant women. In this case, given the anxieties of women around male gaze and the presence of other men, it is important that the privacy concerns as well as the mental and emotional health of women in labour must be addressed before allowing men inside.

Further to the introduction of the labour room guidelines by the health ministry, two major hospitals in Delhi, namely the All-India Institute of Medical Sciences (AIIMS)⁷⁰ Hospital and Safdarjung Hospital, attempted to implement the guideline in their gynaecology units and evaluated its impact. An intervention-cum-study by Bharti *et al.* (2021) at AIIMS hospital found that they were able to facilitate birth companions (no mention of who they were) for 66% of their births in the study period. However, they found that lack of space, human resources constraints, and lack of privacy were the key issues which hindered their efforts to facilitate the presence of companions for women on many days. At the Safdarjung Hospital, a study by Sarwal *et al.* (2021), which explored the perspectives of healthcare providers working in the hospital on this guideline, found that lack of privacy and space hindered this guideline's introduction and implementation.

⁷⁰ AIIMS is the most prestigious medical college as well as one of the best hospitals for all sorts of tertiary treatment in India. Both hospitals mentioned here are funded by the national government. Many families of Rajaji Nagar (as indicated by them) often visit these two hospitals for various treatments as well as childbirth.

As mentioned in Chapter Three, initially, I had planned to conduct some in-person fieldwork at the maternity and gynaecology wards of major hospitals in Rajaji Nagar and gather some perspectives from expectant fathers, but this plan was disrupted due to the COVID-19 pandemic. However, I was able to speak with one expectant father who shared his experience of the labour room and hospital. Shyam Kumar, who became a father for the first time in November 2019, shared his experience of Safdarjung Hospital where his wife was admitted. I enquired about his experience there. He shared:

“Labour room, people are not separated like she told me. This is the very big reason why men are not allowed. Gaye bhaiso ki delivery hoti hai, us type ka hai. [Just like cows and buffaloes are delivered and treated, it was like that]. 10-15 beds are there for hundreds of people. No separation between women so we (men) are not allowed. Thus, it makes sense that we are not allowed. But if it is separated and everyone is in a room, then it would be fine. [My wife and I were kept apart] Till the time, they shifted her to a separate ward after delivery, then they let us meet them.”

(Shyam Kumar, his house, 19th December 2019)



Figure 18 Maternity ward of Safdarjung Hospital, Delhi

Source: Upadhyay (2022) (Due permission was sought from the journalist for publishing this in the thesis)

(The photo was recently quite viral (it was put up by a health journalist) on social media in India as it demonstrates the challenges around the lack of adequate facilities for pregnant women.)

Therefore, overall, there are two reasons why, despite the health ministry's guidelines, expectant fathers are struggling to be present during childbirth. One, the lack of adequate space and privacy is a clear hindrance to allowing men as birth companions as evidenced through my analysis of conversations with two medical professionals, one expectant father and a review of

the two studies conducted in two major hospitals in Delhi. Two, in general, there is a reluctance among gynaecologists and medical professionals to allow men as discussed through the perspectives of Dr Kavita, Dr Debarati and gynaecologists quoted in the *Times of India* (2015) article earlier in this section.

Now that we have discussed the Indian State's exclusion of men from maternal health policies through the perspectives of policy practitioners, medical professionals, and secondary evidence, I will now examine how this exclusion is operationalised (or not) at the primary healthcare level based on my observations in Rajaji Nagar.

4.2. Men's involvement in everyday antenatal care processes (and why it matters): a view from the field

To start my discussion, I return to Hansen and Stepputat's (2001) conceptualisation of the State. They argue that by "treating the State as a dispersed ensemble of practices and technical governance, we can also produce multiple ethnographic sites from where the State can be studied and comprehended in terms of its effects, as well as in terms of the processes that shape bureaucratic routines and the designs of policies" (Hansen and Strepputat, 2001, p. 12). Therefore, in this section, I study and comprehend the Indian State's exclusion of men from maternal health processes through the ethnographic site of Rajaji Nagar, especially the TH20 clinic. This section's discussion and analysis is informed by my observations as a researcher at the clinic.

On antenatal check-up days, when I spoke to expectant fathers, I inquired many times about their experience with the clinic's processes; that is, the primary health system. One such expectant father was Sanchit Kumar, a 35-year-old respondent, who was a taxi driver and

expecting his second child. He told me “*woh nahi chahte ki hum andar aye [the community health workers don’t want us to go inside]. Main dispensary ke andar jake kya karunga [what will I do by going inside the clinic]*”. Shyam Kumar, introduced in the previous section, said that if he goes inside the clinic, women will say: “*What are you doing here among ladies?*”. These comments indicated a sense of peripherality among expectant fathers, which reduced them to being the second sex (Inhorn, 2012) in the clinic. These men viewed the clinic as a gendered space (Spain, 1993) dominated by women health workers, where men had no tangible role to play. This is not to say every husband is hesitant to go inside, but clearly, they were aware that their presence inside the clinic was not welcomed. On hearing them initially, it may appear that they are either shy or simply not interested to go inside the clinic. However, my observations revealed that the clinic’s staff create an unwelcoming environment for men especially on antenatal care (ANC) check-up days and hardly engage with them.

On one such ANC check-up day on 28th August 2019, I witnessed a middle-aged Accredited Social Health Activist (ASHA) worker scolding a husband who was standing with his wife inside the clinic: “*Why are you standing here? Go outside and wait. Don’t create a crowd there*”. This scolding of men in public was a common occurrence at the clinic and was exemplified by one Auxiliary Nurse Midwife (ANM), who was a bit strict and scolded everyone including me when I was introducing myself to everyone as a researcher. On hearing about my research, she remarked: “*Yes, most of the time, we ask the men to go out of the clinic and wait there*”. Although I did not really give much significance to her remark that day, later, as I observed the structural exclusion of men on ANC check-up days, I was reminded of that comment. I also observed this active exclusion at an Anganwadi centre. On 6th November 2019, I was observing an immunisation day at the *gali* no. 7 Anganwadi centre, where an ANM from the TH20 clinic was vaccinating young babies for diphtheria, tetanus and pertussis (DTP).

While I was observing the processes and listening to conversations, a young man (around 30 years old maybe) brought his one-year-old child for the vaccine. Upon seeing him, the ANM gave him a surprised look (as observed by me) and said: “*Koi ladies nahi hai apke ghar mein?*” [*Don’t you have any women in the house?*], to which he responded: “*Yes, there is but today I am here for my child’s vaccination*”. Her comment clearly indicated her belief that childcare is a woman’s job and a father bringing a baby for the immunisation was against the locally established gender norms.

These actions by the CHWs reaffirm the socio-cultural essentialisation of women’s roles as well as the State’s maternalist bias in focusing its policies for achieving maternal health development outcomes solely on engaging with pregnant women. Moreover, there are two more factors which potentially influence these CHWs’ behaviours and actions. Within the Rajaji Nagar community, the clinic and the Anganwadi centres are probably the only spaces where the ASHA workers, who are predominantly from economically backward castes, can wield some influence and exude their power (by scolding for instance) over men of all castes and classes as discussed on the previous page. These workers are mostly between 35 to 55 years of age and their patients are usually younger than them. I suggest that by keeping men out of everyday processes, the CHWs can maintain a sense of authority in the clinic’s gendered space, which they otherwise may not have due to their identity and status as women. As an example, once I was standing outside the clinic and overheard a 50-year-old ASHA worker, Shanti, talking to a young couple: “*See, you have to care for your wife. I cannot talk about these things at your house to you directly because of your parents. Therefore, I am trying to explain you today*”. This comment indicates that despite being government health functionaries, as women these ASHAs are not able to talk assertively or strongly in front of household elders, especially fathers-in-law who are usually heads of the household. However,

the clinic is a space where they can wield their authority as health workers without any inhibitions. By keeping men out or by limiting their presence significantly, the ASHA workers have a sense of being important and powerful, which they may not feel otherwise in the community at large given their subordinated status as women. The second factor is that ANC check-up days in the clinic are usually very crowded, and therefore the demanding work pressures can lead to frustrations among the clinic staff which leads them to shout at men. Usually, on average, there would be about 40-50 women standing in a queue waiting for their consultations which filled up the entire clinic, and there would be very limited space to move around. Given this, coupled with the central focus on women and their reproductive health and the omission of men from policy directives, it is likely that men (including me!) just seemed to be in the way. However, as the ASHA worker Shanti's example shows, which was an exception and not the norm, they can very well engage with expectant fathers in the immediate area outside the clinic if they want. Therefore, while the lack of space within the clinic is a valid factor, ASHA workers can work a way around it if they are keen to engage with men.

The ways in which men are scolded and excluded in the clinic and the Anganwadi leads men to believe that they do not have any tangible role to play in the clinic, which is why even the interested and motivated ones do not enter the clinic. Studies in other low- and middle-income countries (LMICs) have also found that the attitudes of health workers and care facilities' staff act as a barrier towards men's involvement in reproductive matters. Gibore and Bali (2020) found, in rural Tanzania, that the long waiting time at healthcare facilities and insensitive language used by healthcare providers impedes men's involvement in antenatal care. Pafs *et al.* (2016) argued that in Rwanda, the lack of explicitly stated public policy about men's involvement at healthcare facilities contributes to men's disconnection, limits their access to pregnancy information and upholds current gendered domains. Studies in Ghana (Dumbaugh

et al. 2014) and Uganda (Kaye *et al.* 2014) have similar findings.

Guttman (1997, p. 385) thus writes that there is a need to view “men as men” and tend to their reproductive capacities and desires, which will in turn lead to their own happiness and better maternal health outcomes for their wives. While I agree with Gutmann’s approach, I also think that this approach could be over-ambitious especially in a context like Rajaji Nagar and may not be practical. I suggest that focusing on men’s inclusion from an instrumental lens could be a starting point for increasing men’s involvement and then, the whole debate on fatherhood and men’s involvement could transition to working with men for men. I will share an example to substantiate my argument further. In Chapter Two, I explained the daily routine of an ANC check-up day in the clinic, where the most important part of the process is the consultation for pregnant women with ANMs. I witnessed these consultations and one-on-one discussions on several ANC check-up days. Consider the following conversation between a pregnant woman and an ANM in the ANM room.

“ANM: Rani, what is your name? And husband’s name?”

W1: Shyam Devi. Pappu Yadav.

ANM: Phone number and address

W1. (XXX)

ANM: Kitna mahine ho gye? (How many months pregnant are you?)

W1: *Char (Four)*

ANM: *Chal haath nikal. Kapda upar kar le. (Come on, take out your hand. Move up your sleeves)* [This is an instruction in preparation for immunisations such as TT, for example.]

W1: *[silently nods]*

The ANM puts the injection into the woman's arm. The woman moans due to the pain.

AMN: *Ghar jaake thandi sikai kar lena, dard kam ho jaega. (Apply a cold press when you go home, the injection pain will go away.)*

ANM: *Baccha hospital mei karna, ghar pe nahi. (Deliver your baby in the hospital, not at home.)*

W1: *[No response]*

ANM: *Yeh le dawai, [hands one medicine strip] yeh subah sham 1 baar, [hands another medicine strip] yeh do baar. (Take this medicine. Take this one each morning and evening, and this one twice a day anytime).*

[W1 gets up and leaves the room]."

(Antenatal care consultation, ANM room at TH20 clinic, 29th January 2020)

After witnessing around 275 such consultations over a period of six months, the pattern was clear that these discussions (which are largely one-sided and led by the ANM) hardly refer to husbands of pregnant women. Of these 275 consultations, only three husbands were ever called and spoken to, which again is a reaffirmation of the exclusion of men from maternal health processes. The consultations primarily focus on the medical aspects, such as immunisations and handing pregnant women the prescribed medicines. Barring the husband's name and phone number, no other details or information are discussed. In this context, I find resonance with Culley, Hudson and Lohan (2013) who write that, in clinical practice, the primary clinical relationship is developed with the woman and the clinical file is the file of the woman, and not of the couple. During my observation of consultations in the ANM room, I observed that this argument holds true where neither the husband's wellbeing, health, behaviours, or the potential impact of his actions on his wife's pregnancy are discussed at all.

However, as mentioned above, focusing on men's roles through an instrumental lens is a starting point for promoting men's involvement and I will share a brief example to demonstrate how this can be done. During these consultations, I observed that, on average, a pregnant woman is given at least three verbal instructions or guidance points on what to do and how to be careful during her pregnancy, as highlighted in the conversation above. In addition, the ASHA workers, who often 'drag'⁷¹ these women to the clinic for their routine check-ups, offer them frequent advice on nutrition and general care during queuing up or after the consultations are over. If these instructions were to be given at times when she is accompanied by her husband, it is more likely that the instructions and advice given by ANMs and ASHAs will be recalled and implemented. Multiple studies globally (Anderson *et al.* 1979; Ley, 1979; Kessels,

⁷¹ I have used the term 'drag' because the equivalent term in Hindi was used by ASHAs for the same. Often, pregnant women do not want to walk long distances or attend the ANC check-up days (as told by ASHAs). However, these ASHAs persuade them to come because check-ups are important for the pregnant women and also because the ASHAs' financial incentives are dependent upon these visits being registered officially.

2003; Bravo *et al.* 2010; Jenkins *et al.* 2011) on patient recall of information have consistently found that patients do not correctly recall much of the recommendations and information given by their physicians and typically about half of items are found to be accurately recalled (Laws *et al.* 2018). The study by Laws *et al.* (2018, n.p.) further found that verbal instructions are more likely to be forgotten than written instructions and “patients with less than high school education recalled 38% of items freely and accurately, while patients with a college degree recalled 65%”. These two findings are of relevance in my context as all instructions given to the pregnant woman (by ASHAs or ANMs) are verbal and hardly any woman attending the clinic has a college degree. Thus, the probability of them remembering all these instructions is not high.

This is where the role of men accompanying their wives is of significance and I go back to male demographer Ritwik’s comment on p. 97: “*The most important is the ANC check-up card, pregnancy stamp, men and women are not explained properly. All these issues are more important than those men are there*”. Using my observations at the clinic and coupling these with Ritwik’s comments, I suggest that if men accompany their wives and listen to those instructions given by the health staff, the chances of those instructions being implemented by the couple (especially the woman) are higher, thereby possibly leading to better maternal health outcomes. For instance, a study in Rwanda which explored women’s perceptions of men’s roles in maternal health found that some women preferred to receive information and instructions from community health workers in presence of their husbands as it ensured that they were on the same page regarding pregnancy care and birth preparedness (Tuyisenge, Crooks and Berry, 2021, n.p.). Therefore, from an instrumental perspective, men’s presence on ANC check-up days could lead to better recall of instructions later and eventually, improve maternal health outcomes.

Overall, my observations at the TH20 clinic make it evident that the State's exclusion of expectant fathers from maternal health policymaking is reproduced at the primary healthcare level by the CHWs. The everyday antenatal care consultations and maternal health processes at the clinic indicate that the primary engagement is with the pregnant women, with negligible attention given to expectant fathers.

4.3 A holistic analysis of the Indian State's approach towards men in maternal reproductive health

In this section, I build upon my discussions in Sections 4.1 and 4.2 and offer a holistic analysis of the State's approach towards men's involvement in maternal health.

Due to its maternalist bias and emphasis on sustaining the cultural norms of reproduction, the Indian State has created a gender asymmetry in policymaking – male sterilisation being an exception – where a focus on women's lives as a site of reproductive governance is assumed to be sufficient to achieve maternal reproductive health development goals. In doing so, it neglects the relationality of reproduction processes and presumes that women's reproductive lives are a separate entity which can be governed to achieve developmental goals. As multiple scholars such as Ravindran and Panda (2002), Mumtaz and Salway (2007) and Unnithan (2009) have highlighted, feminist scholarship on reproduction in South Asia needs to recast its overarching emphasis on women's autonomy leading to achieve better health outcomes towards a more relational view of gender and reproduction in line with the Critical Studies of Men and Masculinities (CSMM) approach.

Due to this inattention to men and masculinities in relation to reproduction processes, the Indian

State reproduces social and cultural hegemonic masculine norms, where men should focus on being the breadwinner and women should confine themselves to the household and focus on reproductive maternal care. It comes across as striking that from the 1960s to the current day, the Indian State's conceptualisation of men as breadwinners has been consistent. The core difference is that in the 1960s, this conceptualisation was used as a rationale to target them for family planning and sterilisations as Balasubramanian (2018) explains through her historical analysis (discussed in Section 6.1), and in the present-day scenario, the same conceptualisation is used as a justification to exclude men from maternal reproductive policymaking. This emphasis on the male breadwinner model is also representative of the gendered familialism ideology (Palriwala and Neetha, 2011) that is pervasive in the Indian policy discourse, which reiterates care as a familial and female responsibility. The significance of the male breadwinner model is also reflected in my conversations with expectant fathers which I will discuss in Chapter Six.

Therefore, in addition to the reasons highlighted in Section 4.1, I suggest that there are two more reasons⁷² that influence the State's approach towards expectant fathers, which are quite connected to each other. First, except for male sterilisations,⁷³ actively engaging with men as expectant fathers in clinics and health institutions would require a lot of resource investment and planning (such as adding more infrastructure to create more space, hiring more health staff to engage with men, the addition of labour rooms to facilitate privacy protocols). The lack of space in the TH20 clinic led to health workers scolding expectant fathers and asking them stay out of the clinic's main premises, as I discussed earlier. Lack of space has been highlighted as a crucial barrier to men's involvement in other contexts as well (Mullany, 2006; Ditekemena,

⁷² These two reasons are in addition to the reasons highlighted in Section 4.1. I will summarise and connect them in the concluding discussion in Section 4.4.

⁷³ Sterilisations lead to a reduction in birth rate and fertility, thereby achieving India's target fertility rates which are consistent with wider development goals.

et al. 2012; Ongolly and Bukachi, 2019). Thus, infrastructural investments would require enormous financial resources which would be contradictory to the State's neoliberal approach towards development. This argument is also reflected in my discussion in Section 4.1 in this chapter, where the health ministry's guideline to allow birth companions (the only initiative which allows men to be a part of childbirth in some way, at least legally) was introduced as a **low-cost intervention to achieve SDGs** (emphasis added by me) rather than an intervention solely to support women or encourage men's involvement. This is not to say that the State does not have resources to (or cannot) invest in health infrastructure, but this lack of interest in engaging with men brings me to the second reason. The reason is the State's supposition that focusing on men as expectant fathers would not help the State achieve maternal reproductive health goals even though sufficient evidence exists which highlight the positive impact of men's involvement on maternal health outcomes (Barua *et al.* 2004; Mullany, Becker and Hindin, 2007; Singh and Ram, 2009; Carter, 2010; Kululanga *et al.* 2012; Peneza and Maluka, 2018; Mkandawire and Hendriks, 2019). During my fieldwork, it struck me deeply that none of the monthly statistics and data (see Figure 18 below) on maternal reproductive health collated by health workers have a focus on men.

क्र.स. Sr. No.	मूल कार्य Core Activity	अपेक्षित Expected संपन्न किए Achieved	इस मापदंड पर क्रियाशील Functional on this Criteria	अंक Score	टिप्पणी Remarks
1)	वर्ष की आयु तक सम्पूर्ण टीकाकरण हो जाने पर (दिशा निर्देशिका के अनुसार) Achievement on Complete Immunization (Less than one year)	7-6	✓ Yes / No (हाँ/नहीं)	1/0	क्षेत्र में अपेक्षित बच्चों (1 साल से कम आयु) का सम्पूर्ण टीकाकरण करवाने पर, क्रियाशील कहलाएगी तथा 1 अंक प्राप्त
2)	1-2 वर्ष की आयु में सम्पूर्ण टीकाकरण हो जाने पर (दिशा निर्देशिका के अनुसार) Achievement on Complete Immunization (One to Two years) as per guidelines	4-4	✓ Yes / No (हाँ/नहीं)	1/0	क्षेत्र में अपेक्षित बच्चों (1 साल से 2 साल तक आयु) का सम्पूर्ण टीकाकरण करवाने पर, क्रियाशील कहलाएगी तथा 1 अंक प्राप्त
3)	परिवार नियोजन संबंधित गतिविधियों में योगदान (गर्भ निरोधक गोलियों / आईयूसीडी / पुरुष / महिला नसबंदी) Achievement on Family Planning activity (OCs / IUCD / Vasectomy / Tubectomy)	or Follow up 10 couples PPIUCD	✓ Yes / No (हाँ/नहीं)	1/0	(पुरुष/महिला नसबंदी/आईयूसीडी गोलियों) इन में से किसी भी उपकरणों पर व योग्य दंपतियों की सूची बनाने पर क्रियाशील कहलाएगी। इस गतिविधि में क्रियाशील कहलाएगी।
4)	नई गर्भवती महिला का पंजीकरण New Pregnant Women registered	5-3	Yes / No ✓ (हाँ/नहीं)	1/0	क्षेत्र में मौजूद सभी गर्भवती महिलाओं में आशा इस गतिविधि में क्रियाशील कहलाएगी तथा 1 अंक प्राप्त करेगी।
5)	प्रथम तिमाही में गर्भवती महिला का पंजीकरण Pregnant Women registered in first Trimester	3-3	✓ Yes / No (हाँ/नहीं)	1/0	नयी गर्भवती महिलाओं में से 80% या अधिक प्रथम तिमाही में करवाने पर आशा इस गतिविधि में क्रियाशील कहलाएगी तथा 1 अंक प्राप्त करेगी।
6)	अस्पताल प्रसूति में सहायता Institutional deliveries Facilitated	6-3	Yes / No ✓ (हाँ/नहीं)	1/0	क्षेत्र में अपेक्षित प्रसव में से 95% या अधिक अस्पताल में होने पर आशा इस गतिविधि में क्रियाशील कहलाएगी तथा 1 अंक प्राप्त करेगी।
7)	प्रसव के बाद जांच के लिए विजिट Post natal visits made	6-3	Yes / No ✓ (हाँ/नहीं)	1/0	क्षेत्र में हुए घरेलू प्रसव में 24 घंटे के बाद जांच (100%) और क्षेत्र में जन्मे सभी नवजातों पर जांच के लिए अधिक की एच.बी.एन.सी. दिशा निर्देशिका के अनुसार पर 1 अंक की प्राप्ति होगी।
8)	स्वास्थ्य एवं पोषण दिवस/युवा समूह बैठक में भाग लेने/समुदाय में पहुँचकर स्वास्थ्य सेवाएँ प्रदान करने पर Participation in Health and Nutrition Day / Adolescent Group		✓ Yes / No (हाँ/नहीं)	1/0	इनमें से किसी एक और अधिक गतिविधियों में भाग लेने पर क्रियाशील कहलाएगी तथा 1 अंक प्राप्त करेगी।

Figure 19 A page from an ASHA worker's diary

(This page gives a glimpse of the various tasks undertaken by the ASHA worker. The second column lists the total number of each activity undertaken, which will feed into overall statistics for the State.)

