# The Intimate State:

# Female Sterilisation, Reproductive Agency and Operable Bodies in Rural North India

A thesis submitted for the degree of Doctor of Philosophy

by

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To my mother,
the strongest woman I have ever known

# Table of contents

# List of images

# Acknowledgements

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# A note on transliteration

In the area where I conducted my fieldwork, a mix of Hindi, Mewari and Vaghri is spoken. Mewari is considered to be a dialect of Rajasthani – an official language of the state – spoken in its southern parts, including Udaipur district. Vaghri is considered to be a Bhil (a particular *adivasi* group in the area) language. Even though I carried out my fieldwork in a combination of these languages, I use standard Hindi throughout this thesis. In transliterating the Hindi words, I have given priority to the way they sound. I used double vowels to denote long sounds. For instance, to refer to a laparoscope I often use the word for binoculars – दूरबीन – and I chose to transliterate it as "*doorbeen*", in order to emphasise two long vowels in the word. The only exception is the words which are well-known in English spelling, such as *sari*, *chai* or *adivasi*. In these instances, I adhered to their conventional transliteration and did not emphasise long vowels. Appendix A provides a glossary of words which appear several times in the text.

# Abstract

Female sterilisation or tubal ligation remains the most promoted and prevalent method of contraception in India today, especially among the rural and urban poor. This thesis provides an ethnographic account of poor women's experiences of the sterilisation procedure in order to investigate the intricate relationship between the state, biomedicine and poor women in rural North India. The thesis draws on 18 months of ethnographic fieldwork in a mixed-caste village in Southern Rajasthan. Besides engaging with women in their daily lives in the village, participant observation was also carried out in regularly organised sterilisation camps, which were run by Marie Stopes India in two nearby towns. The thesis aims to explore how women experience the female sterilisation procedure, how this procedure relates to concerns beyond the sterilisation camp and how various forms and sources of authority influence reproductive decisions. The female sterilisation procedure encapsulates not only people's engagements and negotiations with the power, practices and discourses of the state, but also with other forms of authority, such as biomedicine, and intersecting structures of gender, caste and class.

The thesis approaches the main research theme – the relationship between the state, biomedicine and poor women in rural North India – by examining various relationships and power struggles within these domains as much as between them. The chapters focussing on the history of family planning in India, on local articulations of the state in the village and on local health workers who are an integral part of "motivating" women for the female sterilisation procedure reflect an effort to problematise "the state" and to investigate how local embodiments and discourses of the state contribute to women's decisions to stop childbearing by undergoing the tubal ligation procedure. The ethnography of a sterilisation camp provides a look into processes of biomedical examinations conducted in the camp before the procedure, and shows how biomedical tools of knowing, seeing and acting are negotiated and contested by various biomedical personnel, bureaucrats, as well as by women seeking the procedure. In such a way, I problematise the category of "biomedicine" and highlight its contested nature. Finally, chapters on reproductive agency and operable bodies examine how women themselves make sense of tubal ligation, how they negotiate conditions under which to undergo the procedure, and how female sterilisation becomes a site to negotiate one's social status.

An ethnographic investigation of the state, biomedicine and poor women as categories which are not homogenous but rather are constituted through multiple internal and external contestations allows a deeper and more complex understanding of how increasing medicalisation of women's lives in rural North India is experienced in various different ways. Furthermore, acknowledging the multiplicity of agendas, discourses and experiences within the categories of "the state", "biomedicine" and "poor women" provides an insight into how power is contested and articulated on multiple levels and by multiple actors, resulting in theoretical contributions to the existing theories on power, governmentality and biopolitics.

# List of abbreviations

ANM – auxiliary nurse midwife
ASHA – accredited social health activist
BJP – Bharatiya Janata Party
BPL – Below poverty line
CHC – Community Health Centre
CMHO – Chief Medical and Health Officer
DoCO – Directorate of Census Operations
DoES – Directorate of Economics and Statistics
DOTS – Directly Observed Treatment, Short Course
EPW – Economic and Political Weekly
ELA – Estimated level of achievement
FIR – First Information Report
FS – female sterilisation
GoI – Government of India
HB – haemoglobin
HDI – Human development index
ICDS – Integrated Child Development Services
ICMR – Indian Council of Medical Research
IIPS – International Institute for Population Sciences
IUD – intrauterine device
JSY – Janani Suraksha Yojana
MDG – Millennium Development Goal
MoHA – Ministry of Home Affairs
MoHFW – Ministry of Health and Family Welfare
MSI – Marie Stopes India
MTP – medical termination of pregnancy
NFWP – National Family Welfare Programme
NGO – non-governmental organisation
NPP – National Population Policy
NREGA – National Rural Employment Guarantee Act
NRHM – National Rural Health Mission
OR – operating room
PHC – Primary Health Centre
PPP – public-private partnership
SDG – Sustainable Development Goal
TB – tuberculosis
TBA – traditional birth attendant
UK – United Kingdom
UN – United Nations
USA – United States of America
USAID – United States Agency for International Development
USFDA – United States Food and Drug Administration
WB – World Bank


**IMAGE 1: THE MAP OF INDIA, FEATURING RAJASTHAN.** Source: Maps of India

# Chapter One

# Introduction

Jimli Bai is an *adivasi* woman in her late twenties, living in an *adivasi* village in Southern Rajasthan, India. Her *kacca* house stands behind a massive *peepal* tree under which a small Hanuman temple is built. Her husband works on a construction site in Ahmedabad, Gujarat, and comes home every couple of months. She looks after her three children, maintains the house and carries out almost all the work required to grow maize, wheat and pulses in their fields. She was in her late teens when her parents arranged her marriage, and she gave birth to her first son a year later. Another son and a daughter were born soon after each other, after which Jimli Bai visited a government-organised sterilisation camp and got her tubes tied. This was four and a half years ago, when Jimli Bai was in her mid-twenties.

I met her one day during the monsoon season. The rains stopped that afternoon and Jimli Bai, her five-year-old daughter and I sat outside for a chat, while her sister-in-law sat further away in the *angan* (courtyard) of Jimli Bai's *kacca* house, nursing her own baby. Jimli Bai narrates that one day she was making food when *sisterji* (a government health worker) came over unexpectedly and invited her to visit a sterilisation camp that day. Jimli Bai and her husband had spoken earlier that they did not want any more children, and she had informed the *sisterji* that she wanted the operation. Her husband was away in Ahmedabad that time and she did not have a phone to call him, so she went to the camp without informing him. Her mother-in-law has passed away a few years earlier, but her father-in-law, who lived in a separate house nearby, was against the operation, so Jimli Bai left her house without alarming him. When I ask her about the reasons she had the procedure, Jimli Bai narrated:

> "I did not need more children – two or three is enough. My three is already a lot, what should I do with more? Look at our neighbour Jivin who has ten children. They don't have enough clothes; they don't get enough good food. And we are five people in our family altogether, so we live and eat well. We were thinking about getting it after two children, but both of them were boys and my husband wanted a girl. Earlier it used to be different; it was my father, not my mother who had the operation. But nowadays they say a man has to do work, so he cannot get the operation. But if his work is driving a tractor, then how much work is it? And I have to bring water, work in the fields. They roam around the *bazaar* and then ask for food after coming back home. But if he refuses, then I have to have the operation".

On the day of the camp, she took her four-month-old daughter and her sister-in-law accompanied her in order to hold her daughter. She says there were 150 women in the camp that day. People running the camp asked her how many children she had, conducted a pregnancy test, administered a couple of injections [she points at different parts of her body] and then they did the operation. Jimli Bai remembers that her eyes were open during the procedure and she saw some doctors hovering over her with a laparoscope.

Stories like this one are common among women in rural Rajasthan, where I carried out my fieldwork. Tubal ligation is the most common method of contraception and women speak about their experiences openly and without any stigma attached to it. Such stories weave together women's experiences of childbearing, unequal gender relations and encounters with institutions. Women regularly discussed matters of contraception with each other and with health workers in places ranging from homes to hospitals and *anganwadis*, to more unexpected spaces, such as subsidised food shops. These conversations with agents of the state are not necessarily welcome but are difficult to avoid. Therefore, women seemed to discuss ending or continuing childbearing in a-matter-of-fact way. The question about contraception invoked narratives and conversations which dealt not only with personal or familial reproductive choices, but also with one's relationships with institutions, government schemes and officers. Contraceptive practices, then, are clearly embedded in ongoing negotiations with partners and institutions (Carter, 1995), and highlights increasingly entangled relationships between global priorities, national policies and local practices.

## Context to the research questions

Female sterilisation is one of the most commonly used methods of contraception in the world (UN, 2015). Its prevalence in different parts of the world is attributed to different historical trajectories and national policies. India was the first country in the world to introduce family planning as an official national programme in 1952. Throughout the decades, various methods of contraception were encouraged and degrees of persuasiveness and coercion were used. Today, female sterilisation remains the most promoted and prevalent method of contraception, especially among the rural and urban poor, and the average age of women getting the procedure after a desired family size is reached is 26 (IIPS and Macro International, 2007). The family planning programme today is implemented through a network of local health workers, the enforcement of unofficial targets and the provision of financial incentives. India's emphasis on population control receives criticism from

academics, human rights organisations and activists, and is often placed in parallel to China's birth control programme and one-child policy. Both the Indian and Chinese governments' preoccupation with demographic objectives have been criticised for abandoning concerns for women's health and reproductive choices (e.g. Hartmann, 1995[1987]; Warwick, 1982).

Whereas the prevalence of female sterilisation in India and China is often attributed to large-scale family planning programmes, in Brazil sterilisation is viewed as "the result of individual women's choices and actions" (Dalsgaard, 2004: 27; Andrade, 1997; Berquo and Arilha, 1992; De Bessa, 2006; O'Dougherty, 2008; Serruya, 1996). For instance, Dalsgaard (2004: 27), who works in a low-income setting in Brazil, argues that sterilisation "relieves immediate pressures and endows [a woman] with recognition as a responsible mother". De Bessa (2006: 221), similarly, argues that sterilisation among poor women in Brazil represents "women's active struggle to improve their lives and to resist the burdens placed on them by unequal gender relations." However, O'Dougherty (2008) contends that academic works on female sterilisation in Brazil often emphasise that the voluntary nature of sterilisation is a myth and that such "choice" arises from powerful and constraining social forces. She scrutinises other authors' suggestions that sterilisation is an example of increasing medicalisation of women's lives, a lack of contraceptive options or the lack of knowledge, and provocatively asks "is it the bodily cutting that makes sterilisation 'radical,' or is it the renunciation of all future motherhood that is radical?" (O'Dougherty, 2008: 420).

Contraception has been discussed by academics as both providing efficient means to avoid pregnancies and placing "women and their bodies under the control of powerful state and medical establishments" (Greenhalgh, 1994: 3). Russell (1999) makes a clear distinction between how contraception is seen from two perspectives – as birth control and as population control. Birth control refers to contraception as an issue of personal decision-making and as a form of care aimed at the individual, whereas population control sees procreation as a problem which needs to be cured, and contraception is seen as serving the nation regardless of the desires of individual women. Permanent methods of contraception, such as tubal ligation, pose particularly difficult challenges in balancing these concerns.

However, anthropologists and other social researchers have demonstrated that women in various contexts are active agents in negotiating the means and conditions under which powerful structures try to control their reproductive lives (e.g. Greenhalgh, 1994; Ginsburg and Rapp, 1991). Understanding women's complex engagements with contraception simultaneously as population control and as birth control requires abilities to challenge strong morally coloured categories. For instance, Dyck (2014) is a medical historian examining

women's reproductive choices and struggles in Canada in mid-20th century, during the simultaneous existence of the eugenics programme and the Catholicism-inspired ban on contraception.[1] Dyck demonstrates that in the shadow of the official eugenics programme, which coerced men and women considered to be "unfit" to undergo sterilisation procedures, some married middle-class women pressured their physicians to provide them with the sterilisation procedure as a method of contraception, which remained illegal at the time. Dyck (ibid.: 183) shows how women demanded "to extend the practice [of tubal ligation] beyond its eugenic or cancer-treating applications and accept sterilizations as a feature of modern reproductive choices". This historical account destabilises the link between eugenics and sterilisations (Bashford and Levine, 2010; Dikötter, 1998; Weindling, 1999), and provides an intellectual terrain to rethink questions of reproductive agency, reproductive restraints and women's pragmatic actions.

The practice of female sterilisation figures extensively in the background of various ethnographic accounts investigating women's reproductive lives in India (e.g. Jeffery, Jeffery and Lyon, 1989; Pande, 2014; Pinto, 2008; Van Hollen, 2003), mainly due to persistent memories of India's history of coercive vasectomies during the National Emergency in the 1970s (Tarlo, 2003; Williams, 2014). However, the practice of female sterilisation has rarely been the focus of anthropological research. The existing accounts explore the intricate nature of agency between women who undergo the procedure and the wider structures of power, mainly kinship and the state. Säävälä (1999, 2001, 2006), for instance, works on women's perceptions of female sterilisation in rural South India and situates reproductive decisions within familial power relations. She argues that even though mothers-in-law exercise significant decision-making power over a couple's reproductive life, young women may push their mothers-in-law towards relative old age by undergoing the sterilisation procedure and entering the post-childbearing age themselves (Säävälä 1999). Moving away from kinship structures and into the relations between the poor and the state, Cohen (1999, 2004, 2005) argues that female sterilisation is one of the ways in which the poor secure some sort of participation in the project of citizenship, modernity and the state. However, neither Säävälä nor Cohen's frameworks fully capture the intricate nature of the practice. The most recent qualitative study by Brault et al. (2015) on women's perceptions of female sterilisation in a low-income neighbourhood in Mumbai shows that even though family planning policies,

[1] It was illegal to sell or advertise birth control in Canada between 1892 and 1969. Two Canadian provinces performed compulsory sterilisation programmes in the twentieth century: Alberta (1928–1972) and British Columbia (1933–1973).

socioeconomic factors and gender relations constrain women's reproductive choices, poor women themselves see the practice of sterilisation as providing them with greater freedom and improving emotional health.

## Research questions

This thesis analyses the practice of female sterilisation in Chandpur,[2] a mixed-caste[3] village in Southern Rajasthan. Drawing on 18 months of ethnographic research carried out between February 2012 and August 2013, I investigate how poor women experience the female sterilisation procedure and what place this intervention occupies in women's everyday lives. Furthermore, I investigate what women's experiences of female sterilisation tell us about reproductive agency and the role of the state in the matters of reproduction in rural North India.

In this thesis, I argue that poor women in my research area navigate through various systems and networks of oppression inherent in the family planning programme either without being caught up in them or in some ways benefiting from such engagement. The encounters at the sterilisation camp are negotiated in frameworks other than the oppressive engagement between the state and poor women. Throughout my time in the field, it became clear that many poor women consciously used the government's insistence on sterilisations to their own advantage. Whereas many women successfully refused health workers' efforts to convince them to get an operation, others chose the sterilisation procedure as a way to end childbearing in order to improve their household's economic conditions, or to avoid further physical and

[2] The name of the village, as well as the names of all individuals mentioned in the thesis, have been changed to ensure anonymity. However, anyone familiar with the region or anyone who knew me during the time of my fieldwork will be able to see through the pseudonyms.

[3] Caste is a form of social stratification that has been classically characterised by endogamy, non-commensality and hereditary occupations. A distinction between two concepts of caste – *varna* and *jati* – is significant. *Varna* derives from Vedic discourses and refers to four hierarchically organised "cosmogonic human types" (Marriott, 2004: 357): Brahmins (priests), Kshatriyas (rulers and protectors), Vaishyas (producers) and Shudras (servants). While there are only four *varnas*, there are thousands of *jatis*. *Jati* means "birth"; it is sometimes considered to be a subdivision of *varna* and refers to complex social groups or "networks of families […] that attempt to preserve and raise their collective natures" (ibid.: 358). Khare (1983: 85) notes that whereas *varna* refers to the "ideal and symbolic […] archetypes", the concept of *jati* denotes the experience of caste in the "concrete and factual" domain of social life. Interpretations of the significance and meaning of caste vary widely. For classic discussions on the caste system in India, see: Béteille (1965, 1996), Dumont (1970), Marriott (2004), Srinivas (1962), Beidelman (1959); for more contemporary perspectives on caste, see: Bayly (1999), Gupta (2000), Natrajan (2012), Rafanell and Gorringe (2010), Rao (2009); for the interpretations of caste as a largely British colonial invention, see: Appadurai (1993), Dirks (1989; 2001), Inden (1990), Quigley (1995). Even though caste as a form of social hierarchy does feature rather prominently in this thesis, I do not engage in discussions surrounding the definition or meaning of caste.

emotional stress that is associated with carrying and caring for yet another child or undergoing numerous widely practiced abortions. When the women from my fieldwork area spoke about their own experiences of the female sterilisation procedure, there was no enactment of victimhood and little that they had been tricked into the procedure. Instead, they articulated a strong sense of relief that came with the end of childbearing and spoke about the procedure in a matter-of-fact manner, or even with a sense of pride.

Broadly, this thesis is about the relationship between poor women, biomedicine and the state in rural North India and the ways in which the rural poor deal with the increasing presence of the state's projects of governmentality in the area of reproduction. My ethnographic focus on the experiential dimensions of female sterilisation demonstrates how this practice represents a particular set of relations of governance and care between poor women's bodies and state power in rural North India. I examine how people engage with biomedicine and the state in the sterilisation camp, and how these engagements relate to the understandings of health, bodies, gender and various sources and forms of power inside and outside the sterilisation camp. I place female sterilisation within the context of biopolitics, but women's experiences of the procedure do not necessarily resonate with the discourses of biopolitics and governmentality in a Foucauldian framework. Instead, I discuss how poor women navigate the competing discourses of care[4] and the questions of who has the right, duty, authority and means to care for their wellbeing without being fully caught up in the process of becoming subjects of the state. I argue that the state does not hold an ultimate authority in the village, at least not in matters related to maternal and reproductive health, and that women's decisions to undergo sterilisation do not necessarily result from the pressure from the agents of the state. Even though women spoke about their experiences of structural inequalities, limited access to healthcare, resources and biomedical knowledge in their everyday lives, women never enacted victimhood in the context of sterilisation.

The idea of women taking control of their lives and bodies, which is prevalent in various feminist discourses, has been challenged by anthropologists who argue such feminist ideas are based on middle-class perspectives and concerns (e.g. Lazarus, 1994). Marsland and Prince (2012: 458) also argue that access to choice – how to live and care for oneself and others – "depends to the large extent on the means people have at their disposal". In line with this critique and in an effort to avoid fetishising the idea of reproductive choice and agency, I

[4] By "the discourse of care", I mean it as a discourse negotiating the provision of welfare and protection of populations as the function of the government in Michel Foucault's (1979a, 2008) line of thought.

avoid the juxtaposition of choice *versus* coercion as a framework for understanding female sterilisation as a reproductive technology. Invoking the language of choice runs the risk of concealing the structural forces and inequalities that shape reproductive decisions. However, the language of violence and coercion also potentially conceals the everyday efforts of women to negotiate and navigate these structural forces and inequalities stemming from patriarchal family structures, unequal distribution of resources and access. Trying to understand how and why women make reproductive decisions that suit their lives does not negate the importance of or the need for the efforts to challenge these structural inequalities. However, it acknowledges that women themselves challenge, accept, negotiate and maintain hierarchies, norms and structures on their own terms.

In a way, this thesis is also about modernity, however relative, ambiguous and contested that concept may be. Cohen (2011: 132) argues that the family planning discourse in India promises a particular future *through surgery* and that it has always been entangled with discourses about modernity and development. In rural India, women's engagements with reproductive and contraceptive technologies, institutional childbirth, the fascination with injections and distrust in pills, to name a few, are all engagements with particular versions of modernity. Chatterjee (1997: 20) argues for the ambiguity, and I would add multiplicity of meanings, when it comes to modernity in a postcolonial context: "The same historical process that has taught us the value of modernity has also made us the victims of modernity. Our attitude to modernity, therefore, cannot but deeply be ambiguous." Investigating the practice of female sterilisation in rural North India provides an opportunity to critique and destabilise the existing understandings about the relationships between the rural poor, the state and multiple modernities in neoliberal India.

In this thesis, I argue that the practice of sterilisation – from the rationalities behind poor women's reproductive decisions, to their engagements with local health workers and their experiences within the sterilisation camp – illustrates the ambiguities and fragilities of care in postcolonial rural India. I suggest that the way structural inequalities of caste, class and gender intertwine with the kind of care that is sought and provided unravels the relationship between what we might term "structural violence" and "structures of care". Discussing the failure of various social welfare programmes in India to relieve persistent poverty, Gupta (2012: 24) argues that these programmes are arbitrary, succeed unevenly or fail, and calls it "violence [...] enacted at the very scene of care". He further emphasises that there is a strong relationship between violence and caring when it comes to the postcolonial Indian state. This thesis demonstrates the ambiguity or, rather, a partial failure of this

conceptualisation by Gupta to capture the nature of some of the government's programmes. Although this thesis does not offer a thorough scrutiny of Gupta's work in a wider sense, it is nevertheless his argument that – however implicitly – provides the driving question throughout. Through the ethnographic explorations of the practice of female sterilisation, I demonstrate that it represents not only violence enacted at the scene of care, but also care enacted at the scene of (structural) violence. Furthermore, I argue that in some contexts, (structural) violence and care are ambiguously indistinguishable and are contextually either resisted or submitted to according to my informants own terms.

## On fieldwork, shortcomings of hospital ethnography and the field

I first came across the practice of female sterilisation in rural Rajasthan while volunteering with Seva Mandir[5] – a local grassroots non-governmental organisation based in Udaipur – in 2009, two years before starting this project. Udaipur serves as the administrative headquarter of Udaipur district in the state of Rajasthan, near the Gujarat border in western India. During the six months I spent there, I was asked to conduct a research project examining the declining sex-ratio in an *adivasi* (tribal) village. With no language skills of my own and a young Brahmin man as my translator, I made regular day-long journeys to the village, insistently asking women and men about the reasons why the village's small population was disproportionately skewed in favour of men in all age groups.[6] Women and men agreed that the sex composition of children born, after which a decision was made to conduct *nasbandi* (sterilisation) – after the birth of two, three or four sons and only one daughter – was to blame. Considering the circumstances, the research project did not uncover deep insights into the daily practices and experiences of gender-based inequalities and violence. However, the project's drawback provoked new interests for me. First, it made me practically realise and appreciate the significance of an in-depth and long-term ethnographic approach and skills needed to comprehend local social realities. And second, however hasty, cursory and

[5] Seva Mandir (*lit*. *trans*. A Temple of Service) is a well-known NGO in Udaipur which has been operational in the area for almost fifty years. It is respected by various government agencies, other NGOs and ordinary people in Udaipur and villages around, who would give (or pretend to give) discounts on *autorikshaw* rides, clothes and jewellery shopping for foreigners who mention that they are working with Seva Mandir.

[6] Son preference is prevalent among different communities in North India and is intricately linked with family building strategies, lack of formal social security structures, and changing work and agriculture patterns (Wadley, 1993). Some NGO circles working in *adivasi* villages in Udaipur operate under the assumption that gender relations in some *adivasi* communities are relatively more egalitarian than among caste Hindu communities (Krishna, 2003). The statistics on the declining sex-ratio among the *adivasi* communities, therefore, pointed to either the falseness of such assumption or changes in gender relations.

mediated through strong gender, caste and class hierarchies the interviews with women were, the ease and lack of taboo or stigma with which everybody in the village spoke about female sterilisation provided me with the research topic for the years to come.

## *Looking for the field*

In 2012, I returned to Udaipur for fieldwork and relied on Seva Mandir to help me choose a village for ethnographic study. It seemed to me at the time that the choice of a fieldwork site should not be a random or circumstantial decision. Therefore, I set off on a mission to look for "the field", while constantly contemplating what I should look for in a "perfect village" for fieldwork.

I started my search in a government space, namely the Chief Medical and Health Officer (CMHO) office in Udaipur, which was responsible for implementing family planning programmes in the district. The first time I visited the CMHO, I was accompanied by Dr. Priya, the head of the Health Unit at Seva Mandir. We were received warmly by the CMHO herself, Dr. Tiwari, and invited into her office. Dr. Priya explained that I was looking for information on family planning programmes implemented in each subdistrict of Udaipur. Dr. Tiwari narrated that most of sterilisations were usually performed before the end of financial year in March, and that between December and February the government provided various extra incentives to the rural and urban poor women for undergoing tubal ligation, such as free transportation, making these the busiest months for sterilisations.

Dr. Tiwari also described the CMHO's other areas of work, including malaria and tuberculosis control, training and supervision of auxiliary nurse midwives (ANM), and children's immunisation. She particularly emphasised the government's efforts to encourage institutional deliveries and to discourage practices of traditional birth attendants (TBA), or *daimas*,[7] as they are known locally. Dr. Priya spoke up about Seva Mandir's efforts in a different direction. For years, Seva Mandir had been providing trainings for *daimas* to perform safe and hygienic home deliveries and care for pregnant women before and after giving birth. According to Dr. Priya, *daimas* encouraged women to deliver at hospitals when possible, and offered to accompany them, but they needed to be provided with necessary training as they remained the primary providers of maternal health care in rural areas. Dr.

[7] Throughout most of anthropological literature, anthropologists use the term "*dai"* to refer to a traditional birth attendant. In my field site, however, "*dai"* was almost always followed by an affix "*maa"* or mother. Therefore, throughout this thesis, I use the term "*daima*".

Tiwari seemed to disagree with Seva Mandir's approach, arguing that *daimas* were to blame for high maternal mortality rates in the area. This disagreement, while uncomfortable in the moment, provided a valuable introduction to the complexities of the issues surrounding women's health care in the area and the various agents who are both competing and working together to provide care.

After these introductory remarks, a man from the IT office came in carrying a printed copy of data tables on family planning methods used between April and December 2011 in Udaipur district, divided by *tehsil* (subdistrict).[8] One page showed a table divided into four methods of family planning: *nasbandi* (sterilisation), copper-T, oral pills and *Nirodh* (condom). Every family planning method was also divided into four graphs: target, per month, until now and percent. Dr. Tiwari reacted swiftly to the surprise in my voice when I said "Target?" out loud. "We do not have targets," she explained, "it is just a guideline of one percent of the population in the area for sterilisations, two percent for condoms and so on". I continued to skim through the table; during the nine months for which the data were available, 8,388 sterilisations were performed, 15,817 copper-Ts inserted, 37,414 packets of oral pills and 43,356 packets of condoms distributed throughout the whole district of Udaipur. Considering that a pack of oral pills and a packet of 10 condoms would last a month, then the number of people reached by these methods is significantly smaller than the number of people who "benefited" from a long-term contraception method – sterilisation or copper-T. At the bottom of the page there was another small table outlining distribution of *nasbandi* among male and female recipients: 58 male sterilisations and 8,330 female sterilisations, which altogether contributed to only 27.18 percent of reached target population for the year 2011-2012. But, as Dr. Tiwari had said before, the busiest two months for sterilisations remained before the current programme year would end and the targets would officially be announced as achieved or not.

Looking through the subdistrict data on distribution of sterilisations in different areas of Udaipur district, I tried to find a number that would give me an "objective" reason to choose an area in which I should conduct research. This data mapped different subdistricts according to the prevalence of sterilisation practices and painted a picture of the ways in which government's family planning programmes organised, approached and treated different areas of the district. The official, and supposedly "reliable", data showed that urban areas of Udaipur contributed to the highest number of sterilisations that year – 2,246 which was 48.15

[8] Udaipur district is divided into eleven *tehsils* or subdistricts, which, in turn, are divided into zones.

percent of the set target, with Girva block coming second – 911 (32.09 percent), followed by Bhindar 869 (30.42 percent) and Jhadol 730 (29.55 percent), followed by other *tehsils*. I rejected Girva, which was too close to Udaipur (geographically close, good infrastructure and migrational links to the city), and Bhindar because Seva Mandir did not work in the area and I relied on their network of local workers for access. Third on the list of prevalence of female sterilisations was the *tehsil* of Jhadol which allowed me to focus my efforts of finding "a perfect village" to the level of a subdistrict. Before leaving the government office, I accepted an invitation to attend an upcoming monthly meeting of subdistrict CMHO officers.

I returned for the monthly meeting in order to meet the CMHO of Jhadol. After two monotonous hours of listening to officers talk in Hindi, table by table explaining changes in old programmes, discussing how to fill in a newly released government form for monitoring ANMs' work, and explaining tedious office matters, such as "please do not use spiral binding – for small piles use a stapler, and for big piles get a punching machine and cheap files", the meeting was over and I made my way to meet the officer responsible for Jhadol, Mr. Sharma. When dealing with government officials, I instinctually provided them with a concrete reason for my presence. I tried to make myself intelligible to "the world of the state" where quantitative facts were privileged and statistical data tables were accepted as accurate statements of social realities. "Sir, my name is Eva and I am doing a PhD and I need village-wise data on family planning in Jhadol", I said without much consideration. He looked at me strangely and said firmly in broken English: "You come on Monday". Here I was, abandoning my role as an anthropologist who prided herself on meticulously gathering ethnographic, lived experiences to understand how people made sense of their local worlds, and chasing after government-collected data in order to impress an officer of the state and help me decide where exactly in Jhadol I should carry out my research.

On Monday morning, I arrived at his office. This CMHO office sat directly in front of the government hospital in Jhadol, which is known in health circles as CHC – Community Health Centre. Mr. Sharma was not in, and after a quick phone call, I was told to wait for half an hour in the office. Bundles of old paperwork, tied together in colourful cotton sheets, were placed on top of metal cupboards that were also overflowing with documents. A filtered water machine was placed next to a *matka*, a clay pot for storing and cooling drinking water, and posters and old calendar images of Ganesha, Krishna and Lakshmi decorated the bleached peach walls that were covered with marks of numerous water leakings during monsoons. One wall had a small notice board with photos of work done: rural women and children receiving services and certificates from the government, women sitting in a meeting, and their blood

pressure and weight being measured by a man in a white coat. It was obvious from this wall that rural women's presence and participation was considered to be the measurement of both the successes of these programmes and development of the area.

Mr. Sharma came in and, after taking one look at me sitting at an empty desk, ordered a woman who followed him into the office to give me three years of data on all family planning methods, used in different CHCs and a sterilisation camp schedule for the next month. He dropped into his office, signed some documents left on his desk, received a phone call and left. A woman from the office was left with the task of providing me with data. She left the office and came back after few minutes with a big file of documents, lists, and certificates. She went through every document in the file and found the sheets for previous years. Under the title of sterilisation were three options – no-scalpel vasectomy (NSV), tubectomy (TT) and laparoscopic sterilisation (LS). The table for 2011 showed that 11 NSVs, 22 TTs and 1,179 LSs were performed in Jhadol block, with Jhadol itself being number one with 213 sterilisations, and Chandpur coming second with 208, with the same dynamic the previous year. As Jhadol is considered to be a small town rather than a village, Chandpur became a destination for my fieldwork, a place where I expected to understand how women made sense of such a common medical intervention as sterilisation and government's involvement in targeting them for family planning and other health care provisions.

## *Situating the study: Chandpur*

This thesis draws on research that was carried out over 18 months in 2012-3 in Chandpur, a village located in Jhadol, one of the predominantly rural and tribal subdistricts (*tehsil*) of Udaipur district in Rajasthan, North India.

Jhadol *tehsil* shares a border with Gujarat and also borders two other *tehsils* – Kherwara and Kotra. In some NGO and local residents' circles, Kherwara and Kotra are considered to represent two different development trajectories. On the one hand is Kherwara *tehsil*, where a rather new highway connecting Udaipur and Ahmedabad, the largest city of a neighbouring state of Gujarat, was built in the middle of the town of Kherwara. The highway stimulated the growth of many businesses, and as a result, education and employment levels grew rapidly, and labour migration to Kuwait became common and is generating relatively high household income. In Chandpur, Kherwara is known as a place where *adivasis* are richer

than Brahmins,[9] and such economic subversion of caste hierarchies (when class overtakes rather than reinforces caste) is understood as highly ambiguous.