Furthermore, as I discussed in Section 4.2, there is hardly any discussion around husbands or their roles during the antenatal care consultations between women and the auxiliary nurse midwives (ANMs), which substantiates my point further.

A key underlying theme that runs across these factors is the obsession of the State with achieving international development targets and statistics. Kielmann (2002, p. 160) argues that health statistics have become key indicators of development according to which countries are

compared and ranked. In her view, “these numbers have tended to acquire a public life of their own and have come to constitute authoritative knowledge in health policy and planning decisions” (Kielmann, 2002, p. 160). In the context of the TH20 clinic, the tasks undertaken by health workers such as institutional deliveries, family planning, post-natal visits, and immunisations among others generate what Hacking (1982, p. 282) terms as an “avalanche of numbers” in a modern State, as Gupta (2001), Unnithan (2019), Kielmann (2002) have found in their work as well.

Thus, this avalanche of numbers (Hacking, 1982) helps the Indian State achieve its developmental agendas in maternal reproductive health but at the cost of neglecting the relationalities of reproduction processes, sustaining the gendered familialism ideology, and essentialising the biological experiences of women.

4.4 Conclusion

This chapter addresses the sub-research question: **In what ways (and to what extent) does the Indian State encourage men’s participation in maternal health?**

It shows that men, as husbands and fathers, very seldom appear in Indian State policies and programmes in maternal reproductive health. There is no focus on men as partners and participants in these policies – male sterilisation in family planning being an exception. This exclusion of men by the State is influenced by four intersecting factors. One, the maternalist bias in Indian policymaking, where the State pays overarching attention to women’s roles as mothers in policies. Two, the social and cultural norms that lead to reproduction being categorised solely as a women’s issue. Three, neoliberal approaches towards achieving developmental goals which refer to using low cost approaches, minimal

investments and maximising them to achieve relevant targets. Four, ignoring the relationality of reproduction processes in turn ignores the impact of men's involvement on maternal health outcomes. As indicated above, the exclusion of men is operationalised through "different ensembles of antenatal care practices and techniques of (reproductive) governance" (Hansen and Strepputat, 2001, p. 12). The State's approach is operationalised at TH20 clinic through the ASHA and Anganwadi workers, and ANMs who are agents of the State (Roalkvam, 2014) and reproduce the State's exclusion of men from maternal health policies at the primary healthcare level.

The State's conceptualisation of men as breadwinners and primary decision makers within families, yet as separate from the day-to-day caregiving operations of the family, has remained unchanged since the 1960s. This framing has been used in distinct ways to justify men's inclusion in contraceptive policy programming as highlighted by Balasubramanian (2018), and exclusion from maternal reproductive health (though not explicitly mentioned or stated in policy documents) in the current day scenario, as my thesis found. The State only 'targets' men as a category of intervention when it believes that including them will lead to an improvement in international development outcomes (such as male sterilisation in family planning which will limit/reduce fertility rates). Furthermore, Neetha and Palriwala's (2011) analysis of social and economic policies in India asserts that these policies are deeply rooted in gendered familialism, which advocates that care work is a private responsibility, women's responsibility, and is embedded in familial relations, thereby defining the pool of carers and care receivers. This indicates that the State's current exclusion of men from maternal reproductive health is mostly deliberate and purposive, which reaffirms the social and cultural norms around these issues. These findings have important implications as the State's lack of focus on men makes it harder for individual fathers to participate in and take an active interest in antenatal care as I

observed at the TH20 clinic. This also effectively squanders opportunities to further improve maternal health outcomes and wellbeing of women. As highlighted through the discussion earlier in the chapter, pregnant women are given multiple instructions by different health staff and thus, the presence of their husbands will aid in better recall of these instructions, leading to improved health outcomes. Moreover, it negatively impacts the incremental changes and efforts being made by expectant fathers (and discourages them), not just in Rajaji Nagar, but throughout India.

Thus, to conclude, the Indian State's approach towards men's involvement in maternal reproductive health remains exclusionary despite reproduction being an important domain where gender inequalities could be addressed. Yet some men in Rajaji Nagar, and elsewhere in India, are showing interest and taking part in antenatal care. Now, I will move on to the next chapter which looks at the ways in which community health workers (CHWs), who are central to the provision of maternal healthcare and who regularly interact with pregnant women and new mothers, promote or undermine men's involvement in antenatal care in Rajaji Nagar.

Chapter Five: Community health workers' notions, perceptions and conceptualisations of men's roles in antenatal care

Introduction

Having explored the Indian State's focus on women in maternal health in Chapter Four, this chapter turns to community health workers (CHWs) to understand the local perceptions and understandings of men's involvement in antenatal care because these women are the ones who interact most frequently with pregnant mothers (and the community at large) and, in so doing, ensure the provision of maternal health services. Although there are three different cadres of CHWs: Accredited Social Health Activists (ASHA) workers, Anganwadi workers (AWWs) and Auxiliary Nurse Midwives (ANMs) as discussed in Chapter One, this chapter focuses primarily on the perspectives of ASHAs and Anganwadi workers. I start with ASHA workers and their perspectives and then merge my discussions to bring in other CHWs. I also draw upon conversations with two male informal health practitioners who operated private clinics in Rajaji Nagar (both clinics were right opposite each other and about 0.2 miles from the TH20 clinic). The question which I seek to answer in this chapter is:

What are the perspectives and experiences of community health workers in relation to expectant fathers' involvement in antenatal care, and to what extent do these perspectives limit or encourage men's involvement?

Locally known as ASHA *Didis* (or ASHA Sisters) in North Indian communities and even in Rajaji Nagar, ASHAs' uniqueness lies in the fact that they work and live in the same community as the pregnant women they serve. This reality informed the very origins of the ASHA programme (Ved *et al.* 2019) because the programme focused on hiring married women

who would not leave their communities.⁷⁴ ASHAs told me that on average, each of them manages⁷⁵ around 28-30 households in their designated localities and supervises four to six pregnancies each month. This means that they are constantly interacting with pregnant women and their husbands, both in their homes and at the clinics. ASHAs can thus play a crucial role in relation to men's antenatal care involvement as they can potentially encourage and to some extent exclude men from participating in their wives' antenatal care in Rajaji Nagar.

Given their dual positioning as both community members and health workers, Unnithan (2019, p. 133) writes: "rather than viewing ASHAs just as government health functionaries, we need to view them as inhabiting different fields of power: social, medical, and occupational; as mothers and daughters-in-laws; and also, as women who may have the same social conditions as the women they care for". Furthermore, Mishra (2014) argues for researching the variables (or categories of respondents) that could track how outcome variables are achieved. The outcome here is men's involvement in antenatal care. Such process evaluation needs to include inputs from different actors involved at different levels, including community health workers (Mishra, 2014). I also find resonance with Roalkvam (2014, p. 912) who argues: "ASHAs can be perceived as constituting the boundary of the state in relation to its citizenry" and thus, understanding their perspectives brings us further closer to understanding the perspective of the State as well.

In addition to conversing and spending time with ASHAs, I also spent a significant amount of time with AWWs who manage Anganwadis⁷⁶ (childcare centres run by the government).

⁷⁴ In almost every context in India, the general trend is that women move to their husbands' homes after marriage. Thus, unmarried women in villages would mostly probably move out and thus, the ASHA programme only hired married women (those who had moved to the village/community after their marriage) who lived in the same community.

⁷⁵ By managing households, I refer to coordination with these households for providing maternal and newborn care services.

⁷⁶ There are more than 1.4 million AWWs who operate through the Integrated Child Development Scheme (ICDS) launched in 1975.

AWWs' roles and responsibilities mainly include providing nutrition and health education to pregnant women and children, managing the nutrition programmes at Anganwadis which provides hot cooked meals to pre-school children, and aiding in implementation of early childhood schemes, among other activities. As I witnessed in Rajaji Nagar, these CHWs⁷⁷ are connected to residents and families through affective ties, everyday relationships, and occupational intimacies. As such, these CHWs can try to influence the behaviours of expectant fathers and husbands, and through this to challenge local patriarchies and gendered norms. This in turn means that they are a key category to investigate to better understand men's localised experiences, roles, and masculinities (as well as masculinism if any) in the realm of antenatal care. Furthermore, I spoke to two Auxiliary Nurse Midwives (ANMs). These ANMs do not live in the community and are posted as per the government's general employment posting guidelines. I mostly observed these ANMs and their activities in the TH20 clinic and Anganwadi centres, which enriched my understanding of maternal healthcare processes and activities. In Table 2 below, I have outlined the formal roles and responsibilities expected of different CHWs in relation to ANC and maternal health according to government policy documents. I have also listed the ANC activities performed by these CHWs as observed by me during fieldwork.

Table 2: Expected roles and responsibilities of community health workers in relation to antenatal care

Health Worker Cadre	Expected roles and responsibilities in relation to antenatal care and maternal health according to ASHA worker guidelines (National Health Mission, n.d.)	Antenatal care and maternal health activities performed by health workers as observed by me
ASHA workers	<ul style="list-style-type: none"> “ASHA will take steps to create awareness and provide information to the community on existing health services and the need for timely 	<ul style="list-style-type: none"> ASHAs connected with pregnant women and supported them to access check-ups at the clinic,

⁷⁷ I use the term CHWs as an umbrella term for ASHAs, Anganwadi workers and ANMs.

	<p>utilization of health & family welfare services.</p> <ul style="list-style-type: none"> • ASHA will counsel women on birth preparedness, importance of safe delivery, breastfeeding and complementary feeding, immunization, contraception and prevention of common infections including Reproductive Tract Infection/Sexually Transmitted Infection (RTIs/STIs) and care of the young child. • ASHA will mobilize the community and facilitate them in accessing health and health-related services available at the village/sub-center/primary health centers, such as immunization, antenatal check-up (ANC), post-natal check-up (PNC), Integrated Child Development Scheme (ICDS), sanitation and other services being provided by the government. • ASHA will also act as a depot holder for essential provisions being made available to every habitation like Oral Rehydration Therapy (ORS), Iron Folic Acid Tablet (IFA), chloroquine, Disposable Delivery Kits (DDK), Oral Pills & Condoms, etc.” (National Health Mission, n.d., p. 1-7) 	<p>offered them basic counselling and advice, and conducted door to door visits for families.</p> <ul style="list-style-type: none"> • They coordinated with <i>Anganwadi</i> workers to organise neonatal vaccination sessions. Usually, one ASHA worker was in-charge of facilitating sessions at four <i>Anganwadi</i> centres. • They counselled pregnant women at the clinic on the importance of birth preparedness, nutrition and medicines. • They attended monthly refresher trainings at the TH20 clinic. These trainings aimed to update their information regarding any new schemes and policies.
<i>Anganwadi</i> workers (AWW)	<p>The roles and responsibilities of Anganwadi workers in relation to antenatal care and maternal health is as follows (Ministry of Child and Women Development, n.d.):</p> <ul style="list-style-type: none"> • “AWW will assist the public health centre staff in the implementation of health component of the programme viz. immunization, health check-up, antenatal and postnatal check-ups etc. • AWW will record the weight graphically on the growth card, use referral card for referring cases of mothers/children to the 	<ul style="list-style-type: none"> • AWWs managed children aged three or younger at the Anganwadi centres. • AWWs facilitated the distribution of hot meals provided by the government for these children. • AWWs supported the ASHAs to ensure the reach of neonatal sessions and

	<p>sub-centres/PHC etc., and maintain child cards for children below six years and produce these cards before visiting medical and para-medical personnel.</p> <ul style="list-style-type: none"> • AWW will provide health and nutrition education and counselling on breastfeeding/ Infant & young feeding practices to mothers. • AWW will do home visits for educating parents to enable mothers to plan an effective role in the child's growth and development with special emphasis on a newborn child" (Ministry of Child and Women Development, n.d., p. 1-2). 	<p>immunisations as far as possible.</p> <ul style="list-style-type: none"> • AWWs also weighed children and recorded the data on an online tracking application introduced by the Ministry of Women and Child Development
Auxiliary Nurse Midwives	<p>The roles and responsibilities of Auxiliary Nurse Midwives in relation to antenatal care and maternal health is as follows (National Health Mission, 2017).</p> <ul style="list-style-type: none"> • "ANMs will deliver antenatal and maternal health services through outreach sessions and camps. • ANM will also deliver services during home and community visits, which include services like ANC, PNC, immunization, family planning and safe abortions are delivered to all eligible beneficiaries, with particular emphasis on the marginalized and hard-to-reach communities. • ANMs will manage and coordinate maternal health care services at the Primary Urban Health Centre. These tasks include facility based immunization on the weekly fixed day/s for this activity, facility based ANC check-ups and refer high risk cases. • ANMs will support ASHAs to ensure home based newborn care for all home deliveries" (National Health Mission, 2017, p. 23-24). 	<ul style="list-style-type: none"> • On antenatal care check-up days on Thursdays, ANMs were the main in-charge of check-ups. They recorded information from the pregnant wives and their companions to collate overall statistics around maternal health. • ANMs also provided free medications to pregnant women such as tetanus toxoid injections, iron and calcium tablets. • ANMs also provided some general counselling and guidance to women. • Occasionally, ANMs did information awareness sessions on breastfeeding at the TH20 clinic.

Given the centrality of ASHAs to the provision of maternal healthcare in the community as outlined in Table 2 above, a total of 30 ASHAs are associated with the TH20 clinic, of which, at the time of my field research, 25 were Hindus. Among Hindus, the number of Other Backward Castes (OBC) was slightly higher than upper castes; only one ASHA was from the Scheduled Caste (SC) community. For the remainder, one was Muslim, two were Sikh and there was one Christian. According to the official hierarchical structure, each ASHA worker monitors four AWWs and is required to work with them to implement different programmes and schemes. The ASHAs and AWWs were a mix of young and elderly women, with experiences in maternal reproductive healthcare ranging from two years to more than 12 years. I had in-depth conversations and interviews with five ASHAs (four upper caste Hindus and one from OBCs), three AWWs (all upper caste Hindus), two ANMs (one upper caste Hindu and another OBC), and two doctors (both upper caste-class Hindus) who were associated with the clinic. Thus, unfortunately, this chapter's findings have a slightly upper caste Hindu bias, which I acknowledged as a limitation in Chapter Three as well.

In this chapter, I explore CHWs' perspectives on men's involvement in antenatal care in Rajaji Nagar. To analyse their perspectives, I use the CSMM framework discussed in Chapter Two. Broadly, this chapter illustrates CHWs' conceptualisations and perceptions of men's masculinities and how men's performing and navigating of these specific masculinities are construed by CHWs as adequate male involvement in their families' reproductive experiences. This chapter is delineated into five sections. One, understanding the community's overall gender norms and practices (Section 5.1). Two, CHWs' understanding of men's involvement in antenatal care (Section 5.2); three, the impact of the type of marriages and families on men's involvement (Section 5.3); four, standard and benchmark of expectations from local men (Section 5.4) and five, the multiple ideological positionings (Section 5.5). Finally, Section 5.6

concludes the chapter.

5.1 An overview of Rajaji Nagar's gender norms and practices

Given the fact that ASHA workers and Anganwadi workers worked and lived in the same community, their experiences as women residents of Rajaji Nagar provided some key insights regarding the overall gender norms and practices of the community as well as the dynamics around antenatal care. Having a sense of the gender narrative in the community enabled me to situate my findings and compare them appropriately within the context.

As is evident in the discussions below, an analysis of their comments tells me that overall, Rajaji Nagar is rooted in patriarchal norms and gender hierarchies, like most contexts in India. However, there are some incremental shifts which the CHWs spoke about, and I also observed, but overall, the gender hierarchy remains intact. I demonstrate this through three gender themes namely: i) son preference; ii) the significance of mothers-in-law in antenatal care, and iii) the norms around women's mobilities. The discussions on these three themes helps understand the overall gender order, norms, and practices in the community.

Let us start by looking at the following quotes around the issue of son preference:

- *“Devanik: There is also this tendency that having a girl child is okay, but a boy child is required for sure. Both boy and girl are okay, but they don't want a single girl child.*

*Anita: Sir I can talk about myself. I have two girls. I never thought of another child. 'Isse zyada agar mai ummed rakhungi ladke ki to **tesri bhi kahin beti hogyi to?** Ladki hai wahin humare bete hain. Ek hi nazar se dekhenge! (If I keep my hopes high, what if the third is also a girl? I thought I should stop; we*

see the girls as boys now.)”

(Anita Yadav, her house, 30th October 2019)

- *“See, in today’s world, educated people don’t differentiate between boys and girls. But, in many houses, if you get 4 boys, and 2 daughters, they will get a difference. Everyone loves first daughter, whether it is during first or second pregnancy. However, if there are more than one daughter, families feel bad. This is not the situation (zamana), it is people’s mindsets (mansikta). Within this zamana, girls have gone a long way, but people have this mindset still. It happens like one daughter then one son. 1-2 din lagta hai but after that it is all normal.”*
(Draupadi Debi, Gali number 2 Anganwadi centre, 20th September 2019)

- *“Devanik: Who does the decision making on how many kids to have?*
Anjali: “If the first child is a son, second child being a daughter is fine. If first is daughter, second is daughter as well, they want a son at any cost. The mother-in-law pressurises them: Ek ladka toh chahiye (One boy is a must). Sometimes, they say do toh jode chahiye (we want a pair of sons).
(Anjali Bantwal, Gali number 5 Anganwadi centre, 5th March 2020)

These CHWs suggest that while absolute son preference⁷⁸ has decreased a bit in Rajaji Nagar; for instance, families are fine with a daughter as opposed to the past where daughters were totally unwanted, but at the same time, they do want a son as well. This indicates that while the attitudes towards daughters have progressed, son preference among families stays strong.

⁷⁸ By absolute son preference, I refer to families wanting only sons and no daughters at all.

Among all, ASHA worker Anita's comment is particularly striking in this regard where she says that she is fine with having two daughters, but her comment "**Agar teesri bhi beti ho gyi toh?**" (*What if the third is also a daughter?*) (emphasis added by the ASHA) reveals the continued preference of having a son among Rajaji Nagar families. While I did not probe the reasons behind this incremental shift as it is beyond the scope of my thesis, several studies examine India's sex ratios and provide in-depth evidence of widespread preferences for sons in India (Unnithan-Kumar, 2009; Mitra, 2015; Roberts and Montgomery, 2017; Milazzo, 2018).

These findings were further strengthened when I spoke with Mohammed Zubair, an informal health practitioner in Rajaji Nagar. He mentioned that son preference among families remains strong. I share an extract of our conversation below.

Devanik: Is there still a son preference prevalent here?

Zubair: If there are continuous girls in a family, they will have a demand that they want a son. But they do care for them both. But it is not like that they will step backwards; they will take care of son more and less for the daughter. They do care equally dependent on the situation. Situation has changed. 21st century time. Preference is there, but preference is that if there are continuous girls, then they will want a son. Similarly, if there are continuous boys, then they will want a daughter. If they see there are 4-5 boys continuously, they will think: we need a girl. The world has changed. Earlier, people were only concerned for boys, but now girls are also taken care of these days.

Devanik: So, having one son is mandatory?

Zubair: It is with everyone. They want a son for sure. Girls will do but a son is needed. But I have seen that in houses, where there are boys, they will want one girl."

(Mohammad Zubair, his clinic, 21st October 2019)

Thus, as is clear, Zubair adds that while the absolute son preference has decreased, and even though daughters are now welcomed and treated equally, having a son is a must among families. I also witnessed the dynamics around son preferences during the weekly antenatal consultations that I observed at the TH20 clinic every Thursday. Many expectant mothers who came for consultations, nodded to the ANM when the ANM referred to the expectant mothers' family's preference for sons leading to multiple pregnancies. For instance, see the following conversation between an ANM and an expectant mother:

- *ANM Pooja: Kitna bacche hai tere? (How many children do you have?)*

Woman: Teesra baccha hai. Do ladke hai. (This is the third child. I have two boys)

ANM: Do ladke hai toh fir kyu paida kar rahi hai? (You have two boys then why are you are producing another child?)