On the other side of the "development story" is Kotra.[10] Kotra has an *adivasi* concentration as high as 90 percent and "is commonly known as *Kalapani* (black waters)[11] – extremely remote and inaccessible – where the government officials are sent as a 'punishment posting'" (Sahoo, 2013: 4). It is considered to be a dangerous area by *adivasis* from other *tehsils* as well, a place where shops and *chai* restaurants close early, and it is not advised to travel after dark, as many people are allegedly robbed and killed on the road.[12]

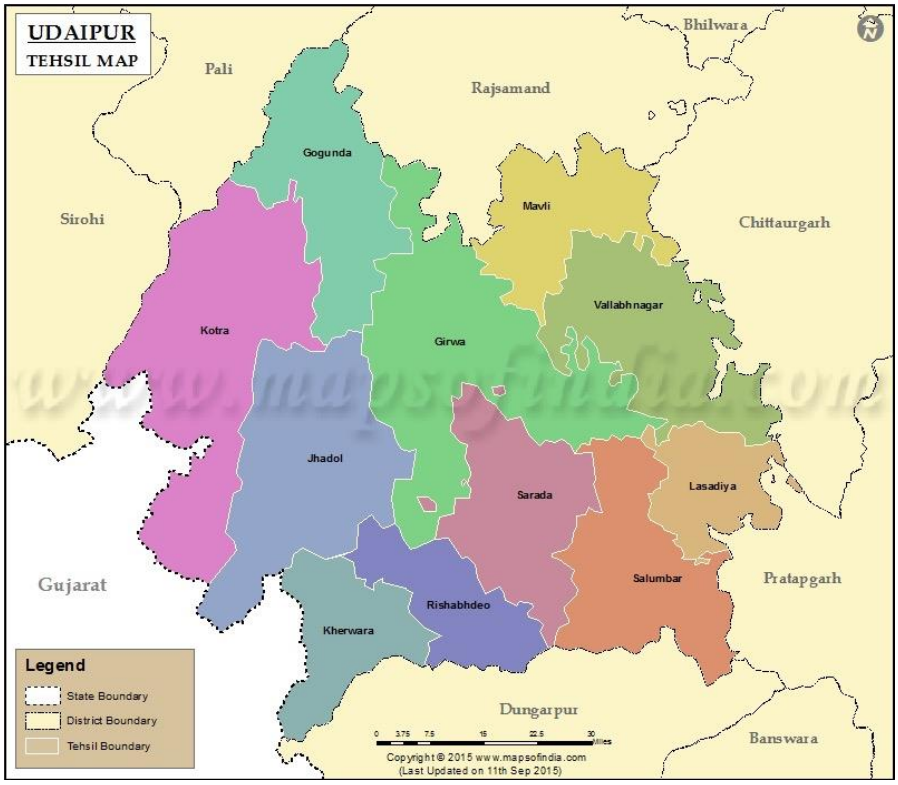



**IMAGE 2: UDAIPUR *TEHSIL* MAP.** Source: Maps of India

[9] This is supposedly surprising because socio-economic status is believed to reinforce caste hierarchies rather than subvert them. Even though the straightforward correspondence between class and caste status in quantitative terms is not overarching and exceptions are common (Dickey, 2010), studies suggest that the lowest castes tend to be the poorest ones and face significant challenges in attaining education and entering particular labour markets (Da Costa, 2008; Jeffrey, Jeffery and Jeffery, 2004).

[10] Kotra used to be a place where a cantonment for the British Army was situated during the colonial times, but was abandoned by the official development efforts since India's independence.

[11] *Kalapani*, or Black Waters, is a metaphor referring to a place overseas where political prisoners, mainly anti-colonial nationalists, were sent to with no hope of return, during the colonial times.

[12] McCurdy's (1964) ethnography of a Bhil village not far away from Chandpur also noted the differences between Bhils from Girwa (near Jhadol) and Bhils from Kotra. He argued that Girwa Bhils preferred peaceful resolution of conflicts and did not commit theft, and portrayed them in contrast to Kotra Bhils who "tend to relish the use of force in the settlement of disputes" and frequently resorted to theft (Carstairs, 1954: 175-176 cited in ibid.: 419, 423).

The *tehsil* of Jhadol is considered to be somewhere in between these two development trajectories – not as poor, dangerous and remote as Kotra, but not as developed as Kherwara to deserve the removal of the "backwardness" label. "Backwardness", according to Baviskar (2005a: 5105), is a generic term used by caste Hindus and the postcolonial state to refer to more than material poverty and economic marginalisation of *adivasis*; it also refers to their failure to conform to the non-*adivasi* set standards in dress, lifestyle and aspirations. Skaria (1997: 727) argues that the very distinction between caste Hindus and *adivasis* draws on colonial constructions of wildness, which nowadays articulate in the discourse on "backwardness".

Udaipur district is one of the poorest districts in Rajasthan, and performs low on various social and economic development indicators. It has high maternal mortality ratio (285), high infant mortality rate (61), and high fertility rate (3.6) (MoHA, n.d.). Poverty in this area is persistent and is interconnected with economic deprivation, poor health and low literacy rate. These, in turn, are strongly connected to the underlying social networks on which people rely for survival, identity and dignity (Du Toit, 2005), which are structured around strong gender, caste and class hierarchies and produce the effects of the structural violence of inequalities (see Baer and Singer, 1995; Farmer, 2005[2003]; Scheper-Hughes, 1992). These experiences of inequality and suffering are caused and perpetuated "by historically given (and often economically driven) processes and forces that conspire – whether through routine, ritual, or as is more commonly the case, the hard surfaces of life – to constrain agency" (Farmer, 2005[2003]: 40). Deep-cutting inequalities and exclusions in Chandpur are historically formed, economically reproduced and socially performed in everyday life.

Chandpur, along with other villages in the area, is reasonably well connected to urban centres. The 55-kilometre distance to Udaipur, the nearest city and district headquarters, takes two and a half hours to reach by bus on a curvy, single-lane asphalt road leading through Aravali hills and jungles. The largest town in the subdistrict, Jhadol, is located 25 km from Chandpur, and houses government offices, a Community Health Centre (CHC) and a wide range of shops.

Chandpur is a mixed-caste village with a population of some 1,500 residents from many different *jatis* (castes) and without a single numerically dominant *jati*. Chandpur is surrounded by *adivasi* villages, some of which are only a few minutes away, and in this way represents a wider tendency in this predominantly *adivasi* subdistrict: *adivasis* tend to live in scattered villages outside larger residential centres, whereas people from other castes

concentrate in bigger villages and towns. Larger villages have seen relatively rapid construction of brick houses in close proximity in recent years. *Adivasis* continue residing in mud houses built on hillsides and next to the fields cultivated by the owners. Locals rarely refer to Chandpur to mean the bounded mixed-caste village, and rather mean the whole zone by the name, including the tribal areas around.

The majority of households around Chandpur are small land owners. Most of the *adivasi* households strongly depend on their land and livestock holdings. Agriculture is primarily a source of subsistence, rather than income. Most households take up crop production for household consumption during the year. The main crops cultivated are maize, wheat, mustard and pulses - black gram (*urad*), red gram (*tur*) and chickpeas. The region depends on rainfall for its agricultural needs, and water scarcity is a major challenge for cultivation. Households with installed irrigation are able to cultivate rice and green vegetables, but such arrangements are relatively rare. Livestock rearing, mostly goats and buffaloes, contributes to daily consumption needs and household income.

Due to low agricultural productivity, wage labour is the main source of income in the area. Many *adivasi* and other low-caste men migrate to Udaipur and other towns in Rajasthan and neighbouring Gujarat in search of employment, mainly in the construction industry. Those who are engaged in manual labour in Udaipur, tend to commute daily, whereas those who work further away, often migrate for periods of 2-4 months at a time. The income was irregular and low. Some *jati* households in Chandpur practice traditional occupations like pottery, goldsmiths, blacksmiths and cater to the needs of local markets. Many upper-caste men, and occasionally upper-caste women, run shops or hold government and NGO jobs.

Men's increasing migration to cities in search of employment combined with migration of children to cotton fields in the neighbouring Gujarat, put increasing pressures of women to tend to their fields. *Adivasi* women in the area are primarily involved in the informal economy and agricultural labour, and have few opportunities for paid work. Some *adivasi* women are engaged in National Rural Employment Guarantee Act[13] (NREGA) projects. Collection of forest produce, such as *mahua* flowers, firewood, bamboo, honey and berries, also forms a source of income and contributes to household consumption. Many caste Hindu women are also significantly involved in agriculture, but rarely participate in NREGA

[13] National Rural Employment Guarantee Act is an Indian labour law and social security measure that aims to guarantee the "right to work". It aims to ensure livelihood security in rural areas by providing at least 100 days of wage employment in a financial year to every household whose adult members volunteer to do unskilled manual work.

projects. Some upper-caste or better educated women are involved in family business, NGOs or government service.

Marriage and motherhood form a central part of women's lives across caste and class lines in Rajasthan. *Adivasi* marriages follow patrilineal clan and village exogamy and tribe endogamy, and the distance within which brides are found is usually less than 20 km. They tend to reside in nuclear households, with sons building their own houses after the wedding. Caste Hindus practice caste endogamy and patrilineal clan exogamy. They tend to reside in joint households, where at least one son and his wife reside with his parents. The age of marriage is generally low, especially for girls, and it reflects a wider trend in Rajasthan, where the median age at marriage for girls is 15. Even though both *adivasis* and caste Hindus practice arranged marriages, various alternative arrangements can be found in the area (ranging from an informal settling into a lover's house without formal ceremonies among *adivasis* to inter-caste court marriages).

*Adivasi* women are generally seen in the literature as in a more egalitarian relationship with men than caste Hindu women (Sinha, 2005: xxix). This egalitarianism is primarily based on less constraining *adivasi* marriage practices (Deliége, 1985: 119). There are fewer restrictions on teenage *adivasi* girls, for example, and elopement among young couples is rather common. Instead of dowry, *adivasi* marriages are settled with parents of both bride and groom providing financial and other resources to the couple directly. Bride-price is usually paid by the groom's family to the bride's family only in the case of a woman's death or divorce at a husband's request. *Adivasi* women can divorce and remarry (*natra*), but such practices are not very common. Polygamy is allowed but practiced moderately in the area, whereas extramarital affairs are extremely common across caste and class lines.

Various forms and patterns of gender inequalities and exclusions are deeply engrained in everyday life in Rajasthan. One reason for such exclusions is a strong preference for sons. The son preference was articulated in many aspects of everyday life of my informants from across different caste and class backgrounds, even though its severity peaked with the upper-caste families. Son preference is justified primarily through the lack of non-familial sources of old-age support, the need for labour power, continuation of a family line, performance of funerary rites and property inheritance[14]. Son preference impacts allocation of resources, such as food, money and care, within the household and may result in sex-selective abortions and female infanticide. The sex ratio of Udaipur district (958 women to 1,000 men) is

[14] For a feminist analysis of son preference, sex-selection and surrogacy in India, see: Sangari (2015).

significantly higher than sex ratio in Rajasthan (928), and rural sex ratio in Udaipur district is even higher - 966 (DoCO, 2011). Even though the prevalence of sex determination techniques and sex-selective abortions could not be accurately determined, other forms of inequality and degrees of neglect of female children were evident since birth. As I observed during fieldwork, the birth of a son was celebrated in a highly visible and institutionalised manner, especially among caste Hindus, whereas girls were breastfed for shorter periods of time compared to boys. Parents' concern with their daughter's modesty and piety, the need for help in housework and the devaluation of girls' education more generally encouraged some parents to remove their daughters from school early. Medical treatment was organised and delivered promptly to sons, but was either denied or delayed for daughters. Occasional luxury food items, such as *ghee* and sweets, in poor households were distributed unevenly to girls and boys.

The control over women's sexuality and bodies take many forms and finds expression across caste and class lines. The practice of veiling (*ghunghat*), whereby a woman covers her face or head with a loose end of her *sari* or *odhni* in the presence of husband's elder male relatives, is common among both caste Hindus and *adivasis*. However, every household has their own norms about how strictly it is imposed, varying from *odhni* (veil) lightly covering the hair to it covering the face completely. Even though the practice is much stricter among the upper-caste families, especially Rajputs, it is sometimes observed in its strictest forms among *adivasi* women as well. The mother-in-law usually delineates the rules for *ghunghat* to the young daughter-in-law upon her arrival at husband's household, but sometimes the rules are also self-imposed by the daughter-in-law herself. This dialectic imposition represents two views on veiling which play out in the village life simultaneously - *ghunghat* as a patriarchal tool to control women's conduct and to silence them (Chowdhry, 1993; Unnithan-Kumar, 1997: 26), and *ghunghat* as a tool women employ to avoid unwanted attention or unwanted relationships. With age, the rules governing women's lives decrease, including the form and the need for *ghunghat*.

Even though women are not usually involved in the formal economy and are primarily involved in running households and caring for children, *adivasi* and low-caste women's lives are not contained within domesticity. The practice of *ghunghat* does not oblige women to observe many types of seclusion and does not prevent them from working alongside men. Their scope of movement and communication is not controlled by their in-laws in the way that upper-caste women's are.

Chandpur has a Primary Health Centre (PHC), a government primary and a government secondary school, two private primary schools, two *anganwadi*[15] centres, and several NGO offices. Chandpur has a bus stand and a well-developed market with general and medical stores, clothes shops, tailor and barber services and *chai* (tea) stalls. Most of the shops are run by people from other districts, and many of the *chai* stalls – where one can purchase *chai*, *samosa*, *kachori*, occasional *daal baati*[16] and sweets – are run by *adivasis*. Chandpur provides rooms for government teachers and doctors working in the area.

In many ways, Chandpur represents the political peripheries or "the margins of the state" (Das and Poole, 2004b; Gupta and Basu, 2012; Shah, 2010; Tsing, 1993). It is geographically, socially and politically remote from any central institutions of power and, therefore, a place where "state authority is most unreliable, where the gap between the state's goals and their local realization is largest, and where reinterpretation of state policies is most extreme" (Tsing, 1993: 27). At the same time, and partially for that exact reason, Chandpur is the target for development interventions organised by the state, various NGOs, Christian missionaries and Hindu nationalist organisations. In this sense, Chandpur is a place stuck between poverty and intervention (Pinto, 2008).

I stayed in three geographical and social locations in the village, slowly moving through different, yet fluid and overlapping, local moral worlds (Kleinman, 1999). First, I lived in a large Brahmin house in central Chandpur; then in a house rented to meat-eating barbers, a Christian nurse and a medical practitioner on the outskirts of Chandpur; and finally in a tribal village just outside the main mixed-caste village. These locations do not simply represent different social worlds, but also different "values in ordinary living" (ibid.: 71). These various overlapping local moral worlds are based on the overlapping hierarchies in the categories of caste and class, and are constantly in negotiation with one another. Spatial organisation of the village is just one example: Brahmins live around the market and the main

[15] The *anganwadi*, or courtyard shelter, is a pre-school centre started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition and can be found in almost every village around Chandpur and throughout India. It is a centre established usually near the school or in one of the rooms in the school buildings, where children between 1 and 6 years of age are supposed to come, play, learn, eat nutritious meals and, therefore, give their mothers a chance to work few hours a day, either at home, in the fields or as labourers outside of the home. The *anganwadi* also serves as a centre where the government's interventions into reproductive, maternal and child health are implemented. The *anganwadi* is a place where immunisation camps are organised once a month, where the weight of pregnant women and children is regularly taken, where teenage girls are distributed with nutritious porridge and where women are talked to about stopping or spacing childbearing.

[16] *Chai* is a sweet milky tea made by brewing black tea with water, milk, sugar, ginger and other spices; *samosa* is a deep fried pastry with a savoury potato filling; *kachori* – a spicy deep fried snack, made of flour filled with lentils, gram flour and spices; and *daal baati* is a dish comprising lentils and hard wheat rolls.

temple, there is a Gujjar *gali* (lane), the street of meat-eaters, Meghwals (*dalits* or untouchables) stay on the outskirts of the village and *adivasis* stay outside Chandpur. Class enters this outline in interesting ways. The *bazaar* in the centre of Chandpur, where most of the shops, restaurants and a bus stand is located, is considered to be a socially dangerous place. Young unmarried girls and daughters-in-law try to avoid visiting it and find ways to cross the village without passing through the *bazaar*, as it is the main hub of gossip and rumour. The *bazaar* is also a place where most of the property is owned and inhabited by Brahmins and other upper-caste families, but, in the eyes of most people outside the *bazaar*, those upper-caste families have been ruined by money and lost their caste-prescribed dignity and customs, and regularly consume meat and alcohol. The *bazaar* was thought to be especially dangerous to girls, and most of the stories I heard of rape and sexual assault were said to have happened there. Whether these stories were real, based on rumour or exaggerated to have an effect, they do tell something about the intersection of caste and class. Many families advised me not to live in the *bazaar*, mostly due to the potential dangers that rich and alcohol-consuming upper-caste men might pose to my safety. Such demonisation of the *bazaar* combined with the ambiguity that the neighbouring Kherwara *tehsil* invokes (where *adivasis* are richer than Brahmins) shows that the intersection between class and caste is seen as highly ambiguous and controversial, and could be interpreted as a form of critiquing neoliberalism in highly moral terms.

## *Ethnographic knowledge co-production*

This ethnography represents a partial and selective description and interpretation of my informants' lives, concerns and opinions. This partial and subjective account is a product of my engagements in the field while simultaneously acknowledging the power that my positionality in the field carried, my vulnerability as an outsider and my intentions to carry out my research in an ethical, reflexive and compassionate manner. My subject position as a white woman living in a foreign land and village away from my family, received mixed reactions from my informants. I was seen as both privileged and cursed with freedom to roam the streets of the village (and the world) with much fewer restrictions and repercussions than my informants. I was also seen as socially and emotionally vulnerable without the net of kinship, especially as the only child from a single-parent household, with no male figures in my life. My gender and ethnicity influenced my relationships with my informants and

contributed to the types of spaces I frequented, types of conversations I had and types of things men and women disclosed to me or decided to hide.

This thesis draws on my observations, experiences and understandings that I recorded in detail in my fieldnotes. I took fieldnotes both at the end of each day and during conversations and interactions when I found it appropriate and convenient. My notes move in and out of four languages – mainly in English with frequent use of words and expressions in Hindi and Mewari, but also entangling with my native Lithuanian. With permission, and when appropriate, I recorded interviews and encounters in hospital spaces. Most of the recorded conversations also combine some mixture of Hindi, Mewari and English. Partially due to the multi-lingual character of this work, every direct quote I use in this thesis - whether taken from a recorded interview or recreated from conversations chronicled in fieldnotes - is a result of translation and interpretation. Translation, however, goes far beyond the efforts of my informants and myself in navigating different languages. The process of translation is one of the central and crucial tasks of fieldwork itself, where both the informant and the anthropologist must interpret their own culture and that of the other (Rabinow, 1977: 151). While acknowledging my own limits in ethnographic inquiry and writing, I follow Scheper-Hughes' (1995) suggested alternative to radical postmodern critiques of fieldwork - to practice a "good enough ethnography". She contends that "while the anthropologist is always a necessarily flawed and biased instrument of cultural translation, like every other craftsperson we can do the best we can with the limited recourses we have at hand: our ability to listen and to observe carefully and with empathy and compassion" (1995: 417-418). Therefore, my informants' voices that are recreated and represented throughout this work should be read as texts produced in collaboration between my informants and myself as an ethnographer through sharing a subjective space and having been parts of each other's lives (Sluka and Robben, 2007: 24).

## *Hospital ethnography: limitations, ethics and other concerns*

In many ways, this work is a product of a multi-sited ethnography (Marcus, 1995). Besides engaging with women in their everyday lives in Chandpur, and in order to better understand women's experiences of sterilisation in particular, I attended regular sterilisation camps organised twice a week in two locations in Jhadol *tehsil*. The camps were organised in the only two towns of the *tehsil*, both a jeep ride away from Chandpur – in Jhadol on Tuesdays and in Phalasia on Fridays. According to the Ministry of Health and Family Welfare, "a

sterilisation camp is an alternative service delivery mechanism, when the medical team conducts sterilisation operations at a rural health facility, where these services are not routinely available" (MoHFW, 2008). Inhorn (2004: 2096, emphasis original) argues that "when those who are not physicians attempt to penetrate the hospital clinic in order to apply an 'ethnographic gaze *on* medical gaze' (in part to examine structures of power), their ethnographic penetration might be viewed as unwelcome". Barriers can be created by the hospital boards, but that is not the only way in which the control over the ethnographer might be exercised. Van der Geest (1989: 1340) writes about the power of medical regimes to dictate what we as anthropologists should do, think, and read. However, I personally did not encounter many of these restraints. Doctors and nurses in the sterilisation camp and the government officials from the CMHO office, overseeing the organisation of the camps, created perfect conditions for me to observe the life in the camp, and the operating room (OR) was the only restricted site. In these clinical settings, I built relationships with doctors, nurses, bureaucrats and local health workers.

Conducting ethnography in clinical settings poses various challenges and requires many considerations regarding ethics and limitations of such approach. When presenting my research at various conferences across Europe and the UK, I am often asked about my ethical considerations when conducting research with such an intimate practice as female sterilisation. It is important to contextualise ethical concerns of privacy and consent in clinical settings within local moral frameworks. I already described how I gained permission to conduct research in the sterilisation camps from the government officers, and Chapter Six opens with an ethnographic vignette of how I gained permission to visit the camps from the team of Marie Stopes India (MSI) doctors. Even though my presence in the clinical settings drew legitimacy from doctors and government officers' explicit permission and regular invitations to particular rooms, I sought implicit and explicit permission from the women who attended these spaces at every personal encounter. In the case of observing childbirth in a local hospital when the woman in labour was in no position to give consent, I always asked the women accompanying her whether I could enter the labour room or the maternity ward. I used my own discretion and sensitivity, and constantly reflected on how my presence was affecting women's experiences and encounters in various clinical spaces.

The rural hospitals that I worked in (the two CHCs that hosted sterilisation camps and a PHC where I observed childbirth) were spaces rather different from how one might imagine a hospital in the UK. The doors of the hospital, labour room and examination rooms were always open and regularly crossed by not only the patients and their family members, but also

by passers-by and *chaiwallas* (people serving tea). The privacy of the patients during various examinations did not seem much of a concern to either the hospital staff or patients themselves. The only exception was the vaginal examination by the gynaecologist in the sterilisation camp, which underwent visible regular transformations due to the doctor's increasing concerns with privacy throughout my time in the field. Whereas at the beginning it was performed in the room with only women present there (gender was the only criteria determining access to the room), it slowly started being performed first with only the presence of the next one or two women in line for the examination, and, at the end, the doctor started demanding that the door to the room would be closed and even other camp staff were not allowed to enter. However, the doctor usually invited me to observe and I tended to position myself on the side of the room where patients put their heads when lying down for examination.

One of the biggest methodological issues I encountered in the field was related to the idea of participant observation in clinical settings (Wind, 2008). An anthropologist in the clinic is a strange creature altogether – I was neither a doctor, nor a patient, so how was I a participant? There were, however, plenty of different roles in the camp besides these two: there were people who accompanied patients, there were frequent visitors from Marie Stopes India (MSI) offices in Jaipur and Delhi investigating the quality of provided services, and there were staff members providing administrative services as well as health workers. But an anthropologist seemed to be the most confusing. On the one hand, I was allowed not only to observe medical examinations and encounters but also sometimes asked for an opinion or help with simple tasks, like marking the injection spot on women's arms or handling Female Sterilisation Case Cards. On the other hand, the staff jokingly but persistently demanded that I convinced women in Chandpur to undergo the procedure and bring in cases as well, and in that way reciprocate their help during my fieldwork. However, it would be a mistake to juxtapose the medical world and the social life of the village. Living, observing and participating in the community is, in a way, as technical, difficult and sophisticated as in medical spaces. Jenkins (1994: 445) makes the suggestion to think of fieldwork as an apprenticeship of learning signs, rules and norms which guide social relations in order to enter particular social worlds. In all the ethnographic moments I narrate throughout the thesis, whether in medical institutions or women's homes, I do not simply describe the social reality but my informants and I co-create these stories and are "engaged in a personal and experiential capacity" (ibid.: 445).

Another challenge for an ethnography of a sterilisation camp is the fact that, by definition, it is a temporary facility. I built long-term relationships with doctors, staff and health workers but not with patients who attended the camps. Women who came to the camp were from different villages in Jhadol *tehsil*, and most of them have never seen me before. So even though there was enough time to interview them, it was difficult to build trust and break down the hierarchies in this short time. Breaking hierarchies seemed to me to be one of the most important tasks to be implemented in the field, and yet one of the most difficult tasks to do in rural India, where the intersecting hierarchies of class, gender, caste, age and race are deeply engrained and reproduced on the daily basis. It was particularly noticeable at the camp and the hierarchies among the MSI team members, between MSI and CMHO staff, between doctors and nurses, between doctors and local health workers, and between the camp staff and patients, were expressed in various obvious and nuanced ways. Soon after entering these clinical settings, strongly infused with power relations stemming from different sources and intersecting in various interesting ways, I realised that my own positionality and background carried much stronger implications in these medical spaces than, for instance, in the village (where many local ideas about my background, wealth and habits were dispelled or established through interactions on daily basis). Therefore, interviews with patients would have been both extremely biased and inconvenient to the patients themselves.

Women who came for sterilisation were at the bottom of this hierarchical pyramid. They were mostly *adivasi*, rural, uneducated women taken out of their daily surroundings and into the medico-political environment, where the health worker who cared for her also spoke for her, where she was told to go to sleep when her "active participation" was not needed anymore, where she would take off her shoes while entering doctor's office but a health worker would not take her shoes off while stepping on a mattress where she was resting. It took a while for the staff to get used to my presence and habits, to being and doing things in a way which was not seen as suitable for a white woman from abroad, something none of the staff or health workers would ever do themselves. These were simple things, like squatting in

general[17] or squatting amongst women who came for sterilisation, or standing in line together with the women, or even joking that I should go and take a nap amongst the women on the mattresses. It is something that MSI and CMHO staff had time to get used to, but there was not enough time for me to establish that sort of relationship with women who came for the procedure. Therefore, for almost every woman who came for sterilisation and saw me there, I was this white *madam*, who was supposed to remain with doctors – the educated people from the city – and was welcomed with some suspicion at every personal encounter.

Some characters and names are reoccurring throughout the chapters, however scattered and differently portrayed the people are. Some chapters, like the ethnography of the sterilisation camp, include numerous names to signify the fleeting encounters I had with multiple women in the camp whom I met only once. In the beginning of my regular visits to the camp, I was observing the patterns in doctor-patient interactions, trying to find out the flow of the procedures, the rhythms and rules of this particular clinical space. Half way through the fieldwork in the camp, I started focusing more on the encounters which did not follow the earlier patterns, sometimes one-off moments of misunderstanding and out-of-the-ordinary interactions. When writing the ethnography of a sterilisation camp in Chapter Six, I try to reflect both continuities in patterns in these interactions and the deviations, breakage from the rules and the flow.

## Tubal ligation: technicalities and local interpretations

Tubal ligation is a surgical procedure during which a woman's fallopian tubes are cut, blocked or tied in order to prevent eggs from reaching the uterus for fertilisation. It is a permanent method of contraception and only in rare cases and with big financial and medical resources could one get this method reversed and reproductive functions restored. There are

[17] Class is inscribed on the body and therefore visible (e.g. Dickey, 2010), and particular bodily positions, such as deep squatting, are considered to articulate lower class status. Once I was hanging out with a good friend of mine from an upper-caste, middle-class background on a lawn drinking tea in Udaipur. Due to a persistent pain in my lower back, I moved from a cross-legged position into a deep squat. He immediately protested such a move, saying that this is how the villagers sit and demanded me to sit properly, otherwise he would leave. McGuire (2011) investigates how new middle class bodily practices are produced through training modules at the call centre in Delhi and how particular urban spaces – coffee shops and shopping malls – require particular bodily practices which encode middle class values.

two main ways[18] in which tubal ligation is performed in India – as an open surgery or a laparoscopic surgery.

There are major differences in the way these procedures are performed, their failure rates and the way people without medical education understand these procedures. Sterilisation performed as an open surgery is called tubectomy. Tubectomy is usually performed in a hospital and only on rare occasions in the camp.[19] A woman is put under general anaesthesia, and a surgeon makes two small incisions in order to gain access to the fallopian tubes. The tubes are cut and different techniques, such as surgical ligation, electrocautery, clips and rings, and sometimes chemical tissue adhesives, might be used to prevent them from reconnecting (Wilson, 1996). This type of sterilisation can be performed postpartum (between 24 hours and 7 days after the delivery), together with a medically induced abortion, or after a self-administered medically induced abortion. Amongst the women in Chandpur, it was known as *bara* (big) operation, *hathwalla* (performed with hands) or *taankewalla* (requiring stitches) operation. *Bara* operation[20] refers to the open surgery, requiring full anaesthesia; *hathwalla* operation describes the fact that the procedure is performed with the surgeon's hands rather than with a laparoscope, and *taankewalla* operation refers to the bigger number of stitches applied on both incisions.

Laparoscopic sterilisation, the procedure usually performed at government sterilisation camps, is a simpler procedure. A woman is given local anaesthesia and an incision is made in her belly button. Her abdomen is filled with carbon dioxide which elevates the abdominal wall above the internal organs to create a working and viewing space. A laparoscope is inserted and a surgeon places plastic rings on both fallopian tubes (other methods of occlusion can also be performed, as mentioned above) and one stitch is applied on the incision. This operation is not performed postpartum (at least 1.5 month after delivery) or together with a medically induced abortion. This operation has higher failure rates, compared to open surgery, due to the plastic ring's slippage or the possibility that the ring was placed on

[18] The gynaecologist I interviewed in Udaipur before starting my fieldwork explained to me that there is a third procedure, which she called a mini-laparoscopic surgery, when the laparoscopic surgery is performed without local anaesthesia. She ensured me that "it takes only five minutes of pain". I did not come across this procedure being practiced in the camps or talked about by the women in the village and, therefore, I do not include it in my analysis.

[19] During 18 months of fieldork, there was only one tubectomy camp organised in a neighbouring *tehsil*.

[20] In some contexts, *bara* operation might also refer to a hysterectomy.

something other than a fallopian tube.[21] However, there are advantages of this procedure as well, such as reduced pain and haemorrhaging, and shorter recovery time. In the village, this operation is known as *karantwalla*, *lightwalla* or *doorbeenwalla* operation. These names require further explanation, as they cannot be directly translated into English without ignoring some important historical nuances that shed light into how this procedure exists in the public imagination.

*Karantwalla* operation refers to the electricity that enters and potentially transforms one's body. *Karant* is one of the Hindi words used to refer to light and electricity and is derived from "current", an outdated word for electricity. Even though there are other Hindi words that refer to electricity, such as *bijli*, *batti* or simply light, they are used in different contexts and not necessarily interchangeably. *Karant* is especially used in contexts when one is electrocuted, usually *karant aa gaya* (*lit*. *trans*. current came [to me]) or *karant ne pakar liya* (*lit*. *trans*. current caught [me]), or even poetically, as shown by Ahearn (2003: 109) in her "Writing desire in Nepali love letters": "Vajra described how afraid he used to be of girls and women; if one accidentally brushed against him, he said, he felt a current (*karant*) of electricity". Therefore, *karantwalla* or *lightwalla* operation is seen as dangerous – it is believed that the machine (laparoscopic instrument) works with electricity and burns the fallopian tube (*nal jalta hai*) and "pulls" or "sucks" the blood (*khun ko kheechta hai)*. People in Chandpur usually provided this explanation together with pointing at the fan, if there was one, to illustrate the power of electricity. It is believed that electricity in this operation creates the heat within the body which follows the same logic of being electrocuted[22]. The heat created in the body by the *karantwalla* operation is not necessarily feared. However, it is widely believed that if an operation is performed during the hot season, then the heat of the body combined with hot weather stops the body from healing and the incision has more chances of getting infected.

*Doorbeenwalla* operation refers to any laparoscopic surgery, whether performed in order to remove kidney stones or to tie the tubes, and this expression tells yet another story. *Doorbeen* is a Hindi word for binoculars or a telescope, an instrument used to see things that are far away. It refers to the laparoscope which allows the doctor to see the inside organs of a

[21] In the abdominal area where the fallopian tubes are located, there are other similar structures and tissues that can easily be mistaken for a fallopian tube; it is considered as one of the disadvantages of laparoscopic surgery in general.

[22] Once, I happened to touch the electrical board with open wires and was strongly shocked by the current of electricity. Right after the incident, my neighbours came and applied *dahi* (yoghurt or curd) to my left arm where the current struck in order to cool down the area, as *dahi* is among foods containing the quality of cooling.

human body through the lens on the top of the instrument or the screen. Therefore, *doorbeenwalla* operation invokes the gaze as the central defining characteristic of the procedure. In South Asia, vision is undoubtedly powerful and the concept of *darshan* (literally sight or view, but also invokes a particular way of engagement with the divine) in religious contexts has been discussed in various anthropological accounts (e.g. Bhatti and Pinney, 2011; Eck, 1998). Vision is also ambiguous and can be invoked in both negative and positive terms in different contexts, and the multiplicity of meanings associated with *nazar* (glance, gaze) – from the evil eye (*nazar lagaana*) to the peak of emotional expression through meeting and holding the gaze between lovers (*nazar milaana*) – exemplifies that (ibid.). Calling the operation *doorbeenwalla* invokes powerful hierarchies inherent in the concept of medical gaze and opens up the conversation about power and visibility. Both of these concepts – *karantwalla* and *doorbeenwalla* operations – invoke power to see within and to act inside the body.

## Discussion on key terms and usages

My research concerns and questions are situated at the intersection of medical anthropology and the anthropology of the state, authority and power. In a way, this thesis provides an ethnography of state practices in clinical settings. However, neither the anthropology of the state nor medical anthropology alone fully capture the themes arising in this thesis. Throughout my ethnography, I use and explore Foucauldian concepts of power, biopolitics and governmentality. However, as Marsland and Prince (2012) point out, these concepts do not fully resonate with some ethnographic contexts, especially the ones characterised by deep-cutting inequalities and the everyday struggles for survival. This is exactly the case I encountered in my field site. Therefore, throughout this thesis, I problematise Foucauldian concepts and allow the ethnography to speak for itself rather than be silenced by vague theoretical concepts. The following section outlines some of the main assumptions underlying this work. I start by emphasising some assumptions about gender and intersectionality, discuss Foucauldian concepts of power, biopolitics and governmentality and provide a brief note on the use of concepts "*adivasi*" and "tribe".

## *Gender, power and intersectionality*

This thesis is fundamentally about gender and gender relations. However, even though gender is already implicated in projects, processes and experiences of power, especially in highly patriarchal contexts of North India, it is done so only in combination with the categories of caste, class, age, rural/urban and a number of other indicators, depending on the context within which these axes for hierarchies materialise. Structural inequalities, resulting from a particular combination of embodied social markers, are experienced in various different ways, and the intersectionality of caste, class, gender and age produce particular experiences of inequality which cannot be reduced to either one of these categories (Collins, 1986, 1990; Glenn, 1999; hooks, 1989; McCall, 2005).

The intersectionality perspective was theorised by feminists of colour in the 1980s as a response to second wave feminism. Feminists of colour criticised the second wave feminist theory and politics of the 1970s as being about middle-class, educated, white women, and demanded attention to other social identities, especially race (Dill, 1983; Hull, Scott and Smith, 1982; Moraga and Anzaldúa, 1981). Rooted in the experiences of women of colour, this critique is based on the underlying idea that "women of color experience racism in ways not always the same as those experienced by men of color and sexism in ways not always parallel to experiences of white women" (Crenshaw, 1991: 1252). The intersectionality approach grew out of concerns with the production and reproduction of inequalities which could not be captured by gender as a single axis of oppression. The idea of intersectionality critiques "the use of *women* and *gender* as unitary and homogenous categories reflecting the common essence of all women" (ibid.: 1776, emphasis original). Instead, it points towards a wide range of different experiences and identities that result from particularities of different contexts, within which these multiple interlocking identities are defined in terms of relative power and privilege, or their lack. The notion of intersectionality allows for placing the focus on "the relationships among multiple dimensions and modalities of social relations and subject formations" (McCall, 2005: 1771), which constitute particular experiences. In other words, the intersectionality approach reveals that one's social identities and locations "profoundly influence one's beliefs about and experience of gender" (Shields, 2008: 301), and gender needs to be investigated in the context of power relations embedded in social relations (Collins, 1990).

The intersectionality perspective combines aspects of social constructionist and phenomenological conceptualisations of gender and other social identities. Building on

Berger and Luckmann (1966) and Foucault (1979a), amongst other scholars, this approach recognises that social categories and identities are historically contingent and socially constructed. Gender, then, is a product of historical processes, power relations and cultural norms. Simultaneously, building on Heidegger (1962), Husserl (1970) and Merleau-Ponty (1962), the intersectionality perspective investigates embodied lived experiences of socially and politically constituted categories and identities. Very succinctly, even though gender as category is socially and politically constituted, it is also experienced in particular ways in our everyday lives. By employing the intersectionality perspective in this thesis, I do not engage with the single notion of gender on a conceptual level,[23] but investigate how gender is constructed and experienced in relation to caste, class and rurality. These intersections become increasingly important and visible in biomedical encounters within and outside of institutional settings, and in this thesis, I unpack how the intersection of gender, caste, class and rurality unfold in relation to discourses, practices and experiences related to female sterilisation.

## *Governmentality, biopower and biopolitics*

Michel Foucault's (1977, 1979a) work on power implicitly and explicitly informed both my fieldwork and the writing of this thesis. Foucault's notion of governmentality (1979b, 1991) allows for a rethinking of "the state" as an ensemble of dispersed processes and practices of governance, regulation and surveillance which extend into various domains of everyday life. Political power is diffused through state and non-state institutions, forms of knowledge, truth discourses, inquiry and expertise functioning in different sites and with different objectives. Neoliberal governmentality[24] refers to "the emergence of new mechanisms of rule and a proliferation of innovative institutional forms that take on governance functions formerly assigned to the state" (Sharma, 2006: 61). Broadly, the conceptual tool of "governmentality" allows us to question and understand "how we are governed […] individually and collectively, in our homes, workplaces, schools, and hospitals, in our towns, regions, and nations, and by our national and transnational governing bodies" (Rose, O'Malley and

[23] For discussions on gender and performativity, see: Butler (1990); for discussions on gender and embodiment, see: Bigwood (1991), Butler (1993), Diprose (1994), Grosz (1994), Young (1989); gender and biomedicine, see: Ehrenreich and English (2005[1978]), Jacobus, Keller and Shuttleworth (1990), Martin (1991), Rapp (1988).

[24] For broader discussions on neoliberal governmentality, see: Barry, Osborne and Rose (1996), Burchell, Gordon and Miller (1991), Ferguson and Gupta (2002).

Valverde, 2006: 101). In this thesis, I engage with the concept of governmentality by exploring discourses and practices, located within and outside formal institutions of the state, through which women's reproductive lives are increasingly being governed in overt and covert ways.

Foucault (1979a) argues that biological life became central to our social and political existence, and that political power takes biological life as an object of management and control. According to the author, such politicisation of biological life in modern societies allows power to be situated and exercised at the level of life, and interventions into collective and personal matters are conducted in the name of life, health and wellbeing. The notion of biopower refers to that regulation and management of biological life. According to Rabinow and Rose (2006: 196-197), biopower refers to "more or less rationalized attempts to intervene upon the vital characteristics of human existence". Biopower simultaneously works on two poles – on the biopolitics of the population, where population emerges as an object of care, welfare and security, and on the anatomo-politics of the individual body, where techniques of the self are aimed at making the human body more efficient within particular truth discourses. Biopolitics is described by Foucault (2008: 317) as "the attempt […] to rationalize the problems posed to governmental practice by phenomena characteristic of a set of living beings forming a population: health, hygiene, birthrate, life expectancy, race".

Foucault's analysis of the concepts "biopower" and "biopolitics" is fragmentary and incomplete, and relies on the historical analysis of the emergence and transformation of forms of power in the eighteenth and nineteenth centuries (Rose and Rabinow, 2006). However, these concepts were adopted by a wide range of contemporary philosophers and anthropologists who continue to conceptualise the technologies of biopower and biopolitics in the twentieth and twenty-first centuries (Agamben, 1998; Donzelot, 1979; Lemm and Vatter, 2014; Peterson and Bunton, 1997), especially in relation to advances in biomedicine, such as genetics, pharmaceutical innovations and new reproductive technologies (Franklin, 2000, 2005; Nguyen, 2005; Ong, 1995; Rose, 2007). Rabinow and Rose (2006) argue that reproductive technologies are the perfect example of biopower, as they have the capacity to act simultaneously on both the biopolitics of the population and the anatomo-politics of the body. The concepts of "governmentality" and "biopower" thus demonstrate that the effectiveness of disciplinary power lays not in its strength or extent, but in its ability to infiltrate and rearrange local social relations, and that the desired effects are reached not through coercion but through continuous instruction and inspection (Mitchell, 1991).

Applying Foucauldian concepts in postcolonial contexts raises a few concerns. Chatterjee (2004: 36-37) notes that in the postcolonial contexts "techniques of governmentality often predate the nation-state", and the history of the use of biomedicine to surveil, control and discipline Indian population in the name of nurturing health and hygiene by the British colonial powers illustrate this point (e.g. Chatterjee, 1993; Cohn, 1996; Prakash, 1999, 2000; Scott, 1995). For example, Prakash (1999: 136) analyses how the programmes of inoculation, medical treatment and hygiene in colonial India extended British administration's control over the Indian population, "dislodge[d] the body from indigenous beliefs and practices", and made it accessible to the disciplinary techniques of the state. Foucault (1980) argued that biomedicine worked as such a powerful tool for governance exactly because it was deemed a solely "technical" means by which to manage "apolitical" biology, which embedded the biological body within increased regimes of surveillance.

## "Adivasi" *and "tribes"*

In activist and academic circles, it has become a common practice to use the term "*adivasi*" (*lit*. original inhabitants or indigenous people) to describe the groups classified as "Scheduled Tribes" (ST) under the Indian Constitution. Besides political and administrative registers, the term is also used by various groups to define themselves when making claims to the state and serves as a source of identity and subjectivity. However, the inadequacy and political history of the term in the Indian context has been widely discussed both historically and ethnographically in an effort to deconstruct the notion of "tribe" in the Indian context (Béteille, 1986, 1998; Sundar, 1997; Skaria, 1998). The main points of critique are the origins of the term in the colonial project of governmentality (Bates, 1995; Ghurye, 1959; Guha, 1999) and the difficulties of distinguishing *adivasis* from caste Hindus (Sundar, 1997; Unnithan-Kumar, 1997). Such differentiation was based on the colonial administration's view of a more "civilised" Hindu society and the "primitive" groups in the social and geographic peripheries of the country. These colonial categories continue today in new forms and *adivasi* areas and communities tend to be politically and economically marginalised, and face a social stigma of being considered "backward" by caste Hindus. According to Sundar (2014: 472), "(t)he Indian state treats *adivasis* as backward and needing paternal protection, and simultaneously as oppressed and dangerous – the 'Other' of the 'mainstream nation.'"

Throughout this thesis, I use the terms "*adivasi*" and "tribal" interchangeably, and, in doing so, do not "subscribe to the implicit notion of essential differences that it invokes, but

[…] recognise the power of this regime of representation" (Baviskar, 2005b: 7). Throughout my fieldwork, I experienced the ambiguity of the concept on the daily basis. The term "*adivasi*" was employed to denote both the sense of pride and occasionally internalised expression of being wild (*jungli*) with both negative and positive connotations[25] by *adivasi* communities themselves, and, at the same time, was mentioned in whispers by the caste Hindus to express the combination of mistrust, ridicule and fear. It is important to note that this thesis is not exclusively about *adivasi* women. Having conducted fieldwork in a mixed-caste village in an *adivasi* area, I narrate stories and experiences of women from various caste backgrounds, always acknowledging the intersection between gender, caste and class which influence women's particular experiences.

## Outline of the thesis

Having laid out the core conceptual tools and ethnographic context that inform this thesis, in Chapter Two I explore the twists and turns of a complex history of family planning in India. I provide a brief but detailed historical perspective on how discourses concerning family planning in Chandpur, which I explore in following chapters, are grounded in the decades of Indian government's involvement in the matter. This chapter pays special attention to the National Emergency in the 1970s that came to be known as "the time of vasectomies" for the decades after and is still vividly remembered today. This historical period and the coercive and drastic measures it introduced in order to reduce population growth in the name of economic development serves as the only past of family planning that is remembered in Chandpur. I therefore outline both continuities and ruptures between the pre-Emergency, Emergency and post-Emergency population control policies in an effort to provide a context within which the government's insistence on female sterilisation and its prevalence should be understood.

Chapter Three, "The state and governmentality in the everyday life in Chandpur", provides an eclectic ethnographic context of ways in which the state articulates and is

[25] Whereas most of the academic literature discusses the negative connotations of being *jungli* and, therefore, backward, some older ethnographies (e.g. Carstairs, 1957 cited in McCurdy, 1964) stress the more positive and undoubtedly romanticised meanings of being *jungli*. For instance, Carstairs (1957: 134-135 cited in ibid.: 474) writes about *adivasis* in Kotra: "The quality which most forcibly distinguishes between Hindus and Bhils is the latter's zest and enjoyment of life, accepting pleasures and dangers as they come. They are as uninhibited as the Hindus are restrained. Meat, drink, love and laughter are all enjoyed without reserve". Being *jungli* is a concept that is employed ambiguously and contextually by my *adivasi* informants.

experienced in the village. In the second part of this chapter, I narrate the experiences of the state in a Primary Health Centre (PHC) in Chandpur, and focus on a recent but overwhelmingly well received transfer of birth from home to the clinic through the government scheme *Janani Suraksha Yojana* (JSY), or Safe Motherhood Initiative. I argue that the institutions of the state functioning in the village draw their legitimacy from traditional authorities, and that they work through structures that are beyond the formal institutions of the state, such as kinship relations and political economy. The hallowed nature of "the state" allows its institutions to be filled with socialities, economies and power struggles which exist outside the institutions of the state.

Chapter Four, "Motivation for sterilisation: networks and ambiguities of intimacy, exchange and power", explores the network of government officials who implement the family planning programme in the village through the process and practice of "motivation" for sterilisation. I discuss how different types of motivators – various health workers, ration shop dealers, school teachers – engage with women through different techniques and narrate their relationships with women according to the levels and strategies of intimacy and exchange involved. I also discuss how the health workers negotiate the state's policies – the targets for sterilisation and a small family norm – and show that the local agents of the state constantly contest the very institution they are supposed to embody. The last section of this chapter deals with the other side of health workers' engagement with poor women: the intimate labour that they provide throughout various reproductive occasions. In doing so, I blur the lines between motivators as embodying the power of the state and as providers of care in sterilisation camps.

Chapter Five, "Reproductive agency and women's weakening bodies", addresses a complex set of concerns that women have regarding the decision to get their tubes tied. Discussing various reproductive occasions, I untangle the complex nature of women's reproductive agency and contextualise it in various everyday life demands that women in Chandpur face. Women's narratives of their weakening bodies due to regular cycles of pregnancy, childbearing, abortions and contraception provide insight into how the tubal ligation procedure is seen, experienced and pragmatically chosen to relieve the everyday suffering.

Chapter Six, "Encounter in the clinic", provides an ethnography of a sterilisation camp. I discuss the process that women go through in the camp, starting with the registration and counselling, various medical examinations, preparations for surgery and arrangements after it. Through a detailed discussion of various processes and encounters in the camp, I

explore a complex interaction between biomedicine, agents of the state and poor women who come for the procedure. I discuss ways in which biomedical authority rises above the mundane and how it competes with the agents of the state for the care of the patients. Furthermore, I look into how different techniques are employed to demand the truth about women's bodies and how regularly occurring disjunctures between the languages and social worlds of patients and those of politico-medical world make the camp a space of constant negotiations of terms of engagement and subjectivities.

Chapter Seven, "The operable bodies: negotiating social status through female sterilisation", challenges the notion of female sterilisation as reducing women to operable bodies. I discuss how women choose different methods of tubal ligation and places to undergo the procedure as a way to negotiate their social status. In doing so, I challenge the category of homogenous poor and homogenous "bare life", inherent in the discourses about female sterilisation. Furthermore, I problematise the notion that female sterilisation procedure inscribes the women's bodies with vulnerability and the power of the state. I argue that those women who have some control over the circumstances within which to undergo the procedure refuse to be marked by tubal ligation in any homogenous way.

# Chapter Two
# A history of family planning and population control in India

*"It was a different time. Now it is different. Now it happens with a* doorbeen [laparoscope], *and before they used to cut it with a* blade. *Now it happens by choice."*
—Old man, Chandpur

## Crumbles of history: blade against *doorbeen*

Walking towards the bus stand on Chandpur's main road, one never misses an old couple sitting on the floor in the doorway of their house. They spend their days observing the slow pace of the village, chatting with passers-by and discussing those small but intriguing pieces of gossip that reach their threshold. Their son runs a small business in Ahmedabad, Gujarat, and sends them money every month, which they spend on slowly renovating their house and getting the empty rooms ready to be rented out to government teachers and nurses who get a posting to the area. One day I sat down with them in the hallway, which on one side looked out onto the main road, while on the other the two buffaloes, slowly chewing grass and peeking through the window into one of the empty rooms. Constantly interrupting each other in order to add significant details and to emphasise particular points in each other's narrative, they told me their story of ending childbearing. The old woman told me she gave birth to four children, but two of them died within days of childbirth. She told me that she had never even considered getting an operation herself because that was the time of Indira Gandhi, the time when they used to do men's *nasbandi,* vasectomies. Her husband interrupted her to tell me that when she was pregnant with the last child, one day he went to the mill to grind the wheat but did not manage to get the job done because some men seized him, took him to the sterilisation camp and conducted an operation. Now *she* intervened to stress that they grabbed him and did it against his will, forcefully (*jabardasti*). She continued:

> "His operation happened against his will and they also cut the blood vein, so blood started pouring. We had to take him to a big hospital, where big doctors

> came to see him, and there was a doctor of our caste who did another operation and inserted a plastic vein. So why was my operation necessary?"

The old man emphasised that the doctor brought him back to life and somewhat dismissively added: "it was a different time. Now it is different. Now it happens with a *doorbeen* [laparoscope], and before they used to cut it with a *blade* [in English]. Now it happens *iccha se* [by choice, by will]". Being familiar with the fact that vasectomies during the Emergency in the 1970s were related to certain economic benefits, I asked them whether they received anything in return for the operation. With a strong sense of injustice they had suffered, they both shouted angrily: "What did we get? We got nothing!"

The sense of injustice I heard in the old couple's tone when they shouted that they received nothing in return for the man's forced vasectomy, which ended in serious complications and required immediate medical attention, needs to be looked at more closely. Even though both of them were angry that his operation was forced and ended with complications, they seemed to be even angrier that they did not receive anything in return for their troubles and suffering, both physical and emotional. The history of family planning provides the background that enables us to comprehend this sense of injustice. The couple's logic clearly shows that the issue of family planning and subjection of one's body to the government is entangled in the network and logic of exchange, a topic I discuss in depth in Chapter Four. Staples (2014), writing about leprosy in South India, tells one of his main informant's stories of being grabbed from the teashop and brought to the clinic to get sterilised during the time of the Emergency, and quotes his informant's way of making sense of what was happening at that time:

> "I think I only worked out what was happening when we got to the hospital and I was talking to some of the other men in the waiting room. But I didn't make a fuss. I didn't think I could have children anyway, being a leprosy patient, so I thought it was probably better to have the operation and be done with it. The agent, the man who took me there, he was paid something, and I got something too, so I suppose everyone was happy with the outcome!" (ibid.: 54-55)

In Staples' ethnography, the man does not sound particularly traumatised by the experience of forced vasectomy, at least for two reasons. Firstly, being a leprosy patient he did not expect either to marry or bear children; secondly, he was compensated for the procedure. The network and logic of exchange within which family planning, in this case forced and compulsory, is experienced is a result of decades of incentives and disincentives, introduced

and promoted by the Indian government. There is more to this story. Other people in Chandpur that I spoke to about the time of the Emergency emphasised the context within which the forced vasectomies and the corresponding incentives emerged. For instance, another middle-aged *adivasi* man from Chandpur described the drought which caused a bad harvest, empty wells, lack of food at home and starving animals, before moving on to tell me that the main reason some men went for vasectomies voluntarily was that they got wells dug in their land which were deeper and closer to home than the existing ones. The pragmatism that found its ways in the context of coerced vasectomies is unmistakable and characterises many aspects of family planning programmes during the Emergency and throughout decades afterwards.

I tell this short story for several reasons. It is important to understand that, taken as a whole, the personal experiences of the twists and turns of India's history of family planning form the context within which the current trends and decisions in Chandpur are made, interpreted and compared. The persistent memories of the Emergency and of state coercion creep into the narratives of both childbearing and the efforts to end it. The Emergency is seen as history, as "a different time", a marker of what today is not. In the narrative of the old couple it is clear that the Emergency is seen as the time of the blade (and the man uses the English word), whereas now is the time of the *doorbeen*. *Doorbeen* is a Hindi word for binoculars and here it refers to the laparoscope, an instrument with which laparoscopic surgeries, including female sterilisations but not limited to them, are performed. Even though the dichotomy between the blade and the *doorbeen* is very simplistic and does not reflect the nuances of how different techniques of sterilisation are seen and imagined (the differences between *doorbeenwalla* operation and *hathwalla* operation as well as the power and the danger of the *doorbeen* were discussed in the Introduction), it is still quite telling in this ethnographic moment. In the old man's narrative, the blade and the *doorbeen* seem to stand for two opposite versions of modernity. As we will see in the ethnography throughout the rest of this thesis, the blade represents the desires and efforts of the Indian government to control its population against people's wishes, and the attempts to forcefully inscribe modernity onto the bodies of its citizens. On the other hand, the *doorbeen* and the possibility of choice are placed in opposition to this top-down project of modernity and represent the people's own understanding of modernity, their desires and efforts to participate in an alternative project by choosing to end childbearing and subjecting their bodies to the power of the *doorbeen*. In order to understand how the *doorbeen* came to represent choice and modernity, however gendered and classed, it is important to go back to the history of family planning in India.

Coming back from fieldwork in rural India to the corridors of academic life in the UK is a difficult task in itself. However, one of the most difficult challenges is the discontinuity in the ways in which the topic I am researching is discussed by women and men in my field site, and by my friends and colleagues back in the United Kingdom (UK). And the problem is not simply in the difference between local experiences and academic analytical gaze. Rather, the way female sterilisation is understood in relationship to other contraceptive methods as well as other government programmes in the area of maternal and reproductive health, as currently and historically used and promoted, is significantly different. It seems to me that in the academic imagination and discourse, at least in the UK, the mention of female sterilisation in India can hardly be separated by a parallel discussion of forced male sterilisations, which immediately comes to the forefront of the discussion. The Emergency period, sometimes dubbed the darkest moment in India's democracy, and its infamous forced vasectomy camps are vividly captured not only in academic literature, the best example of which is Emma Tarlo's *Unsettling memories: Narratives of the Emergency in Delhi* (2003), but also in novels, such as Salman Rushdie's *Midnight's Children* (1981) and Rohinton Mistry's *A Fine Balance* (1996), and in films, such as I.S. Johar's (1978) satirical comedy *Nasbandi*. And if none of these geographically specific sources and their narratives are familiar to my colleagues, then the reserve of histories and narratives of eugenics and its forced sterilisations of the poor, disabled, imprisoned and mentally ill across Europe and North America (e.g. Bashford and Levine, 2010; Dikötter, 1998; Weindling, 1999) serve a similar purpose. However, it is not necessarily so in this village of Southern Rajasthan. Even though the memories of forced vasectomies, as well as the victims of this draconian policy, are still alive and well – as demonstrated by my opening vignette – female sterilisation is hardly ever understood as a continuation of the family planning programmes of the 1970s. This is why it is important to look briefly into the history of family planning in India, and particularly into female sterilisation in its own right.

In this chapter, I neither intend to, nor am capable of providing, a comprehensive and nuanced history of family planning and population control in India.[26] Rather, I try to highlight some of the trends in the various readings and interpretations of historical developments which I find to be relevant in understanding my own ethnographic material that is presented in the following chapters. Throughout this chapter I demonstrate how population control in

[26] For a more comprehensive history of population control programmes in India, see: Rao (2004), Srinivasan (1995).

India is intricately linked with discourses about development and modernity, and how slowly but decisively the family planning discourse has constructed women as primarily responsible for contraception. I argue that persistent memories of the Emergency as the time of coerced vasectomies, which dominate the imagination of history in my field site, suppress the possibility to critique the fact that the burden of contraception today falls on women and their bodies.

## National family planning in a global context

The history of family planning in India demonstrates that contraception has been inherently linked with discourses about development and modernity, both within India and globally. The history of family planning and population control measures in India needs to be read and understood differently from, though having parallels with, similar histories and struggles in Europe and North America. In an introduction to *Reproductive Restraints: Birth Control in India, 1877-1947*, Ahluwalia (2008: 1) describes her book as "a work that reveals how it is that birth control, a subject so many feminists believe to be inherently empowering for women, became part of an elitist agenda that actually restrained women from exercising control over their own reproductive capacities". She traces complex and multiple histories of processes in colonial India[27] that not only constructed women as primary consumers of contraceptive technologies, turning women's bodies into the contested and conflicted sites for control, but also portrayed lower-caste and working-class women's bodies as fecund and inherently embracing irresponsible reproductive behaviours, and, therefore, needing contraceptive interventions (ibid.: 2-3). In other words, in colonial India birth control as a concern for women's wellbeing, reproductive health and empowerment masked and was shaped by the politics of gender, class, caste, race, sexuality, community, demography and nation. Ahluwalia traces birth control discourses back to Indian nationalists, middle-class feminists, Western activists, colonial authorities and the biomedical community, and argues that birth control represents "an essentially elitist, non-democratic, and oppressive politics of reproduction" implemented to pursue the specific agendas of these different groups (ibid.: 5, 21). Later on in the book, the author acknowledges the possibility that the history of birth

[27] For more information on family planning and birth control in colonial India see: Ahluwallia (2004), Ahluwallia (2008), Hodges (2006), Hodges (2008), Ramusack (1989).

control in colonial India can "be understood as simultaneously emancipatory and regulatory, at once constrictive and expansive, inhibiting and liberating" (ibid.: 58).

Hodges (2004) traces a discursive history of "population" in modern India and identifies three major stages in the way the term "population" was used in public discourse in India. First, the colonial government engaged with "population" through the administration of censuses and famine containment[28] and worked according to a principle that "a large population was a good population" (ibid.: 1159). Second, in the early twentieth century Indian economists started to address "population" in the context of increasing poverty, which led to a nationalist-inspired critique that saw "India's poverty as a symptom of colonial misrule", and not a symptom of a large population (ibid.: 1159). Third, the mid-twentieth century saw the consolidation and ascendance of the discourse of overpopulation as the main cause of poverty and the obstacle to India's social and economic development (ibid.). The third passage, argues the author, determined that India's overpopulation problem came to be seen as a global emergency. The following brief overview of India's efforts in family planning and trends in different decades needs to be read in the context of "population" being conceptualised as problematic, with ideas such as "population explosion", "population bomb", "out of control" fertility rates (rather than unequal distribution of resources, for instance) being considered as the main impediment to economic development. India's family planning programme is seen as a gendered and classed nationalist and modernist project, constituting a significant part of a postcolonial developmental agenda (Chatterjee and Riley, 2001).

Williams (2014: 482), discussing family planning during the Emergency, says something that is relevant to periods both preceding and following the Emergency: "(r)eproduction was thus conceptualized as a critical battleground in the war against poverty, in which sterilizations, pills, and IUDs could be used as weapons". Throughout history, a variety of invasive and untested contraceptive technologies, as well as varying degrees of coercion and compulsion, were justified in the name of economic and social development, national progress and the prevention of demographic disasters. Even though this has represented a project of nationalist modernity, it has also been the product of a variety of struggles between actors within, outside and beyond the Indian state, and has been strongly shaped by global discourses concerning population, health and economic development. In her thesis, Williams (2013) examines how and why international organisations and agencies, as

[28] Hodges explicitly disagrees with Appadurai's (1993: 321) suggestion that in the late 19th century the colonial Indian census changed from "an instrument of taxes to an instrument of knowledge". Hodges (2004: 1158) argues that in censuses "'population' is descriptive of the Indian environment rather than productive of it".

well as the Government of India, made India into a "laboratory" for interventions in population control in the post-independence period. She argues that international agencies focused on India because of the scale, poverty and accessibility of its population and because Indian intellectuals and officials also saw population growth as an obstacle to economic development. Other scholars have also extensively discussed the influence of international agencies, such as the World Bank and the Ford Foundation, on the conceptualisation and implementation of population control policies in India (Ahluwalia, 2008; Connelly, 2006; Mamdani, 1972; Williams, 2013, 2014). All in all, the Indian government's family planning agenda emerged as an integral part of global processes, which gradually constructed the size of Indian population as the main cause of country's poverty and as the main obstacle to its social and economic development.

## The 1950s and 1960s – the beginnings and their failures

In 1952, India became the first country in the world to launch an official family planning programme with the aim of reducing population growth. Throughout the decades, various contraceptive methods were introduced and favoured by the government and varying degrees of persuasiveness were employed. During the First Five-Year Plan, between 1951 and 1956, attention was paid mainly to setting up clinics which could provide family planning services and, following Gandhian ideas (Harkavy and Roy, 2007: 305), the rhythm method[29] was the most promoted method of contraception (Letbetter, 1984). During the Second Five-Year Plan (1956-1961), the distribution of contraception was extended to the Primary Health Centres (PHC), government hospitals and dispensaries. However, in the 1950s, even though the new family planning agenda received funding, half of the money was not spent.

The spending on the programme increased only by the mid-1960s when a so-called "cafeteria" approach[30] was adopted to provide a range of family planning methods according to the needs and preferences of individuals – condoms, contraceptive pills,[31] diaphragms, jelly, cream, foam tablets, IUDs and sterilisation for both men and women who had

[29] The rhythm method is a method of avoiding conception by restricting sexual intercourse to the times of a woman's menstrual cycle when ovulation is least likely to occur.

[30] A cafeteria approach refers to choosing a method of contraception from a wide range of available options. A decision to choose a particular method is left for a patient.

[31] In the 1960s, oral contraceptive pills were distributed through the government hospitals and clinics as part of the cafeteria approach, and in the 1970s the government gave it a name – *Mala N* and *Mala D*. Up until today, *Mala N* continues to be distributed free in government hospitals and through the health workers, while *Mala D* is available through social marketing organisations at a minimal price (Jacob, 2008[2005]: 262).

completed their desired family size. Around the same time, a small family norm, targets and incentives were adopted (Satia and Maru, 1986), family planning services started being brought to the people's doorsteps by the auxiliary nurse midwives (ANM) (Jeffery, Jeffery and Lyon, 1987), and a nationwide publicity campaign including posters and radio programmes was launched in multiple languages (Connelly, 2006). These resulted in slogans such as "a small family is a happy family" (*chota parivar, sukhi parivar*), and later on, "we are two, ours also two" (*ham do, hamare do*, a slogan associated with Sanjay Gandhi, see below) to reach even the most remote parts of India and become part of the everyday vocabulary. In 1962, 158,000 men and women (more than 70 percent of them males) were sterilised as the use of mobile units to reach people institutionalised for tuberculosis, leprosy, and mental illness was encouraged (Gupta and Bardhan, 1992: 6 cited in ibid.). In 1968, approximately 90 percent of sterilisations were vasectomies (Chandrasekhar, 1968). The fourth Five-Year Plan (1969-1974) introduced a "camp approach" – a delivery of services to the community through the organisation of regularly held camps – in family planning, first in the state of Kerala and later in other states, as well as a strong emphasis on IUD (Krishnakumar, 1974). Throughout these decades, increasingly coercive family planning policies in India were undertaken at the recommendation or at least with an agreement of international agencies, such as the World Bank, the Ford Foundation, the Population Council, the International Planned Parenthood Federation, and the United States Agency for International Development (USAID) (Connelly, 2006; Mamdani, 1972).

## The 1970s – the Emergency and forced vasectomies

Following the economic crisis of 1966,[32] the Indian government strengthened its emphasis on promoting the notion that population growth is detrimental to economic advancement (Ravindran, 1993). As mentioned in the introduction to this chapter, the most dramatic period in the history of population control in India is the time of the Emergency. In June 1975, the Prime Minister Indira Gandhi proclaimed a state of Emergency which began a period of authoritarian rule lasting 21 months and ending in March 1977. During this period, elections

[32] The 1966 economic crisis in India saw a devaluation of the rupee by 57 percent against the American dollar. Several factors contributed to the crisis: trade deficit, an inability to borrow from abroad, the cutting off of foreign aid, India's war with China in 1962 and with Pakistan in 1965, which significantly increased the government's budget deficit, as well as the drought of 1965-1966, which resulted in the rise of prices. Each of these factors increased deficit spending and accelerated an already high inflation, ultimately leading to the unpopular decision to devalue the currency.

were postponed and fundamental civil and political rights of citizens legally suspended, while the Congress-led government pursued an agenda of economic development under the slogan "*garibi hatao* [remove poverty]". In July 1975, Indira Gandhi announced a twenty-point economic programme which included measures to control the price of essential commodities, tackle rural indebtedness and increase production. However, some of the government's acts hit the country with unexpected violence, with political opponents imprisoned and tortured, the press censored and protests brutally dispersed in the name of the protection of internal stability. According to Indira Gandhi, these drastic measures were "incumbent on a democratic regime to remove obstacles and impediments […] for social, political and economic progress" (Tarlo, 2003: 26). According to Tarlo, in this narrative, modernity was the goal, and the Emergency was the means to attain it (ibid.: 29).