Woman: [Does not say anything]

(Pooja, TH20 clinic, 9th January 2020)

The ANM's comment "You have two boys then why are you producing another child?" demonstrates the fact that having two sons is considered an 'achievement' in Rajaji Nagar and the society at large and thus, the ANM questions the woman's need for another child. Therefore, based on my observations of antenatal consultations and conversations with different people, it is evident that despite the incremental progress regarding acceptance of daughters, the preference for having a son remains strong. The existence of this preference represents the patriarchal gender order in the community.

Moving on, the second gender theme is about the importance of mothers-in-law in maternal reproductive matters. Let us look at the following comments.

- *“Devanik: How much control or agency do you think women have on the number of children they want?”*

Shalini (ASHA worker): Around 50% have a choice, the other 50 % is controlled by husbands and the mothers-in-law. However, things are changing these days and the woman’s choice was way lesser earlier.”

(Shalini Singh, TH20 clinic, 19th September 2019)

- *“Devanik: So, the families who stay here, who are the main decision makers, where to go?”*

Rita: Mostly, it is the mother-in-law who takes these decisions, not the husband.

Husband kam hi lete hai. (Husbands usually do not take decisions)

Devanik: Why so?

Rita: Hota hai (it happens) [with a soft tone].

Devanik: Why? Just because she is a woman?

Rita: No, not because she is a woman. The son thinks: Abhi Maa hai, maa bura nahi kar sakti (Mother is there, she can’t do bad). But in some cases, the mother-in-law does it and there is Satyanash (disaster) because they belong to a traditionalist mindset. Now, whatever she says, it will happen. The mother-in-law is from a traditionalist mindset, she will say “We never had medicines in our time, or never showed to someone.”

(Rita Verma, her house, 18th February 2020)

Therefore, as these above comments indicate, mothers-in-law are among the most important stakeholders in the domain of reproduction. This has also been established in most other contexts of India (Barua and Kurz, 2001; Bloom *et al.* 2001; Robitaille and Chatterjee, 2014; Blanchard *et al.* 2015). The importance of mothers-in-law is further reinforced during the

monthly training programmes for ASHA workers at the TH20 clinic. I share a comment from the clinic's in-charge Dr. Manvi at an ASHA monthly training meeting at the TH20 clinic in August 2019 (Figure 19 below). She said, while addressing ASHA workers, "*We should strive to build such deep bonds with pregnant women so that they tell us first and not their mothers-in-law*". The fact that the doctor mentioned mothers-in-law rather than husbands or expectant fathers clearly indicates the dominance of mothers-in-law in antenatal care matters in Rajaji Nagar.



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Figure 20 Monthly ASHA training day

The third theme demonstrating how patriarchal norms and gender hierarchies remain intact concerns the norms around women's mobilities. Anganwadi worker Anjali shared some examples of the norms around daughters-in-laws' lack of mobility as well as compulsion to wear conservative clothing in Rajaji Nagar.

- *“Devanik: So, there are very few working women here?”*

⁷⁹ I have used blue smileys to hide their faces.

Anjali: If a daughter is working or doing a job, then its fine. But not for a bahu (daughter-in-law). For daughters not much, but for bahu it is a problem. In 15 number lane, my area, women roam around in long ghunghats⁸⁰ (veils).

Devanik: Ghunghats (veils) still exist?

Anjali: Yes, full. It is there. A jeth (brother-in-law) is coming out, so they do ghunghat (veil).

Devanik: You mean, it is still very prominent now?

Anjali: Yes."

(Anjali Bantwal, Gali number 5 Anganwadi centre, 7th March 2020)

Anjali cited another case of a woman, Priti, who got a job but was not allowed to take it up by her husband and his family.

"There is one pregnant woman here, Priti was her name. She had a child recently, last month on the 18th. She has a two-year-old daughter. Now she had a son, this was her second pregnancy. Her family are daily wagers. Her husband isn't even 10th pass.⁸¹ The woman is a graduate (undergraduate). She came to me and asked that if there was any vacancy for Anganwadi, then do tell me. In 2017, she filled up everything, she didn't have a pregnancy then. By the time interviews came, she had a pregnancy, I asked her to check her name in the merit list. Her name was there. She told me: Madam don't tell my family members, that I have filled up this form. She is really interested to do but family doesn't allow. She gave interview in isolation and in secret. She didn't join, however. Mere ghar mei gussa karenge (My family will be angry). Her husband even

⁸⁰ *Ghunghats* in India are veils (using either the saree or another item of clothing) worn by women over the head, face, or both in many cases. The *ghunghat* is supposed to protect women's honour and pride by not showing their face and head to other men and people outside of the household. A 2018 social attitudes survey in Delhi found that around 75% of young Hindu women in Delhi (18-25 years) practice *ghunghat* (Shah, 2018). Among Muslims, the term 'purdah' is used instead of *ghunghat*. (Also see Devi and Kaur, 2019.)

⁸¹ This term means the person has not studied past year 10 or grade 10 at school.

got to know and was very angry. She filled up the form from her own house. She lied multiple times that she is going to the parents' house and managed her application. Then her pregnancy happened, but he refused. I called her husband once and said can you get me to talk to Priti but he didn't let me talk to her. I tried to convince her a lot [to take up the Anganwadi post] that you are getting such a good opportunity. You will be able to care for your kids, earn money. Now she is at home, sitting in her ghunghat (veil)."
(Anjali Bantwal, Gali number 5 Anganwadi centre, 7th March 2020)

Thus overall, these comments and discussions make it clear that the Rajaji Nagar community's gender norms and practices are largely traditional and conventional, thereby sustaining the gender hierarchies and patriarchal systems.

Now that we have a sense of the overall gender norms and practices in Rajaji Nagar, I will expand on the category of 'men' as perceived by these CHWs before going on to discuss how men's involvement in antenatal care is perceived and defined by the CHWs in Section 5.2.

5.1.1 Who are the 'men' of Rajaji Nagar?

During fieldwork, as I conversed with these CHWs, at the time it appeared that the category of 'men' was homogenised by CHWs. While speaking about men's behaviours or CHWs' experiences with them, they did not specifically differentiate between Hindu or Muslim men, or between men of different castes or class. Rather, in their conversations, they spoke of men as a homogenous category in Rajaji Nagar. Almost all CHWs I spoke to, who were all Hindus, did not engage much with Muslim families beyond basic interactions as government health functionaries focused on achieving their monthly targets of home visits, vaccinations,

pregnancy registrations and other related activities and earning their financial incentives based on number of targets achieved. One factor which needs to be kept in mind is the fact as these ASHAs' remuneration depends on incentives for various activities, it is important that they maintain a good working relationship with the community irrespective of religion.

The CHWs engaged with Hindu families through multiple channels such as affective ties, caste relations, political activities, and religious events. While they did not explicitly mention avoiding contact or not interacting socially with Muslims, their views and comments indicated a sense of underlying religious tension. I now share some comments by Draupadi Debi (Anganwadi worker), Prem Lata (ASHA worker), Seema (another Anganwadi worker) and Dr Manvi which demonstrate the ASHAs' lack of intimate bonds and connections with Rajaji Nagar's Muslim families and their sense that these families are different.

- *“My Anganwadi area is very bad and full of Muslims. It is difficult to work with them.”*
(Seema Mishra, Gali number 17 Anganwadi centre, 24th February 2020)

- *“Devanik: The central government is making efforts to bring in a population control law?”*

Draupadi: In our Hindu society, our numbers are decreasing and in the Muslim society, numbers are increasing (Din pe din badhti jar hi hai). Wherever you see, Muslim families have four to six children, whereas you will hardly see Hindu families who have more than three or four kids. There should not be four children. In today's world, one or two kids. Max two, max three. There should be a law, but control must also be imposed on Muslims. It should be imposed on all. It should be implemented in the entire country. A small family is a happy family.”

(Draupadi Debi, Gali number 2 Anganwadi centre, 20th September 2019)

- *“Specifically, there is a need to engage Mohameddan⁸² families. They need to know more about family planning as they have a lot of kids.”*

(Prem Lata, TH20 clinic, 23rd August 2019)

- *“Devanik: Are there any trends or patterns in men’s attitudes according to caste, religion, age, income?”*

Dr Manvi: There is a difference between Hindu and Muslim families. They [Muslim families] say it is haraam (blasphemous) to adopt family planning methods. I would say education makes a difference majorly as they aren’t aware to take care of women. We tell them about intra-uterine devices⁸³ etc. but they don’t understand these things and do not listen. There is only one Muslim ASHA worker, one. For ASHA worker applications, a minimum educational qualification is 8th grade, but we have graduates applying for these roles. Among the Muslim community, there is less education, early marriage and women are not allowed to work. Thus, religion makes a huge difference. In areas like Batla House, Jasola, Jamia,⁸⁴ more than 90% of ASHA workers are Muslims. Shabana is our only Muslim ASHA, but her area includes Hindus. She has never given this feedback to us.”

(Dr Manvi Batra, TH20 clinic, 28th August 2019)

These comments suggest a mix of disdain, xenophobia, and otherness towards Muslims, which is also influenced by and embedded in the broader Hindu nationalist politics that have taken

⁸² Mohameddians is a term used in Delhi and other places in India to refer to Muslims.

⁸³ Intra-uterine device (IUD) is a form of contraception for women.

⁸⁴ These are localities in Delhi which have a high proportion of Muslims (more than 50% of the population).

root in India over the past few years (Chatterjii, Blom Hansen and Jaffrelot, 2019; Wojczewski, 2020). Furthermore, some of these CHWs actively claimed to support Hindu nationalist politics and vote for a Hindu nationalist political party, which partly explains their attitudes towards Muslims. In fact, Prem Lata is a member of this political party in Rajaji Nagar and actively campaigned for it in the Delhi state elections in 2020. Muslim workers are also under-represented within the TH20 clinic, which has only one Muslim ASHA worker (out of 30 ASHAs working with the clinic).

Therefore, these CHWs' perspectives on men's involvement and their behaviours in Rajaji Nagar were based primarily on their interactions and experiences with Hindu families and Hindu men. However, there were exceptions, such as Anjali and Shalini, whose views on the differences between Hindus and Muslims were more accepting of religious differences.

- *“Devanik: Do you think Hindu and Muslim husbands have differing cultures as for rules?”*

Shalini: No Sir.

Devanik: Hindu society has different rules, Muslim something else. Have you seen any difference?

Shalini: No, because in our area there are both Muslims and Hindus. Some Muslims are also good and take care while some Hindus are also bad. Muslim bhi kuch aise hain jo har cheez me acche hain aur dhayan de rahe hain aur kuch hindu bhi hain jo acche hain. (Some Muslims are good in some things whereas some Hindus are also good.)”

(Shalini Singh, TH20 clinic, 26th September 2019)

- *“Devanik: Do you see any differences between Hindus and Muslims in terms of men’s involvement?”*

Anjali: During pregnancy?

Devanik: Yes

Anjali: The Muslims are more or less the same. Muslims who are more educated are conservative. If you go and talk to them, then they don’t let you. I ask them, can you show the dispensary copy, they show it themselves, the wife doesn’t come outside. The wife doesn’t talk. Pata nhi kyu baat nahi karti Mohammedans ki. (I don’t know why wives of Muslims do not talk to me.) They take care to ensure that there is not much discussion. In Muslim families, the more they are educated, they talk less. Their husbands talk more.

(Anjali Bantwal, Gali number 5 Anganwadi centre, 5th March 2020)

Furthermore, a crucial thing which I observed among CHWs was the difference between their proclaimed biases and the actual reality. During these discussions, three CHWs (Prem Lata, Draupadi, and Rita Verma) shared their concerns regarding the high fertility rate of Muslim women.⁸⁵ While they spoke about high fertility, lack of education and negligence among Muslims, during our conversations, they cited examples of women who have had multiple children and abortions, pointing towards these women’s “suffering”, lack of agency and indifference from their husbands. However, all the examples cited by the women referred to Hindus, which is a paradox given the fact that the CHWs blamed Muslims for having too many children. This contradiction suggests two things. One, their assertion about high fertility among Muslims is mostly influenced by the larger Hindu nationalist discourse in India which

⁸⁵ The alleged high fertility rate of Muslim women has become a controversial political issue in India, especially in the past few years where Hindu right-wing organisations use it as a trope to harass and intimidate Muslims (Daniyal, 2015).

demonises Muslims for apparently producing more babies. Two, their lack of sufficient and close interactions with Muslim families means that none of the CHWs were able to provide evidence for their xenophobic claims.

Most of Rajaji Nagar's CHWs' views on men's roles in reproductive health were based on their everyday experiences and interactions with Hindu families and Hindu men and on their social distance from Muslim families and men. The category of men discussed by these CHWs is imagined to be Hindu men. In the next section, I will discuss how CHWs define and perceive these men's involvement in antenatal care.

5.2 How do CHWs define and perceive men's involvement in antenatal care?

“Devanik: If we consider this whole pregnancy as a process....

Rita: Ji ek ghatna (yes this is an event).

Devanik: Do you think that there should be a 50-50 distribution between a man and a woman?

Rita: It should be 50-50 but it doesn't happen.”

(Rita Verma, her house, 20th February 2020)

This conversation between Rita, the ASHA worker, and me assesses men's roles in relation to maternal health. The conversation appears ambiguous because it does not mention 'what' should be included in a 50-50 distribution. 'What' is it that should be equally distributed? Non-pregnancy care work, pregnancy care work or both? I asked this question of Rita Verma, seeking to understand how men's involvement is understood by CHWs in Rajaji Nagar. However, in hindsight, I realised that I framed this question incorrectly. It is impossible to talk

of a 50-50 distribution or about an equal responsibility because undoubtedly, the impact of a pregnancy is deeper for a woman than for a man. As Fontana and Shoenbaum argue: “Only the pregnant woman carries the fetus, constantly feels the fetus and experiences the emotional connection this generates. Only she experiences many of the physical manifestations of pregnancy, including suffering morning sickness and the other health risks associated with pregnancy” (Fontana and Schoenbaum, 2019, p. 344). Nonetheless, this conversation between Rita and me indicates that there is a belief that the distribution of care work and labour in a pregnancy and antenatal care should be equally split even though this does not happen. With this as a starting point, I continued my discussion with Rita, asking: “How do CHWs perceive and define ‘male involvement’?” and “What are the different markers or indicators of men’s involvement in Rajaji Nagar according to CHWs?”

“Devanik: How do you define men’s involvement?”

Rita: Husbands cannot come for ANC check-ups. If they don’t earn, what will they feed the woman? So, it is not important that you [husbands] go with them [their wives to the clinic]. That’s what I think but at least become a co-partner.

Devanik: What do you mean by co-partnership?

Rita: For instance, if the husband says to the wife, “we have to go to the doctor, can you get ready quickly, you also have to go”. This is partnership. “Rather, you get ready and go to the doctor, and I get ready and leave for work”. She goes to the check-up and comes back; you [husband] call once [to hear] what the doctor said. For a woman, this is enough. She doesn’t need your presence always.

Devanik: Physical presence you mean?

Rita: Yes.

Rita: Now if husband is on duty, you can call her at 3-4pm, [to ask] what did the doctor say? She will be happy just by this. That's what I think. Then when you come back, you can ask her, what did the doctor say, what advice did he give? Ok so the doctor said this, so you should also take care of this. If he has asked to eat healthy, then don't be careless. This is enough, I think. It is also not necessary that he is always after her. She will feel that my husband pooch rha hai. Ghar pahuch nhi ki nahi? (She will feel my husband is asking, whether or not I have reached home.) This is quite enough. At least he cares for us, whether I reached or not? Even if he doesn't call, he could say, when you reach home, just tell me. Aurat ko yahi chahiye, usko zyada kuch nhi chahiye. (A woman only needs this; she does not need anything else.)

(Rita Verma, her house, 20th February 2020).

As Rita's comments demonstrate, she is not fixated on the idea of husbands being physically present at the clinic. She argues that husbands must go to the office for work – thereby stressing the ideal of husband as financial provider as perpetuated by notions of hegemonic masculinity – and she recognises that a husband may therefore not be able to accompany his wife for regular check-ups. In lieu of men's physical involvement and presence during check-ups, she proposes the idea of “co-partnership” where a husband calls from the office and enquires about the wellbeing of his wife. She says that if a husband calls his wife after check-ups to enquire about the ANC check-up, and to confirm that his wife has reached home safely, it is “enough” for the wife. (“*She will feel my husband is asking, whether I have reached home? This is quite enough. At least he cares for us, whether I reached or not.*”) Thus, a woman does not need anything else if she feels satisfied that the husband cares for her and is concerned about her wellbeing

(*“A woman only needs this; she does not need anything else.”*)

Through these comments (*“that is quite enough”*), Rita sets a moral benchmark, and if this benchmark is met, then she believes that wives will be satisfied, their emotional needs will be fulfilled, and they “do not need anything else”. Thus, according to Rita, expectant fathers’ performance of hegemonic financial provider ideals as well as ideals of caring masculinities is an indicator of men’s involvement, which wives experience as a form of psychosocial support and feel supported. For Rita, a husband’s physical absence is important for him to satisfy the role of the financial provider, which in turn is a socially constructed hegemonic masculine norm. However, Rita’s perspective –husbands accompanying wives to check-ups is not important – was not shared by other CHWs, such as Shalini, Anjali, and Draupadi Devi. They emphasised that husbands should accompany their wives to the check-ups and ensure their wives’ proper maternal nutrition.

- *“First of all, they [expectant fathers, husbands] should go to check-ups, he should take care of her diet. Medicine, check-ups, doing the needful, remembering dates for the same are some important things they should do time to time. They should collect information from wherever possible, from ASHAs, AWW, PHC, etc.”*

(Shalini Singh, TH20 clinic, 26th September 2019)

- *“Hone chahiye bhagidaari (there should be a partnership/responsibility). If one needs to go to the doctor, husband should go. If during work, she cannot eat medicine, then they [husbands] should take care that they [their wives] are taking their medicines properly. In joint families,⁸⁶ women keep working, get stressed and forget to take care*

⁸⁶ Joint families refer to familial setups which are quite common in South Asia (Rajaji Nagar in this case) where

of themselves. Thus, the husband should take care if the wife has eaten or not, she should not remain hungry during such a time if she needs to go to the doctor so the husband should leave his work and accompany them. If not every time, then at least few of the times, he should go. Assuming there is an emergency at work, and he cannot take leave, if not two times, then at least once he should go. This is what I think. There are people who earn in the day and eat at night and live on daily wages, so they won't be able to accompany their wives, if they won't earn, they won't be able to eat, especially for those who have large families."

(Draupadi Debi, Gali number 2 Anganwadi centre, 20th September 2019)

- *"Devanik: Assuming one must go to the dispensary and hospital for check-ups, who does the wife want as a partner? Husband or anyone else?*

Anjali: Usually the wife wants to the husband to go but it is the mothers-in-law who go.

Devanik: But who is the first choice?

Anjali: Husband should be the one who should be ready to go. During a delivery a mother-in-law can go, but for antenatal check-ups, a husband should go ideally. Pata toh chale usko har cheez. Kya hai kya nhi hai. (He should know the basics at least, what all is there.) What is the weight? How is his child growing?

Devanik: So, in what ways can we involve the husband?

Anjali: First, they should accompany [their wives] to check-ups. He should take care of his wife's diet. Khana (food) Checkup. All this is there."

(Anjali Bantwal, Gali number 5 Anganwadi centre, 5th March 2020)

everyone lives together in the same house (mother, father, husband, wife and other relatives in many cases).

These three CHWs all advocate for husbands' physical presence during check-ups and ANC visits to the clinic and see men as focusing on instrumental tasks such as ensuring that their pregnant wives have the required medicines, food items, and monitoring the wives' diets to ensure the required maternal nutrition needs. This perspective, while being realistic and no doubt important, is representative of the instrumental approach towards involving and engaging men in antenatal care. However, none of these CHWs mentioned the psychosocial aspects of men's perceived involvement, which Rita briefly hinted at (such as a husband calling his wife from work and asking after her wellbeing). The perspectives of Shalini, Draupadi and Anjali, as CHWs, are consistent with the wider literature on Indian men's involvement in maternal issues which strongly emphasises men's physical presence during antenatal care visits and focuses on men's instrumental roles (Singh and Ram, 2009; Kululanga *et al.* 2012; Peneza and Maluka, 2018).

Therefore, for CHWs in Rajaji Nagar, their understanding and framing of the concept of men's involvement is mostly through a traditionalist lens whereby men should focus on achieving and performing hegemonic masculine ideals. For them, the idea of involvement is mainly related to the idea of being 'physically present' to support their wives and ensure better maternal health outcomes, rather than a complex amalgamation of physical, emotional, and mental support. It also appears that these CHWs believe in the significance of visibility of antenatal care; that is, when a husband sees his wife receiving antenatal care, or sees ultrasound pictures of the foetus, it may have an emotional impact on him and encourage him to be more involved in maternal care. While this overarching focus on the instrumental approach to men's involvement in reproduction can be critiqued, it is also a significant means of ensuring that men are involved in maternal health and support their wives. This mode of involvement might be significant for many women as well (Galle, 2021) and thus should not be discarded. While sharing their perspectives on men's roles and responsibilities, CHWs also referred to the supposed

correlation between the family type and men's involvement in antenatal care, which I will now discuss in the next section.