Besides Indira Gandhi's twenty-point economic programme, in February 1976 her son Sanjay Gandhi[33] announced his own four-point (and later five-point) programme: adult education, abolition of the dowry, eradication of the caste system, beautification of the environment and family planning. Whereas the first points did not receive great attention, the last two – the beautification of the environment, which mainly focussed on tree-planting and slum clearance, and family planning – became defining elements of the period of the Emergency, at least for some sections of society (Krishna, 2011: 170). In April 1976, a National Population Policy was announced which included extended family planning targets, increased incentives for the "acceptors" and disincentives for large families (Williams, 2014). For the official purposes of economic development slums were demolished, and forced, mainly male sterilisations were performed on a massive scale. The family planning agenda forms an integral part of the Emergency narrative and, in the public memory, the Emergency is still remembered as a time of vasectomies or *nasbandi ka vakt* (Tarlo, 2003). The Emergency is also remembered as a period of bureaucratic "excesses", when over-zealous bureaucrats, under strong pressure to achieve targets and present results, implemented programmes, especially the family planning one, to an unprecedented extent. A reported eight million people were sterilised, mostly men, and 1,774 people died due to what have been called "family planning excesses" (Rao, 2003: 3452). However, male sterilisation had been a popular method of contraception since the mid-1960s, and over 18 million sterilisations had been performed before the Emergency (Gwatkin, 1979). Nevertheless, it was during the

[33] Sanjay Gandhi held no official post in the government but became the extraconstitutional centre of power (Mehta, 1978).

Emergency that the family planning initiative gained unprecedented scope and implemented unprecedented measures.

Gwatkin (ibid.: 44) offers examples of ways in which the initiative penetrated the everyday lives of various civil servants and government agents as well as ordinary people as targets of family planning:

> "Railroad travellers would find their tickets being checked more carefully and frequently by inspectors, as long-standing regulations against the time-honored village tradition of ticketless travel began to be more rigorously enforced. The many ticketless travellers were subject to heavy fines, but the ticket inspectors would often prove willing to overlook the traveller's indiscretion if he would agree to be sterilized. The traveller would thereby avoid a fine and also receive the handsome cash payment given to vasectomy acceptors. The ticket inspector would have one less person to motivate in order to meet his assigned quota".

Discussing the unexpected relationships between sterilisation and other spheres of everyday life, such as ticketless travel on public transport in Gwatkin's account, Tarlo (2003: 148-154) describes not only how people got sterilised in order to obtain plots of land or keep their jobs as sweepers, bus drivers and factory workers, but also how in a school in Old Delhi all those students whose parents got sterilised passed their exams while those whose parents had refused sterilisation were failed.

The primary targets of forced vasectomies were the illiterate, economically and politically disadvantaged, scheduled castes and tribes, as well as Muslims. However, Tarlo (1995: 2921) argues that the simplified opposition between the bureaucrats as perpetrators and the poor as victims conceals the Emergency regime's power and "ability to draw all kinds of people, through fear, into participation". It is important to understand that the power of the Emergency lay not only in its reach, at least in urban India, through schools, the police and hospitals, but also through private industries, shopkeepers and cinema halls. Tarlo discusses a variety of ways in which two programmes – the forced resettlement of slum dwellers in Delhi in order to beautify the city and family planning – were closely intertwined and the consequences of such intertwining. She shows how sterilisation became a criterion for one's eligibility for housing benefits, such as plots, flats, tenements in resettlement colonies, and how, for the poor at that time, the Emergency only left a choice between sterilisation and homelessness. Most importantly, though, Tarlo breaks down the opposition, or at least blurs the lines between victims and perpetrators by showing how, firstly, "the poor" cannot be considered as a homogenous and inactive category and, secondly, how the poor themselves

became involved in recruiting other, even more vulnerable candidates for sterilisation, in order to avoid their own eviction or homelessness. In this way, the author shows how pragmatism and opportunism in the struggle for plots amongst the poor and their ability to transfer victimhood onto those even more vulnerable contributed to the sterilisation drive, even exceeding the government's targets and expectations (Tarlo, 1995, 2003: 200-201).

Besides Tarlo's work, there are very few ethnographic accounts of how the Emergency was experienced by the people at the time. Schlesinger's "The Emergency in an Indian Village" (1977) is one of these few. Schlesinger was conducting fieldwork in a village in Maharashtra during the Emergency and he writes that "(t)he Emergency in the early days in the countryside was a hard thing to see. There was lots of publicity – words everywhere announcing the new era – but the change was not visible, and the words, the programs, were neither new nor very credible" (ibid.: 633). Discussing the coercive sterilisation programme, he recounts how there was no open opposition to it, even though many disagreed, as "(t)he power of the government to act arbitrarily and without restraint was tacitly accepted" (ibid.: 641). He argues that:

> "The Emergency inspired an unquestionable, no-recourse character of authority, that is, the less questionable, more ambiguous appearance of authority, which implanted fear and gave the police an opportunity to take advantage of villagers. […] The villagers, thus, saw in the Emergency an expansion of, at least a change in, the state's exercise of authority" (ibid.: 638).

Other social scientists also examine the time of the Emergency as a critical moment in India when the nature of power, politics and authority were reconfigured. Re-reading Tarlo's work, Das (2004: 240) argues that even though the relationship between resettlement and sterilisation was "not strictly legal, […] the paraphernalia of recording claims, examining certificates for authenticity, and so on, gave it the aura of a legal operation", and the paperwork surrounding these programmes and practices itself "became proof of the 'legality' of the operations" (also see Gupta 2012). Khanna (2009: 151-152), building on Agamben's (1998) theory of the state of exception, argues that the Emergency was the time when the biopolitics of the Indian state were reconfigured. He explores the juxtaposition of the docile body of the masses, who were portrayed as in need of modernity and development and who were sterilised, against the silenced subject of the politician, the journalist and the activist, who demanded fundamental rights. Khanna (2009: 43) argues that during the Emergency the "citizen-subject, stripped off of its rights was united with the mute body of the 'masses' in its

injury, and it is in emerging from this unity that […] civil society took upon itself the right to speak for the 'masses', a right for which it continues to compete with the state".

Whereas some authors (Dayal and Bose, 1997; Henderson, 1977; Shah Commission, 1978) emphasised the voluntary nature of family planning programmes before the Emergency and regarded the Emergency as a moment of crisis, others (Banerji, 1976; Gwatkin, 1979; Vicziany, 1982) argued that voluntarism in the pre-Emergency programmes was a myth and, therefore, emphasised the continuity between pre-Emergency and Emergency policies, instead of a great rupture. Vicziany (1982) argued that the lack of resistance to the family planning programmes during the Emergency was caused by the elements of continuity between pre-Emergency and Emergency rather than the new factors. Cohen's (2004) work on forced sterilisations during the Emergency and on other sites of mass operations, such as eye camps, also shows the continuities in biopolitical processes between the Emergency and ordinary times. Tarlo (2003: 21) argues that the Emergency, similarly to the Partition of 1947-1948, has been conceptualised as a brief "moment of madness" because it does not sit comfortably with modern India's "history of progress". Therefore, even though the Emergency is imagined and remembered as an extraordinary moment in the history of democracy and especially family planning in India, characterised by coercion and driven by the personalities of Indira Gandhi and Sanjay Gandhi, it is important to see the continuities between the Emergency and the times preceding and following it. It is clear that the discourse of the Emergency both dominates the various versions of history of family planning in India favoured by activists and academics, and is incomplete, full of silences and contradictions.

## The 1980s – a return to targeting women

After the Emergency, in the 1980s the emphasis was placed on reducing infant mortality, linking sectors in health planning, establishing comprehensive primary health care and reducing poverty. The correlation between lower birth rates and the higher status of women, better nutrition, education and healthcare was the driving force of government programmes post-Emergency. The Integrated Child Development Services (ICDS) programme, launched in 1975 and used as a tool for population control during the Emergency, "emerged as the only credible population program remaining" (Gupta, 2012: 246) in the post-Emergency period. The programme aimed at reducing infant mortality and morbidity by providing immunisation, supplementary nutrition and other health services for children and their mothers. As Gupta (ibid.: 246) states, the logic behind ICDS was the idea "that if child mortality could be

decreased, it would reduce the incentives for people to have more children as a form of insurance". In 1980, a National Population Education Programme was launched, and various activities under the header "Population Education" were introduced in the formal education curricula in schools (Pandey, Prakash and Tyagi, 1993: 152). From the mid-1980s, school textbooks were filled with messages promoting a small family norm, delayed marriage, responsible parenthood, and portraying largely rural, illiterate poor as contributing to India's "underdevelopment by producing 'too many' children" (Bhog et al., 2010: 223). The 1980s also saw a comeback of the "cafeteria" approach, offering couples a range of different contraceptive methods. However, the decade saw a shift in focus onto women as the preferred population for birth control (Basu, 1985), with the emphasis on tubectomies and IUDs. Even with a cafeteria approach, tubectomies and laparoscopic sterilisation were promoted, and over 70 percent of sterilisations were laparoscopic operations performed on women in sterilisation camps (Hartmann, 1995[1987]).

Even though vasectomies are associated in particular with the Emergency period, as early as the 1960s several Indian states started providing compensation to cover the out-of-pocket costs for couples who accepted sterilisation (Jha and Harvey, 2012). At that time, vasectomy was the more popular of the two sterilisation procedures. Due to the negative connotation that male sterilisation gained during the Emergency, *nasbandi* came to stand for the infamous family planning initiative in general. The result was a backlash against government-promoted vasectomy – but not against female sterilisation, which instead continued gaining prevalence without interruption. The 1980s thus witnessed the increasing popularity of the female sterilisation procedure, with a strong emphasis placed on its voluntary nature.

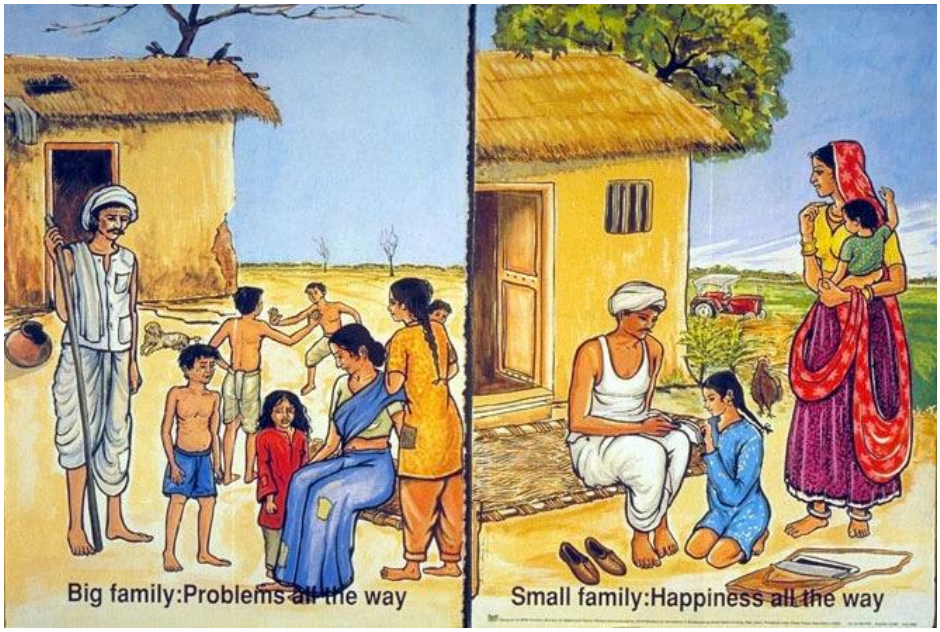



**IMAGE 3: A FAMILY PLANNING POSTER PRODUCED BY THE MINISTRY OF HEALTH AND FAMILY WELFARE IN 1992.**

## The 1990s – a turn to reproductive rights regime

The 1990s saw a lot of contradictions when it came to family planning. The process of economic liberalisation of the 1990s[34] meant that the state renounced its interest in basic health services, while the intense focus of the state, the NGOs, and international funders returned to the problem of the population. The privatisation of healthcare meant that private companies, NGOs and international donor agencies became involved in the delivery of healthcare and family planning. The 1990s saw the increase in funding for family planning in India "in the wake of renewed hysteria over environmental destruction due to overpopulation" (Correa and Reichmann, 1994: 27). After the 1991 Census results, which were perceived as a failure of efforts in family planning, a Committee on Population was set up. The committee

[34] In 1991, the Congress-led government initiated a series of reforms of the Indian economy, mainly aiming at its global integration through a change of the regimes of taxation, trade barriers and investment. These changes led to the increasing privatisation of various sectors, such as healthcare, education, transport, energy supply amongst others. One of the peculiarities of the economic liberalisation in India is that, notwithstanding the introduction of private service providers in many sectors of the economy, the government increased public spending significantly instead of reducing it. Initiatives like the National Rural Employment Guarantee Act (NREGA) (one of the most expensive social programmes in the world), the various subsidies destined to households categorised as living Below Poverty Line (BPL), the extension of the Integrated Child Development Services (ICDS) are just a few examples (Gupta and Sivaramakrishnan, 2011). Social scientists have widely discussed the implications of economic liberalisation in India, including the changing role of the state, the reconceptualisation of poverty and democracy, as well as changing class and caste relations; for some of these discussions, see Chatterjee (2008), Corbridge and Harriss (2000), Gupta and Sivaramakrishnan (2011).

proposed the formulation of a National Population Policy and recommended legislation prohibiting any person with more than two children from holding certain public posts, from *panchayats* to Parliament (Buch, 2005). The states of Rajasthan (1992), Andhra Pradesh (1993), Haryana (1993) and Orissa (1993) all approved laws following this principle for elected *panchayats* and other local bodies.[35] The underlying logic was that community members would perceive the elected representatives as "role models" and follow the small family norm themselves. The two-child norm was critiqued as anti-poor and anti-women. Buch (ibid.) reports situations in which elected representatives tried to declare a lower number of children and the adverse effects of these efforts on women. The author reports cases of male *panchayat* members abandoning their wives expecting a third child, or accusing them of adultery in order to claim the third child was not theirs, and female *panchayat* members undergoing abortions in order to contest elections or hiding their third children altogether, preventing them from breastfeeding and bringing children along to the meetings. All in all, studies show that the majority of those disqualified from contesting elections or removed from current posts due to violating a two-child norm were young, poor, lower caste and illiterate (Buch, 2005; Visaria, Acharya and Raj, 2006).

At the same time, following the 1994 International Conference on Population and Development in Cairo, India in the 1990s showed an invigorated emphasis on reproductive health and rights, a "target-free" approach and other idioms implying agency and choice (Pinto, 2008: 220). In 1996, the Indian government officially abandoned family planning targets. Instead, the new index of Expected Level of Achievement (ELA) was introduced and functions up until this date. ELA "is estimated for each state by the indicators reflecting the community needs like contraceptive usage, parity, unmet need and existing fertility" (MoHFW, 2015: 135), but still functions in a manner very similar to previous targets. Qadeer (1998) shows that the idea of "reproductive health" hides within itself a technocratic approach with a technological fix to the problem – contraception. She argues that the concern with reproductive health and rights still works on the main assumed relationship between population growth and fertility as the main causes of poverty, and, therefore, "women are

[35] The two-child norm is only applicable to persons of active reproductive age and exempts older persons who have completed their families (Buch, 2005). It is also important to note that the two-child norm is not enforced as an entry requirement but through a complaint procedure. The Rajasthan High Court considered the validity of this norm and observed "though having more than two children does not, in any way, affect the working of the *sarpanch*, *panch* or a member of a panchayat raj institution but the population explosion has affected the economic condition of the state and it is with the purpose to implement the mandate of the directive principles of state policy that this measure was considered necessary" (Mukesh Kumar Ajmera and others v. State of Rajasthan and others, 1997).

identified as the central focus of intervention to reduce population and, thereby, poverty" (ibid.: 2679). Furthermore, Qadeer (ibid.) also argues that the reproductive health framework has reduced the issue of women's health to a matter of service delivery and quality, without providing space for questions about structural issues of inequality and discrimination. Therefore, what the 1990s fundamentally witnessed was a switch in the implementation of population control from a narrative of economic development to one of reproductive health and rights.

## After the millennium

In 2000, the Government of India adopted a National Population Policy (NPP) which stated that the government was committed to "voluntary and informed choice and consent of citizens while availing of reproductive healthcare services, and continuation of the target free approach in administering family planning services" (GoI, 2000). Amongst the goals set for 2010 in the NPP, such as delayed age for marriage and compulsory education up to the age of fourteen, the government also aimed to "(a)chieve 80 percent institutional deliveries and 100 percent deliveries by trained persons" (ibid.). The health minister at the time, Anbumani Ramadoss, stated that the national government did not support the two-child norm, but since health is a state subject, it was not possible for the central government to influence the policies of different states (Rai, 2005 cited in Visaria, Acharya and Raj, 2006). In 2000, the two-child norm was adopted by Himachal Pradesh and Madhya Pradesh, in 2003 by Maharashtra and in 2005 in Gujarat. In 2001, the Government of Rajasthan (2001[1954]: 13) extended its two-child norm to government employees by including the following segment into the Rajasthan Administrative Service Rules 1954: "No candidate shall be eligible for appointment to the service who has more than two children on or after 1 June 2002". In 2003, the Supreme Court of India upheld a Haryana law prohibiting a person from contesting or holding the post of *sarpanch* or *panch* in the *panchayat* institutions if he or she had more than two children, and found this norm consistent with the NPP. In its ruling, the Supreme Court stated that "In our view, disqualification on the right to contest an election by having more than two living children does not contravene any fundamental right nor does it cross the limits of reasonability. Rather it is a disqualification conceptually devised in national interest" (Javed and others v. State of Haryana, 2003). Emphasising India's increasing population as a national problem causing congestion in urban areas, shortfalls in food grains, rising unemployment and reduced per capita income, the Supreme Court observed that "it has to be

remembered that complacence in controlling population in the name of democracy is too heavy a price to pay, allowing the nation to drift towards disaster" (ibid.). In spite of the verdict, between 2005 and 2006, Haryana, Himachal Pradesh, Madhya Pradesh and Chhattisgarh revoked the two-child norm.

## A brief note on the women's movement's engagement with contraceptive technologies

With the exception of the Emergency when the government's focus was on male sterilisation, it was Indian women's fertility and bodies that were made into objects of intervention of the developmental state and had to bear the costs of economic development. The history of the government's efforts in population control does not, however, fully reflect the history of violence associated with contraception in India. Various women's groups raised concerns over the relaxation of drug regulations, which were part of liberalisation policies in the 1990s, in order to speed up the introduction of long-acting, invasive and often hazardous contraceptives in the face of unrealistic population control targets, market liberalisation and privatisation of healthcare (Sarojini and Murthy, 2005).

Unlike elsewhere, the women's movement in India never had to fight for women's right to abortion, as the liberalisation of the strict colonial law criminalising abortion began in 1964, at least according to the official discourse, due to the concerns for the high maternal mortality ratio and the prevalence of complications deriving from illegal abortion practices (Hirve, 2004). In 1966, the Shah Committee, formed by the Government of India to investigate legal, social and medical aspects of abortion, recommended legalising the procedure (GoI, 1966). However, the questionnaires used to investigate these aspects show a clear link between abortion and population control, especially through sterilisation. For instance, the question "Do you consider that abortion should be permitted in the following cases?" is followed by a list of situations: if the mother has already three children and is willing to get sterilised concurrently with abortion; if the mother has already three children but is not willing to get herself concurrently sterilised nor her husband; if the mother has three children and both husband and wife are willing to get sterilised (Phadke, 1998). As a consequence of recommendations from the Shah Committee, abortion was legalised by the Medical Termination of Pregnancy (MTP) Act of 1971. However, according to activists in the

women's movement,[36] the Act came about not because of feminist concerns or concerns for the wellbeing of women, but purely as an instrument of population control (see, for instance, Gupte, Bandewar and Pisal, 1997). Therefore, instead of struggling for the right to abortion, Indian feminists found themselves raising questions about the unintended and unforeseen consequences of reproductive technologies on women, the ways in which these technologies perpetuate unequal gender relations and the widespread sanction for abortion rather than contraceptives, especially condoms, as a method of controlling population (Menon, 2012). The women's movement and health rights activists raised questions about the safety and long-term effects of various contraceptive technologies, the way in which clinical trials are conducted, and the problematic nature of informed consent, and also protested against the inclusion of women in the healthcare system only as reproductive beings and the exclusion of their other health needs. Furthermore, issues such as sex-selective abortions and female infanticide are seen as instigated by national concerns with population growth (Agnihotri and Mazumdar, 1995).

The 1980s saw one of the first campaigns for banning E-P Forte, a drug based on a high-dose combination of synthetic female hormones, oestrogen and progesterone, being used to detect pregnancy. The widespread misinformation that this drug can terminate pregnancy and its illegal over-the-counter sales increased the risk of congenital abnormalities (D'Mello, 2002). In 1983-84, the Indian Council of Medical Research (ICMR) initiated a Phase IV trial in urban and rural areas to assess the acceptability of Net-En (a hormonal injectable contraceptive) towards its introduction into the National Family Welfare Programme (NFWP). The study recruited poor women in Andhra Pradesh without informing them about harmful side effects. In 1986 women's groups, including Saheli, Stree Shakti Sanghatana and others, filed a writ petition to the Supreme Court against the Union of India, ICMR and others asking for a stay on the Phase IV clinical trials of Net-En on the grounds of the hazardous nature of the drug, its unsuitability for an ill-equipped health delivery system and concerns over informed consent (Bal, Murthy and Subramanian, 2000). In 2000, the government admitted that due to potential risks, lack of monitoring and follow-up, the mass use of Net-En in the NFWP was not advisable (Sarojini and Murthy, 2005). A similar campaign was launched against Depo-Provera, another hormonal injectable contraceptive, which was introduced into the Indian market in 1994. In 1967, its approval as a contraceptive in the USA

[36] For some of the debates surrounding the definition, composition and history of the women's movement in India see: Menon (1999), Agnihotri and Mazumdar (1995), Kumar (1993), Anagol (2005), Ram (1998b).

was denied due to evidence of carcinogenic effects, but it was eventually approved as a contraceptive in 1992 by the USFDA, however, with warnings of strong side-effects. Women's groups argued that Depo-Provera's side effects, such as menstrual disorders, irregular and heavy bleeding, can have catastrophic consequences on women in India, many of whom already suffer from anaemia. The recommendations made at the Drugs Technical Advisory Board meeting held in 1995 stated that "Depo-Provera is not recommended for inclusion in the Family Planning Programme" (ibid.). Similar issues were raised concerning the use of contraceptive implant Norplant, quinacrine sterilisations (George, 2004) and anti-fertility vaccines. The women's movement's engagements with and critique of particular contraceptive measures demonstrate a different side of the Indian government's family planning agenda post-Emergency. The women's groups' explicit critique of women's bodies being subjected to invasive and often hazardous methods of contraception, once again, highlights the continuities, rather than disjunctures, between the measures employed during the Emergency and the decades afterwards.

## Conclusion

Even though condoms have been available in India since the 1940s and India introduced its own brand of condom, *Nirodh*, in the early 1960s, this has never been the most promoted form of contraception, at least not in rural India. Vicziany (1983) argues that the failure to promote it fully before 1977 makes sense only in the context of the government of India relying on the more dramatic results promised by vasectomy. Mazzarella (2001, 2014) compares *Nirodh*, a condom promoted by the Government of India, and *KamaSutra*, one of the commercial brands of condoms to emerge in the 1990s. He argues that whereas *Nirodh* represented the government and its efforts in family planning (even the name *Nirodh* was derived from a Sanskrit-derived word meaning restraint and control), *KamaSutra* stood for self-realisation and the pleasure of consumerism and the market (2014: 214-15). By juxtaposing two different ideas – citizens have sex and consumers make love (the title of the article itself) – illustrated by different discourses surrounding *Nirodh* and *KamaSutra*, the author opens up an interesting conversation about the technocratic and instrumental nature of the family planning programme in India throughout the decades. A long and complicated history of the ways in which contraception has been conceptualised not in terms of women's autonomy, freedom and agency, but as part of an official family planning programme resulted in a concept of birth control as subjection, at least partial, to the state's power and authority,

and a way to economic development and social mobility, which articulates in the narratives of both men and women in Chandpur which I discuss in Chapter Five. In this state-promoted family planning narrative, sex is spoken about without exploring matters of sexuality, pleasure and desire, matters reserved for those who have access to the pleasures of the market and consumerism.

In this chapter, I located India's population control policies in relationship with global forces and processes in an increasingly globally interconnected world (Ferguson and Gupta, 2002; Gupta and Sharma, 2006; Trouillot, 2001). Since its beginning in the 1950s, India's family planning agenda has employed various levels and methods of coercion, and underwent multiple reconceptualisations depending on the historical circumstances and particular concerns of the decades. The programme's first steps in the 1950s and 1960s saw efforts in building the infrastructure to distribute contraception and increasing contraceptive options within the so-called "cafeteria" approach. The state of Emergency in the 1970s brought the most drastic and coercive measures in population control history, and forced vasectomies came to dominate the public memory of this whole period. The 1980s witnessed the integration of a family planning agenda within a wider conceptualisation of poor health, and a return to targeting women. Although the International Conference on Population Development in Cairo in 1994 urged governments to abandon coercive measures and targets in family planning and focus on women's reproductive rights and choices, family planning initiatives continued targeting poor women in India, similarly to other global contexts (Castro, 2004; Greenhalgh, 2005; Maternowska, 2006; Morsy, 1995). The adoption of a two-child norm in various states across India in the early 2000s once again illustrates that the concern for women's reproductive rights, health and choices remains a political discourse, instead of a lived reality. In this chapter, I emphasised the role of international development agencies, aid and their influence on internal politics illustrated clearly through the history of the family planning agenda, including the reproductive rights regime which emerged in the 1990s, and pharmaceutical corporations' treatment of India as a laboratory for drug testing.

Understanding the main trends in the intricate history of India's efforts in family planning is important for several reasons. Female sterilisation was introduced in the late 1960s but became popular only in the early 1980s, when contraception method acceptance shifted from vasectomies to female sterilisations. This shift can be partially explained by the stigma attached to vasectomies, which were forcefully performed during the Emergency, and the development of laparoscopic techniques for female sterilisation. Memories of coercive measures in family planning initiatives serve as a background for the experiences of female

sterilisation nowadays. However, in order to understand the realm of meanings within which the decisions to get sterilised are made nowadays, it is very important to understand people's perceptions of coercive sterilisations during the Emergency and the ways in which the experience of the Emergency gains new life and takes new forms nowadays. From the conversations with my informants it becomes clear that the Emergency comes to stand as the past embodying the simplified version of the history of family planning in India. It is difficult to tell whether the Emergency is simply dominating the discourses of "how it was before" because of the means of violence and coercion which live vividly in the memories and narratives of my informants, or whether the lines between pre-Emergency, Emergency and post-Emergency times, programmes and their means are completely blurred in Chandpur. In the following chapters, it will become clear how experiences of and references to this overwhelming Emergency, understood as the only past and the only reference point in contrast with what today *is not*, creep in in a variety of ways. The forthcoming ethnographic accounts of women's experiences of and encounters with the institutions and discourses of the state in the context of female sterilisation must be read and understood against the historical context outlined in this chapter. I argue that the female sterilisation procedure today is not experienced as coercive or violent partially (and precisely) because people's main reference point is the Emergency, long gone but not forgotten.

# Chapter Three
# The state and governmentality in the everyday life in Chandpur

Eva: "*sarkar kya hai?* [what is the state?]"
Jimli Bai: "*koi sanstha hoga* [it will be some institution]"

"*India has never been more governed than it is today*"
—Partha Chatterjee (2012: 318)

## Inscription of the state in the everyday landscape

On a jeep or motorcycle journey through Jhadol *tehsil*, one cannot help but notice a variety of objects and buildings that seem to be out of place with the continuity of landscape around. Amongst the hills, the maize and wheat fields and sparse forests, mud huts, an occasional dried out river bed and small market places at road intersections, one spots seemingly random

**IMAGE 4: LANDSCAPE IN RURAL JHADOL.**

yellow and white painted signs on sides of houses and rocks with educational messages in Hindi. Messages encouraging healthy habits, educating one's children, valuing the girls, planting trees and sometimes limiting family size cover every side of the bigger and smaller roads in Jhadol. They are written on sides of houses, rocks, school, hospital and other walls: some are signed by NGOs or National Rural Health Mission[37] (NRHM) but some are anonymous. The distinctive architecture and uniformly peach pink colour of government schools and primary health centres also stands out significantly in the rural landscape. However, after a longer time spent in the area, it turns out that these buildings and messages form an integral part of rural Rajasthan landscape. They mark a particular set of institutions, practices and interventions which, if contextualised historically, can help one to unravel the everyday significance and meaning of the state and other modes of governmentality in rural North India.

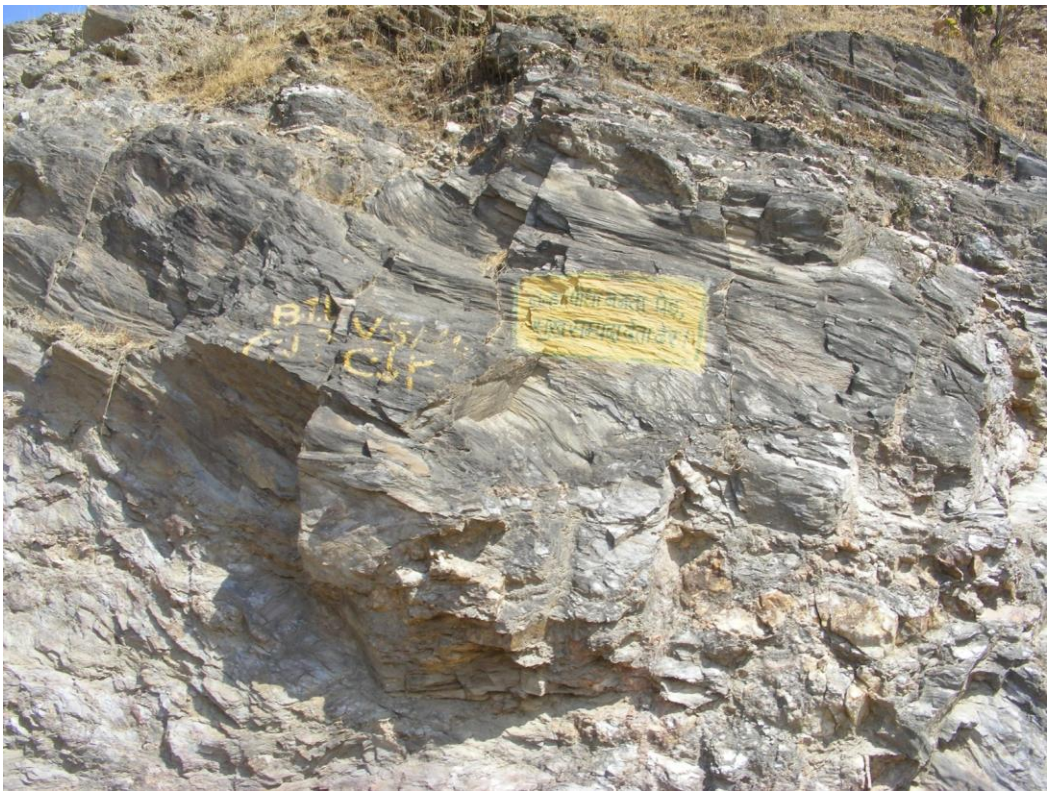


**IMAGE 5: AN EDUCATIONAL MESSAGE ON THE SIDE OF THE ROCK.** It is difficult to read but it says: *nanha paudha banta per, sukh sampada deta der* (small seedling becomes a tree, the waiting/time gives happiness and wealth).

[37] The National Rural Health Mission is an initiative launched by the Government of India in 2005, which seeks to provide accessible, affordable and quality health care to the underserved rural areas.

One can spend almost an entire jeep journey of about 20 kilometres from Jhadol to Chandpur reading one message after the other. The richness of this discursive landscape indicates the presence of state and state-like actors. The failure of the post-colonial state to bring development into rural Rajasthan meant that the development work is carried out by a variety of actors, signalling the presence of different forms of neoliberal governmentality. These actors include Christian missionaries, Hindu nationalist organisations, local and international NGOs which perform governmental welfare functions (Ferguson and Gupta, 2002) and, at the same time, contribute to the construction of the state as discreet, powerful and autonomous through everyday development practices (Sharma, 2006). Development is an important part of the Indian state's postcolonial identity and serves as a source for the state's legitimacy (Chatterjee, 1993; Ludden, 1992) and, at the same time, is one of the key sites where cultural narratives about the state are created and negotiated (Sharma, 2006).

It is important to note that these messages are almost completely irrelevant to people living in these areas, even though the efforts to make them legible (for instance through Hindu mythologies, see Image 3.3 above) are also visible. Not many people can read, and even those who can, tend not to pay attention to these signs, as they blend in with advertisements for phone companies, soft drinks, and tyres. The work of writing and the written word in the area where illiteracy is prevalent is not contradictory however. It is both a demonstration of power, and a basis for authority (to write and to read), and it forms a thread that will surface in many of the following chapters. These messages become important to visitors – the funding bodies who provide funding to NGOs, and visitors like myself who are searching for the articulations of the state and state-like actors and their efforts in development. This landscape, overcrowded with signs of development activity and enthusiasm, stands in contrast to the very irrelevance of these signs to the people living there.