5.3 The role of family types in influencing men's involvement in antenatal care

CHWs are the backbone of the maternal reproductive health system in India, and their focus includes promoting institutional deliveries, referring pregnant women to primary health clinics, vaccinations for pregnant women and infants, and family planning services. As such, although CHWs work primarily with women, they are keenly aware that women's different family arrangements influence both reproductive health and men's participation and engagement in antenatal care of their wives. They suggest that men in nuclear families must be involved because these families lack the female support systems found in joint families which care for pregnant women and provide guidance on antenatal care issues. Furthermore, the CHWs assumed a congruence between type of marriages and type of families, believing that love marriages implied nuclear families and arranged marriages implied joint family living conditions:

- *Rita: "In today's time, they [expectant fathers or men] do take care [of their pregnant wives] because now they don't have family. Earlier, people used to live in joint families so there are many people: Devrani, Jethani, Sasur, Saans, etc. (sisters-in-law, mothers-in-law, fathers-in-law). So, they [expectant fathers or men] think someone is there to take care. And if there is a single family, then they would have to take care.*
Devanik: For instance, if there is only a husband and wife.
Rita: Yes, in that case, they would have to take care."
(Rita Verma, her house, 18th February 2020)

- *“Nuclear family people know that only I [the husband] have to do everything. In joint families, husbands don’t pay much attention as they know there are people [other women, mothers-in-law] who will take care of the wife. The nuclear family husband knows that whatever happens, I have to handle it. The child also I [the husband] will have to handle and the wife also. And in nuclear families, if husbands don’t get time, then they call someone. That’s what happens.”*

(Anjali Bantwal, Gali number 5 Anganwadi Centre, 5th March 2020)

Anjali and Rita’s comments suggest that men’s participation and engagement is influenced by the family type. If there is a broader family support system such as within a joint family setup, then men can afford to be more relaxed and disengaged in their approach as compared with a nuclear family context, where a husband and his wife are solely dependent on each other for support (with occasional help from neighbours and friends). These arguments were further strengthened by Mohammad Zubair, the informal practitioner, who also highlighted the challenges for nuclear families. He said:

“If they are staying in a joint family, then guardians are also responsible and then responsibility comes on the family, it becomes comfortable for the husband and does not fall on one person. Mother-in-law, father-in-law, brother-in-law, all people they have to care. Before pregnancy, after pregnancy. In India, all things are handled by everyone. Not separately. In joint family, everyone can look. Elders have experience of rearing a child, so they pitch in. If there is a couple, and woman is pregnant for the first time, she does not have experience and she is a living with her husband only, she has to face all challenges.”

(Mohammad Zubair, his clinic, 21st October 2019)

My conversation with Partha Mandal, an informal health provider in Rajaji Nagar who ran a family healthcare clinic (Figure 20 below), revealed similar findings. Partha is from the state of West Bengal, but he has been living and working in Rajaji Nagar for five years. During a conversation with him in his private clinic on 20th January 2020, he said *“Many people here are in small-time businesses, they stay outside thus, their parents are there to take care of the wife, who take care. They leave it to their parents. After that, whatever is needed of the husband, they do help. I have seen this often here.”*



Figure 21 Outside Partha Mandal's clinic

(The Hindi text translates into: All types of disease are treated here including piles.)

As these conversations clearly indicate, in joint families, it is mainly elder family members,

who have previously experienced pregnancy and childbirth, who manage the antenatal care and household work, with the husband's role being limited to certain tasks and only required upon contingency as Partha explained. Rajaji Nagar is a community composed of working class migrants from neighbouring states of Delhi, with many men living in nuclear family setups. Thus, CHWs' assertions that, in certain cases, men have to be involved and engage in antenatal care work holds true, as often there is 'no-one else' – or rather, no other female family member – to support pregnant women and their pregnancy-related needs. Thus, the CHWs' correlation between nuclear families and higher levels of men's involvement accurately sums up the situation: men in nuclear family setups may not have other female family members to 'fall back upon' who can manage the antenatal care of their wives. These expectant fathers living in nuclear households were also the most willing to talk about their experiences and to share their perspectives (discussed further in Chapter Six).

An analysis of family health data by Allendorf (2010, 2013) in the state of Madhya Pradesh, a predominantly rural region, suggests that more than the nature of marriages, it is the quality of family relationships that matter when it comes to utilisation of maternal healthcare. Allendorf suggests that "high-quality family relationships motivate family members to do their best to secure the health of women during pregnancy, childbirth, and the postpartum period in a variety of ways. Husbands, in-laws, and other family members consciously look after the women they care for by giving them special foods, ensuring that they receive healthcare, paying for their health needs, and providing space and time to recover from childbirth and illness" (2013, p. 625). Shekhawat *et al.* (2018) found that women living in nuclear family households in rural Jaipur, the capital of Rajasthan, were less able to access and utilise antenatal care though the reasons behind this were not explored as it was a survey-based study. In Delhi, Rustagi *et al.* (2021) also found that expectant mothers from nuclear family setups have a higher prevalence

of not receiving proper antenatal care. A review of existing studies on maternal healthcare in India by Hamal *et al.* (2020) found that women living in joint or large families were more likely to seek post-natal care than women living in nuclear families. However, a study by Jungari and Paswan (2019) among the tribal community in Maharashtra, a western state in India, found that women living in nuclear families were more likely to access maternal healthcare facilities than those in joint families.

All studies quoted above are quantitative and survey-based, and thus, we need more qualitative studies to better understand the associations between the type of families and access to antenatal care by women and the reasons behind this. However, based on the existing evidence across India, it appears that women living in joint families are a bit more likely to access proper and quality antenatal care as compared with women living in nuclear families (Shekhawat *et al.* 2018; Hamal *et al.* 2020; Rehman *et al.* 2020; Pradhan and Mondal, 2021). In the context of Rajaji Nagar, CHWs seem to be aware of the correlation between nuclear families and higher levels of men's involvement in antenatal care, which is partly corroborated by expectant fathers; yet this may not necessarily result in adequate antenatal care for pregnant women.

5.4 Low benchmark of CHWs' expectations from local men

As discussed till now, CHWs' perspectives and conceptualisations of men's involvement in antenatal care tends to be rooted in traditional norms and practices. Their expectations of expectant fathers reinforce gendered hierarchies and hegemonic masculine norms, and as shown above, they put the onus of managing antenatal care primarily on pregnant women, with husbands' roles limited to instrumental/materialistic tasks such as managing finances (being a provider), bringing food and supplies.

This perspective is reflected through AWW Draupadi's reflections (documented in Section 5.2). Draupadi suggests that husbands should take care of their pregnant wives and be actively involved in antenatal care (even taking leave from work to accompany their wives to antenatal check-ups). However, as the conversation progresses, her perspective shifts from a husband always leaving his work to accompany to his wife, to a husband going a few times and finally, to a husband accompanying his wife at least once. This indicates that while Draupadi advocates for husbands' increased role, eventually, she gives them leeway and lowers her expectations thus reinforcing gendered dichotomies and hegemonic masculine norms. I suggest that this damping down of CHWs' expectations could possibly be because she was initially responding with what she thought I wanted to hear. Moreover, it appears that at first, she was outlining an ideal situation but as the conversation progressed, she voiced a more viable expectation which fits with local masculine norms, in other words "accompanying one's wife least once".

Either way, Draupadi's statements suggest a tempering of her expectations from men. Similar processes and analogies are visible in India's everyday social media conversations. On social media, Indian men who cook or do household chores (going against gendered labour divisions and against the norms of hegemonic masculinity) are celebrated and praised by the society at large, especially during the COVID-19 pandemic. However, many women point out that men should not be praised or celebrated for doing something that is a necessity for survival and given the highly disproportionate burden of care work falling on Indian women, the lower bar of expectations of men means that any husband doing basic household chores is celebrated and praised. This lowering of expectations of men means that, in turn, the care work burden on women remains much the same. Thus, the views held by Draupadi leads to a low benchmark for husbands to be held up to. Similar views are echoed by ASHA Rita who said:

“Samjhegi toh wahi (only she [a man’s wife] has to understand). It is the woman who has to give birth, not the husband. He will get the stuff and keep it. It will be you (the woman) who has to move her body. And if we don’t move our body, we will keep getting thinner. The more you work, the more you will be healthy.”

(Rita Verma, her house, 20th February 2020)

Rita’s comments reflect the same perspectives as those of Draupadi. Her statements “Only she has to understand” , “He will get the stuff and keep it” and “It will be you (the woman) who has to give birth, not the husband” limit the expected behaviour from husbands to instrumental objectives (meeting medical or dietary requirements for the mother and getting equipment needed for the baby) and puts the primary onus on pregnant women to be responsible for their self-care and bodily needs. In Rita’s view, a pregnant woman’s body is legitimised only through pregnancy and non-pregnancy care work, and this work will make her healthy. Rita continues:

“Mostly the woman should understand. As far as pregnancy is concerned, the woman has to deliver the baby. More than the husband, it is the woman’s work because she has to manage the household as well as and do care work too. If you don’t care for the husband, how much can the husband do? He comes at night, has dinner, and goes to duty [a colloquial term used for work or jobs] in morning. Use koi matlab nhi hai (He doesn’t have to do anything with it.) He will get his monthly income, he will go. The rest is your job. If you [a pregnant wife] cannot keep your responsibility, nobody can.”

(Rita Verma, her house, 20th February 2020)

Rita's comments put the onus of 'understanding' on women and emphasise a gendered division of labour in which both reproductive and care work are mainly women's responsibilities whereas husbands cannot do much ("How much can the husband do?") and their primary role is to be the breadwinner and ensure financial security ("He will get his monthly income, he will go"). In other words, husbands should focus on performing and achieving hegemonic masculine ideals, whereas pregnant wives should manage the household work as well as see to their self-care. Rita's perspective is, as Smith-Oka (2012, p. 106) argues, one in which "mothers are often encouraged to engage in self-blame where society imposes nearly total responsibility on women as prospective mothers for assuring a favourable birth", which is the case in many contexts of India. Rita's construction of an expectant mother exemplifies an ideology of "intensive mothering", as articulated by Hays (1996, cited in Cantillon and Hutton, 2020, p. 1) which states that caregiving should be the main priority of 'good' mothers, who invest their time, money, and emotional labour in their children or, in this case, their future children.

Other ASHAs made similar comments, suggesting husbands' wellbeing should be leveraged as a bargaining tool to convince them to ensure proper antenatal care. Let me explain through the following comment from Shalini: *"Aapko hi jhelna padega bimaar ho gyi ya kuch ho jaega toh (we keep telling him [a pregnant woman's husband] that you will have to suffer if anything happens)"* (Shalini Singh, TH20 clinic, 19th September 2019).

During the same conversation, she added:

"Yes, when we see that he [a husband] is not caring, we explain how important it is for the health of the mother and child. I tell them if she is fine, she will be able to care for you. Wo swasth rahegi to aapka bhi dhyan degi. (If she is healthy, she will be taking your care also.)"

(Shalini Singh, TH20 clinic, 19th September 2019)

On being asked whether this makes a difference, she said: *“Sir samjhane se thoda bohot fark padh hi jaata hai. Baar baar wahi baat karenge, baar baar samjhaenge. (Sir, by explaining to them repeatedly, there is some difference. If we talk again and again and explain again and again).”*

These comments suggest that Shalini tries to motivate husbands (*samjhana*) by suggesting that if they do not care properly for their wives, they will be the ones who will suffer and not their pregnant wives and, in so doing she connects his wellbeing with hers. The second part of her sentence: *“Wo swasth rahegi to aapka bhi dhyan degi (If she is healthy, she will be taking your care also)”* is indicative of Shalini’s promise that if a wife is healthy, she will be able to take care of her husband as well, which again emphasises a woman’s caregiving role and reinforces the culturally constructed idea of motherhood. This notion of motherhood puts the onus on women for managing themselves, their husbands, and their households. In both her statements, ASHA worker Shalini tries to convince husbands to contribute to women’s antenatal wellbeing using a different approach: by promising them a stress free and healthy life; in other words, the husband’s wellbeing is leveraged as a bargaining tool to ensure good care for his wife. Thus, while CHWs emphasise the need for husbands to play a role and be engaged, they themselves often resorted to status quo gender norms and indirectly put the onus of antenatal care on pregnant women.

The low benchmark of expectations of expectant fathers in Rajaji Nagar and the reasons behind it were also expressed by other CHWs who mentioned that overall, the level of men’s involvement in their wives’ antenatal care remains minimal, and even extending to neglect in

some cases as the following comments from different CHWs demonstrate.

- *“We cannot reach men and explain them these issues (maternal health and antenatal care). Yahan aadmi zyada samajhdar nahi hai. (Here, the men are not very mature). They are not mostly available on a Sunday or holidays and thus, we do not get to interact with them.”*

(Prem Lata, TH20 clinic, 23rd August 2019)

- *“There was a case, which I remember. It was their second child. The wife went into labour pain at night. The baby was delivered, still the husband ran and called the ASHA worker. Then the ASHA arrived and said what happened? The husband said aap hi sambhalo (you only handle). She did something and told me I have seen such a case first time, that aadmi ko koi matlab hi nahi hia. (He [the husband] called me and went inside; he didn't do anything at all), it has been a year. Then ASHA was telling me that it is the first time I have seen him. He is not even worried that my wife is like this. Men are like our job is to conceive a child, the rest is a woman's responsibility. I have seen this here; most husbands are like this.”*

(Anjali Bantwal, TH20 clinic, 7th March 2020)

- *“Padhai se kuch nahi hota Sir, jo kuch bhi nahi padha wo apni biwi ka dhyan deta hai aur hum kai gharon me dekhte hain padha likha insaan hoke bhi biwi ka pitai kar deta hai, pregnancy me bhi. (No, it's nothing about education, it is more about understanding. Some [men] understand very well and take care even without education and some others just feel that pregnant women will deal with it. I have seen educated men beating up their wives during pregnancy.)”*

(Shalini Singh, TH20 clinic, 19th September 2019)

Thus, as we can see, there seems to be consensus among CHWs that, broadly, husbands are not very involved in their wives' antenatal care and some men even demonstrate complete neglect of their wives. This consensus leads to a lower benchmark of expectations of men regarding their roles in antenatal care.

While these insights and perspectives around the behaviour and actions of men was mostly gathered through personal conversations with these CHWs, I also saw a glimpse of pregnant women's attitudes towards their husbands during an information session⁸⁷ at the *gali* no. 17 Anganwadi centre on 24th February 2020. The session was led by a woman Anganwadi supervisor, who was addressing around 15 pregnant women and speaking about the importance of having nutritious food for themselves and their future children. She focused on things like how women should keep their own value in front of husbands, not worship them, not eating days-old food while ensuring freshly cooked meals for their husbands, among others. She further emphasised that, being pregnant, women should think about their future children and focus on their own care too. When she finished speaking, a woman said: "*Aur agar koi chutiya*⁸⁸ *mil gya hai jo sara din peeya padha rehta hai toh kya kare fir?* (If I have gotten an idiot, who is drunk the whole day, what should I do?)", to which everyone started laughing. To this, the supervisor responded: "Focus on yourself, leave him to his condition".

Therefore, from these conversations and observations, it is evident that there is no wider

⁸⁷ These information sessions are led by health department officials (who supervise and monitor Anganwadi workers). The sessions are meant for pregnant women as general discussions or information about dos and don'ts during pregnancies. This session was led by a woman supervisor, who managed around 10 Anganwadis in Rajaji Nagar.

⁸⁸ Chutiya is an expletive word used in North India, mostly to denote someone as an idiot.

narrative regarding the involvement of men and expectant fathers in antenatal activities in Rajaji Nagar. Antenatal care in Rajaji Nagar is mostly the responsibility of the women (wives as well as mothers-in-law in joint families) with minimal or no involvement from their husbands. These realities lead to a low benchmark of expectations of men regarding their roles and involvement in antenatal care.

However, despite these gendered realities and the prevalence of hegemonic masculine norms in the community, some CHWs do make some efforts and try to influence husbands' behaviours and actions to improve maternal health outcomes. While most CHWs shared the above-discussed conventional views regarding men's involvement, two ASHA workers initiated conversations (*samjhana*) about situations where they felt a husband needed to be spoken to; they tried to influence men to adopt social behaviours and responsibilities that they, as CHWs, thought were suited to men as husbands and fathers.

For example, let us look at another of ASHA Shalini's comments.

"We try positive reinforcement and I think that helps when we show them [expectant fathers] examples of other people who care, we try giving examples. We show them men who take care and discuss how their wife and child are doing well and he does not have to suffer. That makes a difference. Setting examples work well. We tell them to talk to these men and see how good their family is."

(Shalini Singh, TH20 clinic, 19th September 2019)

In this comment, Shalini tries to promote a certain set of beliefs and expected behaviours which husbands can undertake, and which she feels will help pregnant women. In this case, the CHW

is trying to change the behaviour of the men she interacts with. This example also demonstrates Shalini's usage of other men as role models to influence behaviours of others through presenting examples of other caring and responsible men in the hope that this will influence others to act similarly. On another antenatal check-up day (20th February 2020) when I was standing outside the clinic, I overheard a 50-year-old ASHA worker, Shanti, addressing a young couple and facing towards the husband. She said: *"See, you have to care for your wife. I cannot talk about these things at your house to you directly because of your parents. Therefore, I am trying to explain you today."* In this case, Shanti is engaging with the husband and asking him to be more involved. Apart from these two women, other CHWs clearly told me that that they did not engage with men much mostly because men were away for work on weekdays and were only available on Sundays.

5.5 Multiple ideological subjectivities of CHWs

Thus far, I have highlighted the perspectives of CHWs regarding men's roles and involvement in antenatal care, as well as discussing their opinions on whether men should be involved or not. These CHWs have multiple ideological subjectivities, and while they are aware of the local gender norms and practices which stigmatise and resist active participation of men in antenatal care, they also understand and emphasise the importance of men's roles to some extent. I suggest that this prevalence of diverse ideological subjectivities of CHWs is due to them encompassing multiple identities.

From social and cultural perspectives, the CHWs don different 'hats' such as ordinary residents, mothers, wives and mothers-in-law, and have been living in Rajaji Nagar community for several years and decades which illuminates their affinity towards local gender norms and

practices. However, from an institutional perspective, they are trained in public health programmes which propagate certain goals such as the two-child norm for families and excluding men from everyday antenatal care processes. Thus, ASHAs perceive and conceptualise men's involvement depending on the 'hat' they are wearing: one as a government health functionary, second as a resident of Rajaji Nagar and third, as women who provide maternal healthcare to other women. These three roles and accompanying sets of beliefs contradict, agree, and intersect with each other in complex ways, as I will discuss in this section. For instance, see this conversation between ASHA Shalini and me on domestic violence:

"Hitting is wrong. I advise the women to hit back if they are being hit [by their husbands]. That is the best. I tell her to make him understand, then complain in family, leave home, if he gets some sense, he will come to take you if he doesn't, then put a police complaint if he still does not understand, repeats, and keeps beating then hit him back, then only he will be fine."

(Shalini Singh, TH20 clinic, 19th September 2019)

Within the same conversation, she cited the example of a particular woman who faced violence.

*"There was this woman who used to suffer. Her husband used to come home drunk and beat her in front of everyone. Initially she did not say anything and just tolerated but eventually she started hitting him back with her slippers on the road. After three or four times, he stopped hitting his wife. **You should tolerate a little bit but not every time** (emphasis added by me)."*

(Shalini Singh, TH20 clinic, 19th September 2019)

As is evident in this quote, Shalini tells women to retaliate if they face domestic violence, but in the second part of the conversation, she also says “*you should tolerate a little bit but not every time*”, which again is an indication of women’s socially disadvantaged position and the popular patriarchal argument that women should tolerate men’s actions and display “ideal” women’s behaviour (Sharma, 2015). Thus, her perspective on domestic violence oscillates between two contrasting perspectives. Let us look at another example to further understand how CHWs’ behaviours are rooted in local cultural and social norms.

During Anita’s comments around son preference on p. 143, she stated that: “*If I want, even today I have the ability to produce a child, but my husband and I don’t want that*”. She added: “*I have never thought of another child. What if the third is also a girl?*” In the first comment, she emphasises her ability to still produce a child. Her statement is reflective of Unnithan’s findings (2015, p. 52), who, in the context of North India’s patriarchal society, writes, “childbearing is intrinsic to the construction of women’s personhood (in a structural sense) and their attainment of full adult social status as mothers and wives”. Yet, Anita says: “*but my husband and I don’t want that*”. This means that while she is content with her two daughters, she is indeed worried about potentially a third daughter if she conceives again, which could be challenging for her given the norms around son preference in the society.

As these discussions with Anita and Shalini demonstrate, their own views and perspectives are rooted in the traditional social and cultural norms which they themselves experience and live in. During most of our discussions of gender roles and of men’s involvement in antenatal care, these CHWs reflected on their own life stories and experiences (such as Anita’s own example above of having two daughters) and used these as a basis from which to answer my questions. This approach indicates that CHWs’ attitudes and perceptions towards men’s roles in antenatal

care, a highly gendered issue, is rooted in, and influenced by, their own gendered lives and experiences.

During these conversations with CHWs, I also came to know that their reproductive lives are strongly influenced by the Indian State's ideological agendas and policy objectives. In India, the two-child norm has long been portrayed as the desired family size and all family planning programmes focus on having only two children (Nordfeldt and Roalkvam, 2010; Mishra and Roalkvam, 2014; Khaitan, 2020).