**IMAGE 6: SOCIAL ADVERTISING ON THE SIDE OF THE HOUSE ON THE OUTSKIRTS OF JHADOL.** Translations from left to right: Get the vaccines and regular check-ups, so that no harm comes to the child, signed by Child Fund; Leprosy's treatment is free; Forests drink poison like Shiva and produce wealth like Kamadhenu. They compare the forests with lord Shiva and Kamadhenu (a divine bovine-goddess described in Hinduism as the mother of all cows). The way lord Shiva in order to save the world drunk the poison that came out during the churning of sea, forests do the same by absorbing the poison ($CO_2$) from the atmosphere and making it safe for mankind to live. The way a cow produces wealth (in form of milk, cow dung to be used as fuel/manure) throughout her life, forests also produce wealth (in form of food, fodder, minerals, and most important of all Oxygen) throughout their life.

I use this landscape as a metaphor extending to the wider presence of the state in rural North India. Just like these messages cover the landscape without anyone reading them, the state situates itself in the everyday life of rural North India without addressing the people as citizens. Hansen (2001: 35) argues that the imagination of the state in India is characterised by the disjuncture between its profane and sublime dimensions, where the profane encompasses the technical side of governance, its incoherences and failures, and the sublime contains the higher forms of rationality, resources and power. Whereas Hansen speaks of public performances and imposing buildings in Mumbai as consolidating the idea of a distant and powerful state, Kalra (2015: 251), argues that in rural Southern Rajasthan "it is a rural landscape dotted with distinctive architecture of government schools, development offices, and primary health care centres, and the seasonal visibility of NREGA programs". The

educational messages covering every wall presumably create the effect of the presence of a higher structure, possessing the resources and rationality, which is able to inscribe itself on to the rural landscape.

Hansen (2001: 36) also proposes that the idea of a sublime state allows a possibility to interpret the dispersed everyday "procedures of bureaucracy, into meaningful signs of something larger". I seek ethnographically to investigate the articulations of both profane and sublime aspects of the Indian state and the ways in which it merges with other powerful actors. In this chapter, I discuss various ways in which the state articulates itself and is experienced by women and men in Chandpur through a variety of forms of governmentality. I aim to locate the state in terms of everyday practices, people and encounters. I am interested in investigating how the state manifests itself in the daily lives of people through a variety of encounters, which will later allow me to move to discussing the articulations of the state in the practice of female sterilisation. In this chapter, I argue that even though the state is overwhelmingly present in rural Rajasthan, it engages with the people as populations rather than citizens, and remains present through its failures, contradictions and irrelevance, rather than its coherence. Furthermore, I prepare the ground for the following chapters by demonstrating that the disciplinary power of the state in rural North India lies not in its scope or means of coercion, but in its ability to infiltrate local structures of power, to transform them and to work through them.

## Defining the state

The state is not a clearly defined unitary actor, a coherent body or a set of institutions and practices which are clearly separated from society (Fuller and Benei, 2001; Mitchell, 1991). The state manifests itself and articulates in a variety of everyday situations, relationships and dispersed practices (Corbridge et al., 2005). Gupta (2012) suggests approaching the state as a disaggregated array of institutions that operate at different levels, in multiple locations and with diverse and sometimes competing agendas. He further suggests that this disaggregated quality of the state makes every effort to analyse the state necessarily partial (ibid.). Through investigating the power such as that of the state only through direct manifestations of it, such as struggles for power in local and national elections or competing over state resources, one risks losing sight of much more mundane and intimate manifestations of that power. Shah (2007: 129) suggests that we can see the state only by not looking at it directly: "It is precisely when the state is not the centre of analysis but instead emerges through the wide remit of

ethnographic research in multiple forms, in unexpected encounters, and through unpredictable relationships, appearing and disappearing in broader social processes, that insightful analyses result". However, in this chapter I suggest that one must look at some state institutions in Chandpur directly, for instance the Primary Health Centre, in order to see that these institutions function through networks and practices outside the institution itself. In other words, the hallowed nature of state's institutions allows them to be filled with local imageries of power, desires and fears (Aretxaga, 2003), as well as with economies and socialities which lie beyond the state.

In the Foucauldian framework, the state is seen as a mechanism for regulation and control over its people and, by extension, people's relationship with the state is always a relationship of power and regulation on the one hand, and the relationship of resistance on the other (Foucault, 1982). Following Mbembe's (2006[1992]) suggestion that binary oppositions, such as subjection and autonomy or resistance and passivity, do not fully capture the nature of relations of power in the postcolony,[38] I argue that a simple juxtaposition between power and resistance to describe the relationship between the people and the state does not capture people's engagement with the state in the everyday practices. There is a need to find the vocabulary to describe the nuances of these engagements. As I show below, on the one hand, the state is not the only source of authority in the village and it draws its own legitimacy from a variety of other networks and relationships. On the other hand, people engage with the state pragmatically, and use the resources provided (or withheld) by the state to their own ends.

Talking about the state brings the conversation to matters and projects of citizenship. Rose (2007: 131) vaguely defines projects of citizenship as "the ways that authorities [think] about (some) individuals as potential citizens, and the ways they [try] to act upon them in that context". He continues elaborating on the concept by suggesting that he is concerned with various ways in which the state tries to encourage certain ways of thinking, feeling and acting, and these ways include introduction of compulsory education, of a single national language or a single legal system as well as designing particular buildings and public spaces (ibid.). This way of talking about the projects of citizenship is distinct from the view of citizenship as a

[38] When talking about the postcolony, Mbembe (2006[1992]: 381) refers to "the specific identity of a given historical trajectory: that of societies recently emerging from the experience of colonization" which can be characterised by a chaotic plurality, multiplicity of identities and their constant transformations. Even though Chandpur is undoubtedly a postcolonial space, these aspects inform my analysis but mostly remain implicit, rather than becoming the main framework.

qualitative relationship between citizens and the state, where citizens make rights-based claims to the state. This rights-based relationship marks the relationship between civil society and the state. Instead, Rose's concept resonates better with Chatterjee's (2004) notion of political society. Political society refers to the idea that the state engages its people as "populations" who have to be both looked after and controlled by various governmental agencies. As Chatterjee (2004: 38) puts it,

> "Most of the inhabitants of India are only tenuously, and even then ambiguously and contextually, rights-bearing citizens in the sense imagined by the constitution. They are not, therefore, proper members of civil society and are not regarded as such by the institutions of the state. But it is not as though they are outside the reach of the state or even excluded from the domain of politics. As populations within the territorial jurisdiction of the state, they have to be both looked after and controlled by various governmental agencies".

The author builds on Foucault's (1979b, 1991) concept of governmentality, where the state draws its legitimacy from providing care to the population rather than through an active participation of citizens in its decision-making. Chatterjee (2004: 34) continues saying that, contrary to the idea of a rights-bearing, demands-making and actively participating citizen, the idea of a population brings about the possibility to instrumentally reach large groups of people as targets through a set of particular policies, be it welfare or economic policies, the law or political mobilisation. Replying to Menon's (2010) argument that struggles in political society are aimed against governmentality rather than at the pursuit of governmental benefits, Chatterjee (2012: 318) disagrees and argues that since the 1970s

> "It is the steady widening and deepening of the web of governmentality, not merely as technology but as practices of everyday life among rural people. Contrary to those who argue that the state, in its recent neoliberal heartlessness, has withdrawn from the welfare role it played during the days of Nehru and Indira Gandhi, I believe that its arms, bearing the instruments of coercion as well as of looking after populations, is now able to reach more corners of the territory […] than any formal governmental structure has ever done in Indian history. India has never been more governed than it is today".

Throughout the following sections, I demonstrate that the unprecedented degree of governmentality is especially visible in rural India. However, people's engagements with and conceptualisations of these processes and practices are ambiguous, contradictory and constantly changing.

## The local state

In the village, we see some aspects of the state engaging with the people as citizens with rights, duties, claims and demands, mainly through party politics. However, the presence of a variety of state institutions, programmes and initiatives does not speak of the relationship of citizenship. Rather, it speaks of the state engaging with a variety of "populations" produced through administrative procedures, mainly such as targeting the Below Poverty Line (BPL) poor, who need to be governed, developed and protected. Corbridge et al. (2005: 47) argues that the construction of a category, such as BPL, is a certain form of poverty construction and creates social spaces and occasions through which the poor see and experience the state. In Chandpur, there is a strong sense of what the poor deserve and should get from the state. Identification with the poor people (*garib log*) is felt and performed in everyday life. As Gupta (1998: ix) puts it, "underdevelopment is a form of identity, something that informs people's sense of self. The way people think about themselves and how they can make their lives better are influenced by institutions and practices of development". These categories, employed by the development discourse, become part of the way people imagine themselves and their social worlds (Pigg, 1992: 507). In other words, the categories used to name groups of populations in order to implement government's policies in development, such as BPL, are internalised and appropriated in everyday life (Hacking, 1986). However, that sense of being entitled to state's support because one is poor, cannot be acted upon because the relationship with the state is usually mediated. The mediators – government workers, elected *Panchayat* members and institutions – are also seen as either corrupt and untrustworthy, or too powerless to do anything about it.

There are a variety of ethnographic moments which tell a story of the state's claim to govern the people in and around Chandpur legitimate. One such example is the story of how the government entered the tribal village, closest to Chandpur. A few years ago, a local government in Udaipur decided to build a primary school and an *anganwadi* in this village because the villagers were not using these institutions in Chandpur. The government officials came to meet a chief of the village, *mukhiya* or *gameti*,[39] to ask for land for these two institutions to be built. The *mukhiya* was a man highly respected and listened to not only by the people of this particular tribal village but also by the other *mukhiyas* from the villages

[39] For more information on the role of the village chief in Bhil villages in Rajasthan, see McCurdy (1964).

nearby and further away.[40] When approached by the government officials, the *mukhiya* decided that the villagers could benefit from the government services being brought closer to their homes and gave a part of his own land for the school and a small building for *anganwadi* to be built behind his house. The house of the village's *mukhiya* is called *bara ghar* (big house) and is considered to be the house of the community. Even though since the death of the *mukhiya* and his wife, the big house is barely used anymore, symbolically it still stands for a strong sense of community and the previous powerful authority of the chief. The current *mukhiya*, the previous *mukhiya's* oldest son, does not live in this house and does not take his functions as a chief very seriously, and, in the eyes of the villagers, the empty big house stands for the lack of authority that today's *mukhiya* holds. However, the school and *anganwadi* standing behind the big house still draw their legitimacy from the traditional authority of the *mukhiya*. This short ethnographic example demonstrates that the state does not undermine the traditional authority but rather draws its legitimacy from it. In other words, the state works through the existing relationships and networks of power and substitutes them, rather than competes with them. The state is not powerful on its own; it builds its power and transforms it from other sources of authority. Even though it is difficult to tell where the state begins and where it ends, it is important to look at various overlaps between authorities, which are competing and complementing each other at the same time.

Another ethnographic example shows that even though the state is present and active more than ever in rural India through its policies of governmentality, it is, to some extent consciously, not the most immediate authority. The institutions, the rules and the sociality of the village and the community (*samaaj*) are much more immediate, closer, and their effects upon the lives of the villagers more real than those of the state. Filing "a case" with the police is a common practice in the village when dealing with quarrels over land, beatings, murders, and accidental deaths. Filing "a case" is a term which refers to the filing a First Information Report (FIR) and takes the form of a written document prepared by the police when they receive information about a cognizable offence as a result of an official complaint lodged by the victim or by somebody on the victim's behalf.

To illustrate this process, on one hot day in May I heard that my neighbour, Jivin, got into a quarrel with his brother, Natu, who was living in front of him and who filed a police case. Natu's son, Krishna, narrated the story how Jivin, drunk as every other day, got angry

[40] People say that when the *mukhiya* passed away from tuberculosis a couple of years ago, his funeral brought hundreds of people from various villages to come to pay their respects.

after seeing that one of Krishna's goats sneaked into his fields. The quarrel escalated with Natu blaming his recently deteriorating health on Jivin's wife's evil eye. There was some physical fighting but it is difficult to know who hit whom first. The next day, Jivin filed a report with Jhadol police against his brother, accusing him of physical violence. Krishna was worried that a criminal record in his family might compromise his chances of ever getting a good job.[41] Two policemen came the next day but did not stay long. The policemen said that there was no need for two real brothers to fight amongst each other and advised that the villagers should seat them together, eat *gud* (unrefined sugarcane sugar)[42] together and make up. They asked Jivin and Natu to come to the police station the following week and report if their conflict had been resolved or whether they needed the police to mediate the process of *nyay* (justice, settlement). In the context of the inevitable bribery that accompanies police involvement in local cases, it is rather common for the police to leave small conflicts to be resolved within the community, as there is not much for the policemen to gain financially. If a conflict is big and big sums of money are involved, policemen are usually present. However, the very fact that the policemen – the agents of the state – advised the quarrelling brothers to resolve their conflict by sitting down with the whole village, shows that the state is not interested in being involved in every aspect of people's lives. In this case, the agents of the state acknowledge that the traditional practice of resolving conflicts within the community is much more immediate and useful than that of the state.

In Chandpur, whereas men and women might aspire, expect or seek a government employment,[43] like Krishna described above (for the salary as much as for the job security) or other financial benefits coming from the state, neither men nor women seek the state for its own sake, or for simply being included in the project of the state. There is a strong

[41] Krishna is educated to a Bachelor degree level and is aspiring for a government job. His exam results were not very good, so he is still waiting for the posting and acknowledges that if he had Rs. 2 lakhs (or Rs. 200,000), he would be able to get the posting via bribery. He even applied for a government-advertised position to drive Chandpur PHC's ambulance, but somebody else supposedly bribed the *sarpanch* and got the job. In the meantime, Krishna buys marihuana from local farmers and sells it in Udaipur. He acknowledges that it is a risky activity and if he gets caught, he could never get the desired government job. However, he also says that it is the fault of the corrupted system which prevents him from getting a proper job which corresponds to his qualifications. This very ambiguity – a desire to be a part of the government system, being critical of practices of corruption and, at the same time, surviving through illegal sales – is what characterises some people's relationship with the state.

[42] *Gud* is quite often involved in various conflict resolution contexts, whether it is consumed or buried. It symbolises leaving the bitterness behind and maintaining sweet social relations. In some parts of rural North India, *gud* used to be distributed to the labourers when the work creating dust was overtaken, such as cutting wheat. *Gud* is seen as purifying the body from dust.

[43] The state can be desired only by those who are educated but it is actually attainable only to those who have financial and social capital.

disappointment with the state's services and even the poorest families sometimes manage to afford to educate their children in private schools or manage to arrange the money for treatment in private hospitals. The state is seen as an institution commonly referred to as a site where nobody cares (*dhyaan nahi dete*). The same idiom is employed when talking about the hospital care, schools, police attitude and practices of corruption by local politicians (mainly *sarpanch*). The rules and procedures of the state, both official and unofficial, are a source of anxiety rather than desire. The way to get around these anxieties is by engaging with the state through mediators. The relationship between the women and the state, for example, is almost always mediated. As we see later in this chapter, the *daima* (traditional birth attendant) is the one bringing the women to the hospital to deliver, and the *anganwadi* worker has to visit every household in the area in the morning of an immunisation camp in order to make the women and their children come for vaccines. The mediator between the women and the state is usually someone who is known on personal terms with the woman. This relationship is also a relationship of power, but this power is not ultimate. The state is the terrain of unfamiliarity, and that is why one always needs someone to mediate, to speak the language of the state and to explain the procedures.

No matter how negatively the state is imagined or disregarded, people still engage with the projects of governmentality in pragmatic ways. There are many places where the state – by which here I mean the procedures, the time and the ideas of the state – can be encountered in the village. For instance, the way the hospital and the ANM function demonstrates the presence of a specific form of "state time" which structures the activities and practices of the state. In other words, the state also articulates itself through the introduction of state time – fixed days on which particular services are provided or particular activities are organised. Sterilisation camps were held on Tuesdays in Jhadol and on Fridays in Phalasia; every first Thursday of the month, an immunisation camp was held in one village, and every second Thursday in another; health workers' meetings were held on the 8th of every month and so on. Such a fixed schedule for activities following a Gregorian calendar is introduced by the state and is not particularly familiar in villages where seasons, festivals and days are structured according to agricultural activities and are constantly changing rather than fixed.

These examples represent an effort to "look for signs of administrative and hierarchical rationalities that provide seemingly ordered links with the political and regulatory

apparatus of a central bureaucratic state"[44] (Das and Poole, 2004a: 5). The state can come to one's home in the form of a health worker or an occasional surveyor. It can also be encountered in spaces such as police station, a ration dealer's shop or the *anganwadi*. For many women in and around Chandpur, a local government hospital is one of these places of direct contact. The following section discusses the process of encountering the state in this hospital and unravels the complexities of social relations as well as imaginaries coming together in such a space.

## Encountering the state in the clinic

My own journey in looking for the articulations of the state in Chandpur started in the local hospital, the Primary Health Centre (PHC). I moved to the village in February and it took me a couple months to settle in, to get to know my neighbours and build other relationships, and to observe the everyday life in the village before I embarked on a journey to find out how sterilisation is motivated for, conducted and talked about. By that time, the season for sterilisation (see Chapter Five) had passed and my every attempt to visit sterilisation camps in Jhadol was unsuccessful because these camps were not organised during that period. Talking to women revealed that none of them went for the procedure on their own but were accompanied by a nurse. Therefore, in order to find those nurses who accompany women during the sterilisation procedure and to find out about other government efforts and discourses concerning family planning, I found myself on daily visits to the PHC.

The staff in the hospital kept changing throughout my time in the field. At first, there was an Ayurvedic woman doctor and a nurse, Kamla, from Udaipur, a male nurse called Rajuji who had lived in Chandpur for almost 15 years and another nurse, Basanti, who mainly did the night shifts because she lived in a rented room near the hospital. An Ayurvedic doctor was the highest ranking doctor in the hospital, but due to the shortage of Ayurvedic supplies and her lack of qualifications in biomedicine, she did not perform any medical procedures or treatments. She refused to conduct deliveries, because it was "a dirty job" and she "personally" did not like it. According to her, she had conducted a few deliveries during medical school but chose not to do them anymore. Rajuji was addressed by almost everyone in the village as *doctor sahib*. One day Kamla told me that he was not a real doctor but a male

[44] For other anthropological works informed by this approach, see: Ferguson and Gupta (2002), Fuller and Harris (2001), Herzfeld (2001), Hansen and (Stepputat 2001) amongst others.

nurse. According to Kamla, "he is a man and that is why people think he must be a doctor". Rajuji recently bought a big *kacca* house[45] on the main road in Chandpur and started running his own private medical shop and was probably the most trusted "doctor" in the village, for both medical treatments and deliveries. Padma Devi was the only auxiliary nurse midwife (ANM) in Chandpur and conducted field visits, immunisation camps and deliveries in the PHC, amongst other things. She came from a Meghwal family (the only *dalit* caste in the village) and lived in a huge *pakka* house on the very outskirts of Chandpur, across the whole village from the hospital. Basanti came from an *adivasi* family from Banswara, a district in Southern Rajasthan, rented a room near the hospital and mainly covered night shifts in the PHC. Rajuji, Padma Devi and Basanti, all coming from lower caste backgrounds and residing in Chandpur, were the personnel conducting most of the deliveries in the hospital. Kamla as well as newly posted Aisha, were reluctant to deliver babies but did it if and when absolutely necessary.

For a person from the city, receiving a government posting for a position of a teacher, nurse or a doctor in a rural setting would be undesirable. Kamla, Aisha and the Ayurvedic doctor all complained about the problems of commuting between Udaipur and Chandpur and back, as well as about "the people of Chandpur" – that they were dirty, uneducated, and did not understand anything. One day in the hospital the Ayurvedic doctor and Basanti had an argument about misplaced signatures in one of the registers. The doctor shouted at Basanti for taking too many holidays. Basanti shouted back: "I live in this village, so people come to me any time, I am 24 hours on duty, people wake me up in the middle of the night!" The doctor quickly packed two of the smaller office books into her handbag and left the hospital to catch a bus back to Udaipur at 11 am. The fact that she simply left, particularly when viewed against the backdrop of the widely reported absenteeism of teachers and doctors all across rural India[46] speaks about a particular feature of the way the state is enacted and, furthermore, imagined. Anthropologists have discussed the "imagination of the state" as acting alongside its material aspects (Hansen and Stepputat, 2001; Ferguson and Gupta, 2002; Taussig, 1997),

[45] *Kacca* and *pakka* are two opposing categories which are used in a variety of contexts in India, and can describe food, houses and roads, amongst other things. *Kacca* means raw, uncooked, incomplete, incoherent, and *pakka* means cooked, proper, substantial, solid, coherent. In my work area, *kacca* house refers to the house made of clay and *pakka* to a brick house; *kacca* road refers to an unpaved road and *pakka* to an asphalted one.

[46] The weekly absenteeism survey reveals that, on average, 45 percent of medical personnel are absent in subcenters and aid posts, and 36 percent are absent in the (larger) primary health centres and community health centres. The situation does not seem to be specific to Udaipur: these results are similar to the absenteeism rate found in nationally representative surveys in India and Bangladesh (Chaudhury and Hammer, 2003; Chaudhury et al., 2006).

and their analysis sheds light on the ethnographic moment described above. There is a particular temporality and uncertainty when it comes to imagining the state – sometimes it is there, and sometimes it is not.

Rajuji, Padma Devi and Basanti lived in Chandpur and were seen by the villagers in a very different light compared to other nurses and doctors who came to the hospital for a few hours every day. They had built personal and neighbour relationships, were known, respected for their social status that came with having a government job, and were trusted by the villagers in some contexts. The commuting staff tended to maintain a level of formality when dealing with patients and midwives, and visited the market only to catch the bus. They projected a much greater social distance and maintained their status as urban, educated and usually upper-caste. However, neither the local staff nor the commuting nurses and doctors were trusted with full confidence. Their authority was always acknowledged but not necessarily acted upon.

Throughout my time in the hospital, I conceptualised three ways in which the hospital is used and experienced by the villagers. The hospital is seen as a place for childbirth, free medicines and paperwork. All three forms of engagement with the hospital unravel a number of ways in which the state articulates itself in the village as well as how people experience and make sense of that local state.

## *Hospital as a place for childbirth*

The hospital in Chandpur always had at least a couple of pregnant women wandering around its corridors or the area outside. After entering through the main hospital doors, one sees a labour room at the very end of the long corridor. It is a small grim room with a few pieces of equipment – delivery table, the lamp, foot-operated pump and scales. A National Rural Health Mission (NRHM)-labelled neonatal care incubator also stands in the corner, but it serves as a shelf for black plastic bags. These big black plastic bags are used to cover the delivery table and the bed in the maternity ward so that they stay clean. One bag is also put inside the rubbish bin which is put under the side of delivery table, so that the childbirth blood and other fluids form a stream and run down the table and into the rubbish bin. Next to the labour room is a maternity ward – a big room with seven beds, where women are allowed to stay for three days after the delivery. Some days the maternity ward was packed with women who had recently given birth, with their babies lying next to them and their female kin sitting on the floor and male kin gathering outside, and other days it was completely empty.

Traditionally, in rural North India maternal health care was in the hands of *daimas*. *Daimas*, or traditional birth attendants, tend to be older women from the community who look after pregnant women, conduct deliveries and look after the postnatal women and their newborns for approximately forty days after the delivery – they bathe the newborns, massage them and wash women's and their babies' clothes. Whereas in *adivasi* communities, any woman can learn to be a *daima* (usually from her mother-in-law), in mixed-caste villages, women of the *Nai*[47] caste become *daimas*. Chandpur had only one *daima* from *Nai* caste who looked after every woman in the village, whereas tribal villages surrounding Chandpur had one or two *daimas* each. It is important to note that almost everybody in a tribal village is connected to everybody else through kinship relations; therefore, one's *daima* is also a family member. In spite of the government's disapproval of *daimas*' role in childbirth, as it was articulated to me by the Udaipur CMHO officer during our meeting at the very beginning of my fieldwork and discussed in the Introduction, and their alleged incompetence in biomedical practices, *daimas* still are an integral part of childbirth in institutional as well as home settings.

In 2005, the Government of India, as part of National Rural Health Mission (NRHM), launched *Janani Suraksha Yojana* (JSY), a Safe Motherhood Initiative. NRHM seeks to provide accessible, affordable and quality healthcare to the rural population, especially the vulnerable groups. JSY in particular aims to reduce maternal and neonatal mortality by promoting institutional delivery among poor pregnant women (MoHFW, n.d.). Women in rural Rajasthan are offered a financial incentive of Rs. 1,400 if delivering in the hospital. Institutional deliveries in rural Rajasthan and Udaipur district have significantly increased since the introduction of this incentive, but have not reached the set targets. Since the JSY was introduced and the word about it spread via the network of midwives and government health workers, the PHC in Chandpur became a place where most of the women from surrounding villages as well as some women from Chandpur came to deliver their babies. Rajuji recalled that ten years ago nobody even thought about giving birth in a hospital. Traditionally childbirth was, and in many parts of rural North India still is, conducted in the comfort of one's home with the presence of a midwife and female kin. With this in mind, it is

[47] *Nai* caste in North India are barbers. Besides hair cutting and conducting deliveries, they also work as bloodletters and bonesetters. Such contact with human body parts and fluids is considered polluting, therefore, *Nai* are positioned low in caste hierarchy and are classified as Other Backward Caste (OBC) (Singh, 1998: 681-684).

extremely important to understand that seeing a government hospital as a place for giving birth is a very new but unexpectedly well accepted idea in Chandpur.

Ram (1998a) and Van Hollen (2003), both scholars who have worked with women in rural Tamil Nadu, narrated the anxieties and fears associated with institutional deliveries, whereas other anthropologists wrote about the comfort and support women received during a home birth (Pinto, 2008; Sagar, 2006). When I asked my neighbour why her daughter-in-law chose to deliver in the hospital, whereas she herself successfully gave birth at home five times before, she replied: "In hospital they give you injection (*sui*) and money. The baby comes out easily that way. And if you give birth at home, the government will not give you the money". Such a reply was very common. Women believed that if they could have given birth at home, then their daughters-in-law could do the same thing. However, Rs. 1,400[48] is a significant amount of money and seemed to be worth the change of setting.

Another reason why institutional deliveries became rather accepted in and around Chandpur is that the local midwives are very well incorporated into the networks of the state. Trainings for traditional birth attendants (TBA) in safe delivery practices have been organised by Seva Mandir for years. The midwives have a strong sense of pride in being certified by this particular NGO and proudly carry symbolic objects – identity cards and bags – that mark them as representatives not simply of this NGO, but of development and institutions in general (Jordan, 1993[1978]). Seva Mandir portrays the midwives as the agents of change in their respective communities, practicing safe antenatal, childbirth and postnatal care practices. Along with most international health agencies which view TBAs as "a valuable medical resource, socially close to their clients" (Jeffery, Jeffery and Lyon, 1987: 152) and against the view of the Indian government, Seva Mandir does not demonise home births and encourages the midwives to practice safe childbirth first; whether it is at home or in the hospital is a consideration which comes second. However, Seva Mandir has a strong relationship of cooperation with the agencies of the state and indirectly supports the transfer of childbirth

[48] Currently, Rs.100 can be converted into 1£. An average daily income of manual labourers in the construction sites in Jhadol *tehsil* ranges from Rs.70 for carrying and sieving stones, usually done by women, to Rs.300 for a supervisory role and mixing cement. The rates are higher in Udaipur but daily commuting costs between Chandpur and Udaipur need to be taken into account. It is rather difficult to provide an average monthly income of any household, as the number of family members engaged in employment varies significantly, and employment itself is not regular: some work a week every month to cover the living costs, others work daily for a few months in a row and take a few months off, and so on. Even though the daily cost of living is not very difficult to cover, especially having in mind that most households grow many produce themselves, the extra costs associated with various kinship obligations are high and frequent.


**IMAGE 7: THE WOMEN IN THE FAMILY, INCLUDING THE *DAIMA*, ARE READY TO LEAVE THE HOSPITAL IN CHANDPUR AFTER A DELIVERY WITH A GOVERNMENT-RUN AMBULANCE 104.**

from home to the clinic also. Therefore, the midwives became the main agents facilitating the sudden increase in institutional childbirth in Chandpur.

Childbirth in the hospital does not necessarily mean a safer choice. The village hospital is not equipped with the necessary resources to deal with emergencies. In rural areas, the focus of institutional childbirth is on changing simple practices which at home might cause problems – applying antibacterial solution, cutting the umbilical cord with clean instruments, sewing tears in the vagina with a clean needle and so on. When a nurse suspects that the baby is positioned sideways, or is afraid to deliver a woman's first child due to a supposedly difficult labour, the woman and her companions are put into the ambulance and transported to either the Community Health Centre (CHC) in Jhadol or a government hospital in Udaipur. Most of the women, their midwives and female kin find it inconvenient and demand that an experienced doctor, usually Rajuji, is called. Rajuji is thought of as somebody who can deliver babies in any situation and is not afraid to take risks. However, when he is not available, the family has to get into the ambulance and be taken to a bigger hospital. If a

child is born in an ambulance, it is considered to be an institutional delivery and the woman is eligible for the financial incentive of Rs. 1,400.

After 2005 when the institutional childbirth programmes were introduced and lots of resources were put forward to implement them in rural settings, the role of *daimas* has changed. Instead of performing home deliveries and caring for women during pregnancy and after the delivery themselves, *daimas* more and more often encourage pregnant women to deliver at hospitals and accompany them on such trips. Up until very recently (sometime halfway through my fieldwork), *daimas* were paid Rs. 150 by the government every time they brought a pregnant woman to the hospital for the delivery. Afterwards, these payments were stopped and *daimas* kept receiving Rs. 100 from Seva Mandir for every delivery they conducted, regardless of whether it was a home or hospital delivery. These payments were on top of payments by money or food products such as wheat, maize and *ghee* from the family.

During my visits to the PHC in Chandpur, I observed ways in which the traditional maternal health care practices were integrated into, or at least happened alongside, the comparatively new biomedical practices propagated by the government. Every pregnant

**IMAGE 8: *DAIMAS* SUBMITTING THE REQUIRED PAPERWORK AND RAJUJI FILLING IN THE REGISTER FOR THE PAYMENTS FOR AN INSTITUTIONAL DELIVERY TO BE PROCESSED.**

woman who came to deliver at Chandpur PHC was accompanied by her *daima* and other family members. In addition to their traditional role as birth attendants, *daimas* were people with knowledge of the system and process of the government hospital. They were the mediators between pregnant women and doctors and nurses in the hospital during the registration process, dealt with the jeep drivers who brought women from their more or less remote homes to the hospital, and they also helped women claim their financial incentives. When delivering in a hospital became a common practice, the need to navigate these official hospital procedures and the *daimas*' abilities to do so expanded what is considered to be authoritative knowledge in childbirth (Jordan, 1993[1978]).

After somebody from the hospital staff checked how many centimetres a pregnant woman's cervix was dilated, the *daima* would take care of women until the very last minute before the baby was about to come – they sat or walked around the hospital together, and showed women positions which were supposed to induce labour. *Daimas* were also present in the labour room and helped with deliveries alongside the doctor or nurse. However, there was a clear division of labour inside the delivery room and their functions were different from the functions of biomedical personnel: *daimas* were responsible for the woman's upper body – they pushed the baby from above – whereas biomedical staff were responsible for pregnant woman's lower body: helping the baby to come out of the vagina, cutting it when necessary and sewing up the tears afterwards. Furthermore, as Chandpur hospital did not have money designated for a cleaner's position, it was the job of a *daima* to clean up the labour room after the delivery, which, even though in a new setting, corresponded with the link between childbirth and ritual pollution which made childbirth the most polluting practice, far greater than menstruation, sex or death (Jeffery, Jeffery and Lyon, 1989).

Traditionally, the placenta of the newborn is buried near or within the house. Such a practice became more difficult to follow when the deliveries started to be conducted in institutional settings instead of the home. On various occasions it was a duty and sometimes an initiative of the *daima* to procure the placenta from the labour room and bring it home to be buried. As mentioned earlier, all the materials coming out of the woman's body during childbirth were collected into a bucket that was put underneath the labour table. After the birth of the child, as part of their cleaning duties, *daimas* emptied the bucket into a cramped space between the hospital building and the wall surrounding it, just outside the window of the labour room. This space was used to dump not only the biomedical waste and anatomical refuse, but also empty boxes which used to contain medical supplies, old paperwork and used syringes and bandages. Stray dogs and crows liked scavenging through this space, looking for

their preferred items. When the hospital nurse left the labour room and before emptying the bucket, some *daimas* used to take out the placenta from the bucket, wrap it in a plastic bag and hide it in their bigger plastic bags under other items.