Figure 22 A poster on the two-child norm at an Anganwadi centre

(These charts are prepared by Anganwadi and ASHA workers and displayed at these centres and clinics. Translation of the Hindi text: Only two children are fine, use family planning

methods.)

As mentioned earlier in this chapter, two CHWs, Draupadi Devi and Shalini, highlighted the significance of just having two children and mentioned it as an ideal family size. Having worked in Rajaji Nagar for over four years, I have not come across any community norm or practice around having only two children. Many families⁸⁹ I know of in Rajaji Nagar have more than two children. However, notably, none of the ASHAs had more than two children; some had one, but most had two children, which demonstrates that these CHWs and their families practised the public health system-inspired two-child norm among themselves. Thus, in the context of family planning and children, it is evident that CHWs have moulded themselves and limited their family size to two children, and that they attempted to promote this message to others with some success.

In the context of men's involvement in antenatal care, while these CHWs actively exclude men from everyday antenatal care processes as I discussed in Chapter Four, in individual conversations with them, they emphasise the importance of expectant fathers in antenatal care while not letting go of the gendered familialism ideology (Neetha and Palriwala, 2011) that emphasises care as a familial and female responsibility. Their emphasis on involvement of expectant fathers is contrary to the Indian State's stance (as discussed in Chapter Four), which does not pay attention to men as expectant fathers in policymaking. I suggest that this contradiction can be attributed to their identity as women who care for other women (as carers). Due to their lived experiences as women and mothers in the community, these CHWs are aware of the local realities, and they know that an increased effort on the part of these husbands could

⁸⁹ I have worked in Rajaji Nagar before as part of a teaching fellowship with a non-profit organisation. Thus, I have prior knowledge regarding family sizes and connections with families.

lead to an improvement both in the wellbeing of their subjects and in broader maternal health outcomes.

To summarise briefly, these CHWs' perceptions and actions around the role of expectant fathers in antenatal care is influenced by three different but intersecting identities. As the Indian State's agents who follow the prescribed policy guidelines (Unnithan, 2022, p. 131), they exclude men from antenatal care processes; as residents of Rajaji Nagar, they argue for upholding gender norms around reproduction due to the prevalence of hegemonic masculine norms and a low benchmark of expectations of men; and as women who care for other women subjects, they advocate for an increase in men's involvement as they are aware of its potential impact on maternal health outcomes. These three identities are strongly tied to each other and together, these result in CHWs suggesting that men should help – a little bit – and be – a little bit – involved in antenatal care. However, this suggestion does not translate into active and regular efforts by the CHWs to involve and engage with men as my discussion in Chapter Four indicated.

5.6 Conclusion

This chapter addresses the second sub-research question, namely: **What are the perspectives and experiences of community health workers in relation to expectant fathers' involvement in antenatal care, and to what extent do these perspectives limit or encourage men's involvement?**

As is evident in the above discussion, CHWs' perspectives towards men's involvement in antenatal care are diverse; this can be attributed to their multiple identities as government health workers, residents of Rajaji Nagar, and as women carers who care for other women. They told me that they too experience pressure to conform to gendered expectations of women, and that

ongoing community expectations such as son preference, women's mobility, and even the clothing worn by women perpetuate traditional and patriarchal norms, which seek to uphold and maintain the subordinated position of women and girls in the society. This patriarchal view of antenatal care being a woman's issue is also sustained by mothers-in-law in Rajaji Nagar, who within the realm of reproduction, have the highest authority in terms of decision making, especially in joint families. It is these mothers-in-law who dominate the decision making around everyday antenatal care affairs rather than the husbands of these women, thereby limiting opportunities for men's involvement in their wives' care. Moreover, community health workers' messages about appropriate pregnancy behaviours and health often clash with men's mothers' more traditional perspectives and overarching control.

Due to the prevalence of these dynamics and issues in Rajaji Nagar, CHWs have a low benchmark of expectations of men, and thus their perceptions of involvement for expectant fathers are mostly limited to performing their roles as financial providers and doing materialistic tasks for their pregnant wives. In holding these low expectations, the CHWs' perspectives reaffirm the Indian State's imaginings that men should mostly be kept out of the realm of antenatal care and restricted to their role as breadwinners.

In relation to the second part of the research question, which asks about the extent to which CHWs' perspectives limit or encourage men's involvement, CHWs do not actively encourage men's involvement in antenatal care. Rather, most CHWs highlight gender norms that uphold hegemonic masculinities and patriarchal practices and do not actively make any efforts to resist or challenge them. There are two reasons for this. Firstly, as community level providers of maternal reproductive health services and given their precarious situation as health workers on low pay, they mostly focus on tasks which offer them financial incentives. These tasks are exclusively related to working with women and children and providing maternal

reproductive and newborn health services. Therefore, engaging with expectant fathers and making efforts to encourage them will not offer them any financial gains. The second reason why CHWs, and more specifically ASHAs, may not challenge hegemonic masculine norms and gender relations within the community is the fact that they might not want to damage their relationships with these families by ‘interfering’ in their cultural norms and practices and by going beyond basic advice and guidelines. As the ASHAs’ remuneration depends on incentives for various activities, it is important that they maintain a good working relationship with the community. Given their identity as women residents, an overemphasis or a sustained effort to critically engage with husbands on their involvement in antenatal care may negatively impact their community relationships as well as potential financial incentives linked to their tasks.

These findings resonate with other studies which find that the capacity of these workers to stir change and challenge gender norms is restricted and limited. In the North-Eastern state of Manipur, Saprii *et al.* (2015) found that ASHAs’ incentivised roles, such as linking pregnant women to antenatal and institutional delivery care, receive greater attention which in turn limits ASHAs’ participation in their non-incentivised roles of social activism, community mobilisation, counselling, and home visits. This focus, combined with their identities as women – which subordinates them to the men of the community – means that challenging men and transforming gender relations may be difficult (Saprii *et al.* 2015). Ved *et al.*’s (2019) research on the origins of the ASHA worker programme found that the decision to hire only female health workers worked within the existing gendered norms of caregiving to address child health rather than challenging patriarchal norms which framed women as being primarily responsible for childcare.

CHWs’ positioning relative to mothers-in-law and the patriarchal norms of Rajaji Nagar also suggests that nuclear families might present more opportunities and windows for encouraging men’s involvement in antenatal care, yet the quality of that involvement also differs depending

upon the contextual realities. As the CHWs themselves pointed out, these men had to be more involved in the daily household routines as they could not rely on other members of their families. Yet, women living in nuclear families in Rajaji Nagar and elsewhere in India (Shekhawat *et al.* 2018; Hamal *et al.* 2020; Rehman *et al.* 2020; Pradhan and Mondal, 2021) are unlikely to receive better antenatal care than those living in joint families, although the reasons behind it have not been greatly explored qualitatively yet. Thus, while international maternal health guidelines and initiatives led by different organisations focus on promoting men's involvement in maternal health, in the context of India, the intersection of the family type and quality of men's involvement needs to be further examined. There is a need for more context-specific studies and research while exploring these relationships in much more depth, which can then be leveraged to design and implement policies to encourage the role of expectant fathers.

Given all this, it is perhaps not surprising that CHWs do not have high expectations of men, that they articulate that expectant fathers should be involved, but ultimately have a low benchmark of expectations. Instead, CHWs place the onus of managing antenatal care primarily on pregnant women. This chapter has demonstrated why and how, despite recognising that men's involvement can help produce positive maternal health and reproductive outcomes, CHWs temper their expectations of men. In so doing, they underscore the absence of recognition of men's role in India's maternal health and reproductive policies. This creates a context in which there are strong pressures on men to conform to hegemonic masculinities, and to not engage in maternal and reproductive health processes. The following chapter examines how expectant fathers in Rajaji Nagar position themselves in relation to maternal and reproductive health.

Chapter Six: Men's subjectivities, emotions, and vulnerabilities during expectant fatherhood

Introduction

As shown in the previous chapter, CHWs do not have high expectations of men in terms of their engagement in maternal health. In downplaying men's involvement in their wives' pregnancy and birth, these CHWs are echoing societal values. Similarly, in the public and academic discourse in India, it is usually assumed that Indian men are neither active participants nor emotionally invested in reproductive and maternal healthcare, and that they are instead gatekeepers of a hierarchical gender system which subjugates women and prioritises men's reproductive choices and decisions while putting the reproductive burden primarily on women. This assumption is guided by the lived experiences of women and reaffirmed by several studies that have been conducted on women's reproductive and fertility experiences over several years (Unnithan, 2001; Unnithan-Kumar, 2010; Deb, 2015; Mishra and Parasnis, 2018; Parsekar *et al.* 2021; Sivakumar and Manimekalai, 2021). These studies indicate that reproductive decision making is dominated mostly by mothers-in-law and, to a lesser extent, husbands, with least autonomy accorded to new wives.

Due to the historical subjugation of women through an essentialisation of their procreative ability and attempts by feminist anthropologists to correct the male bias in social sciences⁹⁰ (Moore, 1988), in the past few decades, there has been significant focus on studying and theorising women's lives by female anthropologists and researchers. Powis (2020, p. 170) writes: "until the 1970s, because of the overwhelming authorship of men as well as a discursive

⁹⁰ The male bias in the social sciences refers to the dominance of male anthropologists researching and speaking for women and representing women's issues and lives through a male point of reference, which does not represent their actual lives correctly (see Moore, 1988).

consideration of men as the default gender, most of the global health and development studies (and social science literature) was really about men”. However, the key issue, Powis (2020, p. 170) highlights, was that men were rarely portrayed as “gendered agents” in these analyses.

In the context of reproduction, researchers and academics in South Asia have mainly focused on deploying the autonomy framework imported from Western scholarship to achieve better reproductive maternal health outcomes for women. Though there are many variations of the autonomy framework, broadly this refers to the assumption that if women are fully autonomous and independent in their reproductive decision making, rather than being dominated by husbands and other family members, their health outcomes will eventually improve. However, over time, this approach has been revisited and critiqued. For instance, building upon their ethnographic research among women in rural Pakistan, Mumtaz and Salway (2007, p. 20) suggest that we must think beyond the autonomy paradigm in reproductive maternal health which “places undue emphasis on [women’s] independent, autonomous action including unaccompanied mobility, final decision-making authority, and control over financial resources”. Given the strong bonds and intimate relations between different household members in South Asia, it is important to look at how reproductive decision making is influenced by this relationality among household members (Mumtaz and Salway, 2007). In the context of India, Ravindran and Panda (2002, cited in Unnithan, 2009, p. 15) similarly argue that focusing on increasing women’s autonomy is not a necessary condition for improving reproductive health outcomes.

Furthermore, given the fact that “men and the socio-cultural construction of masculinities are now recognised to have important implications for women’s reproductive health outcomes and thus, research based within the autonomy paradigm seems unlikely to produce a full

understanding of these complex influences” (Mumtaz and Salway, 2009, p. 9), I employ a Critical Studies of Men and Masculinities (CSMM) oriented approach that is needed to understand antenatal care through the lens of men and masculinities as a category of empirical analysis. Given the significance of strong relationships, personal bonds, and gendered negotiations between mothers-in-laws, husbands and wives in India and South Asia as a whole, it is important to not overlook an entire category of stakeholders and their perspectives.

The debate over how to conceptualise masculinity has also undergone rigorous review and analysis over the past few decades. In this chapter, I draw upon Connell (n.d.) who writes on her website “to speak of masculinities is to speak of gender relations; masculinities are not equivalent to men; they concern the position of men in a gender order”. Philip (2022, p. 17) similarly writes that “masculinity is an inherently relational term. It exists in relation to femininities and other masculinities to create a gender order of men and women positioned relationally to each other”. I also find resonance with Brittan’s (1989) differentiation between ‘masculinities’ and ‘masculinism’. He argues that while **masculinities** refer to those aspects of behaviours which fluctuate over time and differentiate men, **masculinism** draws attention to power differentials evident in hierarchical structural arrangements and ideologies which justify and naturalise male domination in the household, economy, and polity (1989, p. 6-7). In the sections below, I apply these different conceptualisations of masculinities to men’s experience of maternal health. There is no doubt that masculinism is widely prevalent in the domain of reproductive maternal health in many contexts within India (Santhya *et al.* 2007; Mahapatro *et al.* 2011; Unnithan, 2019; Sivakumar and Manimelakai, 2021), and this has led to academic research focusing on and prioritising women’s experiences, journeys, and challenges in the realm of fertility, reproductive maternal health, and childbearing. However, as the current evidence on men’s involvement suggests and as I have demonstrated in this thesis, focusing on

men as a category of empirical analysis could help improve maternal health outcomes and advance gender equality overall. Thus, I move away from a generalisation of men's behaviours and actions in antenatal care and apply masculinities as a plural and dynamic concept to analyse expectant fathers' experiences and subjectivities through a CSMM framework.

For my discussion, I draw upon some specific masculinities, briefly referred to in Chapter Two. This includes the concept of hegemonic masculinity (Connell, 1997), which is considered by researchers to be at the top of a hierarchy of masculinities against which other masculinities are constructed and desired. The conceptualisation of hegemonic masculinity is described as "a set of values, established by men in power that functions to include and exclude, and to organize society in gender unequal ways. It combines several features: a hierarchy of masculinities, differential access among men to power (over women and other men), and the interplay between men's identity, men's ideals, interactions, power, and patriarchy" (Jewkes *et al.* 2015, p. 113). I also draw upon the concept of caring masculinities (Elliott, 2016), referred to in Chapter Two. Caring masculinities are "masculine identities that reject domination and its associated traits while embracing values of care such as positive emotion, inter-dependence, and relationality" (Elliott, 2016, p. 240).

Thus, this chapter explores the question: **How do expectant fathers construct, perform and navigate multiple masculinities in the realm of antenatal care?**

I answer this question by offering a holistic exploration of working class expectant fathers and their masculinities in the realm of antenatal care. I build my analysis on the premise that the discourses around men's involvement in antenatal care and pregnancy need to be problematised and that this necessitates a much more careful consideration than the catch-all rubric of

patriarchy (Srivastava, 2018). I further find agreement with Srivastava's simple differentiation between patriarchy and masculinity. In his view, "patriarchy refers to the systemic relationship of power between men and women, whereas masculinity concerns both inter- and intra-gender relationships" (Srivastava, 2012, p. 2). Thus, in this chapter, in addition to examining expectant fathers' individual experiences of maternal health, I also explore the construction, interaction, and negotiation of their masculinities in context of their relationships with their parents, most notably their mothers, and wives during periods of reproduction. Academic literature in India and South Asia has mainly focused on the relationships between mothers-in-law and daughters-in-law and the effect of these relationships on women's reproductive maternal health (Vera-Sanso, 1999; Singh, 2017; Kohli, 2017; Barua and Kurz, 2001; Bloom *et al.* 2001; Robitaille and Chatterjee, 2014; Blanchard *et al.* 2015; Speizer *et al.* 2015; Varghese and Roy, 2019; Anukriti *et al.* 2020). Far less, however, has been published on how expectant fathers construct and view their participation in antenatal care in relation to their mothers and wives.

This chapter is organised as follows. In Section 6.1, I focus on expectant fathers' emotions and their roles in the construction of masculinities. I further explore how these masculinities are also constructed and influenced in relation to their kinship system. In Section 6.2, I discuss the different pathways through which these expectant fathers perform their multiple masculinities. In Section 6.3, I focus on how these expectant fathers negotiate/navigate their own masculinities within their gendered households and the community. Section 6.4 concludes the chapter.

6.1 Constructions of masculinities

In this section, I focus on how expectant fathers construct their masculinities through a) deploying their emotions, subjectivities, and vulnerabilities (Section 6.1.1), and b) influence

and relations with their kin members (Section 6.1.2). Although in the economic sense, all these expectant fathers belonged to the working class, they were not homogeneous. The group of fathers included first-time fathers, second-time fathers, and third-time fathers as well as both Hindu and Muslim fathers (thus representing the two main religious groups in Rajaji Nagar).

6.1.1 Emotions, subjectivities, and vulnerabilities of expectant fathers

Chapter One highlighted that interventions and studies on increasing men's involvement in maternal health have been criticised as they are instrumental in their approach and primarily focus on men's 'physical involvement' in care activities to ensure better maternal child health outcomes, rather than including men's own subjectivities, emotions, and attitudes (Comrie-Thomson *et al.* 2015; Tokhi *et al.* 2018). While this criticism is valid and strongly underscores the need to study men's involvement and engagement beyond an instrumentalist perspective, it is important to discuss why studying their emotions and vulnerabilities matters.

Daniels (2008) writes that it is only when we recognise men's vulnerabilities and see evidence of men's weaknesses, that gender injustices such as in the realm of reproduction can be corrected. For instance, there have been some interventions which have focused on implementing gender-transformative programmes with young boys and adult men in different Indian states which have found that boys and men have changed their attitudes and behaviours towards gender issues such as violence and sexuality (Achyut *et al.* 2011; Das and Singh, 2014; Freudberg *et al.* 2018; Santhya *et al.* 2019). I agree with Hanlon (2012, p. 66) who argues: "we cannot understand power and dominance without appreciating men's emotional lives. Moreover, we cannot deconstruct male power without reconstructing the emotional lives of men". Thus, to address the unequal gender burden of women in maternal reproductive health and focus on promoting the involvement of men from a Critical Studies of Men and

Masculinities (CSMM) perspective, it is important to understand men's emotions and masculinities. Furthermore, Draper (2003, p. 753) argues that the "lack of having an embodied experience of pregnancy means that men are always able to opt in and opt out of their involvement physically. They can be focused on their everyday lives, frequently their paid work, rather than on the minutiae of the progress of the pregnancy"; yet this should not be read as automatic evidence of their lack of involvement. Thus, for men, their subjectivities, emotions, and vulnerabilities remain largely unknown despite shaping their experiences and constructing their masculinities in the realm of reproduction.

As there are multiple perspectives on emotions, it is important to define 'emotions' and explain how I perceive it in the context of my research. I follow Unnithan-Kumar's (2009) conceptualisation of emotion, inspired from Shweder (2001). Unnithan-Kumar (2009, p. 10) sees emotion as a "complex notion wherein particular sensations of sadness, guilt, and envy are derived from various combinations of wants, beliefs, feelings, and values".

During my research, in some cases, I inquired about expectant fathers' emotions directly, while in others, they themselves shared their emotions and expressions through stories and experiences. In these discussions, four emotions were most frequently referred to: care, fear, anxiety, and guilt. From a demography perspective, Basu (2006) writes that the limited research we have on emotions and reproductive health is mostly about negative emotions and its negative implications on reproductive health. This is also the case for India; except for Unnithan-Kumar (2009), there has been limited focus on looking at emotions and understanding their positive implications for reproductive processes and health outcomes. Thus, in this section, through three different cases, I describe how men's emotions are experienced and deployed in decision making to create a more positive experience and work

towards achieving positive outcomes for their families within their limitations. I also demonstrate how these expectant fathers care about their wives and offspring and invest significant efforts to achieve positive outcomes. Furthermore, I elucidate the different ways in which emotions help these men to construct their own masculinities.

I start with a focus on Shyam Kumar (first introduced in Chapter Four), who became a father for the first time in November 2019. He is a 32-year-old Hindu man, who worked as an employee at a takeaway restaurant. His father was deceased at the time of interview, and his mother had – as a rarity in Rajaji Nagar given the gender norms – full-time paid employment in a factory around 25 kilometres away. This is particularly significant as having well-educated mothers who have participated in paid work is a factor known to be associated with more gender-equitable behaviours and male caregiving in the next generation (McGinn, Ruiz Castro, and Lingo, 2019). He also has a pet dog, usually a hobby of the middle and upper-middle classes in India only, and a rarity in the local community.⁹¹ When I conversed with him in September 2019 during his visit to the TH20 clinic, in response to a question about the changes he had undergone because of his wife’s pregnancy and impending fatherhood, he said: *“Not physical, but I have undergone mental changes. I have become more responsible and caring as there will be a new member.”* (Shyam, TH20 clinic, 12th September 2019).

Following this conversation, we were in touch with each other and on 16th November 2019, a chilly winter morning in Delhi, I woke up to a picture of Shyam’s newborn daughter which he had sent me on my phone around 5.30am. I congratulated him and promised to meet him soon. After a few days, we decided to meet at his house to speak further. When I met him at his house

⁹¹ Here I speak based on my own experience as someone who has lived in India for 25 years. In India, having a pet dog is mostly limited to upper-middle class and upper class households due to the costs involved in maintaining a pet.

in December 2019, his voice and words exuded emotions and happiness. On being asked: “How does it feel after the childbirth?” he said:

“Feeling is good. Thoda (little), feels good, thodi tension, thodi nervousness. Pehle ki jo life thi, yeh dikkatein badh jaati hai. Raat mei sone ko nhi. [With a smile.] Jab so rhe hai toh theek hai. Jab ro rahe hai, are yaar, kya musibat hai? (My earlier life of comfort has changed, and problems have increased. When I am able to sleep at night [when he is not disturbed by the baby waking, needing feeding or changing], it is fine, but when I am not able to, I get a bit frustrated.”
(Shyam Kumar, his house, 19th December 2019)

In the first comment, Shyam acknowledged the emotional impact of this pregnancy on him and highlighted his newly felt feelings of responsibility and care. His usage of the word “caring” hints at what Elliott (2016) terms “caring masculinities” in CSMM literature. Elliott (2016) writes that caring masculinities are those masculine identities that reject domination and its associated traits while embracing values such as positive emotion, interdependence, and relationality, which are exactly what Shyam also emphasises. His remarks about fatherhood challenges and about the emotional upheavals that come with having a newborn in the household are also significant. It is consistent with academic literature which suggests “a father’s perspective about pregnancy and childbirth may include apprehension, concern, anxiety, fear, joy, and ambiguity” (Marie Talley, 2017, p. 1). Furthermore, during our conversation, Shyam also shared instances of his anxiety and fears and the actions he took to address them. The expression of these fears can be construed as his perception of reproductive risk given that childbirth is a process fraught with uncertainty and risk, which he has little control over, as the following comment shows:

“I am visiting the dispensary (TH20 clinic) because I want to have a government record backup for my wife in case, she needs to have an emergency. Else there is Sharma and HMF Hospital [two private hospitals around Rajaji Nagar], because government hospitals sometimes refuse to take people who are not registered with the primary clinic.”