When I witnessed it the first time, however, there was no secrecy surrounding the act. I joined the delivery when the baby was already out but the umbilical cord was not cut off yet. The *daima* was holding a plastic bag on the side of the delivery table for the placenta to be put in. She must have discussed the issue with Rajuji before because he was being cooperative and gave me a meaningful look – "are you seeing this?" The *daima* and the mother-in-law were both participating in this effort. "What are you going to do with it", I asked. "We are taking it home and we will put it into a dug hole outside of the house", the *daima* replied smiling. Burying the placenta is a fairly common practice throughout rural India and symbolises a variety of relationships and concerns, such as an embodied relationship with the land, rootedness in a particular territory and a child's future being tied to the natal land (James and Kay, 2003 cited in Santoro, 2011:83; Lambert, 2000; Pinto, 2008; Poonacha, 1997), as well as fears of infertility and evil eye (Jeffery, Jeffery and Lyon, 1989; Pinto, 2008).

"Are you going to do it today or after she returns from the hospital?" I asked again. "Today itself because it will start stinking by the time she comes back", the *daima* replied. After massaging out the placenta, putting it into the *daima*'s plastic bag and disinfecting the vagina by spilling iodine from a big bottle from a distance, Rajuji left the room. Following his previously given instructions, the *daima* and the mother-in-law put a bandage around the woman's waist first, then took an already prepared bundle of bandage to serve as a sanitary pad and, after fitting it outside of the vagina, tied it to the string around her waist. The *daima* denied the mother-in-law's suggestion to change the woman's dirty *ghagra* (skirt) for a clean petticoat: "We will do that later". The woman who just delivered was struggling to put her enlarged breasts back into a tiny black blouse and one of them was left half out. The mother-in-law covered her head and body with the shawl. She was slowly taken out of the labour room and into a post-delivery ward. The *daima* carried the placenta, while the mother-in-law carried the baby. Some *daimas* explained that they needed to almost steal the placenta and do it secretly because the doctors might scold them. However, this first time I witnessed the *daima* doing this shows that Rajuji had no problem with this act and simply saw it as something that *adivasis* and their *daimas* did. "It is their custom, what can I do?" he explained to me. In very simplistic terms, this shows how the "traditional" finds ways and tactics to function within the spaces and the times of the "modern", and how the "modern" adapts to

provide space and sometimes incorporate the "traditional". It also shows how the hospital is a mixture of tradition, modernity and various its mixtures and forms in between.

Several months later, I met Dr. Chopra, an experienced government surgeon who sometimes helped out the Marie Stopes India team, in one of the sterilisation camps in Jhadol. We discussed the coexistence of various healing traditions in the village and the way some people knew how to treat one particular condition or another,[49] and then moved on to talking about *daimas* working in institutional settings. He embarked on a monologue:

> "You know, everything in India happens by *jugaad*. It means an alternative arrangement, for instance using somebody's glasses for one time reading or using whatever you have to make it work, such as a scooter's tyre to fix a car. My government is also by *jugaad* technology – three percent from this party, three from another. Everybody is *jugaadi* – everybody is trying to push life. Liver disease's treatment is sugar, and people think it got better from the swirled oil.[50] The only difference between home deliveries with *daimas* and hospital deliveries is infection prevention and detection of complications, which are not possible at home. Childbirth is a natural physiological process, and so many times babies get delivered. If the baby and the way it is positioned is normal, there is no need of anybody there, no need for any intervention, it is a natural process. There might be only ten percent of complications but *daima* cannot detect them – there are vaginal, uterus tears which cause infection. And *daimas* deliver ninety babies successfully and ten die, but they do not think it was preventable. That is why they are advised to bring women to the institution".

*Jugaad*[51] is a polysemic word that is used in a variety of everyday contexts and refers to solving problems in a context of scarce resources, "qualities of resourcefulness and recombination" as well as "the ability to get close to and combine forces with other subjects who can help make a specific goal attainable" (Jauregui, 2014: 77). Dr. Chopra's employment of *jugaad* to describe the coexistence of various healing practices, including the role of *daimas* in home settings, has rather negative connotations in this context. For him, *jugaad* technology is a way to "push life", to get by using any means available, even though

[49] Some people were known to be able to cure headaches, others – stomach aches, jaundice and other small ailments.

[50] He refers to the local treatment of jaundice. My friend Aarti's father was not considered to be the healer in general, but was thought to know how to cure one particular condition – jaundice. Men, women and children from surrounding areas used to come for treatments for three days in a row, and Aarti's father used a bowl filled with mustard oil and swirled it with a bunch of grass until it turned bright yellow. The patient, then, was asked to dispose of the oil on the road and, after three such sessions, jaundice was thought to be cured.

[51] For the etymological origins of the word and the discussion on *jugaad* and corruption in police practices in Uttar Pradesh, see Jauregui (2014); for the discussion of *jugaad* as an entrepreneurial strategy among lower-middle class and dalit youth in Uttar Pradesh, see Jeffrey andYoung (2014).

temporarily functional, to combine "temporary necessity and social-material capability" (ibid.: 84-85). Dr. Chopra uses two different meanings of *jugaad* to refer to two different contexts in his monologue. He describes *daimas* conducting deliveries in home settings as a way to get by in the context where resources are scarce – *jugaad*. He also seems to promote an active role of *daimas* in encouraging institutional deliveries which points to another meaning of *jugaad* – recombination and junction of different things together. The idea of *jugaad* resonates with the concept of bricolage elaborated by Levi-Strauss and Derrida. Whereas Levi-Strauss (1966) uses the idea of bricolage – the creation of work from a diverse range of things that are available – to refer to reusing available elements in mythical thought, Derrida (1978) extends this notion of borrowing concepts from different sources to apply to any discourse. In this sense, reused elements are not simply copied, but gain new meanings and lives in the next context. The practice of institutional childbirth and, by extension, the state in rural India, then, is also seen as bricolage – built by reusing and combining forms of care that are already available in local contexts, but also becoming something completely new.

It is not clear whether the role *daimas* play in institutional settings today – motivating women to deliver at hospitals, mediating between them and hospital staff, negotiating with jeep drivers – was intended or unforeseen. However, it is clear that at least government officials on the ground acknowledge *daimas'* capacity to navigate through official procedures and settings, something that pregnant women and their relatives tend to be anxious about (Ram, 1998a; Van Hollen, 2003). Furthermore, this anxiety of not knowing how to behave in the hospital might be one of the most important reasons why some women choose not to go to the hospitals for deliveries in the first place. Through training sessions provided by Seva Mandir and continuous practice, *daimas* gained the capacity to navigate the official procedures of the hospital, and this capacity amounts to a form of cultural capital (Bourdieu, 2011[1986]). Therefore, having a *daima* as an agent who mediates between women and their families on the one hand, and hospital staff, regulations and procedures on the other might be one of the success factors for significantly higher numbers of institutional deliveries. The roles that *daimas* play in institutional childbirth today also challenge the clearly juxtaposed ideas of "tradition" within the home *versus* "medicalisation" within the institution. Institutional childbirth in Chandpur exemplifies that, in increasingly governmentalised rural North India, "(e)very space is between home and institution; […] every space appears full of contradictions" (Pinto, 2008: 104).

In this section, I illustrated two separate points. Firstly, it is clear that the state's work of regulation acts through political economy, kinship and traditional structures of maternal care, rather than through official appeals to safe motherhood. Just like an earlier example of the government school and *anganwadi* drawing their legitimacy from a local *mukhiya*, the government scheme JSY is built on the network and newly gained functions of the local midwives, as well as on the offer of rather significant financial incentives. Secondly, as shall become increasingly clear in the following chapters, such a rather quick uptake of institutional childbirth among Chandpur's women resonates with what Donner (2004: 130) argues when discussing middle-class women's experiences of hospital births in Calcutta: "(w)omen themselves learnt how to gain from the increasing medicalisation of reproduction, albeit at the price of subjecting their bodies to various interventionist procedures". Such a view blurs the lines between supposedly clearly separated concepts of power and resistance by suggesting that it is possible to engage with the structures of power pragmatically, and to articulate resistance through negotiating the meanings associated with subjection to these power structures.

## *Hospital as a place for free medicines*

The second way in which the government hospital is used in Chandpur is as a place where people come to get free medicines, simple treatments – like bandages for cuts and bruises – as well as blood and TB tests. The Chief Minister of Rajasthan, Ashok Gehlot, launched a scheme for distribution of free generic medicines at all government hospitals and healthcare institutions in Rajasthan in October 2011. However, the Chief Minister's Free Medicine Scheme is advertised to a much smaller extent than JSY. In spite of this scheme, PHC was rarely the first choice for those seeking medical treatment.

The PHC was only one place in the medical landscape of the village. Medical pluralism in India is a well-documented phenomenon (e.g. Khan, 2006; Khare, 1996; Lambert, 2012; Leslie, 1976; Leslie and Young, 1992; Minocha, 1980; Nichter, 1980; Sujatha, 2007; Sujatha and Abraham, 2007) and these accounts investigate various overlapping and competing discourses, pertaining to various "traditions" and "modernities".

Besides various "traditional medicine" practitioners,[52] Chandpur had a large number of private medical shops which were run by both qualified and unqualified personnel, including those who received nursing training but did not do well enough to receive a government posting, some government nurses and doctors from Chandpur and other nearby areas who also ran their own private shops, and some who simply ran such shops as a business without any medical training. Many of these practitioners worked within the biomedical framework and provided *angrezi davaai* (English medicine). They worked on the margins of legitimacy and drew authority from medical institutions without their formal sanction (Pinto, 2004), and many people in the village were aware that these practitioners were not "real doctors". However, many of the private practitioners and self-proclaimed doctors lived in the village and had much more personal relationships with patients: they were available 24 hours a day, unlike the hospital doctors and nurses who stayed in the hospital mostly between 9 am and 1 pm[53] and then either went back home to Udaipur or rented a room in the village, leaving no opportunity to build relationships there. In Chandpur's diverse and plentiful medical landscape, the government hospital was not seen as a superior site to receive treatment and medicines.

Another reason for people choosing private "doctors" instead of the government hospital was people's preference for injections and glucose drips, which were more willingly given by the private doctors and were much rarer at the hospital. Pinto (2004: 351), mainly referring to the use of oxytocin injections by unsanctioned medical practitioners during childbirth in rural Uttar Pradesh, argues that giving injections (*sui*) is an example of an "act through which legitimacy is borrowed from institutions". In this context, "giving injections is a way to demonstrate technical ability, biomedical knowledge and access to institutions" (ibid.: 351). The same applies to other healing contexts. Biomedical practice in India has long been infused with power and status. As Arnold (1993: 8) argues, colonial medicine and its efforts to use "the body as a site for the construction of its own authority, legitimacy, and control [were] integral to colonialism's political concerns, its economic intents, and its cultural preoccupations" (also see Prakash, 1999). Administering injections in rural North

[52] In this context, I use "traditional medicine" practitioners to refer broadly to those healers who work outside the biomedical framework. Such healers include bonesetters, jaundice healers, and those specialising in one particular type of pain – headaches or stomach aches, for instance – and heal through massage and *mantra* (sacred utterance). These practitioners rarely did it as a profession, and more often than not because they were believed to be good at it as well as did it as a hobby (*shok se*) (see Pinto, 2004).

[53] Half way through my fieldwork there was an incident when a higher official came for an unannounced visit and found the hospital empty, so staff attendance after that improved and even night shifts were properly covered with a use of a written schedule put up on the wall in the doctors' room.

India is yet another context infused with ideas about science and modernity, and, according to Kotwal (2005) "(t)he needle signifies the power to heal through hurting and condenses the notions of active practitioner and passive patient" (also see Nichter, 1980).[54] At the same time, medicine is one of the sites "where 'fragmented resistances' to the hegemonic project of modernity occurred and freedom of imagination was exercised" (Lock and Nichter, 2002: 7). In this way, biomedical knowledge gained a life of its own, independently from the institutional settings (Arnold, 1993; Lock, 1993; Lock and Nichter, 2002; Young, 1995). For the recipients of injections, Pinto (2004: 353) argues, "it injects power into the body, establishing another site in which those in positions of authority perform hierarchy and borrow from the legitimacy of institutional forms – the work of doctors and the stuff of hospitals".

Banerjee, Deaton and Duflo (2004), analysing results of a health survey conducted in Udaipur district, demonstrated that the poorest households relied heavily on private health care providers instead of the government ones, and their expenditure on health was relatively high. The authors suggested that people were regularly charged for medicines and treatments in government hospitals even when these are meant to be free (ibid.). However, my informants seemed to disagree with these economists' suggestion. Many people in the village refused to visit the PHC for small ailments exactly because the medicine was free. The distribution of free medicines might be advocated by human rights activists as a human right and an essential part of a welfare state, but the villagers themselves did not trust the healing abilities of free medicines. In Chandpur, free medicines were not seen as empowering but rather as a suspicious practice, and speculations about expired medicines were common. People believed that they got better treatment when they paid money to private health care practitioners and the financial transactions involved in obtaining medicine were seen as establishing a more egalitarian relationship between the buyer and the seller.

Various forms of abuse experienced by the poor in government hospitals across India have been documented (George, Iyer and Sen, 2005; Jeffery and Jeffery, 2010; Mavalankar and Reddy, 1996; Singh, Lahiri and Srivastava, 2004). Even though I have not witnessed any physical abuse towards patients in the Chandpur PHC, there were instances of some other kinds of mistreatment. I provide here a brief example. One day an old lady, an old man, a young woman and a little boy came to the hospital. The old woman explained that it was

[54] For the readings on the preference for injections in other parts of the Global South, see Birungi (1998), Gumodoka et al. (1996), McVea (1997), Van Staa and Hardon (1996).

hurting when she urinated and that she had a stomach ache. Without saying a word, Kamla went into the room where the medical supplies were kept and brought the tablets for the urinary tract infection. She handed the tablets to the young woman and gave instructions on when to take them. When they left, I asked Kamla why she did not give the tablets and instructions to the patient herself, the old lady, who clearly described her symptoms. Kamla replied:

> "She's old, she will not understand; she will ask me ten times if she should take them before or after food. The young woman will feed her the medicine because she understood. These old working people's IQs are low, they do not use it. If I asked her to turn on the fan switch, she would have said 'I do not know how' and she would not have even tried. You and me, we would at least try".

The hospital staff's attitudes towards patients who were old and poor are just one example of how inequalities based on class, gender, age and caste were perpetuated in the clinical space. The commuting doctors treated the villagers more often than not in a patronising manner and facilitated patriarchal and ageist norms by addressing men or younger people when delivering important information, asking questions or demanding decisions to be made. The hospital is a place where social hierarchies outside the hospital still determine the way the patient is treated. Urban educated doctors and nurses look down on poor patients, demonstratively cover their noses if a patient has an unpleasant smell, avoid any unnecessary touching and ask patients not to rest their hands on doctors' chairs.

The idiom of a government hospital being a place where "nobody cares" – about the quality or expiration date of medicines, about patients' preferences for injections instead of pills, or about addressing patients directly and respectfully – translated into people's preference to use private "doctors" and facilities. Even when people acknowledged that it was more expensive to receive treatment at a private medical shop, it still seemed a preferable option.

### *Hospital as a site for the production of paperwork*

The third context in which the PHC was seen was as a place where doctors and nurses spent most of their time producing paperwork, registers and statistics on behalf of and for the purposes of the state. Any given time one entered the hospital, at least one of the doctors or nurses was filling in one of the many registers covering half of the desk. There was a book for

deliveries, another one for births, distributed medicines, treatment provided, also a book for women who stay in the maternity ward, and TB patients receiving DOTS (directly observed treatment, short-course). Compensations for women who delivered in the hospital as well as their midwives and jeep drivers were written in a separate register and also required an amount of extra paperwork to be filled in, including photocopies of *daima's* accreditation and proofs of the family's BPL status. Padma Devi, Chandpur's ANM, spent quite a few days a month not going to the field because she needed to write reports to be submitted to the CMHO office in Jhadol. According to her, monthly reports covered information on how many women and children were vaccinated that month, and how many iron tablets, *Nirodh* (condoms) and contraceptive pills were distributed in the area.

This process of producing paperwork together with various kinds of official documents, such as ration and identity cards, vaccination logs, birth and death certificates, as well as the sterilisation cards and certificates (which will be discussed in depth in Chapter Seven), is a significant way in which people in the village encounter the state (e.g. Gupta, 2012; Hull, 2012). These documentary practices allow the state to make its populations legible (Scott, 1998), objectify and reify particular sociological categories (Cohn, 1987), and are a technology that "encodes a great many levels, genres, and expressions of governmentality" (Dirks, 2002: 59; Joyce, 1999). Trouillot (2001: 126) suggests that these practices designate the "production of both a language and a knowledge for governance and of theoretical and empirical tools that classify and regulate collectivities". Das and Poole (2004a: 15) argue that "(t)hese documents bear the double sign of the state's distance and its penetration into the life of the everyday". However, the everyday life of the Chandpur hospital provides the critique of the constitutive power of documents. Looking at the documentary practices in the PHC reveals something about the social relations that bind the ones producing paperwork and those who are being documented, which cannot be fully captured by the idea of governmentality. The following ethnographic vignette illustrates that there is another type of doubleness in the encounter between villagers and the hospital staff visible in the process of documentation.

My friend Aarti was complaining of a toothache for days and finally I convinced her to come to the hospital with me. She was a second girl in the family, divorced and lived with her own parents, so her mother and father denied her going to Udaipur for dental treatment

due to the lack of money.[55] It was the new nurse Aisha's fifth day in Chandpur. Aisha gave Aarti three types of pills and asked for her name to be entered into the book. Without asking, Aisha wrote down 16 as the patient's age. I silently elbowed Aarti and she told Aisha she was 20 years old. Aisha did not even lift her eyes from the book while writing the ailment type and said it did not matter, and simply ignored Aarti's comment. On the way back from the hospital, Aarti cheekily told me she was 23 or 24[56] years old and giggled about lying to the nurse.

This encounter speaks of the double blindness of the state. The nurse was not interested in the real age of the patient; the written entry, whether true or false, was important in itself. The act of writing it down was of importance. On the one hand, the process of writing produced the paperwork that needed to be submitted to higher state authorities in order to justify the activities and the use of supplies in the hospital. In these government spaces where the paperwork circulated later on, the producer of this paperwork, Aisha, "claim[ed] to represent, engage with, or constitute realities 'in the world' independent from the processes that produce[d] documents" (Hull, 2012: 5). On the other hand, in an area like rural Udaipur where illiteracy, especially among women, was prevalent,[57] the work or an act of writing gave the writer a higher social status. It also kept all the nurses and doctors looking busy all the time, and provided legitimacy for their time. Also, the state was reproduced through and lived as paperwork (Gupta, 2012), for both the bureaucrats who had to fill in registers as well as patients who had to deal with official forms. The state was and came alive where the written work was undertaken. Both of these points show that the making of that entry into the book itself constituted the production of the state effect itself.

Interestingly, Aarti was not interested in providing genuine information either. She was not asked to provide anything more than her name: she could have volunteered to say that she was 24, but instead she purposefully lied without even a blink. There was no explicit political or economic reason for her to withhold information about her age. It was precisely

[55] This is an instance of multi-layered son preference which manifests in a variety of ways in the village. I witnessed many daily struggles for resources between Aarti and her only brother, Varun. Aarti was regularly denied *ghee* with her food because it was expensive, whereas Varun helped himself to a spoon of it with almost every meal. Varun was also always given more money for clothes than Aarti. This was not simply because Aarti was a daughter, but because she was a daughter who divorced her husband and came back to her natal village.

[56] She explained to me that her mother wrote down the date of birth of her older sister and younger brother. However, she was very dark as a newborn and her mother resented her for two months, refused to hold or feed her. That is why there are no photos of her as a child and that is why she does not know her exact age.

[57] According to the 2011 census, in rural areas of Rajasthan, literacy rate for males and females stood at 76.16 percent and 45.8 percent respectively. Average literacy rate in Rajasthan for rural areas was 61.44 percent (GoI, n.d.).

this double disinterest – from Aarti and from Aisha, or both from the people and from the state – in the process of producing a written fact and both of their comfort with the dissonance between real age and the written one that points to a particularly interesting characteristic of engagements between the state and its people. Both women in this encounter are much more than the instrumental objects or facilitators of the bureaucratic process. Aarti and Aisha are both actively engaged in forging paperwork and, by extension, in forging the relationship between the state and its people.

## Conclusion

Just like a rural landscape in Rajasthan, dotted with frequent colourful educational messages, the state is overwhelmingly present and visible in its various forms in the everyday lives of Chandpur people. The institutions of the state (and NGOs alike) rely on and draw their legitimacy from networks and structures of power, trust and care which might be termed "traditional" or beyond the state in any simple sense. Whether it is the institution of *mukhiya* in an *adivasi* village, whose gifted land legitimises the institutions of a government primary school and an *anganwadi*, or *daimas*, whose newly gained symbolic capital of navigating the rules and procedures of the hospital facilitates the transfer of birth from home to the clinic, the state seems to be built on existing social relations (Shah, 2007). The agents and institutions of the state simultaneously blur and reinforce the lines between the "traditional" and the "modern". A traditional birth attendant becomes an unintentional facilitator of institutional childbirth, but, at the same time, their practices of burying the placenta are at least covertly condemned as "backward".

There is a particular temporality, instability and, therefore, irrelevance that characterises the imagination of the state. The educational messages cannot be read by most of the residents of the area and they blend in with advertisements for consumer products. Police arbitrarily refuse to intervene in conflicts which they see as lacking financial opportunities and leave the resolution to the communities. The government doctors and nurses stay in the hospital for a couple of hours a day and leave whenever they please. Whereas many expect the PHC to be closed at any point of a given day, people rely on less qualified medical practitioners who live in the village, even when incurring significantly higher financial costs. The state as the place where "nobody cares" is imagined to be found in every encounter.

People navigate the dispersed practices and manifestations of the state and its projects of governmentality in ways that cannot be clearly put into the narrative of citizenship. They simultaneously rely on and embrace some programmes, such as the category of BPL and food subsidies, but refuse and distrust others, such as free medicines. Even though people in Chandpur engage with the projects of governmentality, whether conducted by the state or by state-like actors, they do not necessarily conceptualise or find it important to conceptualise who is implementing them. Most of the time women who underwent the female sterilisation operation or refuse it do not even think that it is the state organising the camps or paying their incentives. When one of my informants, Bindu, told me about the cars going from one village to the next starting their journeys in autumn, with speakers on their roofs inviting women to come for the operation, she became confused with my question when I asked her whether these were the government cars. "It must be the government, who else could it be?" she replied. The resources spent on organising such an information/motivation campaign – the cars, the speakers, the people paid to do it – point to an agency that *must be* the state because the state is associated with the concentration of meta-capital (Bourdieu, Wacquant and Farage, 1994). Interestingly, however, most women were aware that it is precisely the state encouraging them to deliver in hospitals and paying their incentives of Rs. 1,400. The engagements with the practices and institutions of the state, however dispersed and unevenly implemented they are, do not produce the effect of the state as being a necessarily powerful agent. People use the state pragmatically to draw out available recourses and simultaneously refuse its services.

In an effort to explore the Indian state ethnographically, Gupta (1995) suggested that for the majority of Indians the most immediate context within which they encounter the state is their relationship with government officials and bureaucrats at the local level. In the following chapter, I move onto discussing one particular type of this government official – the motivators for female sterilisation – who facilitate the everyday experience of the state in rural India through motivating women for the procedure of female sterilisation.

# Chapter Four
# Motivation for female sterilisation: networks and ambiguities of intimacy, exchange and power

**"***This is a backward area, so nobody understands anything, especially about children"*
—Sangita, ANM, Chandpur

## Setting the scene: female sterilisation in unexpected places

Seva Mandir was the main NGO in the Chandpur area that provided training for *daimas* who became certified and, until recently when the government payments were stopped, received payments based on these certificates for every pregnant woman they brought to the Primary Health Centre (PHC) for delivery. Seva Mandir provided regular training sessions approximately twice a year to the same group of registered *daimas* and organised monthly meetings at local offices where information on the number of home and hospital births as well as childbirth complications were collected. I was invited to participate in one of these training sessions for *daimas* and arrived at the meeting when all the *daimas* had already gathered but were still waiting for the big guests – the head of the NGO's Health Unit and the Chief Medical and Health Office (CMHO) officer in Jhadol. At the time of the meeting, I knew many of the *daimas* in the room quite well because I had been a regular guest at the PHC in Chandpur, observing deliveries for around six months. After entering the meeting room, I was warmly welcomed by many women at the back and was forced to sit among them before I could make my way to the front and say hello to everyone in the room. There were around 50 *daimas* in the room, mostly from the areas around Chandpur. A few minutes later, the CMHO officer Mr. Sharma arrived and sat down on a wooden chair in front of all the *daimas*, who were sitting or lying down on the floor. "Does everybody know me?" he asked the crowd in a pleasant and friendly manner. After all the women nodded, he continued:

> "Does everybody have a card? When you go to the hospital with pregnant women, you have to have the card on your neck or with you. If you do your work *dhyaan se* [carefully, considerately], you will get a lot of money. The more work you will do, the more money will come to you. You also are a *dukaandaar* [shopkeeper]; this is your business since you started putting

> *daima* behind your name. This is why you need to do marketing also: say *Ram Ram* to everyone you meet in the market, ask them how they are doing and when the time is right, people will come to you for help. If you do *seva* [service], you will get profit. Keep a mobile phone, it is not expensive; give your number to all the pregnant women, keep the numbers of jeep drivers and 108 for an ambulance. However, bringing women to the hospital for the delivery is not enough. You also need to care for the women during pregnancy – remind and encourage them to get the necessary injections. Also remember that your job is only to bring women to the hospital and help them to get registered. Do not even touch the woman who is delivering. You should help with delivery only in emergencies, when the child is coming already and there is no doctor around. If a pregnant woman refuses to go to the hospital due to jeep problems, do not conduct delivery at home but call 108 and an ambulance will come to pick you up".

From the very beginning of this meeting, I was puzzled about the reason why the Jhadol CMHO officer was addressing the *daimas* in the first place. During my earlier visit to the CMHO Head Office in Udaipur, the officer-in-charge expressed the government's official discouragement of traditional birth attendants' involvement in maternal health care. Therefore, Mr. Sharma's visit at the *daima* training in general and the polite and friendly manner in which he addressed them was somewhat confusing. However, from the previous monologue, one might suspect that he came to the meeting with an agenda. *Daimas* were seen as agents who could facilitate government's efforts in transferring childbirth from home to the government hospital. They simply needed to be encouraged to bring women to the hospital and discouraged to conduct deliveries themselves, either at home or in a hospital. Furthermore, Mr. Sharma also recognised *daimas*' influence in the local communities and, most importantly, encouraged them to be reproductive entrepreneurs and employ social marketing techniques to increase their childbirth business. From this speech, it seems that as long as the *daimas* could be turned into agents facilitating the government's agenda of increasing institutional deliveries, their role in the communities could be strengthened through social mobilisation and marketing techniques.

I was surprised how gentle and friendly Mr. Sharma was in the way he talked to the women in the room. He called them *bahinji* (sister) every time he addressed them. After listening to women's complaints about the jeep drivers who took money from them for the journeys between the homes of pregnant women and the hospital, he wrote down the jeep drivers' names and promised to track them down. He lifted his head from his notebook and continued: "Each of you, sisters, should motivate for one woman for sterilisation per year".

Very unexpectedly the conversation turned in a different direction and Mr. Sharma's presence in this space suddenly started making so much more sense to me. Family planning is one of the biggest functions ascribed to CMHO and his speech addressing a room full of women who were financially interested in encouraging other women to continue childbearing rather than ending it did not make much sense to me up until now. Only after several months of my fieldwork did I realise what was happening during this TBA training session. As I was reading through the consecutive annual reports of the Ministry of Health and Family Welfare, which tended to be copied and pasted from year to year, with updated statistical configurations filling in the tables, I came across a section called "Increased institutional delivery vs. postpartum family planning". The section stated: "The huge potential for post-partum contraception offered by the increasing number of institutional deliveries has not been tapped adequately due to lack of planning, lack of trained postpartum family planning service providers and lack of infrastructure in most of the high focus states". (MoHFW, 2015: 148)[58] This brings us to Van Hollen's (1998, 2003) idea of "moving targets", which will be discussed in the following chapter in more detail. Here, it is suffice to say that the increasing practice of institutional deliveries in rural India makes women more reachable by the state, governable and disciplined, in spite of the form or quality of service provided by the rural hospitals. They are no more "moving" in terms of distance or time, but rather simply pure "targets". However, it is more than that. It is clear that Mr. Sharma is trying to push the government's agenda of family planning through new avenues of facilitators in the context of the increasing tendency to deliver in rural hospitals. To the contrary of what is stated in the extract from the annual report above, the effort is put not into training service providers, creating infrastructure or in other ways strengthening the biomedical sphere. Rather, the biomedical agenda is being expanded and projected onto the traditional birth attendants. Having the government's agenda to use the increasing prevalence of institutional deliveries as avenues to facilitate the family planning goals in mind, Mr. Sharma's engagement made so much more sense. He continued:

[58] Anthropologists working in South India have long been writing about the prevalence of postpartum sterilisation procedures and IUD insertions, but I have not come across any cases of it during my fieldwork. However, the MoHFW's conviction that "(i)n order to capitalize on the opportunity provided by increased institutional deliveries, the GoI is focusing on strengthening post-partum FP services" (MoHFW, 2015: 143) allowed me to see the matter in a different light.

> "When you make a case, do you make it in your name or in the name of an auxiliary nurse midwives[59] (ANM)? Make it in your name, we will give you Rs. 150 for it. If you do not feel comfortable going to the camp on your own, join the ANM when she goes there with the case of her own, but do not give your case to her. Your own *NGOwalli* sister [referring to me] who is sitting at the back will also help you, she comes to the camp every time, so do not worry. If you attend to women when they are pregnant and to their children, she will call you immediately when she is pregnant again or when she needs sterilisation".

Mr. Sharma acknowledged the competition for sterilisation cases between ANMs, who are the main motivators with the highest unofficial targets for sterilisation set by the government, and other health workers. He encouraged *daimas* to build a network of "clients" who trusted their "service provider" and came to them not only for childbirth but also for the sterilisation procedure. Furthermore, he expressed that institutional anxiety – anxiety about not knowing the rules and procedures of official settings such as the sterilisation camp – was an important factor contributing to people's decision not to participate in these official spaces and practices. Even though *daimas* were familiar with hospital rules and procedures concerning childbirth and helped women function in these spaces without much discomfort (see Chapter Three), they were not familiar with sterilisation camp setting, regulations and activities. The camp is a space full of rules such as paperwork, the order of medical examinations, pre- and post-operative care, and motivators need to be familiar with this system of procedures and relations. Therefore, Mr. Sharma encouraged *daimas* to either come to the camp with ANMs from their respective areas or with me, as I was a regular attendant of every camp in Jhadol and familiar with what happened there. Furthermore, it was clear that Mr. Sharma was trying to push the government's agenda of family planning through new avenues of facilitators. To my surprise, during this training *daimas* were not only acknowledged as intended or unforeseen facilitators of transfer of childbirth from home to the clinic, but were also encouraged as possible family planning motivators.

The last part of Mr. Sharma's engagement with *daimas* was listening to and addressing the problems they had on the way to or in the hospital. Many women in the room

[59] According to the World Health Organisation (WHO 1961:4), "an auxiliary worker is a technical worker in a particular field with less than full professional qualification". Jesani (1990) argues that the ANMs were present in India even before the Independence, but their job roles were changing significantly throughout the decades, even though Jeffery , Jeffery and Lyon (1987: 161) argue that ANM's training was introduced after 1956 as part of post-Independence expansion of medical provision specifically directed at women. The ANM was created in order "to fill the gap between the primary curative centre and the people, especially for maternal and child health care and family planning service", and is the lowest level professional cadre (EPW, 1997: 184).

complained about a new doctor and a new nurse posted to the PHC in Chandpur who refused to deliver women's first children and tended to send the pregnant woman, her *daima* and her relatives to a hospital in Jhadol or Udaipur which were supposedly better equipped for complicated deliveries. "Every time they say that the baby is sideways, so you need to go to a better hospital", said Paru Bai, one of the *daima*s. They also emphasised that Chandpur's doctor Rajuji, introduced in Chapter Three, used to conduct any and every delivery and would never refuse or refer them to another hospital with better equipment. Mr. Sharma replied that these new people came very young and asked *daimas* to treat them with patience and give them time to learn. This way of addressing ways in which traditional birth attendants have problems dealing with hospital staff and procedures seems to be a way of training them, making them a part of the official system, even though with many reservations, and institutionalising tradition. However, whereas Seva Mandir to some extent acknowledged *daimas'* knowledge, expertise and experience of facilitating childbirth, the government officials seemed to use them only for their embeddedness in local social relations. This is a good example of how government officers use established traditional networks of maternal health care providers to put forward their agendas. It is not clear whether the role that *daimas* play in institutional settings today – advising women to deliver in hospitals, mediating between them and hospital staff, negotiating with jeep drivers – was intended or unforeseen. However, it is clear that local government officials acknowledge *daimas*' capacity to navigate through official procedures and settings, and attempt pragmatically to employ their services to further the family planning agenda.