(Shyam Kumar, TH20 clinic, 12th September 2019)

Through this comment, Shyam tells me that while he is not satisfied with the clinic’s services and quality, and that their (he and his wife’s) primary purpose of being registered with the government clinic is to get free vaccinations, medicines, and have the wife’s name registered in government records. This is because, in India, there are cases of women being refused admission in government hospitals if they do not have government identification numbers (Financial Express, 2018) and if they do not receive referrals from the primary and secondary healthcare centres (Khera, 2019) (discussed further below). Therefore, this particular action by Shyam, which reflects his fears about government hospitals refusing pregnant women entry for delivery in the event of a medical emergency, represents his perception of reproductive risk (see Fordyce and Maraesa, 2012), and his actions to address the risk as far as possible. It also demonstrates his care for his wife’s and future child’s health, which is why he is taking pre-emptive actions to avoid any issues during childbirth.

Thus, analysing Shyam’s comments overall, I find that through his transition from just being a husband to an expectant father, to a first-time father, he has become caring and responsible in his actions. His assertions of becoming more caring and responsible are bolstered by my observations outside the pre-determined times I spoke to him. As I visited the clinic for weekly

ANC check-ups on Thursdays, I twice saw him accompanying his wife (12th September and 24th October 2019) to the clinic. The World Health Organization (WHO) recommends a minimum of four antenatal check-ups for a woman during the pregnancy. Assuming that his wife had those four check-ups and I met him at two of these check-ups in a period of two months, this strengthens his claims of being caring and responsible.

Furthermore, as I mentioned in Chapter Five, many CHWs claimed that it is tough to engage with men and husbands as they are usually at work on weekdays. Given this context and Shyam's semi-skilled working class background, it is noteworthy that he makes the time for attending the antenatal care check-up (which is once in 4-6 weeks). On 12th January 2020, I saw his wife Rashmi who had come to the clinic to get some information from the staff regarding her newborn daughter. She was accompanied by Shyam's younger brother. I asked her "Bhaiya nahi aye? (Your husband [referred to as brother by me] didn't come?)", she replied: "*Today he has to go compulsorily [to work], else he always comes.*" It is important to emphasise that Rashmi said "*else he always comes*", which indicates that accompanying his wife at check-ups is a priority for Shyam. Thus, as is seen, Shyam's fear of reproductive complications, his concern to ensure access to medical services and his care for his wife are significant emotions, which he deploys to construct his caring masculinities.

I heard about, and sometimes witnessed, emotions of love, anxiety, and care during my conversations with Shyam. When I conversed with Amit Sharma, a 28-year-old third-time expectant father, he shared an experience of reproductive loss and internal guilt. Sharma had a young son (aged around four years old at the time of the interview). However, his second child, who was a girl, was stillborn due to some complications. Amit attributed this stillbirth to his carelessness, and he felt that the death of his child changed him and made him more responsible

as he prepared for the birth of his next child.

“My last child had died; I had made a mistake. Now I don’t want to do it [make the same mistake again]. Khyal nahi rakha maine. Bahut gandi situation thi. Galti ho gyi (I did not take care. It was a very bad situation. I made a mistake).⁹² My parents were quite affected too. I used to have a government job, but I left as, after my infant’s death, I wanted to care for my wife. I am doing a job where attendance is much easier, etc. Now, I try doing all jobs which included plumbing, manual labour, etc. because I need money.”

(Amit Sharma, TH20 clinic, 9th January 2020)

During our entire conversation, Amit explicitly mentioned his guilt regarding the neonatal death three times. As he was speaking, I observed his body language and facial expressions, which were non-verbal signs of guilt and repentance. I noticed that he slowed his pace of talking, clenched his lips, and shifted his gaze which can be seen to indicate his genuine feelings of guilt (see Julle-Daniere, 2020). During this conversation, my attention constantly shifted between looking at his face, hearing him speak and trying to memorise what he was saying as it was an unrecorded informal conversation. Sharma is cautious and apprehensive about the potential risks for his next child, feeling that his previous lack of involvement in his wife’s pregnancy was the cause of their loss. Thus, during this pregnancy, he is making extra efforts and taking additional care such as spending more time with her and focusing on ensuring that the required medical and non-medical care and other arrangements are in place. His experience has made him fearful of the pre-natal period and the risks during his wife’s pregnancy, leading him to change his job, so that he can dedicate time to his wife, her health and that of their future

⁹² Emphasis added by me.

child.

Sharma indicates that his multiple emotions of guilt and care have made him more caring and responsible, thereby aiding the construction of his caring masculinities. Furthermore, this example also suggests that harbouring an unpleasant emotion and using that emotion positively can potentially lead to improvement of future health outcomes. Indeed, Sharma's comments reveal both his guilt and the construction of his caring masculinities, and, like Shyam, he accompanied his wife twice to her antenatal check-ups at TH20. Even though Sharma was well known as an advocate for caring masculinities, stating that: "*Main hi samjhata hu sabko. Log mujhe Love Guru bolte hai (I am the one who explains to everyone [the importance of managing antenatal care work]. I am known as the Love Guru in my lane)*", he demonstrated did not know the month of his wife's pregnancy was or when his child was due. Studies conducted in other countries (Johnson and Puddifoot, 1996; Kimble, 1991; Armstrong, 2001) have found that fathers' responses to perinatal loss often correspond with their feelings of failure in the role of provider and protector. Armstrong (2001) explored fathers' experiences of perinatal loss and found that in subsequent pregnancies, fathers exhibited a greater need to monitor the progress of their wives' current pregnancies.

Naresh Chauhan, another father in Rajaji Nagar, offers a unique example of conflicted masculinities. Chauhan, a 25-year-old Hindu man, became a father for the first time in December 2019. He was a small-time garment and textile trader, operating in various markets of Delhi. He got married in March 2019 which meant that he and his wife had an immediate conception following marriage. He mentioned that his mother-in-law is an Anganwadi worker (AWW) in the state of Rajasthan, who had come to support them during the delivery period but had gone back after a few days. He has lived in Rajaji Nagar almost his entire life and

currently, he is staying in a rented house with his wife in the same locality, while his parents and brother stay in their family house due to an ongoing conflict between his mother and his wife, who do not like each other. This information is significant because, in India, wives usually go and stay in their husbands' parents' houses after marriage and any deviance from this is either a resistance to traditional and patriarchal norms or due to a particular job posting. However, in this instance, both houses are within walking distance from each other in the same community, which is why Naresh's case is unique and complicated.

During our conversations (7th January 2020 and 22nd January 2020) on the pregnancy process, Naresh Chauhan chose to speak about his experience during labour and childbirth, which offered some insights on how his masculinities are constructed in relation to his family and prevalent gender norms. He shared that he had had to struggle a lot to get his wife admitted in a government hospital for the delivery. This was because multiple government hospitals would not admit his wife for delivery as she did not have any prior consultations or prescriptions from the local clinic which act as a referral for tertiary care.⁹³ This is an issue which Shyam (discussed above) had highlighted as well, and which had led Shyam to be extra careful in ensuring that he and his wife were regularly connected with the clinic. Naresh Chauhan mentioned that he had finally managed to get his wife admitted in a small private nursing home, Jadhav Nursing Home, a few kilometres away from Rajaji Nagar. I spoke to him at length regarding his harrowing experience and general perspectives. Here is a snippet from our conversation.

“Devanik: Say you are giving care to your wife. In our society caregiving is considered

⁹³ Due to the Indian government's extensive focus on reducing maternal mortality rate through institutional births and receiving government subsidies, the absence of a referral from a primary health centre or no documentation could prove problematic and lead to denial of maternal healthcare and entitlements.

a woman's work, what do people in Rajaji Nagar think about this?

Naresh: What can one do? People have to see for themselves. When someone has nobody else to take care of, a man only will have to do it. If in my family, my mother could take care of her, she would do it. But now because of the fight that is not possible.

Devanik: If the relationship between your wife and mother was fine then? What would you want?

Naresh: Then I wouldn't have so much trouble and stress. I would have wanted my mother to take care of her as she has helped me grow and she has more knowledge. I don't have that knowledge, say what should be fed, etc. Mothers can do it the best; nobody can do it like that. We lack knowledge.

Devanik: What do you think about man's involvement in pregnancy when the woman bears the child during pregnancy?

Naresh: I never thought I would do so much, I had to run so much. Aise time pe zyada sharam lagti hai lekin maine is baare me kuch socha hi nahi, socha jo hoga dekha jaega. (One feel shy during situations like these. But I never thought like that, I thought whatever happens I will see). I took her everywhere and did my best.

Devanik: There were indeed many problems during the delivery but when you saw the child how did you feel?

Naresh: Mujhe to bahut khushi hui, jitni khushi maa ko hoti hai utni khushi hui. Key chalo kam se kam meri beti safe to hai, Bohot darr lag raha tha' (I felt really happy. I felt as much happiness as much as a mother feels. I felt at least my daughter was safe. I was very scared.)"

(Naresh Kumar, TH20 clinic, 22nd January 2020)

This conversation demonstrates the multifaceted complexity of Naresh's perspectives on

antenatal care. He points out that due to some ongoing conflict (he did not share exactly what the conflict was) between his wife and his mother, he was the one who managed the antenatal care-related work in his household, although he would have ideally wanted his mother to do so: *“What can one do? People have to see for themselves. When someone has nobody else to take care of, a man only will have to do it. If in my family, my mother could take care of her, she would do it. But now because of the fight that is not possible”*. He also said: *“Then I wouldn’t have so much trouble and stress. I would have wanted my mother to take care of her as she has, helped me grow and she has more knowledge.”*

Naresh’s comments clearly indicate that he would have liked his mother to manage the antenatal care of his wife but due to the conflict, he is living with his wife separately and is “compelled [*a man only will have to do it*]” to manage the antenatal care affairs. Despite this initial reluctance, Naresh took cognisance of the conflict between his mother and wife and took it as a challenge to his masculinity to achieve a positive outcome: *“Aise time pe zyada sharam lagti hai lekin maine is baare me kuch socha hi nahi, socha jo hoga dekha jaega* [I did feel shy as I did not have a thought about this situation, but I did my best and whatever happens, I will see to it].”

As our conversation above demonstrates, Naresh shared his emotions and feelings regarding his newly acquired fatherhood. *“Tab maine use pehli baar godi me liya tha, mujhe bohot khushi hui thi* (*I took her [the baby] in my arms for the first time then. I felt really happy that time*). Furthermore, he made a significant comment which stuck with me. He said, *“happiness equals to that of a mother”*. This signifies two things. First, he recognises that men are the ‘second sex in reproduction’ due to their physical disembodiment from pregnancy. And second, that Naresh wants to be an equal participant in the process, as he emphasises that his happiness

equals that of a mother.

Thus, in Naresh's case, his caring masculinities are constructed in response to the absence of his mother in his antenatal care affairs. Though Naresh also talks about love for his wife and the importance of a husband's support for his wife, ultimately, he would have preferred it had his antenatal care affairs been managed by his mother. Naresh, like many other men in Rajaji Nagar, is conditioned to believe that reproduction is a woman's domain and men should not have much say in it. This argument is further strengthened by this comment, which demonstrates that Naresh did not speak with, or seek guidance from, or interact with his father on this issue.

"Devanik – Did you share this with your family?"

Naresh – Abhi mummy se baat nahi ho rhi hai aur papa se aise cheezo mei baat karne mei sharam aati hai (Currently, I am not on talking terms with my mother and I feel shy talking about these things to my father)."

(Naresh Chauhan, TH20 clinic, 22nd January 2020)

Naresh's example challenges the usual assumption that Indian men mostly practise masculinism and do not exhibit or have any emotional involvement in antenatal care and in relation to the pregnancy of their wives. In this context, I agree with Hunter, Riggs and Augoustinos (2017, p. 2) who write: "it is important that taken-for-granted understandings are critically evaluated. It is particularly important that we focus on the ways in which constructions and understandings of fathering are intertwined with constructions and understandings of masculinity". These emotions and feelings have a significant role in constructing men's caring masculinities, which can lead to better physical and mental health

outcomes for their families. However, the articulation of these caring masculinities is also diverse and plural among Rajaji Nagar's men. Shyam was quite actively involved in the everyday antenatal care affairs of his wife and did not seem to feel compelled to do this. His caring masculinities appeared to be constructed out of a genuine desire to care for his wife and child as well as his own beliefs around the role of men. Amit's newly acquired masculinities around care and responsibility (in addition to striving towards the financial provider ideal) were due to the past stillbirth of his daughter which made him feel guilty and led him to make significant decisions around his life and reorient himself. Finally, Naresh, who challenged familial norms by living separately with his wife but still lamented that he would have ideally liked his mother to manage the pregnancy process as she had more knowledge and awareness. Thus, as demonstrated above, each of these men had their own versions of caring masculinities derived from different events and experiences.

These discussions now lead to the next section, where I will go beyond individual men's experiences to examine how men's relationships with their kin members affects their experience of maternal health and their masculinities.

6.1.2 Expectant fathers' construction of masculinities in relation to their kin members

As argued by multiple scholars and discussed earlier in this thesis, the concept of masculinities is inherently relational and dynamic (Philip, 2022; Srivastava, 2012; Brittan, 1989; Connell, 1989) and thus, it is imperative to analyse these masculinities within the wider gendered context of the household. In my research, I found a strong emphasis on expectant fathers' relationality with their mothers, of varying degrees and attitudes. Although multiple expectant fathers spoke about the role of their mothers and their dependence on these women for their own reproductive

futures, I would like to start with the case of Imran Ansari because his case represents how men's masculinities can be subordinated to their mothers' wishes and control.

I met Imran at one of the ANC check-up days (3rd October 2019). He was 30 years old and expecting his second child (his first child was five years old at the time). Initially, when I asked him about his role in the pregnancy, he said: *"I cannot tell much. My mother only manages this. Or my Devrani (sister-in-law) will do this. I am not involved much. I do not know the month of pregnancy. Auratein hi dekhti hai, mujhe pata nahi. (Women only manage, I do not know much.)"*

A bit later, as he opened to me and talked further, he told me – with a look of disappointment on his face – that he had wanted to delay having more children, but he bowed under pressure to his mother's demand for a child. He said: *"Meri mummy ne bola ki pehla baccha 5 saal ka hai. Ab kar lo. (My mother said your first child is five years old, it has been a gap.) Mujhe thoda baad Mei chahiye the. (I would have wanted a bit later.)"*

Imran's comments suggest that he was unable to challenge his mother in the reproductive decision-making domain and he had to conceive a child at that point in time. Thus, it is evident that his mother overrode his reproductive choice and used her dominant position and agency to assert the need for him to have a second child, which he (and possibly his wife) did not yet want. Furthermore, his comments also tell us that his inability to resist his mother's imposition is increased by the fact that it is only the women in the house who manage antenatal care, most notably his mother and sister-in-law. This deeply personal experience as shared by Imran reveals that, despite the dominance of hegemonic masculinities, at times a husband's agency may also be limited in familial settings where their mothers hold supreme power. The

consequences of Imran's mother's decision will have to be borne by both Imran and his wife, while also producing, in him, emotional and personal feelings of being inadequate, as he was unable to shape his own reproductive processes and because his own notions of masculinity were subordinated to meet his mother's instruction.

Although no other men from Rajaji Nagar shared accounts of their agency and masculinities being subordinated to their mothers, they did speak about the different ways in which their participation and caring masculinities were influenced and constructed. Let us look at the following comments from different expectant fathers.

- *“Devanik: Did you share your anxieties regarding the pregnancy with your mother?”*

Shyam: I shared with my mother, and she used to scold me also as sometimes we take it a bit lightly. Mother scolded me that ladies are the ones managing it, you won't understand it.

On being asked about his paternity leave when his wife gave birth, he said:

We get one month leave in year, for whatever reason. Starting, the mother took a leave of 15 days, then I took it. Later, also, you need it. So, we managed it somehow.”

(Shyam Kumar, his house, 19th December 2019)

- *“To be honest, I am involved because my mother is taking care of my sister ,who is pregnant as well, so how many people will she take care of?” (Mohd Akram, TH20 clinic, 5th September 2019)*

- *“Sometimes, I sought information from my sister who stays in Dwarka with her in-laws. As she lives in a more educated family, she has good knowledge.”*

(Sanchit Kumar, TH20 clinic, 11th September 2019)

As one can see, these expectant fathers have a significant reliance on their mothers (and other female family members) for antenatal care support and information. These findings echo the current literature on the role and power of mothers-in-law in influencing reproductive decisions (Barua and Kurz, 2001; Bloom *et al.* 2001; Robitaille and Chatterjee, 2014; Blanchard *et al.* 2015; Speizer *et al.* 2015; Varghese and Roy, 2019; Anukriti *et al.* 2020), though my findings are from the viewpoint of the son/husband rather than the daughter-in-law/wife.

6.2 Performance of masculinities

In the previous section, I discussed how expectant fathers deploy their subjectivities, emotions, and situations to construct caring masculinities. In this section, I explore how these newly constructed masculinities and their ideals are performed by expectant fathers. I elucidate this performance through three different pathways: a) masculinity and financial provision; b) seeking pregnancy-related information and guidance on the internet; and c) assisting in household work. The first two pathways were the ones most emphasised by expectant fathers and the latter two to a slightly lesser extent, and this has some implications for how caring masculinities overall are understood and performed. The section below draws on Butler’s (1990) theory of gender performance, which refers to the idea that gender is something inscribed in daily practices, learned, and performed based on cultural norms of femininity and masculinity (Figuera, 2016). Inspired by Butler, I use the term ‘performance’ in relation to

expectant fathers performing their caring masculinities through different actions and efforts, which consolidate their ideas of ‘being expectant fathers’.

6.2.1 Masculinity and financial provision

A key aspect of hegemonic masculinities is the provider and breadwinner role undertaken by men. This aspect means that there is a general expectation from society that a man must be able to provide adequately for his family to live up to the ideal of manhood (Haas and Hwang, 2008). In Rajaji Nagar, almost every expectant and new father I spoke to shared his concerns about finances and explained his efforts to shore these up for their future children. Being the primary financial provider is an ideal perpetuated through hegemonic masculinities, and men, in India and elsewhere, are expected to construct their identities as fathers through paid work (Hunter, Riggs and Augoustinos, 2017, p. 3). In Rajaji Nagar, these expectant fathers were anxious about fulfilling this ideal and providing for their families.

Amit Sharma, introduced in the previous section, who shared his grief and guilt about a stillbirth, and left his government job to be able to spend more time caring for his wife, also expressed financial anxieties as mentioned in Section 6.1. However, Amit’s life portrays a more complex engagement with this masculine ideal. As mentioned in the previous section, he left his government job after his baby’s neonatal death. A government job is highly prized in India, and a man having a government job is highly regarded in the marriage market. Thus, leaving a government job to be at home more, and having more time at one’s disposal to accompany one’s wife to the clinic in the hope of having a safe pregnancy and childbirth is, in the case of Amit, a significant rejection of a much-valued ideal of hegemonic masculinities in the Indian context.

After leaving his government job, Amit focused on contractual jobs such as plumbing, manual labour, and other similar tasks to make ends meet and to provide for his family. Through these actions, and despite his anxiety, he is hoping to combine financial security with a more hands-on compassionate role as an expectant father; in other words, combining the ideals of caring and hegemonic masculinities. Combining these different forms of masculinities is not, however, without challenges. For example, the government hospital told Amit that his wife needed to have a routine ultrasound examination, but given that there are long waiting periods in public hospitals, many people get it done at a private clinic (the government one is free). As Sharma said: “*Yes the doctor has told me, but I have to think about money as well*” (TH20 clinic, 9th January 2020) which highlights his anxiety about being able to (or not) spend money for a private ultrasound test. Despite being aware of the importance of an ultrasound test, Amit was in two minds due to financial worries. Thus, in seeking to establish a more caring masculinity, Amit has found that he is not able to perform the desired hegemonic masculinity ideal of being a financial provider in the way he would have wanted to. His comments suggest a sense of despondency and highlight the economic privilege experienced by other expectant fathers who choose to or are better equipped to fulfil the criteria of dominant and successful masculinity and fatherhood (Strier *et al.* 2014, cited in Malinga and Ratele, 2022, p. 274). His comments also show that it is not always easy to combine different forms of masculinity and that, depending on one’s circumstances and choices, achievements in one version of masculinity may undermine one’s prowess in the other.

As such, Amit’s position and masculinities differ from those of Shyam, whose financial situation is better than Amit’s and who was able to demonstrate his caring ideals as well as perform his hegemonic masculinity ideal by paying for two ultrasound tests in private hospitals:

“At the government hospital, they gave us a date of four to five days later for ultrasound. Then we thought, that the better the sooner. Immediately, we thought of going to the private rather than waiting for five days that’s why two ultrasounds we got it done outside at Surya Labs [a private lab outside of the public health system].”

(Shyam Kumar, his house, 19th December 2019)

Thus, while Shyam and Amit both recognise the significance of getting an ultrasound quickly to get an update on the health of their unborn children, the former has the means to achieve and perform his financial provider ideal, but the latter is unable to do so. Shyam is probably one of the few men in Rajaji Nagar who can afford a private ultrasound test,⁹⁴ and Amit’s situation is more representative of the wider situation in Rajaji Nagar, where all the other men as well as CHWs mentioned that they must wait for several days to get an ultrasound and they cannot afford private ultrasounds. Just one ultrasound test would cost around 15-20% of their monthly income.

Vinod Das, a 34-year-old third-time expectant father shared how he and his wife had planned to have two children only, but they ended up having a third pregnancy accidentally, which he termed a mistake. This put more pressure on him to ensure adequate finances, and he said:

“I used to work in a factory, but since this pregnancy, I have been driving a rickshaw for money. I wanted to earn more and live independently, and it gives me flexibility.”

During our conversation, I asked him: “what constitutes care for your wife and future baby?”, to which he said, “*Dekhbhal (Keep up) means money*” (***with a gesture with his***

⁹⁴ The cost of an ultrasound/sonography test is around INR 1,500-1,700 (GBP 15-17). In addition, the transport cost for two people travelling for the test would be between Rs 70-100 return trip on a shared autorickshaw (GBP 0.7- 1).

fingers, see Figure 22 below). “Care toh karni padegi, khyal rakhna padega (I have to take care. I have to be careful about my wife). I have to earn money because one should be able to manage expenses. My factory job was seasonal hence you could earn for few months, then no income at all but I have fixed costs.”

(Vinod Das, TH20 clinic, 19th September 2019)



Figure 23 Financial gesture

(This is the gesture Vinod Das made (referred to in the comment above this figure) while talking about finances and care. This gesture is mainly used to refer to money-related matters in India.)

Das is anxious about the financial expenses associated with an impending third child and thus he changed his job, believing this will give him some flexibility to decide when he works and thereby enable him to both manage his time and make more money than he had done in his seasonal factory job. His notion of the kind of care that he as a husband and father can provide is a form of caring masculinities. Yet it is also strongly tied to being able to comfortably manage financial expenses for his family, thereby reflecting and reinforcing the hegemonic masculinity ideal of men being the primary breadwinners and providers (Hunter, Riggs and Augoustinos, 2017). The efforts of these three fathers – Vinod, Amit, and Shyam – thus

represent their performances of intersecting hegemonic and caring masculinities. In addition to comments on financial provisions, anxieties and challenges by Amit, Vinod, and Shyam, other expectant fathers also shared their concerns as shown in the quotes below. The emphasis on finances by most fathers signifies the importance of this ideal.

- *“My monthly income will remain the same, but the costs will increase so I am worried about that.”*
(Imran Ansari, TH20 clinic, 3rd October 2019)
- *“After few months, I will get a life insurance scheme for my daughter which will be a support from my side.”*
(Sanchit Kumar, TH20 clinic, 11th September 2019)
- *“I have planned and sorted out my finances for the upcoming future as of now.”*
(Gulshan Rajput, TH20 clinic, 20th February 2020)

While these discussions and quotes highlight the significance and importance of financial provision/stability in the minds of these expectant fathers, I also witnessed the role of families in emphasising the financial provider ideal among their sons. This again reiterates the previously discussed argument of how masculinities of expectant fathers are influenced by their own kin and households. For example, on 20th February 2020, an ASHA worker, Prem Lata, took me to speak with Rekha, an eight-month pregnant mother and her in-laws. As I was speaking with her initially and later, her in-laws, I told them that I would like to speak with the expectant father (who was not home at the time of the conversation). On hearing about my research and my desire to meet his son regarding his experiences of pregnancy and antenatal

care, Rekha's father-in-law said: *"Woh kuch nahi bol paega. Humne use bahar rakha hai in sab se. Maine bola hai, tu Naukri pe dhyan de. Yaha sab kuch hum dekhenge so main aur inki mummy le jate hai dispensary. (He would not be able to say anything. We have kept him out of it. I have told him. You focus on your job, here your mother and I will manage it and we will take her to dispensary or check-ups whenever required)."* At that point, Rekha's mother-in-law interjected and said: *"Nothing like that. You please let him [the son] speak for himself. He will share his views. You come next month and speak to him."*

Though I was not able to speak with Rekha's husband due to the COVID-19 pandemic, this conversation signifies that Rekha's husband's father clearly had assigned the role of a financial provider to him while they manage his wife's pregnancy and related issues. And in this case, surprisingly, Rekha's mother-in-law interjected and stated that her son would indeed have something to share. This also reflects the role of parents; in this case, the patriarch of the family in influencing his son to perform his hegemonic masculine provider role, rather than adopt a caring masculinities approach which sought to balance emotional care and financial provision like other expectant fathers described in this chapter. This incident is representative of how Indian families engender their sons' masculinities to fit within and sustain the wider patriarchal system (Philip, 2018).

In addition to the societal and family pressure put on husbands and expectant fathers to ensure financial provision, a comment by an Anganwadi worker Anjali sheds light on how young boys are influenced into prioritising their financial provider role at all costs. I share a snippet of our conversation below.

"Here they are some families who have four to five sons. Bahut badi families hai (there

are huge families here). Then they stop. In every area. Not only in this area [in that lane of Rajaji Nagar where Anjali's Anganwadi centre is situated], but everywhere. The boys which are here study till 5th/6th [grade, then] start working. They are auto drivers or work in shops. Thoda yaha ka mahaul bhi sahi nahi (the area's environment is also not right). I haven't seen boys studying here, very few. If parents are invested then its fine, but very few parents are literate here. I won't say people aren't economically well off. There are very poor as well as rich people but when they don't have education, they just think of earning. Kamate jao kamate jao. (Just keep on earning and earning.) They don't think that our sons should study a bit. 12, 13-year-old boys are working at shops. Their parents have a lot of money and have given out many houses on rent. Here there are very few boys who go to school."

(Anjali Bantwal, Gali number 5 Anganwadi centre, 7th March, 2020)

Thus, Anjali's comments clearly suggest that, from a young age, many families – even those who are financially better off than most – focus on getting their boys to work and earn money, thereby inculcating the importance of being the financial provider for their families over educational achievements. While no other CHW mentioned this, this comment helps to understand expectant fathers' prioritisation of the financial provider ideal. Most of the expectant fathers I spoke to had been living in Rajaji Nagar for several years after migrating from neighbouring states where similar norms prevail, and thus were very probably influenced by these norms and practices from a young age. These discussions also demonstrate that the Indian State's positioning of men as breadwinners and financial providers is also replicated at the household level.

Overall, these discussions and findings on expectant fathers' need to ensure financial provision

are echoed in literature on male involvement in maternal health in countries such as Tanzania, Malawi, Nepal, and Chile where many studies emphasise the importance of performing and achieving the financial provider ideal in the context of pregnancy and child-rearing; and where the provision of finances is considered a key parameter of men's involvement in antenatal care as well as fatherhood overall (Greenspan. *et al.* 2019; Muheirwe and Nuhu, 2019; MacMohan *et al.* 2016; Story *et al.* 2016, Thapa Kaji and Niehof, 2013; Kululanga *et al.* 2012; Olavarria, 2003). For instance, the study by Greenspan *et al.* (2019) found that, in rural Tanzania, men often struggled to fulfil the role of a financial provider when seeking expensive maternal care. In Ghana, Story *et al.* (2016) found that the lack of financial provision from husbands led to delays in accessing antenatal care for their wives and financial burdens on other family members. However, given my thesis's focus on analysing men's masculinities and relationalities through a CSMM lens, my findings resonate more closely with Hanlon's (2012) research on Irish men where caring masculinities were found to be strongly perceived to be tied to breadwinning and paid work (Jordan, 2020, p. 25).

My findings show men trying to create opportunities to meet the ideals of both caring and financial masculinities and, furthermore, highlight the potential ways through which these hegemonic masculinities ideals are thrust upon young husbands by their family members which in turn helps to sustain these norms within the household.

6.2.2 Seeking maternal health information online

As discussed in Chapter Two, in the development studies and public health literature, almost all male involvement indicators – be this antenatal care attendance, attendance at mothers' check-ups, ensuring a skilled attendant at birth, or men's presence during labour – have a

“medicalisation of birth”⁹⁵ undertone. In other words, all these indicators are somehow linked to presence in medical institutions and clinical interventions. Through my research, I attempted to examine this approach and focus on investigating different indicators of men’s involvement in antenatal care.

In Rajaji Nagar, multiple respondents emphasised to me that one way in which men could show their involvement – in other words, perform their caring masculinities – is through their knowledge of maternal health issues and their ability to find relevant pregnancy-related information through different channels. More specifically, the use of the internet to seek information is seen as a way in which men express their commitment to maternal and reproductive health issues in their families and seek to ensure the ongoing wellbeing of their wives and newborn children. The internet is important to men’s performances of masculinities because both socially and culturally in India, there are deep interlinkages between perceptions of and access to technology, and masculinities, as the society-specific understanding of masculinity and femininity creates a situation where “technologies are usually regarded as a typically ‘male’ domain and women are regarded as incapable of handling them” (Nikpur, 2015, p. 5). Furthermore, Lohan (2000, p. 902) writes, “which is considered technological is also perceived to be masculine, emphasising the cultural association of technology/technological virtuosity with men, hegemonic masculinity, and status. By contrast, women’s everyday encounters with technologies are rarely recognised as representing technological competence”. During an interview with Dr Kavita, a policy professional and the

⁹⁵ Medicalisation of birth has been used as a phrase to signify the increase in clinical interventions over women’s bodies during pregnancy and childbirth. For instance, in high income countries, the involvement of obstetricians and medical interventions has become routine without much evidence of it being effective. For a more detailed discussion, see Johanson, Newburn and Macfarlane (2002). In my context, I use the phrase because all indicators for men’s involvement are somehow linked to the medical technology and presence in health institutions and do not include socio-cultural and emotional factors.

dean of a nursing school, she said: “*Men are interested in high technology things*”. Thus, in the Indian context, men are usually drawn to, and associated with, activities which are technologically more advanced, and use this as part of their performance of masculinity – yet men’s adoption of technological information about maternal health is interesting because it offers an intersection between hegemonic masculinities (men in control of technology) and caring masculinities when they use this technological dominance to look up information about maternal health and apply it for the benefit of their wives and families.

In Rajaji Nagar, men from working class backgrounds have access to high-speed internet⁹⁶ on their mobile phones and, as they told me during conversations, they are leveraging the internet to access information regarding pregnancy and childbirth issues. Prior to 2016, most of the men in Rajaji Nagar would not have been able to access the internet and watch high speed YouTube videos. Yet by 2019, expectant fathers were actively embracing this, as I witnessed and heard. Below, I share their comments.

- “*YouTube/Internet is a major source of information for husbands. Education is important and how much information the man has and how much information the man is trying to collect; that I am being more responsible, and a major responsibility (the birth of my child) is coming soon. It is said that you should know as much as possible about a coming musibat [it means problem, but he is referring to the baby in this case]. The more you know, the better it is, whether it is through friends or net [the internet] or guardians.*”

(Shyam Kumar, TH20 clinic, 12th September 2019)

⁹⁶ This development has been aided by an economic decision taken by a large telecom company which made internet data both accessible and cheap. Due to this explosion of extremely cheap data schemes and packages, India has the lowest cost of mobile internet globally per gigabyte. At the time of the interview, a data pack for 2.5 GBP per month (INR 250) gave you two gigabytes of data daily for free.

- *“I get my information on pregnancy-related topics from YouTube. I have been working for Zomato⁹⁷ for one year and ever since then, I have been using net [the internet] significantly for finding information on these issues.”*

(Mohd Akram, TH20 clinic, 5th September 2019)

- *“Right now, there is access to the internet, and we get our information on pregnancy, health, and diet plans from there. I speak to my office friends who have experience on what to do, how to do. There is YouTube, Google. You can find anything there on these issues.”*

(Deepak Gaur, TH20 clinic, 5th September 2019)

In addition to these men whom I spoke to individually, all expectant fathers who came to the clinic on ANC days were mostly busy on their mobile phones (mostly playing games or surfing the internet) as they waited outside the TH20 clinic for their wives to finish their consultations. The three men quoted here, Shyam, Akram, and Deepak, stress the importance of YouTube and the Internet as major sources of information on pregnancy-related topics such as diet and things to do and not do. These expectant fathers put in efforts to curate pregnancy-related information online and used the information with the hope of ensuring better health outcomes for their wives and future children. I suggest that the effort to search, read, and implement the knowledge acquired online is a performance of their caring masculinities.

This performance is also aided by their professional employment as these three men were all in customer-oriented employment, which requires a good working knowledge of the internet.

⁹⁷ Zomato is a popular food delivery app, like Uber eats or Deliveroo in the UK.

Shyam worked in a take-away restaurant, Akram worked as a delivery executive for a technology company that specialises in food delivery through an app, and Deepak as a shop assistant for an international fashion firm in a shopping complex. All these roles require good communication and effective technology skills, which has probably made them aware of the role of internet in seeking information. However, Naresh Kumar, who was a small-time garment seller and trader – and therefore not in customer or technology-oriented employment – also explicitly mentioned using the internet for accessing reproductive health information.

“Devanik: Do you know how to use YouTube? Have you seen any tips on it?”

Naresh: Yes, I saw many things on phone as to what I should feed my wife and child. I see videos. I saw a lot about pregnancy and the treatment process. It tells a lot.

Devanik: So, your wife must be knowing how to use a mobile phone?

Naresh: Yes, she knows everything.

Devanik: So, she must be using it for taking information.

Naresh: No, only I tell her about what could be helpful.

(Naresh Chauhan, TH20 clinic, 22nd January 2020)

Naresh’s comment is significant because he does not have internet-oriented employment and he still accesses pregnancy-related information. The second part of the conversation reveals then complicates his claims. His comment: *“No, only I tell her about what could be helpful”* clearly indicates Naresh’s dominance over his wife even though his wife is more educated than him and was a former cabin crew trainee (as told by him).

This association between men and technology, and its manifestation in the idea that expectant

fathers should mine information about maternal health, also results in women requiring permission or waiting to be told that it is okay for them to also source information. This was evident when I went to meet Rekha (introduced above). She said *“I look at diet charts and nutrition on the internet/YouTube. My husband does not have time himself due to his job, but he compels me to look at them and follow them.”* (Her house, 13th February 2020)

As shown above, some semi-skilled working class men in Rajaji Nagar have a strong interest in, and trust of, the internet as a channel to mine information on pregnancy and antenatal care (diets, nutrition, and dos and don'ts). Even when they do not have time to look at it themselves, they ask their wives to do so as seen through Rekha's example. Therefore, the efforts made by them to find information online can be construed as an indicator of men's involvement and a performance of their caring masculinities with the aim of improving health outcomes for their wives and future children. Furthermore, it is evident that the impact of the post-2016 cheap internet data revolution⁹⁸ in India extended to the reproductive maternal health domain.

These findings build upon the existing literature on how access to technology and the internet provides a strong catalyst in improving husbands' knowledge and, ultimately, their wives' access to healthcare. For instance, an evaluation of an 'm-health' intervention in Uttar Pradesh by Hazra, Khan and Mondal (2019) found that providing husbands with knowledge on maternal child behaviours on their phones enhances their knowledge and increases their wives' access to proper antenatal and post-natal care. Although, as mentioned earlier, mothers-in-law in India yield significant power and influence on maternal reproductive health issues and related decision making (Barua and Kurz, 2001; Bloom *et al.*

⁹⁸ The impact of this widespread access to internet data was felt across the country in many ways, even affecting the ways in which political campaigning is managed. For a detailed review, see Mehta (2019).

2001; Robitaille and Chatterjee, 2014; Blanchard *et al.* 2015; Speizer *et al.* 2015; Varghese and Roy, 2019; Anukriti *et al.* 2020), accessing information online provides a way for men to bypass their mothers and seek information independently, thus circumventing traditional sources and challenging the authority of mothers in the antenatal care domain to a certain extent. Even though this resistance of their authority may not be visible or direct, these acts have enabled men to diverge from a situation in which their mothers are the sole authoritative experts on childbirth issues and, in so doing, they have been able to challenge their own exclusion from maternal care roles. Prior to the advent of the internet and the availability of previously protected information, husbands would have been even more excluded from the domain of childbirth (see Chapter Four for a discussion of men's exclusion from maternal health policymaking).

As shown above, even women from lower classes and lower-middle classes are – with their husbands' permission – accessing pregnancy information online, as compared with pre-2016, when this kind of access to information was limited to middle and upper class backgrounds (Jayaseelan and Pichandy, 2016). This democratisation of information has enabled men's greater involvement and participation in antenatal care and is an area for further research and policy considerations.

6.2.3 Assisting in household work

Thus far I have examined how expectant fathers focused on achieving their financial provider ideal and sought information regarding antenatal care and pregnancy on the internet; in other words, performing their caring masculinities to achieve good maternal health outcomes for their families. However, three expectant fathers shared how they are performing their masculinities by assisting in household work as the following comments demonstrate.

- *“Currently, in terms of care, I do the heavy work in the house such as lifting things and carrying stuff from one place to another.” (Gulshan Rajput, TH20 clinic, 20th February 2020)*
- *“Taking care means preparing food, washing clothes especially jeans, which require a lot of efforts.” [On being asked what being involved in antenatal care means to you?] (Amit Jadhav, TH20 clinic, 13th November 2019)*
- *“I do not let my pregnant wife do heavy stuff. We also cook food together.” (Mohammed Akram, TH20 clinic, 11th September 2019)*

Husbands’ assistance in household work was also mentioned to me by an expectant mother. On an antenatal check-up day (19th September 2019) at the clinic, I was able to speak briefly with Hazara, a second-time expectant mother. When I asked if her husband was involved in antenatal care, she said: *“My husband makes hot milk for me and does other small tasks as I cannot climb upstairs in this condition.”*

The unequal distribution of domestic care work between men and women is one of the most important stumbling blocks in the fight against gender inequality (Chopra and Zambelli, 2017; Chopra, 2018; Singh and Pattanaik, 2020). Given the strong gendered nature and dynamics around domestic work, I suggest that beyond performing masculinities through financial provision and seeking information online, assisting in unpaid domestic work is a good indicator of caring masculinities and a sign that normative ideas around masculinities and fatherhood are being challenged. However, while expectant fathers’ claims of assisting in domestic work must

be acknowledged and encouraged, given the fact that few expectant fathers mentioned it explicitly and even the ones who did, did so only briefly, we must distinguish between men ‘helping’ their wives in domestic work and those who undertake their fair share of household work, which is unlikely as Olavarria, (2003, pp. 336-337) found in their research on working class fathers in Chile and Mkandawire and Henriks (2019) found in Malawi. Burgher and Flood (2018), working in Mizoram, India also found that, despite fathers’ involvement in caregiving, ultimately mothers perform the bulk of parenting and care work. However, they also argue that, within this arrangement, lie the possibilities of transforming gender relations, even if this transformation is gradual and constitutes daily tasks that may not be classified as revolutionary.

However, not all Rajaji Nagar’s expectant fathers sought to take on or help in domestic chores. Just few weeks after the birth of Shyam Kumar’s daughter, when I visited his house for an interview on 19th December 2019, I saw his wife nursing their daughter. When I sat on the chair, Shyam asked his wife Rashmi to go and prepare tea for me rather than doing it himself, which I felt a bit awkward about (although I did not say no to the tea). Thus, while some of Rajaji Nagar’s expectant fathers are adopting caring masculinities through new and innovative performances, I did not find any indications of a radical upending or even transfer of domestic work to men. In this context, I find myself agreeing with Jordan (2020), who argues that caring masculinities may not always be deployed in a way that strongly resists or challenges the gender hierarchies. In her research on fathers’ rights groups in the UK, Jordan (2020, p. 36) found “caring masculinity is currently frequently expressed in ways that are far from ideal in feminist terms and may incorporate, rather than reject, domination”. Therefore, the concept of caring masculinities needs to be deconstructed further in different contexts and requires further research at the intersection of care, masculinities, and maternal health.

6.3 Negotiation and navigation of masculinities

6.3.1 Within the household

In addition to showing concern and accessing knowledge of pregnancy and childbirth, some expectant and new fathers in Rajaji Nagar are resisting, navigating, and negotiating local gender norms within their families and the local community. Their caring masculinities guide their behaviours and decision making in relation to reproduction within their families. Rather than seeing this as the domain and work of women, as indeed many men do in Rajaji Nagar, these men carefully navigated the prevailing norms of hegemonic masculinity, finding ways to construct their own masculinity ideas which assert their interests and desires. In this section, I focus on how some expectant fathers navigate and negotiate norms within the household to perform their caring masculinities.

I highlight the example of Mohammed Akram, a 34-year-old third-time expectant father (briefly mentioned in Section 6.2.1). At the time, Akram had two children, and his wife was pregnant with their third child. He said: *“My dad sees me doing household work and abuses me”*. As this comment shows, Akram’s father does not fully approve of his caring actions, which are a form of resistance to the local norms around women’s roles and care work.