This chapter is not about the changing role of *daima* in childbirth,[60] neither it is about how the encounters between "tradition" and "modernity" produce locally specific effects,[61] all of which were hinted at during the ethnographic narrative. Instead, I want to take some points from this ethnographic encounter to explore the logic behind the idea of motivation for female sterilisation. I started this chapter with this particular ethnographic vignette because it is only in the encounter between the government officer and those outside the world and logic of the state, the *daimas*, that the peculiarities and particularities of the process of motivation are articulated. Specifically, further in the chapter, I elaborate on two particular intertwined ideas

[60] On the role of midwives in India and South Asia, see: Pinto (2008), Van Hollen (2003), Rozario and Samuel (2003), Chawla (2006), Jeffery, Jeffery and Lyon (1989).

[61] For the ethnographies discussing how the intersection between modern scientific techniques and traditional practices produce multiple and locally specific effects in the context of South Asia, see Adams (1998), Cohen (1998), Gupta (1998), Towghi (2012).

which arise from this particular encounter – the intersection of intimacy and exchange as the basis and strategy to be employed during the process of motivation for sterilisation. Cultivation of intimacy and exchange comes about most vividly in Mr. Sharma's encouragement for the *daimas* to cultivate their social relations in order to further their business, and to provide a good and trustworthy service during the delivery, so that women come back to them for more services, such as sterilisation. Also, starting with the ethnographic vignette concerning the government officer's insistence that daimas also do the work of motivating for female sterilisation allows me to draw parallels and contradictions between different types of motivators and the strategies employed.

In this chapter, I focus on the motivators, the agents of the state who have a duty to motivate women for sterilisation, their understanding of their role, their relationship with the women who agree to get the procedure or successfully refuse such efforts and their relationship with other motivators and other agents of the state and biomedicine. In order to understand what it means and takes to be a motivator, one has to look into two sets of relationships that motivators engage in on behalf of this role – firstly, relationships with women in their work area and, secondly, relationships with doctors and other motivators in "official" settings, such as the sterilisation camps. The languages, logics and relevant hierarchies of these two arenas are different though overlapping, and motivators navigate them with a variety of tools available to them. I seek to show the motivators' perspective on their motivation efforts and to show their position of middleness and ambiguity. I employ the category of brokerage and investigate a variety of ways in which motivators enact and embody the positionality of being between the women and the state, between the women and biomedicine, and the ways they decide to create, maintain and mediate relationships between them. They enact and embody middleness in different ways and demonstrate a list of different concerns when navigating the field and the camp. Therefore, this chapter is about relationships between two groups of women in rural Rajasthan – the health workers and poor rural women in their working areas – all of them entangled in wider networks of kinship, political economy and the state. A wide range of demands coming from these networks to both groups of women means that they have to navigate through various systems of value and be as pragmatic as they can in achieving what they want – whether it is avoiding sterilisation, seeking help in getting the procedure done or reaching yearly sterilisation targets. However, a closer look into ethnographic data reveals that on the daily basis of this engagement, much smaller things are at the centre of negotiation – getting home early from the camp, not being shouted at by the doctor or having somebody to defend you in front of the nurse.

## Motivators as brokers

Following Aldrich (1982) and Marsden (1982), Fernandez and Gould (1994: 1457) define brokerage as "a relation in which one actor mediates the flow of resources or information between two other actors who are not directly linked". The concept of brokerage emerged out of the effort to investigate the discrepancies which emerge between formal policies and the ways they are implemented, negotiated and conceptualised by variously located actors. Brokerage played a key role in political anthropology in the 1960s and 1970s and dealt primarily with relationships between colonial authorities and local populations (e.g. Bailey, 1963; Gluckman, Mitchell and Barnes, 1949). In such contexts, variously institutionalised intermediaries - village chiefs, local interpreters, village healers - emerged as taking advantage of their positionality between two distinct social, political and cultural realms. Boissevain (1974) defined the broker as a mediator between two social units who benefited from such mediation. The broker capitalises his/her belonging "to both worlds, by emphasising either his closeness to the local actors or his control of universes situated beyond their reach and scope of knowledge" (Bierschenk, Chauveau and Olivier de Sardan,, 2002: 17). Wolf (1956) and Geertz (1960) developed the idea of cultural brokerage to examine transformations in relationships between villages and metropoles, and emphasised the role of cultural translation played by such mediating actors.

Neoliberal regimes and the emergence of development and aid industries inspired researchers to redefine brokerage as a phenomenon operating in situations of greater fragmentation, compared to the colonial encounters characterised by clear dichotomy. The idea of mediation and brokerage in anthropology was revived with a new interest in development brokers (Bierschenk, Chauveau and Olivier de Sardan, 2002, Lewis and Mosse, 2006) and brokers in rapid social transitions (James, 2011).

Investigating the role of mediators provides an opportunity to investigate how social actors manoeuvre and reconceptualise normative scripts rather than simply follow them (Bierschenk, Chauveau and Olivier de Sardan, 2002). The position of a broker is highly ambiguous, characterised by contradictory interests and value systems and defined as balancing between power and vulnerability (Wolf, 1956). Being positioned on the interfaces of kinship structures, political authority and livelihoods creates challenges in mediators' efforts to combine their place within the village, within the political organisation and within the economic system. Mendras (1976 cf Bierschenk, Chauveau and Olivier de Sardan, 2002)

argues that the marginality of brokers' position is precisely the reason they are able to mediate between social and cultural worlds and to become "gate keepers". The broker is morally ambiguous precisely because s/he crosses social boundaries and his/her motives are constantly questioned by both sides.

In a way, the idea of brokerage speaks directly to similar efforts in analysing the local embodiments of the state which were discussed in the previous chapter. Various forms of brokerage in rural India have been discussed widely (Corbridge et al., 2005; Gupta, 1995; Jeffery, 2002; Jeffrey and Lerche, 2000; Neale, 1983; Reddy and Haragopal, 1985; Simon, 2009). Motivation for sterilisation can be conceptualised as highly specialised and institutionalised form of brokerage. ANMs, ASHAs and other government agents involved in motivation for sterilisation clearly mediate between local communities and the government's family planning agenda. As it will become clear in the following sections, motivators are ambiguously located both in relationship to rural women and to the state - both parties simultaneously trust and distrust them and both parties engage with motivators pragmatically to achieve their desired results. Motivators, on the other hand, use their positionality to preserve their source of livelihoods while simultaneously maintaining good relationships with women in their work areas.

Interesting parallels can be drawn between motivators for sterilisation in India and birth-planning cadres in China. Birth-planning cadres are asked to explain the one-child policy and its relationship to national economic situation and modernisation to rural and urban communities. They are responsible for obtaining marriage and birth permissions, supply of contraception, making arrangements for abortions and sterilisations and administering incentives. Greenhalgh (1994, 2003) writes about rural Chinese population's resistance to one-child policy and about local birth-planning cadres' inability to enforce it. According to the author, government's birth-planning cadres sympathised with rural women's desire for two children and at least one son and with their fear of sterilisation procedure. They also, however, felt the pressure from higher officials to achieve targets and found themselves stuck between demands of two worlds. Greenhalgh (1994: 13) argues that birth-planning cadres, who were part of local communities but were obliged to enforce family planning policy as part of their job description, "soften[ed] state policies to accommodate pressing peasant demands" (also see Shue, 1988) and negotiated new, informal and locally more acceptable norms. She continues arguing that local women, who were targets of one-child policy, used birth-planning cadres to actively contest policy elements they did not like (Greenhalgh, 1994). Even though Greenhalgh does not use the vocabulary of brokerage, she describes a particular

type of an intermediary who actively carves space for action, negotiation and interpretation for herself and for local women. This type of an intermediary introduces scripts, rules and regulations which differ from the official ones and only in such a way manages to remain part of both worlds - the world of the state and the world of a local community whose reproductive lives are being targeted for control. As it becomes clear in the following sections, motivators negotiate official policies in a similar fashion.

## Who are the motivators?

India's population control policy is a direct manifestation of the state: it is influenced by intergovernmental bodies, such as the United Nations[62] (UN) and the World Bank (WB), it is debated in parliament and in government offices, written in official documents, enforced through a bureaucratic machinery ranging from central offices in Delhi, down to the Rajasthan state office in Jaipur, down to Udaipur, then to Jhadol. Finally, it is enforced, implemented or facilitated (depending on the narrator's perspective on the family planning) through a network of local government workers in the villages. However, once one goes all the way to the bottom to the local health workers, it is evident that the state that they are speaking in the name of – the state whose policies they are enforcing and the state which is their source of livelihoods – is a very different creature from the way it is imagined and created at the top. However, in order to understand what that local state is, it is not enough to understand the process of motivation for sterilisation *per se*. Unlike Van Hollen's (1998, 2003) findings that maternity wards for poor women in Tamil Nadu were the key sites where the government was trying to implement its family planning policies by pressuring women to

[62] The UN has recently signed the 2030 Agenda for Sustainable Development and agreed on Sustainable Development Goals (SDG) which are going to define the agenda beyond 2015, when Millennium Development Goals (MDG) framework expired. Currently, the 3rd SDG, "Ensure healthy lives and promote well-being for all ages", includes a target: "By 2030, ensure universal access to sexual and reproductive health-services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes" (UN, 2015). The signing was preceded by a long process of public consultations, and the current form of the SDGs underwent significant changes during this process. For instance, one of the initial suggestions relating to sexual and reproductive health was to include the following formulation of a target "Rapid voluntary reduction of fertility through the realization of sexual and reproductive health rights in countries with total fertility rates above [3] children per woman and a continuation of voluntary fertility reductions in countries where total fertility rates are above replacement levels", under the goal "Achieve development within planetary boundaries" (Leadership Council of the Sustainable Development Solutions Network, 2013: 28-29). Such formulation received a lot of criticism from various activists and groups who raised concerns, such as "(d)espite possible good intentions of promoting both sustainable development and sexual and reproductive rights, this feeds the old population control agenda shifting blame for environmental degradation, poverty and hunger to the reproductive behaviours of populations in the Global South rather than addressing their root causes within an unsustainable development" (khanna, 2014).

accept IUDs or undergo sterilisation right after childbirth, the key sites of the motivation for female sterilisation in Chandpur are located outside of the clinic. Motivation is carried out through a network of government workers, both those whose work relates to matters of health, and those whose work does not seem to have anything to do with it. Through the active role of health workers and other government employees with targets for sterilisation, the biomedical discourse and practice is no longer located within the hospital; every corner of the village – the ration shop, one's courtyard, or the market – is a biomedical site, at least when it comes to family planning, childbirth or vaccinations.

Even though family planning targets were officially abandoned in 1996, the programme still operates according to similar principles on the ground. Local health workers, nurses and doctors working in rural hospitals, pre-school teachers and other government workers in villages have the duty "to motivate" women from their work areas to get a sterilisation operation after the number of their desired children is achieved. The English words "motivator" and "to motivate" are widely used by the health workers, sterilisation camp staff and other government employees in reference to sterilisation and I consider it to be a local term. In the family planning discourse, motivation is not internal to the subject, but located externally (Ram, 2001: 93). Motivation includes convincing women to get the procedure and accompanying them to a sterilisation camp or a hospital in Udaipur. The Indian government accesses poor, *adivasi*, rural women's bodies for sterilisation via an extended network of local government workers – the motivators. With coercive measures being abandoned, the local agents of the state have to utilise their local social relations to make rural women's bodies available for the state's intervention. The local health workers complain about the difficulties of finding "cases" for sterilisation, about saving them for the next year's target count and about fighting amongst each other over whose name the woman should go under.

Almost every government employee in Chandpur has an unofficial target (officially an Estimated Level of Achievement or ELA which is usually 1 percent of the population in the work area) to motivate women or men for the sterilisation procedure. This includes not only the health workers, the ANMs, accredited social health activists (ASHA), doctors and nurses staffed in the PHC, but also *anganwadi* workers, teachers in government primary and secondary schools and ration dealers, otherwise known as subsidised food shop agents who distribute wheat, rice, tea leaves and kerosene for the households Below Poverty Line (BPL) for the prices subsidised by the government as part of Indian food security programme. Technically all these government employees serve as motivators because all of them have

unofficial targets to reach. However, in everyday life in Chandpur and the clinic, whether the PHC or the camp, the ANMs, *anganwadi* workers and the ASHAs were seen as the real motivators and dominated the spaces and discourses surrounding maternal and reproductive health, and family planning. It is important to emphasise that there are no official requirements for the proportion of male and female sterilisations motivated which means that the policy itself is not gendered. However, as will be discussed later, the motivators are embedded in social contexts within which they work in particular ways and, in the process of navigating particularly gendered areas of reproduction and fertility, the targets are understood as targets for female sterilisation.

Depending on a motivator's job, they engaged with women in different spaces and ways. I will briefly introduce three types of motivators – ANMs, *anganwadi* workers and ration shop dealers.

### *Auxiliary nurse midwifes*

I got to know ANMs in a variety of settings and observed their interactions with poor women, other motivators and doctors. According to Jesani (1990: 1100), the ANM as an outreach worker "faces the community less as a healer, nurse and midwife and more as a woman canvassing or motivating people to accept family welfare programmes, […] and lives and works at the interface of the organised health care services and the community". Jesani (ibid.) also points out how the intersection of gender, work, caste and class makes the ANMs vulnerable both socially and in the hierarchy of the medical and bureaucratic world. My own experience in the field resonates with his observations only partially. Even though many ANMs are from lower castes or Christian, government employment secures them a stable socio-economic status in their interactions with the women in their work area. For example, Rudra is an ANM from Banswara district who has been working in a village five kilometres away from Chandpur, for many years. Together with her teenage son and daughter, she rented two rooms in a *pakka* house on the outskirts of Chandpur, together with other meat-consuming families. We sat down in the poorly lit, wide hallway in the middle of the house, Rudra on the third step of the stairs leading to the terrace and I on the *khat*[63] brought out of her room to the hallway. I asked her to tell me about her job and, at first a little sceptical about

[63] *Khat* is a woven bed consisting of wooden or metal frame and a set of knotted ropes, widely used in rural India.

my question as I had been accompanying other ANMs to the field so, supposedly, knew everything I needed to know already, Rudra narrated what being an ANM involved according to her:

> "We as ANMs have a lot of work in the field – I have to organise immunisations for pregnant women and their children, I visit a different village every day and ten-fifteen houses in them. I tell them to deliver in a hospital, I give iron tablets to anaemic women, I tell them about a small family; if somebody has fever or other small ailments, I give them tablets; I also do check-ups for pregnant women – their weight, haemoglobin, urine test, I look if they are weak".

In this narrative, Rudra described her job as the provision of services and information (*jankaari*) to women of reproductive age and their children. Here, the proliferation of sites of the biomedical beyond the clinical encounter becomes more than evident. Discourses concerned with the transfer of birth from home to the clinic, iron deficiency, family planning together with idioms and practices of medical tests are brought and discussed in people's homes, which, for Rudra, form "the field". Most of the health workers referred to the villages they worked in as "the field" and used the English term. When I asked about motivation for sterilisation in particular, she replied:

> "If somebody has two children or more and wants the operation, we prepare them (*taiyari karte hain*). If somebody has three, then we make them understand that you do not need another one, and then they come for the operation. If somebody says not now, now all three children are girls, let me have a boy and then I will come, then there is nothing we can do. If some woman says that I do not need the operation for sure, then I talk to her husband and try to make him understand that they should not have more. Usually they agree they want the operation but say that not now, in a year, when the winter comes, and then we wait for the winter. Now, during the rainy season most women refuse to get the operation so I convince them to take the pills and *Nirodh* [condom] before they are ready for the operation. In my work area, I know who had it done and who had not".

When it came to motivating women for sterilisation in their homes, *anganwadis* and hospitals, the motivators "sold" a story of upward social mobility as the main tool to encourage the uptake of sterilisation – they talked about having fewer children but being able to educate them, having a better house and better clothes. Rudra put it like this:

> "If you have less children, you can educate them which will bring you some gain [*phaida*], and you can look after your own family and home. I tell them that if you have more children, how will you educate them, how will you feed them and provide for them, especially if nobody has *naukri* [mainly referring to a secure government job] or if there is not enough land?"

This quite clearly resonates with the concerns of the women themselves, which are discussed in Chapter Five. Women agree to surrender their bodies to the government's biopolitical intervention in exchange for the offer of upward social mobility that health workers convince them can be theirs. However, the relationship between the health workers and the women was never quite as simple as that.

In one of the camps in Phalasia, for example, I met a couple of ANMs who were passing by the hospital to drop off some paperwork but did not bring any cases to the camp. Sangita invited me for a cup of *chai* in her rented room and we left for that half an hour between medical examinations and the operation itself. On our way through the narrow streets of Phalasia, I noticed that a middle-age woman was following us but could not hear if she was saying anything because of the ongoing conversation with Sangita and another health worker. Still engaged in the conversation, Sangita started searching for something in her handbag, took out a sheet of pills and gave them to the woman following us, without stopping, turning or saying a word to her. In a second, the woman behind us was gone and we continued making our way to the room. I asked Sangita about what had just happened and she replied:

> "She is from one of my work villages and she is having a stomach ache but I did not have any medicine with me, so I gave her antibiotics. If I did not give her anything, she would have made a big deal about it in the village tomorrow. So antibiotics will kill everything that is wrong with her".

Another ANM contributed to our conversation with reiteration of trust as the basis of their engagement with the women: "People trust us more than doctors. We come to their houses daily, so they can ask us anything anytime". However, this trust seems to be based not on a genuine care for the women, but on the very notion which was articulated by the CMHO officer during the *daima* training session I described at the beginning of the chapter – "social marketing" or a continual engagement with women in the villages in order to keep them as clients. Sangita's understanding of the idea of building trust is a rather technocratic one. She acknowledged that she had to give the woman *something*, and gave her antibiotics which were not particularly necessary to treat the woman's stomach ache but was the only medicine Sangita had in her bag. By providing this ethnographic moment, I want to emphasise that the

relationship between the women and the ANMs is much more complex than how Rudra narrated it above. This relationship involves transactions, genuine or not, which are supposed to build trust and intimacy.

## Anganwadi *workers*

On hot summer days, when there were no sterilisation camps held in the area for me to attend because it was not a sterilisation season, I visited various other spaces in which women discussed their maternal and reproductive health matters – from *angans* and the market, to *anganwadis* and a local hospital. That Thursday immunisation camp was held in a small neighbouring *adivasi* village, two kilometres away from where I stayed. Walking through the gate into the yard of the only *pakka* (concrete) building in sight, a government primary school and a room for an *anganwadi*, I saw a school desk brought out of the school room into the shade outside, covered with a pile of massive registers. Two Brahmin women from Chandpur were seated on the plastic chairs behind the desk, both filling in the paperwork. One of them was ASHA whom I knew from my visits to the hospital, and another one introduced herself as Deepika, *anganwadi* worker. After some small talk and gossip from Chandpur, I moved on to ask her about the logistics of running this particular *anganwadi* and whether women were eager to come here. In her rather patronising upper-caste tone of voice Deepika narrated how the Indian government took care of the women in different stages of their lives:

> "Children between one and six years of age come to the *anganwadi*, and we give them proper food once a day. You know, some of them get nothing to eat at home all day. When they turn six, they go to school and get a nutritious school meal. Many girls stop going to school after year 7 or 8 [of school], when they are thirteen-fourteen years-old, and then they can come to the *anganwadi* again to pick up porridge that we give to teenage girls. And we do that until they turn eighteen. After that, girls are deleted from our lists because they get married to other villages. Then they have to register with *anganwadis* in new villages and when they get pregnant, they come there again for check-ups, get their haemoglobin levels tested, their weight taken and they get injections. Then they give birth in the hospital where the government gives them *ghee* and money, and then they bring their children to the new *anganwadi* for injections first and when the children are old enough, they send them to the *anganwadi* for meals. You see, our government is doing so much for these *adivasi* people. And they still do not come, so we have to go to their houses every day asking them to come and get what the government is giving them".

This holistic narrative of women's health being targeted by particular state health interventions designed for particular stages of women's reproductive lives left me unsettled until a different encounter a couple of months later. I was passing through the centre of Chandpur when I met a crowd of *anganwadi* workers leaving their monthly meeting, where an official from *tehsil* came to collect monthly statistical data. They stopped me in the middle of the road and asked why I did not attend the meeting, as I had done few times before. I told them I had to go to a sterilisation camp in the neighbouring town. One of the workers immediately replied: "But this is exactly what our work is about – family planning. We have to convince women to stop giving birth to children". This short statement of what their work was about came from a person who was running a preschool centre for children. Even though *anganwadi*, by definition, is much more than a preschool centre and involves the delivery of maternal and reproductive health services to women in rural India, family planning as one of the goals of this space was unexpected. These two ethnographic encounters read together allowed me to see the *anganwadi* as an institution attempting to socialise women into a particular state-dictated framework and understanding of health, wellbeing and care. In Deepika's words, poor *adivasi* women are offered regular care by the state at different stages of their reproductive lives leading them to undergo the sterilisation procedure.

### *Ration shop dealers*

An article from a Rajasthan edition of a national newspaper on 22 March 2013 expressed surprise at the fact that ration dealers in Bundi were asked to "motivate" (*pregit karna*) men and women who come to buy subsidised wheat, sugar and kerosene to get the sterilisation operation. According to the article, every ration dealer was asked to find two cases of sterilisation before 30 March the same year. The following caricature was published together with the article, where the presumed husband tells his wife: "God! Now you go to get 'ration!' " (Patrika, 2013) A man's fear of getting "motivated" for the vasectomy is a


**IMAGE 9: A DRAWING ACCOMPANYING AN ARTICLE ON RATION-DEALERS' STERILISATION TARGETS.** The man in the drawing says to his wife: "God! Now you go to get 'ration!'"

reference to the Emergency as the time of *nasbandi*, and reflects the unevenly balanced gender relations where women's reproductive power and strength is more disposable than that of a man. However, such depiction does not resonate with the situation in Chandpur, where it is mainly women – wives as well as unmarried daughters – who usually come to pick up the subsidised food. Neither, for the people of Chandpur, is it surprising that ration dealers have to "motivate" for sterilisation.

In Chandpur, both ration shop dealers had been prescribed yearly targets and did not see it as problematic at all. Piyush, a Brahmin running a ration shop in the *bazaar*, told me on one of the days when villagers, mainly women, came to buy subsidised wheat, sugar and kerosene: "five hundred families come to the shop every month, so it is not difficult to convince even twenty of them to undergo sterilisation per year". Piyush articulated the very logic behind the intuitively surprising idea that somebody who distributes subsidised food has an obligation to motivate for family planning. This logic is ration dealers' exposure or contact with the social networks of the poor. However, this access to the social networks is not based on sharing the moral world but, quite the opposite, on occupying the position of power to distribute food. It is important to emphasise that ration dealers tend to be important men in the village: they either get the job because they are already on good social and economic terms and arrangements with those in the positions of power in the *Panchayat*, or become important because of the job (even though it is not the income from the job itself but rather the possession of resources – wheat, sugar, kerosene – which come from Udaipur and are not distributed, and the connections that come with the job that make them important). It seems that Piyush finds it incredibly easy to find "cases" for sterilisation as, according to him, he meets "five hundred families" every month, exactly because his relationship with the women is based on economic exchange infused with power, rather than any sort of social or geographic intimacy or trust, however masked.

## Intimacy and exchange in "motivation" for female sterilisation

The relationship between women as motivators and women as "cases" is central to this thesis. More precisely, the motivators are agents of the state – or work as temporary agents of the state during this particular moment – who are asked to create a particular relationship between poor women and their bodies on the one hand, and the state and biomedicine on the other. It is

not a straightforward relationship though. On the one hand, the motivators are somewhat part of the village community.[64] Some of them are from the village they work in (but rarely related to *adivasi* women through kinship) and others are posted to the village from other parts of Rajasthan but spend a lot of time in the villages where they work. On the other hand, the motivators tend to be more educated, in a position of government employment and financially and socially better-off than women they interact with "in the field". Therefore, the motivators are partially trusted as part of the community but also treated with suspicion due to their higher social status and the fact that they are implementing their own agenda or that of the state. In spite of the social and economic differences between the health workers and the women they work with, maintained through the discourses from both sides, the relationship between the motivator and the women is, supposedly, a relationship of intimacy. It is intimate in a sense of geographical closeness – motivators live within villages and visit women's homes – and it is intimate in a sense that motivators are given some access to the issues relating to the women's bodies, periods, pregnancies, and sexual lives. This intimacy, then, allows us to talk about the intimacy of the state or, rather, intimacy as a means through which the state's policies are implemented.

In a rather simplified way, it is possible to situate different kinds of motivators on the scale of intimacy to the women they are supposed to motivate for sterilisation. Access to women's bodies and intimate lives can be granted or gained through a variety of means. Intimacy, in a sense, is a particular quality of social relations. For instance, a local midwife or *daima*, as discussed in the opening vignette, is linked with the women in the most intimate of ways,[65] both through the intimacy of childbirth but also through the social intimacy of kinship

[64] Here, I use the concept of community quite vaguely, but it refers to the types of sociality within which certain issues are resolved or contained. For instance, in a mixed-caste village like Chandpur, there are several different socialities which matter in certain situations for each person: the most immediate is the family, and daily conflicts between neighbours would be resolved between families. Then there is *samaaj* (lit. community) which refers to the caste group expanding beyond the village, and within which issues like marriage arrangements would be conducted. Lastly, there is a concept of the village community which would come together on certain occasions, such as particular festivals or when particular conflicts between neighbours or kin escalated and affected the village. For instance, when two brothers running two different shops in the *bazaar* kept fighting openly for days, some villagers came together and locked the shop belonging to the brother thought to be causing the conflict in the name of the whole village. They promised to return the key to the lock only once the brothers made peace. Such *ad hoc* village meetings were called on various occasions, included people from different castes, and were not organised by anyone holding formal political power. Other examples included villagers meeting to discuss what to do with a buck, a male goat, which was roaming around the village and attacking people, or gathering to protest one man's demand for a big compensation from another villager who was driving the first man's wife on his motorcycle when, coming across a speed bump, she fell off the vehicle, hit her head and died.

[65] My argument here contradicts what Jeffery, Jeffery and Lyon (1987) argued about *dai's* low caste status and the polluting work of conducting childbirth as reasons to keep them at a social distance.

and geographical proximity. Whereas *daimas* engage with women through relationships of kinship, ANMs and other motivators have to create relationships of trust and intimacy through other means. For a local ANM this is a little bit more complicated. On the one hand, she is not related to the women in her work area through kinship, resides in the bigger mixed-caste villages while working in dozens of small tribal villages, and her higher social status and the presence of an agenda forms the ground for some suspicion from the side of the women. On the other hand, she spends many years regularly visiting homes and encounters women during a variety of reproductive occasions, not always welcome but not always unwelcome either, which makes her accessible, reliable and insistently intimate from her own effort. Furthermore, the ANM is seen as the carrier of biomedical knowledge and techniques which are respected and sometimes sought after. ASHA is known to work on a commission-basis and, therefore, is seen as having a much bigger economic agenda in her encounters with the women in the village. She is also seen as less trained than the ANM, but still her experience in reproductive matters and presence in spaces where these matters are discussed, are respected. The doctors at the PHC and school teachers are respected for their social class standing, the respective knowledge they possess and embody, but the presence of a strong power relationship overshadows women's engagements with them that remain formal and strongly hierarchical in terms of caste and class, and rarely transcend to the realm of intimacy. At the very end of the intimacy scale is a ration dealer whose interactions with the women are mainly economic, entangled within strong relations of power through the intersection of gender, caste and class, as both ration dealers in Chandpur were rich Brahmin men.

Besides the variation in levels and forms of intimacy, the relationship between a motivator and a case is a relationship of complex, complicated and uneven exchange, just like the definition of a broker suggests. Mr. Sharma suggests to the room full of *daimas* that they are offering their care and trust to women in exchange for agreeing to be sterilised. From the opening narrative it is clear that the midwives and other health workers are encouraged to compete for local women's trust to deliver their babies and, later on, to care for them at the sterilisation camp. At the same time, this care work provided by the health workers is exchanged for women's agreement to become operable and available for the state's intervention with the recognition and financial incentive to a particular motivator. However, depending on the motivators' relationship with particular women and their own strategies of engaging with these women, much more than care can be exchanged. It also seems that the more the relationship between the women and the motivator is about intimacy, the less it is about exchange in monetary terms. Conversely, the less this relationship is about intimacy,

the more it is about exchange. Other government employees, such as teachers, doctors and ration dealers, most often employed their economic and social relationships to find "cases" and rarely engaged in "motivation" themselves (I discuss this in more depth in the next section). However, if we think about the relationship between the motivator and the case as a relationship of exchange, this relationship involves transactions which are socio-political rather than simply economic. Besides the promise to care or to give money, the motivators also offer information, knowledge, and access to other medical services and particular biomedical spaces.

## Negotiating the targets for sterilisation

As stated earlier, almost every government official in Chandpur has an unofficial target to motivate men and women for the sterilisation procedure. The yearly targets for every official differ significantly. The ANM's target is the highest, above twenty cases of sterilisation per financial year, PHC doctors have six-seven, whereas that of a ration dealer is two or three cases. According to the State Institute of Health and Family Welfare (n.d.) in Jaipur, ASHA has one sterilisation case per month as a monitoring indicator.

Academics and policy makers agree that target-setting in family planning is problematic, to say the least. Khalil and Myntti (1994: 5) note that "pressures to meet targets were transferred down through the system to the community-based family planning worker, who was then made to show numerical results". However, there is very little ethnographic evidence on how health workers reach their targets, what language they use on the ground and, in general, how official target-setting policy translates into actions on the ground. Before moving onto my attempt to contribute to this lack of ethnographic data, it is important to emphasise that family planning is not the only government programme which is implemented through official or unofficial targets. A much less spoken about system of targets is also operating in the context of the Indian government's efforts to transfer birth from home to the clinic. The article in *The Udaipur Times* (2014) entitled "PHCs trail in fulfilling targets of Institutional deliveries in South Rajasthan" informs:

> "Administration has issued instructions to the Medical department in Udaipur on Staff Salary to be withheld if number of deliveries fall below 10 at primary health centers. Cash incentives to women for child births in hospitals [*Janani Suraksha Yojna*] seems failing since figures indicate institutional deliveries in South Rajasthan is on a decline. Udaipur ranked 32 in the progress report upto

> November, laid by the Directorate of Medical, Health and Family Welfare services. [...] Upset by the poor show of the medical department in fulfilling the targets, Udaipur Collector issued instructions to the Health wing to chalk out an action plan at the earliest. [...] In Udaipur, against the annual target of 95,133 cases upto March 2014, only 38,253 deliveries have been registered in Government hospitals and Dispensaries, which accounted to 40% of the target up till November 2013. The figure was observed to 7 percent below the targets achieved in 2012".

I use this example to illustrate that targets and target-setting is not limited to the family planning agenda in India. Other healthcare sectors and schemes also operate according to similar mechanisms. For instance, the success of the National Rural Health Mission and JSY is measured primarily by the increases in institutional deliveries and not by reduced maternal mortality because there is no mechanism to ensure that maternal deaths are reported systematically (HRW, 2009; Jeffery and Jeffery, 2010). Therefore, the system of targets in institutional deliveries, which are ascribed to PHCs, is a way to perform better on the indicators measuring the success of the NRHM and to guarantee a continued funding. The target system *per se* does not seem to be a concern of activists, academics and the public. It is the context within which the targets are set that provide particular meanings and receive criticism.

The biggest pressure to reach the targets fell on the ANMs because their targets were the highest. However, even though targets were something that facilitated the ANMs to motivate others for sterilisation, not all ANMs took them too seriously. As Chandpur zone is one of the biggest in Jhadol *tehsil*, Chandpur's ANM, Padma Devi, had the highest target of all the ANMs I met throughout my fieldwork. Whereas other ANMs' targets were around twenty cases of sterilisation per year, Padma Devi's target was seventy. She laughed while telling me the number and rhetorically asked: "who could possibly reach that?" Padma Devi said that everyone at the Jhadol CMHO office, to whom she was directly accountable, knew that seventy is an unrealistic number and she had set up her own, more realistic target of twenty cases that year. She said she would feel good about it if she managed to reach this number. She told me that those higher up were threatening everyone with stopping their payments, but that was all. Rudra, mentioned in the first part of this chapter, also took a critical position towards the setting of targets and acknowledged that it was a tool used by the higher officials to make her do more work: "those above me keep telling me to do this or that or we will not give you payment or other things. But they only stop the payment, we always receive it in the end".