Gulshan Rajput, a first-time expectant father, like Naresh Chauhan who moved out of this natal home due to a conflict between his wife and mother, told me that he was able to exercise independence from his mother, navigate patriarchal norms, and focus on his own choices. He also shared that his father was no more. When asked about his engagement with parents, he said:

“I don’t engage with my mother much. Right now, I am having a fight with her, and we aren’t talking much. My wife and I do the decision making. I did not even tell them [his parents] about the miscarriage.”

(Gulshan Rajput, TH20 clinic, 20th February 2020).

When I met Gulshan, it was about a year since his wife had had a miscarriage, which is why they took the decision to have a gap before conceiving again. He told me that he and his wife are the primary decision-makers, and he does not engage with his mother on reproductive issues. This is an example of how men – potentially in solidarity with their wives – navigate familial norms and expected hegemonic masculinity norms to have better control over their reproductive decision making. It is noteworthy that Gulshan Rajput is only a school graduate while his wife holds an undergraduate degree. Studies in India (Jungari and Paswan, 2019; Yadav *et al.* 2021) suggest that higher education levels of husbands are correlated with better maternal health outcomes. Thus, Gulshan’s case is unique as he is less qualified than his wife and this could also possibly explain the limited influence of Gulshan’s parents on this couple’s decision making. He also told me that he had a love marriage, a deviance from arranged marriages in Rajaji Nagar, which potentially explains his distance from parents regarding reproductive decision making and his ability to exercise his independence.

It must be noted that expectant fathers who spoke about navigating and negotiating different masculinities within the household were the ones who lived in joint families, which again highlights the intersection of family type and men’s involvement in antenatal care.

6.3.2. Within the community

During my interviews and conversations, as I spoke to multiple people, I became curious to

know what motivates men to challenge the hegemonic masculinity ideals in the context of their communities and to practice caring masculinities, as well as how they do this. Gammeltoft (2007, p. 136) writes: “experience is always, by definition, intersubjective, arising out of social interactions and relationships in lived worlds. An individual’s experience cannot be understood without deconstructing it by showing how it is continually fashioned, challenged, and refashioned during everyday lives”. The above discussion shows that men were, in part at least, influenced by their parents, wives and previous childbirth events. Building upon Gammeltoft’s (2007) arguments, I inquired further about expectant fathers’ interactions with other men in Rajaji Nagar. These conversations suggested that while their masculinities and social norms are usually developed through interaction with their friends, local surroundings and hegemonic or local notions of masculinity, this may not always be the case. Men such as Shyam, Sanchit, Amit, and Akram navigate their own masculinities vis-à-vis local masculinity norms. This is indicated in the following two quotes from Sanchit Kumar and Shyam Kumar.

- *“Insaan ki soch hai. Jo bolne pe nab hi badal sakti ho na bhi bhi badal sakti hai. Like they told you, Kya lugaio wale kaam kr rha hai ya aur auratein wale. (It is up to a person’s mindset, which may not change even after explaining to them. They will say you are doing feminine tasks.) Either they listen to friends, who are just friends in the society, or they listen to their wives with whom they are staying. So, it is up to them as to how they utilise their brain. For e.g., there is a non-drinker person who will be nudged by his friends to drink. ‘Arre pee le, koi baat nhi’ (‘Go on drink it, nothing will happen’). But it is up to him, whether he wants to drink or not. So, he may take any decision but later, it can become an addiction. Hence, people think that their name in the society may be affected. But with me, it does not make a difference to me. Whether it involves ignoring a couple of people or becoming bad in front of*

them.”

(Shyam Kumar, his house, 19th December 2019)

- *“A man can change if he wants to. You can educate the person but if he isn’t right, then nothing will happen. (When asked about caring and taking responsibility of one’s pregnant wife’s needs and desires). “Insaan jaisi sangati mei rehta hai waisa hi hota hai.” (A man’s company surrounding shapes his behaviour.)*

(Sanchit Kumar, TH20 clinic, 11th September 2019)

Both, Shyam and Sanchit emphasise that, while a person can be educated and made aware of different ways of behaving, he will only change if he really wants to. Shyam explains this using the example of alcohol addiction to show that a man may be persuaded and coaxed by his friends to drink alcohol but ultimately it is up to him whether he becomes an addict. Sanchit also stresses that a man’s company shapes his behaviours and perspectives, but those individual men make their own choices, thereby implying men can navigate local norms, practices, and masculinities to perform their own, somewhat divergent, masculinities if they choose to. These men’s engagement with their friends on antenatal care and pregnancy also finds mention in other conversations. Two expectant fathers reported having discussions around antenatal care with their friends. Amit Sharma, the 28-year-old expectant father introduced earlier, whose loss of a child led to him to be more caring and to pay attention to antenatal care said, when asked whether he discussed this with his friends:

“Mai hi samjhata hu (I only explain to them). I have a friend who is a model and is too occupied in his modelling while his wife is pregnant. I told him that you have done enough modelling, now you should focus on your upcoming child and

take adequate care [of your wife and child].”

(Amit Sharma, TH20 clinic, 9th January 2020)

Akram adds that he also discussed the importance of ensuring that he, as a husband, provided adequate antenatal care with his friends but said that these are not always easy conversations to have and that there are challenges. While Akram tries to explain the importance of caring for his wife to other men, he told me that some men feel that he is attacking their masculinity through his insistence on doing ‘feminine’ tasks. He said: *“My friends make fun of me and say ‘Tu Biwi ka Ghulam hai’ [you are your wife’s slave]. Mai haske nikal deta hu. Tumhare kismet mei nahi hai kaam karna biwi ke lie. (I pass it off through laughter. I tell them it is not in your destiny to care for your wife).”* He further added: *“If you try to explain to other men [about the importance of caring for their pregnant wives], they will feel that you are trying to make them ‘kamzor’ (weak).”*

While these expectant fathers shared their discussions around antenatal care with their friends, at the clinic, expectant fathers who waited for their wives outside the clinic’s main area were mostly alone and on their phones. Over the course of my fieldwork, I hardly saw any expectant fathers striking up a conversation with another expectant father even though they waited for hours outside. This was contrary to pregnant women in the queue, who often struck up conversations with other women and chatted with each other. These are gendered observations that indicate the lack of mutual solidarity and connections among men regarding expectant fatherhood. These observations raise the need for more research on why this is so and its implications for the potential of men’s involvement in antenatal care.

6.4 Conclusion

In this chapter, I answered my third sub-research question: **How do expectant fathers construct, perform and navigate multiple masculinities in the realm of antenatal care?**

Expectant fathers in Rajaji Nagar are leveraging their emotions, vulnerabilities, and fears to construct and perform their caring masculinities, which in turn guides their participation in antenatal care. These findings indicate that within the context of Rajaji Nagar, and potentially in other working class communities in Delhi, expectant fathers are making notable shifts in their behaviours and approach towards antenatal care, a domain which has to date been characterised as typically ‘feminine’ in India. These incremental shifts by a few men are a departure from the conventional notions of patriarchal fatherhood (Olavarria, 2003).

These shifts in how expectant fathers perceive, construct, and perform their masculinities in relation to fatherhood are also influenced by their mothers. Every expectant father I spoke to, made a reference to his mother and her ability to influence their participation, to varying degrees. Yet, no expectant fathers mentioned their own fathers’ involvement or role, or engaging with them or seeking their help. This suggests that there are no male role models for men to look up to or be inspired by who wish to be more involved in their wives’ maternal and reproductive health. Firstly, the lack of discussion or lack of any mention of their own fathers reiterates the essentialisation of reproduction and related work as women’s issues. This means that these men have grown up seeing antenatal care (as well as childcare) as being mainly managed by their mothers with limited involvement of their fathers. Two, the lack of mention of their own fathers signifies the continued dominance and dependence on mothers (or mothers-in-law) in managing maternal reproductive care and its potential influence on the psyche of

these men, who have grown up seeing these issues as mainly women's issues.

The chapter's findings problematise the way caring masculinities are understood and perceived among men as well as by academic researchers working on masculinities. While these masculinities are guiding expectant fathers and influencing their participation in antenatal care, they are not translating into a radical alteration of household work burdens or transforming power relations significantly. This finding reflects those of other studies on men and fatherhood (Lam and Yeoh, 2015; Thao, 2015; Burgher and Flood, 2018) which suggest that increased engagement of fathers in caregiving does not radically alter gender dynamics and patriarchal norms. The caring masculinities of expectant fathers in Rajaji Nagar are strongly tied to their anxieties and efforts around financial provision, which is a continuation of the Indian State's conceptualisation and privileging of men's roles as bread winners. Brittan (1989, pp. 114-115) argues that this male breadwinner model keeps men in a position of power within households. Thus, given the cultural norms around gender roles, being a successful financial provider will inevitably help these expectant fathers to maintain their privilege and power over their wives, regardless of how caring or attentive a husband might be to matters of maternal and reproductive health. This also reflects a collective interest among these expectant fathers to maintain their provider role. Thus, I agree with Jordan (2020) who argues for a more critical interrogation of care, masculinities, and ethics of care, and investigating the ways in which caring masculinities may promote domination rather than reform or challenge it.

Finally, this chapter makes it clear that there are no broader social, cultural and institutional systems in Rajaji Nagar to actively and structurally support or encourage men's involvement in maternal reproductive health. As shown above, these expectant fathers are trying to carve out a space for themselves to be more involved, yet they are not inherently feminist, nor are

their actions disrupting prevailing power relations and gender norms. Rather, as Srivastava (2012) suggests, within the existence of different masculine identities in different forms and different times lies the possibility of creating appropriate policy measures to institutionally support and nurture these forms of caring and masculinities.

In the next chapter, I offer my concluding remarks and arguments for this thesis.

Chapter Seven: Conclusion

This thesis explores men's involvement in antenatal care in India through the lens of various stakeholders, using an in-depth qualitative approach. To do so, it asked the question: **In what ways is men's involvement in antenatal care conceptualised, experienced, and operationalised in an informal settlement of Delhi?**

The thesis shows that men's involvement in antenatal care needs to be understood, analysed, and approached as constituted both through men's behaviours and desires and through the perspectives and actions of multiple other stakeholders, as reproduction in India is highly gendered, relational, and regulated by different institutions and stakeholders. While the findings from Rajaji Nagar may not be generalised and expanded across India, the increased involvement and participation of men is challenging given that a strong confluence of factors and forces – such as State policies, essentialisation of women's roles, health systems processes, patriarchal norms, and importance of being financial providers – inhibit men's participation. This also suggests that encouraging men's participation in antenatal care through targeted policies and programmes will require addressing some of these issues, if not all.

This thesis makes some contributions and additions to the academic literature and research on men's involvement in maternal reproductive health.

It is the first in-depth qualitative study undertaken in India which uses a Critical Studies of Men and Masculinities (CSMM) framework to intimately analyse and examine men's involvement in antenatal care in an informal settlement. The only other study I know of in India which used a CSMM lens is by Burgher and Flood (2018), who explored fatherhood and masculinities

among urban fathers in the North-Eastern state of Mizoram; however, it focused on fatherhood rather than antenatal care.

In terms of the empirical findings of this thesis, Chapter Four examines the Indian State's approach towards men's involvement in maternal reproductive health and its impact on men and women's wellbeing and health outcomes, which is among the few research studies that exist on this subject. It indicates that while State-regulated reproduction policies have an impact on women, as has been documented extensively, it can also impact and affect men's desires and interest to be more involved in antenatal care.

Chapter Five gives an in-depth view of CHWs' perceptions towards men's involvement in antenatal care (and reproduction processes in general). Given their connections, networks, and embeddedness in the community, ASHA workers are important stakeholders who interact and engage with families and households regarding maternal health. Building on the work of Ved *et al.* (2019) and Saprii *et al.* (2015), it shows the conflicted positions that ASHAs find themselves in, their own limited expectations of men and their limited capacities to stir change in their communities.

Men's involvement in everyday antenatal processes is shaped by family type. Chapter Five and Chapter Six show that men in nuclear families in Rajaji Nagar are more likely to be more involved in the antenatal care of their wives than those living in joint families, and that this is partly by choice but also partly determined by circumstances. However, the existing evidence (Shekhawat *et al.* 2018; Hamal *et al.* 2020; Rehman *et al.* 2020; Pradhan and Mondal, 2021) from other parts of India suggests that women living in nuclear families receive less antenatal care than those living in joint families. Thus, this raises a pertinent point that while men's

involvement in antenatal care is desirable, this may not always mean quality and there may be a cost.

Chapter Six draws on the theoretical concept of caring masculinities – which emerged from the European literature – and asks how it is understood and practised in India. For some men in Rajaji Nagar, the concept of care revolves strongly around financial provision and the male breadwinner role, which in turn, is associated with hegemonic masculine ideals that prioritise this ideal. For these men, the primary way of caring is through making sure that their wives and prospective children are provided for and cared for. Therefore, the initial concept of caring masculinities as proposed by Elliott (2016) – which seeks to distance itself from hegemonic masculinities and the patriarchal dominance that comes with this masculine role model – needs to be re-examined and accommodate contextual differences and realities. While one can use Elliott's (2016) definition as a point of departure, the concept of 'care' here may differ significantly across contexts. In the working class context of Rajaji Nagar, some men combined their caring masculinity with the male breadwinner role. Their financial provision enabled them to ensure that their wives had access to medical treatment and specialised technology that would help ensure their wellbeing and reproductive success.

Caring masculinities are also manifested in the ways in which expectant fathers in Rajaji Nagar are increasingly using (as well as telling their wives to do so) various internet sources such as YouTube, Google, and so on to scout for pregnancy-related information and implement it for their wives. Given the advent of low-cost internet and widespread digital accessibility in India, this could be a good entry point to introduce and implement some interventions around encouraging men's involvement in maternal reproductive health.

Finally, this thesis also raises new considerations and questions for future research about how men's engagement in antenatal care affects women and their everyday lives.

A key question that needs to be investigated is: Do Indian women want more involvement from their husbands in antenatal care? While the reasons behind encouraging men's involvement have been discussed extensively in the literature, given the gendered norms prevalent in Indian society, it is important to also understand pregnant women's perspectives and whether they want more involvement from their husbands in everyday antenatal care. The importance of researching women's perspectives is emphasised through a study by Ganle *et al.* (2016) in Ghana which found that while most women understood the significance of men's involvement, not many women supported an increased role of men, and they expressed negative attitudes towards involving them, as they feared it would limit their mobility and freedom. This thesis suggests that perhaps men's involvement is not desired by CHWs and mothers-in-law alike but that there is a need for more research in India on questions such as: Who is men's engagement good for: wives, husbands or future children? Is men's full engagement really a good idea? Could a form of partial engagement present a better way forward and produce better maternal health outcomes while still preserving maternal reproductive health as an area of women's autonomy?

This leads us to the second question that should be pursued for further research: Does men's involvement in antenatal care lead to redistribution/reduction in household and care work for women? Although men in Rajaji Nagar have become more involved in antenatal care, they never extended their involvement to housework or to the more repetitive, menial aspects of care work. This suggests that these nascent caring masculinities are unlikely to result in a radical upending of gender norms or the reduction/redistribution of household and care work

for women. It is also unclear, at this stage, whether men's increased involvement has any impact on power dynamics and relations within the household and whether, in households where men are actively taking up antenatal care responsibilities, there are any shifts in major household decision making.

In raising these considerations, this thesis re-emphasises that research and praxis on men's involvement in maternal reproductive health needs to take a relational view of reproduction, rather than focusing on men and their subjectivities alone. Efforts and initiatives to encourage men's involvement in maternal health should not come at the cost of depoliticising women's concerns and interests. Instead, the priority should be to reclaim reproduction as a gendered site of engagement and ensure the physical and emotional well-being of all stakeholders involved.

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Annexes

Annexure 1

Questions/Talking points for semi-structured interviews with community health workers⁹⁹

- Do you think men should be involved in maternal health/pregnancy? What is your view? As historically reproduction has been a women's domain.
- Who are the main stakeholders in decision making in pregnancy?
- How much this primary health clinic (TH20) involved in maternal health care? How many births in a month do you register on an average?
- Do you support recruiting male health workers for PHCs? There are studies which say that men can complement women's efforts.
- In your experience, how often do men accompany their wives/female relatives to this PHC? Do they come for ANC checkups or specific tasks? Do you interact with men at all?
- Are there any trends/patterns in men's attitudes according to caste, religion, age, income?
- Do you think the clinics are welcoming *for husbands/men*?
- How can we involve/motivate men to participate in maternal health?
- What is your view on medicalization of childbirth? Institutional v/s home deliveries? Are there any specific trends?

⁹⁹ As these were semi-structured interviews, these points and questions were mainly used as a guide but often conversations went beyond these points.

Annexure 2

Questions/Talking points for semi-structured interviews with policy practitioners

- What is your view on men's involvement in maternal health in India?
- How does the current policies on maternal and reproductive health perceive men's involvement?
- How can we involve/motivate men to participate in maternal health?
- In your organisation's work in maternal reproductive health, do you work with men directly or indirectly? Have you had certain observations regarding their involvement?
- How does the health system engage/treat men during maternal healthcare?
- Do you support recruiting male health workers at the community level? There are studies which say that men can complement women's efforts.
- What do you think about labour room policy guideline that allows companions? Should men be allowed to accompany their partners?
- Do you have any suggestions or policy prescriptions to encourage more men?

Annexure 3

Questions/Talking points for semi-structured interviews with expectant fathers

- Should/Is antenatal care and maternal health solely a woman's issue? What's your view?
- How are you feeling now that a new family member is arriving?
- What do you think about men's involvement in everyday antenatal care?
- How has been your experience at this clinic with regards to the maternal healthcare processes?
- Are you connected with the local ASHA worker here for medicines and support?
- Do you think men in your community take active interest in antenatal care?
- How do you define men's involvement and care?
- Do you speak with anyone else regarding your concerns and feelings about expectant fatherhood?
- How has your daily schedule changed post the pregnancy?
- Do you get any support from wider family members for this?

Annexure 4

Ethics Approval from University of Sussex Research Ethics Committee (C-REC)



Social Sciences & Arts C-REC
c-recss@admin.susx.ac.uk

Certificate of Approval	
Reference Number	ER/DS447/2
Title Of Project	Experiences of Pregnancy & Childbirth From the Perspectives of Husbands, Fathers & Development Actors (COPY)
Principal Investigator (PI):	Devanik Saha
Student	Devanik Saha
Collaborators	
Duration Of Approval	3 years, 2 months, 21 days
Expected Start Date	11-Oct-2019
Date Of Approval	11-Oct-2019
Approval Expiry Date	01-Jan-2023
Approved By	Vacancy
Name of Authorised Signatory	Liz McDonnell
Date	11-Oct-2019

*NB. If the actual project start date is delayed beyond 12 months of the expected start date, this Certificate of Approval will lapse and the project will need to be reviewed again to take account of changed circumstances such as legislation, sponsor requirements and University procedures.

Please note and follow the requirements for approved submissions:

Amendments to protocol

- * Any changes or amendments to approved protocols must be submitted to the C-REC for authorisation prior to implementation.

Feedback regarding the status and conduct of approved projects

- * Any incidents with ethical implications that occur during the implementation of the project must be reported immediately to the Chair of the C-REC.

Feedback regarding any adverse(1) and unexpected events(2)

- * Any adverse (undesirable and unintended) and unexpected events that occur during the implementation of the project must be reported to the Chair of the Social Sciences and Arts C-REC. In the event of a serious adverse event, research must be stopped immediately and the Chair alerted within 24 hours of the occurrence.

Monitoring of Approved studies

The University may undertake periodic monitoring of approved studies. Researchers will be requested to report on the outcomes of research activity in relation to approvals that were granted (full applications and amendments).

Research Standards

Failure to conduct University research in alignment with the Code of Practice for Research may be investigated under the Procedure for the Investigation of Allegations of Misconduct in Research or other appropriate internal mechanisms (3). Any queries can be addressed to the Research Governance Office: rgoffice@sussex.ac.uk

(1) An "adverse event" is one that occurs during the course of a research protocol that either causes physical or psychological harm, or increases the risk of physical or psychological harm, or results in a loss of privacy and/or confidentiality to research participant or others.

(2) An "unexpected event" is an occurrence or situation during the course of a research project that was a) harmful to a participant taking part in the research, or b) increased the probability of harm to participants taking part in the research.

(3) <http://www.sussex.ac.uk/staff/research/rqi/policy/research-policy>

Annexure 5

Research Permission from Directorate of Health Services, Government of NCT of Delhi

OFFICE OF THE CHIEF DISTRICT MEDICAL OFFICER, SOUTH-EAST DISTRICT,
DIRECTORATE OF HEALTH SERVICES, GOVT. OF NCT OF DELHI,
Delhi Govt. Dispensary Building,
PVR, Complex, Saket, New Delhi-110017
Phone No. 26566590, 26566591, 26566592
Email : cdmoseast@gmail.com

No. F.(1)2014/CDMO/SE/Estt/MiscFile /2353

Date 22/08/19

To whom so ever this may concerned

Permission is hereby granted by Director, Directorate General of Health Services, to Mr. Devanik Saha, perusing PhD from University of Sussex, United Kingdom for to conduct qualitative study on examining men's experiences of pregnancy and childbirth in Primary Urban Health centres, Delhi Govt Dispensary and Mohalla clinics in south east district with the directions to share the findings of the research with this department.

Dr Geeta
CDMO
SED

No. F.(1)2014/CDMO/SE/Estt/MiscFile

Date

Copy to:

1. Mr. Devanik Saha (with the directions to submit undertaking as mentioned above)
2. Office copy

Dr. Geeta
CDMO
SED