For the motivators, reaching the set targets seemed unrealistic and this thought was shared by the officials in the CMHO office in Jhadol. Therefore, many ANMs had their own unofficial targets which they came up with as a response to the official unofficial targets being unrealistic. For example, those who had a target of twenty spoke about trying to do twelve cases that year; the rule varied from health worker to health worker – a little bit more than a half for some, two thirds for the more eager ones. Ankita, an ANM from a village near Phalasia, told me she had a target of thirty-two cases and she had done twelve at the time of our conversation in January 2013. With only two months left before the financial year was over, she aimed at finding another five women for sterilisation which would make up to fifty percent of the target. Whereas reaching the target was understood to be impossible by most of actors on the ground, an effort itself in bringing cases was seen as the most important. As will be narrated in more detail in the ethnography of a sterilisation camp in Chapter Six, sometimes motivators came to the camp with women who were immediately rejected for the procedure for some obvious reasons, such as a previous C-section or pregnancy. Every time it happened, other motivators at the camp said that the ANM did know that the woman would be rejected but brought her to the camp anyway. They speculated that it was done just because this particular motivator wanted to be *seen* at the hospital bringing in cases and chatting up to the doctors and officers in the CMHO office. It suggests that achieving yearly targets is only one of the things at stake for the motivators in their daily work lives, and other negotiations and interactions may be as important as the official targets.

One of the positive strategies to encourage the motivators to be more eager to reach their targets was an award ceremony held at the CMHO office in Udaipur on 26th of January of every year, the Republic Day.[66] According to the ANMs I talked to, those who reached their full targets received a certificate of accomplishment during this ceremony. Even though I have not met any health workers who were particularly motivated by the promise of the certificate or participation in the ceremony, it still is quite telling. The ceremony of awarding certificates of recognition to health workers who provided the state with the biggest number of women and their bodies for sterilisation on the Republic Day shows the inherent relationship between the family planning programme and the project of nationalism. Social scientists have long recognised that social constructions of gender are often central to the imagination nationhood (e.g. Mayer, 2000; Yuval-Davis, 1997; Yuval-Davis and Anthias,

[66] R. K. Gupta, the doctor who operated on eighty-three women in five hours at a hospital in Chhattisgarh where at least fourteen women died in November 2014, had also been given an award on the Republic Day for a record 100,000 surgeries in his career by the state government (Das, 2014).

1989). The celebration of achieved targets for sterilisation on the Republic Day shows the appropriation of poor women's bodies as objects on which the desire for the project of nationalism can be inscribed, and the memory for the future made (Das, 1996). The motivators, then, are rewarded as the heroes of the nation for providing the state with the bodies of poor women.

Everyone involved in the organisation of sterilisation camps agreed that finding cases for sterilisation was a difficult task. The ANMs claimed that *adivasi* women were not listening to their advice and in that way demonstrated their "backwardness" and illiteracy. Padma Devi also acknowledged that her own target of twenty cases was possible to reach but difficult:

> "Some of the women see me walking on the hill and know that I am coming to see them, so they hide inside and pretend not to be home because they do not want to listen to me anymore. I have created new footpaths to some of these houses because I come regularly but they do not understand".

Poor women's resistance to the efforts of motivation for family planning was clearly acknowledged among the motivators themselves. However, the acts of hiding inside, a regular postponement of the operation, refusals to go to the camp on the very morning the meeting was arranged and other instances were not regarded as acts expressing a conscious resistance to the power of the state and the motivator. Rather, the motivators interpreted these acts as signs of not being able to understand what was good for them and what was not. Women's resistance was interpreted by the motivators as yet another proof of their "backwardness", a failure to care for themselves (Staples, 2012) and an inability be and become *samajhdaar*. *Samajhdaar* literally means the one who is sensible, able to understand and comprehend.[67] According to Susan Wadley (1994: 66), this capacity to understand in rural North India stands as the basis for hierarchies among genders, families, and castes.

There were other reasons given as speculations of why motivators found it difficult to get women for the operation. Some of the motivators suggested that every woman in their work area had the procedure already and regretted reaching full targets in previous years. Some of them suggested that after reaching half a target this year, they would "keep" the women who wanted the operation for the next year's target. An *anganwadi* worker from

[67] McCurdy (1964: 440) writes about Bhils becoming *samajhdaar* (or *hamajdaa* in a local dialect in many tribal villages in Jhadol, where "h" takes the place of "s" in many words) as becoming wise and crafty, mainly referring to the villagers' abilities to "survive" in cities like Udaipur without being cheated.

Gogla told me they had a target of five cases set for the three workers in the *anganwadi*. Her plan was to find one woman herself and that was enough. If she and her colleagues did not do it, she was afraid that somebody would come "to ask"[68] about it. She strongly stated that "everybody needs cases – ANM is looking, ration dealer is looking, *patwari* also goes looking. You don't get them!"

She further described a strategy she herself employed in convincing a woman to come to the camp with her: "I told her I would give her Rs. 200, half a kilo of *ghee* and the hospital would give her another Rs. 600. That is how she agreed". However, the ANMs strongly opposed the possibility that they themselves brought cases after offering them extra incentives. One of them explained: "We bring cases because we have a relationship with them and women trust us because we keep coming before and after deliveries, vaccinations. But the ration dealers do not do this kind of work, so they always have to offer women 20 kg of wheat, Rs. 1,000 or Rs. 500. They buy cases and we do not". Rudra told me that women from her work area asked about what they could get for the operation themselves: "Some ask what will you give me for an operation, so I have to tell them that I will not give you anything; you will get Rs. 600. Earlier they used to give something small also like a tiffin or a duvet but not anymore".

From everything I learned during my fieldwork these possible unofficial cash transactions between the motivators and the women who agree to come for the procedure, however widespread, seem like strategies employed by some motivators to get close to the set targets, but also as strategies employed by the poor women themselves in negotiating the best conditions under which their operation could be performed. These conditions involve going with the motivator one trusts, the place for the procedure – whether at the camp or the private hospital in Udaipur (discussed further in Chapter Seven) – as well as how much can be gained from it, including the financial gain whenever possible. However, a suggestion that the financial gain might be the reason to agree to get the operation or that women might be tricked or bribed into the procedure with 20 kg of wheat or Rs. 1,000 was laughable and even insulting to my informants even from the poorest households.

[68] This refers to the fear of being asked, or being forced to give an answer to those who are in positions of authority. In Chandpur, the fear of police also articulates as the fear of "being asked".

## Contesting the state from within

Conversations with the motivators highlighted a variety of ways in which they negotiated official government policies concerning reproductive and maternal health, including family planning, and expressed their subjective understandings of local realities which posed constraints to the implementation of these policies, both when it came to engagements with the women from their work areas and in their private lives. In this section, I provide a few ethnographic examples of the motivators' efforts to contest government policies and methods related to family planning and a two-child norm.

### *Jasoda*

I met Jasoda when she was visiting Hema, one of the most influential and well-off Brahmin women in Chandpur. Jasoda is an ANM working in Hema's paternal village, rather far away from Chandpur. She is in her forties, comes from a sub-caste of Brahmins and her husband is a teacher in their village. Jasoda was sitting comfortably on the floor of Hema's veranda while Hema herself was washing clothes near the water pipe. It was the time of the day when the electricity was on, the water motor was running and neighbours kept coming to fill up their smaller and bigger *matkas* for the day's supply of water. The abundance of water, spilling from the pipe on the cement floor between the *matkas* in Hema's courtyard, stood to the contrary of draught-prone neighbourhoods where, in the heat of the summer, women struggled to find public water pumps with water. In this scene of abundance, literally of water but metaphorically of social and economic wealth, Jasoda started telling me about how the poor *adivasi* people in these areas were so poor and uneducated that they did not understand that having one or two children, instead of five, might help them to live a little bit better financially. She continued complaining that her job was very difficult and unrewarding because people did not follow the advice she gave them on how to live their lives.

After such an introduction, I asked about her own family. Her tone changed from the patronising and, to some extent, rehearsed to one that was more personal, experiential and cheerful. She told me she had two sons and a daughter and that her husband was a teacher in the same village where she worked. We both immediately picked up on the contradiction between the way she just preached about a small family of two and her own rearing of three children. She quickly emphasised that she gave birth to all the children before getting a government job, otherwise, it would not have been possible. According to the two-child norm

implemented in Rajasthan,[69] government employees would lose their employment if and when bearing a third child. Once she let go of the official and rehearsed discourse of the state, I asked if she wanted any more children. She giggled and said that yes, both her husband and she wanted a fourth one. However, according to Jasoda, that would not be possible because her husband and she would lose their government employment, and added: "And then what? If we do not have the money to feed the children and to build houses for them, then what is the point?" The very acknowledgment of her own desire for a family that is bigger than the government's propagated small family, coming from the government health worker, is an illustration of at least a couple of things. In the context outside of her work, at least in this ethnographic moment, Jasoda negotiates and contests the government's ideas surrounding a small family and various tools of implementing them. This allows us to discuss the ambiguities of power, authority and the state when Jasoda perpetuates the official discourse of the state in her work rhetoric but undermines it in her private life and reproductive desires, nevertheless unfulfilled. And lastly, it seems that the aspirations and promise of social mobility via family planning is not only relevant to those struggling with poverty, but also among those who are better-off.

### *Padma Devi*

One morning when I dropped in at the PHC to wait for the opportunity to observe childbirth, I found Padma Devi busy with paperwork as usual. Padma Devi was lucky to get a job in her husband's village and has been working as Chandpur's only ANM for many years. We got talking about a high number of children being born in the hospital and a number of women using contraception. Half-way through our conversation she said: "People here understand about a small family, but one son is not enough, like eyes, in order to see the full world". She smiled cheekily and left the room to return the registry to a shelf in a different room. Padma Devi's statement is significant in several regards. Firstly, it shows that she, as the government's health worker and, therefore, as one of the most visible and important agents of the state, is embedded more in the local world and its logic for son preference and reproductive power that stems from it, than in the official world of the state where preferential treatment for girl children and small families are encouraged through a variety of schemes and

[69] Rajasthan was the first State in India to implement the two-child norm in 1992 barring people with more than two children after 1994 from contesting panchayat and municipal elections. This was further extended to government employees with a cut-off date of June 2002.

programmes. Secondly, Padma Devi's cheeky smile shows that she sees and acknowledges the disjuncture between these two worlds. As the agent of the state, she knows she is not supposed to live by the local logic deemed "backward", but, rather, encourage the official government policies and ideas not only through the work she does but also through her own example. Thirdly, Padma Devi has two sons herself, so she speaks of her own experience as part of the village and includes herself in the category of "people here". In the circles where the health workers gathered, such as the camp or monthly meetings, more often than not very clear boundary-making was at work and strict lines between "them" and "us" were drawn: they, the uneducated poor backward tribals, and us, the educated health workers who understand what is good and what is bad for one's health and wellbeing. Padma Devi's ability to erase these strong lines of variety of inherent hierarchies is rather rare but telling. It speaks to the contradiction between the state as an external structure and apparatus, on the one hand, and the state as enacted, contested and undermined by the people, therefore, internally constituted, on the other.

### *Kamala*

On my way to Jhadol for the monthly meeting of health workers, I met an *anganwadi* worker from a village neighbouring Chandpur on the jeep. Kamala, an *adivasi* woman in her late thirties, was going to the office in Jhadol to submit paperwork for the institutional delivery she "motivated" yesterday. She gets Rs. 300 for every woman she brings to the hospital for the delivery. I asked her why childbirth in the hospital was better than at home and she replied that it was better because some people did not keep their houses clean (*saaf-safaai*). Here, a clear boundary-making on the basis of caste and articulations of purity and pollution is at work.[70] "But the hospital is not very clean either", I decided to reply. She thought about it for a couple of seconds and said: "the government is telling us to bring women to the hospital, so what should we do?" She told me it was easier to convince women to give birth in the hospital than to convince them to get the operation. "It is a very difficult [*kathin*] job. People say these are our children, so we will feed them, how is this your business [*aapko kya lena-dena*]?

[70] During my time in the field, ideas about ritual pollution often articulated as concerns with "real" dirt and uncleanliness. When upper-caste men and women advised me not to eat in lower-caste homes, they rationalised it in terms of uncleanliness of the house: according to them, *adivasis* and Meghwals did not keep their houses clean, did not wash their clothes and prepared food in dirty dishes and with dirty hands. For more on the relationship between caste, ritual pollution and cleanliness, see Khare (1962), Luthi (2010).

These people do not understand". Kamala told me she used to take *Mala-N* (contraceptive pills) but her period got heavier, so her husband started using *Nirodh* (condom). She added that she did not get the operation yet: "I am alone at home and need to do a lot of work, there is no mother-in-law to help me. So when my boys get bigger, then I will go for the operation". I asked Kamala if they wanted a girl also and she replied: "Two boys are already a lot. They will throw me out of my job if I get a third child. And what if it is a boy again? Then we will need an even bigger house; where will we get the money from?" Just like in the first example in this section, Kamala's experience as a motivator as well as a woman with her own reproductive concerns unravels a variety of disjunctures between the government's proposed worldview and her own desires and considerations. She acknowledges that women in rural India give birth in hospitals not because it is safer or cleaner there, but because the government insists on it, and that women resist the government's efforts to convince them to get the operation with arguments about being responsible for the wellbeing of their children themselves. Furthermore, Kamala also expresses that her own decision not to have more children is influenced by the government's demands on the employees and her fear of losing the source of livelihoods. According to her, she does not have any more children not because she believes in the notion of a small family *per se*, but because the birth of another son and the subsequent loss of government employment would put further economic constraints on her family.

In my conversations with ANMs in the village as well as in immunisation and sterilisation camps, it became clear that many of them questioned and negotiated power relations within which they were embedded in their work lives. These power relations ranged from the way caste and class played out in their encounters with women they "served" in their work areas, to the way they were treated by doctors in local hospitals and sterilisation camps (discussed in Chapter Six), to the demands posed by the higher government officials.

## Women's resistance to the motivators

Unlike in some ethnographies where women were portrayed as fearing the ANMs and their insistent efforts in looking for sterilisation cases (e.g., Jeffery, Jeffery and Lyon, 1989),[71] women in Chandpur seemed to have a different relationship with the health workers. The health workers' efforts to convince women to get the operation were rather easily dismissed by the women who did not want the procedure, or the health workers were used as a resource by those seeking the procedure. As already articulated by the health workers earlier in this chapter, village women who did not want the procedure employed a variety of techniques, or weapons of the weak (Scott, 1985) to avoid them, to hide from them and in various other ways to subvert the health workers' agendas. One of the main techniques employed by the villagers in a variety of power-infused contexts, including dealing with the health workers as well as other patronising people, was to agree with everything they said. This was a very clearly articulated tool and was taught to me by women and men who witnessed me getting argumentative in some contexts. The villagers taught me to keep nodding when somebody in a supposed position of power was trying to tell me how to behave, whom to talk to and whom to avoid. "Just keep telling them they are right and keep agreeing. And when they leave, continue doing what you were doing previously", was articulated to me by many. Such a tactic, even though acknowledging the authority of the speaker, also acknowledged the limits of this authority. Men and women acknowledged that the health workers had no other means to pursue their agenda of family planning but through talking. And once they were gone out of people's homes and sights, women were left to make reproductive decisions within networks and structures of power other than the state.

In an effort to avoid romanticising resistance (Abu-Lughod, 1990), I agree with Ahearn's (2001: 115) suggestion that "(w)hile one can certainly understand the impulse behind equating agency with resistance, agency should not be reduced to it. Oppositional agency is only one of many forms of agency". I will discuss women's reproductive agency in

[71] Jeffery, Jeffery and Lyon's (1989) ethnography is based on fieldwork conducted in Uttar Pradesh in the early 1980s. UP's geographical proximity to the capital (compared to Rajasthan) and a short time between the Emergency and the conducted fieldwork might possibly be the main reasons for their findings. However, the visits of health workers to implement the government's family planning agenda were already mentioned in much earlier ethnographies. For instance, McCurdy (1964: 8) working in a tribal village in Udaipur district wrote that the women of the village spread the rumour that he had come to the village to sterilise men; the rumour was based on a visit of a family planning team few years earlier who attempted to persuade men to undergo vasectomies. However, his narration did not imply fear and anxiety associated with this visit which might be explained by a sporadic nature of family planning campaign in the 1950s.

the following chapter, but here I want to emphasise that the relationship between the health workers and the rural poor women as targets for female sterilisation is much more complex than a simple opposition between power and resistance can capture. Resisting the health workers' efforts in "motivation" can be driven by a variety of reasons, including a husband's denial of contraception, parents-in-law's desire for more offspring, rather than a simple denial of the power of the state. For instance, during my encounter with several NGOs in Udaipur, a concern for women as victims of oppression was clearly articulated in the context of female sterilisation. None of these NGOs motivate women for sterilisation, but run programmes raising awareness about and distributing temporary methods of contraception, such as pills and *Nirodh*. In their discourse, the practice of female sterilisation illustrates poor women's oppression but not by the state. As one of my informants in Seva Mandir once told me:

> "There are lots of women in the villages who want to finish having children but their husbands or parents-in-law deny them getting the operation because they want more children. On the other hand, if a family decided that they do not want to have any more children, why is it women who have to go through an operation, why not men? Vasectomy is much simpler and more effective, isn't it?"

Here, she argues that women are denied their right to end childbearing and a right to a sterilisation procedure by their powerful husbands and in-laws. Women, especially poor and tribal women in rural areas, are portrayed as victims, but not of government's manipulations and family planning campaigns. They are portrayed as victims of their husbands' uncontrolled desires for children which supposedly stand for the expression of their wealth and power to make and maintain them. In a way, resistance to the agents of the state, in this context, can be seen as surrendering to other sources and networks of power – the oppressive gender and kinship relations, as well as demands of political economy. These different sources of power contradict, complement and compete with each other at the same time, and enter women's considerations whether to get the operation or not in complex and contradicting ways. As we will see in the following chapter, for some women, agreeing to get the sterilisation procedure is a way to negotiate gender relations at home and then the health worker becomes an instrument to carry out women's agendas which have nothing to do with intentionally surrendering to or resisting the power of the state. It is especially important to emphasise that women deploy and enact their bodies in particular ways not as acts of resistance, but simply as a form of pragmatic action (Lock and Kaufert, 1998).

## Intimate labour and care work

We need to acknowledge that besides having their own agenda, dictated mainly by the requirements of the government job and the power relations within which the motivators are embedded in the workplace which, in turn, are dictated by the national agenda, international politics and global health priorities (Maes, 2015:7), the motivators also, in a way, provide intimate labour which involves "tending to the intimate needs of individuals inside and outside their home" (Boris and Parrenas, 2010: 5). Let me offer a brief example of how the motivators figure in some women's narratives. Sunita is a woman from a higher caste but her household income is not stable. Her husband is employed by a small restaurant in Chandpur and they rent an unfinished *pakka* house in one of the *galis* of the village. The central role in Sunita's narrative is played by the health worker. She tells me she has three children – two boys in 10th and 8th standard and a five-year-old daughter. Sunita continues:

> "Three years ago I got the operation in a private hospital in Fatehpura, Udaipur. Padma Devi, the ANM, came to my house and took me there. She told me I should get the operation done but I kept thinking I was scared and I would not go. She told me not to be afraid and come with her, that she would take me there and drop me home afterwards. That is why I went with her. But at first I was scared, but Padma Devi used to tell me that there is no reason to be scared because lots of women went with her for the operation before. I got really scared in the hospital after seeing all these women lying on *khats*. I told to *sisterji* that if anything happens to me, the responsibility is on you. And she told me: 'nothing will happen *didi*, just go to sleep'. Then my number was up, they asked me how many children I had, names of my husband and father in-law and asked whether my husband knew I came here for the operation. Then they put me in the room and put me to sleep. For an hour or two I was resting and I was so dizzy and I was thinking that now I will definitely die. Then *sisterji* told me – *tension mat lena* [do not take tension, do not worry], nothing will happen, I am here with you. From that morning I did not drink water, or *chai* or have food. *Sisterji* told me if I ate in the morning, then the operation would not happen and then I would become pregnant again. That is why I went with an empty stomach. I was really scared when we were approaching the hospital, *mera dimag kharab ho gaya* [my mind was going mad], but then I decided that whatever happens, it will happen, I needed to go anyway".

The relationship between the government health worker as a motivator and the woman as "a case" is one of the most important dynamics to understand in order to comprehend the nature of conflicted agency and subjectivity leading to and born out of the sterilisation procedure. The relationship between the motivator and the woman is long-term and surfaces at significant reproductive occasions – during pregnancy in the motivation for immunisation and

institutional delivery, during childbirth at the hospital, during early months after the delivery and again in immunisation, during unwanted pregnancies in seeking the medical abortion and, lastly, during the process of making a decision regarding the end of childbearing. Whereas the motivator is demonised by the media, activists and many academics for their efforts to reach family planning targets and is seen as intruding and patronising by those women and families who do not want the operation, for other women a motivator is somebody who provides support and care. Narrating their own stories of the procedure, women never failed to mention which health worker took them to the camp or the hospital. Women never went alone for the procedure and the presence of the motivator was the necessary condition of them going to the camp in the first place. However, the presence of a motivator was necessary not because motivators coerced women to go by offering incentives. Rather, the motivator's role in the sterilisation camp and the period prior to that is much more complicated.

Motivators have certain duties to the women who decide to come with them for the procedure. For instance, one of the biggest fears related to the procedure is the fear of losing one's consciousness and becoming dizzy due to anaesthesia. Bindu, who underwent the tubal ligation procedure a few years ago, put it like this: "after the injection I could not understand what was happening and what was not happening". Therefore, from the women's own perspectives, the presence of a motivator was necessary to look after them when they got dizzy from anaesthesia. Health workers offer to care and look after the women from the moment they pick them up from home in the morning to the moment they drop them back home after the procedure late that afternoon. Some of them employ kinship imaginaries in promising to care, like one of the motivators who encouraged a woman who came with her to the camp by saying: "I am your sister today, so I will care for you like your sister does". Just like the local midwife's role in institutional childbirth, the ANM or ASHA serve as translators of the language and the rules of the state and the hospital. They offer to mediate between the women and the doctors in the camp, to help them navigate through the rules and procedures of the camp, including filling in all the paperwork, to look after them when they get dizzy from the local anaesthesia and to care for the dignity and wellbeing of their exposed bodies after the operation (discussed in depth in Chapter Six). This care work is what they offer to the women in exchange not for simply agreeing to get their tubes tied, but rather for becoming "motivated" by this particular health worker.

It is also important not to forget that the conditions for the intimate labour that ANMs, ASHAs and *anganwadi* workers do are created by the institutions of the state, in contrast to the intimate labour that connects *daimas* and women undergoing childbirth in home or

institutional settings. In this context, Berlant (1998: 288) suggested to investigate "how public institutions use issues of intimate life to normalize particular forms of knowledge and practice and to create compliant subjects". In the context of motivation for female sterilisation, health workers' access to rural women's intimate lives is not simply legitimised by the state, but is a very condition for the engagements between women and agents of the state. By demanding intimate knowledge, health workers constitute rural women as docile subjects. Women who deny health workers the knowledge about their menstrual cycles, sexual encounters, or husband's income, on the other hand, are deemed uncooperative and uncaring about their own wellbeing. Zelizer's (2005: 14 cited in Boris and Parents, 2010: 4) argument that intimate labour leads to "knowledge and attention that are not widely available to third persons" interpreted in a context where the network of state agencies and institutions creates the possibility of such relationship to occur also demands to read the care work that motivators do with nuances, and acknowledge the contradictions inherent in this care work.

The care work that government health workers provide to rural women seeking to get the tubal ligation procedure is full of contradictions. Livingston (2012: 96), working in the oncology ward in Botswana, writes about care-giving by the nurses as "an inherently political act [because it is] an extension of the state's commitment to care for its people". Furthermore, she argues that "(n)ursing is the moral face of citizenship in Botswana's system of universal care" (ibid.: 101). Similarly, when it comes to the motivators in and around Chandpur, their interactions with the women and efforts to motivate for sterilisation are also a deeply political act. However, it is a political act not because it illustrates the state's commitment to the improvement of the conditions of the lives of the poor, but rather because it shows the very contradictions inherent in the state's effort.

## Conclusion

In this chapter, I outlined the social, economic and political networks through which the motivation for female sterilisation is conducted in the village by various government workers. In so doing, I located the state ethnographically in its everyday practices, links and networks, and provided a glimpse into the world of the local state and its relations with rural women in the context related to female sterilisation. I demonstrated the ambiguities of power relations binding different motivators with the village women, the ways in which motivators themselves negotiate a variety of work-related demands, such as targets, as well as how they try to make sense of the policies that they are employed to implement. I problematised the

concept of power by showing that the relationship between the women and the health workers is much more ambiguous than the neatly defined opposition between power and resistance could capture.

The concept of brokerage has been useful in analysing the role and position of motivators. Anthropologists defined brokers as ambiguously located, capable of linking socially and culturally distinct worlds and as benefiting from the work of such mediation. The way motivators for sterilisation in rural India mediate between poor rural women and the government's family planning agenda and services can be analysed through the lens of brokerage. The fact that the concept has been used primarily in political and economic anthropology limits its analytical potential and could be extended to other forms of relations which cannot be clearly contained within the realms of politics, power and economics. Seeing motivators as brokers does provide a tool to frame their ambivalence and ambiguity in theoretical terms. However, the concepts of brokerage and translation do not suffice to account for other types of exchange and aspects of relationships between motivators and rural women, such as intimate labour.

Gupta (2012) asks how is it possible that in India, where the improvement of the lives of the poor is at the centre of the state's agenda and the legitimacy of political order itself, poverty still remains endemic. Looking at the daily implementation of various welfare programmes, he argues that structural violence and the care found in everyday practices of social welfare programmes coexist together and, what is more, the poor are not neglected by these programmes but are subjected to structural violence that is "enacted at the very scene of care" (ibid.: 24). That is particularly true and evident when it comes to programmes, discourses and efforts in family planning and female sterilisation. The pressures of the target system are closely intertwined with the motivators' efforts to care for the women during various reproductive occasions. Health workers who have the duty to "motivate" for the procedure, also have the "duty" to care for women in the camps. This care work is not simply a rhetoric but is clearly narrated as part of women's experiences of the procedure.

Before elaborating on the inequalities, hierarchies and power relations affecting the care and treatment women receive in the sterilisation camp in Chapter Six, the following chapter provides the discussion on the women's reproductive agency and explores their own perspectives, concerns and experiences of female sterilisation. In doing so, I aim to show that even though the Indian government targets poor women by motivating them to undergo the sterilisation procedure through the network of motivators, women have much more immediate concerns in making such a decision. These concerns are related to gender roles, domestic

responsibilities and economic restraints, and bear much more weight in the process of deciding if, when and how to end childbearing, than the practices and discourses of the state.

# Chapter Five

# Reproductive agency and weakening bodies: why do women get sterilised?

I begin here with a story I introduced in the opening lines of this thesis – that of Jimli Bai, an *adivasi* woman in her late twenties, whose husband works as a manual labourer on a construction site in neighbouring Gujarat. After an arranged marriage in her late teens, she gave birth to three children – two sons and one daughter. She runs the household with irregular cash that her husbands sends home, works in the fields and looks after children and cattle. Four and a half years ago, after the birth of her daughter, Jimli Bai visited a government-organised sterilisation camp and got her tubes tied. Here, I present an extract from our conversation.

> Eva: Why did you have the operation?
>
> Jimli Bai: I didn't need more children – two or three is enough. My three is already a lot, what should I do with more? Look at Jivin who has ten children. They don't have enough clothes, they don't get enough good food. And we are five people in our family altogether, so we live and eat well. We were thinking about getting it after two children, but both of them were boys and my husband wanted a girl. Earlier it used to be different; it was my father, not my mother who had the operation. But nowadays they say a man has to do work, so he cannot get the operation. But if his work is driving a tractor, then how much work is it? And I have to bring water, work in the fields. They roam around the *bazaar* and then ask for food after coming back home. But if he refuses, then I have to have the operation.
>
> E: How did you decide to get the operation?
>
> JB: One day when there was a camp in Jhadol, I was making food when *sisterji* came. I told her before that I wanted to get the operation, so that day I did not say no and we went. My daughter's father and I spoke before that three is enough, but that day he was away from home, so I did not tell him. We did not have a phone then, so I could not call him either, so I just went. My mother-in-law is dead, but my father-in-law was against the operation, because he wanted another boy. So I did not say anything to him that day and went on my own. I took my four-month-old daughter and my sister-in-law with me to hold my daughter, because *sisterji* would not do that. So we went to the camp, I got an injection and they did the operation. There was a hundred and fifty women in the camp that day. I left home around 11 o'clock and the operation happened only at 5 pm. There they only asked me how many children I had

and nothing else; they did a pregnancy test, but my small one was only four months-old then, so I could not have been pregnant; I got few injections in different places (she points at different parts of her body) and then they did the operation. I do not even know which operation they did; my eyes were open and I saw some doctors around, but I am not sure whether they did *karantwalla* operation or not. It was in the camp, so it must have been the *karantwalla* - there were so many women there.

E: Did you speak to the other women there?

JB: I did not speak to anyone there, I was just sleeping under the blanket. I could hear women moaning this and that, just like during childbirth, but I did not feel anything myself. I was in so much *nasha* (*trans*. intoxication, dizziness, here due to the effects of a local anaesthetic). I do not remember anything that happened after the injection. I was so dizzy, I do not know how we got home. Then later on at home the incision started hurting, but before I did not feel anything. If I knew it would hurt so much afterwards, I would not have done it (laughs). But I understand that if one's stomach is cut, it will hurt. It got better in seven or eight days; this is when *sisterji* took out the stitches. But I did not do any work for the whole month - I was just lying in bed; a neighbour's daughter used to come to do the housework. *Sisterji* told me that if I do not rest, my body will become weak, waste away. If I rest, my body will recover. I did not go to my husband[72] for a month also, even though I was told to stay away for six months because it can open up again. There is another neighbour who got pregnant after the operation (laughs). She got a second operation after another daughter was born. She went with the *sisterji* who took me, not with the one who took her the first time. She did not stay away from her husband after the operation and that is why it opened up again. He drinks a lot, so she could not stay away from her husband. My period is heavier after the operation. I got it checked out at the doctor in Chandpur, he gave me a drip and it got a little bit better. But nowadays it comes every month, every single month. Before it used to come once in twelve months because I was having children.

E: What about other methods of contraception? What about the pill?

JB: Pills destroy your body, they poison your blood and you can die. I don't know where the pill goes when I swallow it, but I know it is not good for you. Just do the operation, it is the best. If you need to do something every day or every week or every month, how can it be good for your body? There is this

[72] *Pati/patni ke paas jaana* is widely used to refer to sex and is equally used in variety of its forms - to go to (or near) one's husband, to go to one's wife, even though most women acknowledged having passive roles in initiating or participating in sexual activity. Once my friend's neighbour Sangeeta came over for a chat and was giggling away before revealing the main reason for the visit. She could hardly speak through her laughter while explaining a request her husband made that day. Her husband showed her a short porn video on his phone in which a white woman was sitting on top of a white man and asked her if she could try doing the same the next time they have sex. Sangeeta found the request hilarious and was demonstrating how the woman in the video was moving her hips, saying that this is what her husband wanted her to do. "*I told him it is your work, why should I do anything at all, especially this? I am not going to sit and move like that!*", she explained to a small circle of giggling women.

> neighbour, who needs to clean her uterus every month, so she goes to Udaipur every month. I do not know what it is called. That is because she did not have the operation. If you had an operation, then there are no more worries, and if you did not, then you have to keep doing things which are not good for you.

Throughout this chapter, I return to Jimli Bai's narrative while telling other women's stories in parallel. These stories illustrate how female sterilisation is placed in the narratives women create about their own lives. More precisely, the operation occupies a significant place in narratives related to childbearing, women's health, work and desires for a better future. Sterilisation also provides an insight into women's efforts to navigate gender and kinship relations. Discussing these concerns allows me to draw a more complex picture of women's everyday lives and efforts to navigate a variety of demands arising from their social, economic, and physical conditions. I aim to show how a decision to get a sterilisation procedure makes sense to some women, and in order to do that I aim to "*situate fertility*, that is, to show how it makes sense given the sociocultural and political economic context in which it is embedded" (Greenhalgh, 1995: 17, emphasis original). I investigate how women make sense of the sterilisation procedure and, in doing so, I examine the relationship between women's reproductive restraints, understandings of the body and illness, biomedical technologies and gender relations.

## Defining reproductive agency

Female sterilisation is a type of reproductive technology, a term rarely deployed in this context, but one that helps to "crystallise issues at the heart of gender, reproduction and family relationships and give insight into the engagement with modernity" (Stanworth, 1987: 4 cited in Unnithan-Kumar, 2004b: 1). People's perceptions about the use of female sterilisation allow us to investigate their relationship not only to biomedicine and the state, but also their relationship to each other, their understanding of women's bodies, selves, family structures, and reproductive powers.

Women's engagements with biomedical technologies have served as a way anthropologists investigate questions of agency, reproductive choice and women's autonomy. Advances in reproductive technologies simultaneously increased women's abilities to make choices about their fertility and placed women's bodies under scrutiny by powerful authorities (Rapp, 1990; Rowland, 1987; Stanworth, 1987). This twofold capacity of reproductive technologies – to extend women's control over their reproductive processes or to enable

medical professionals, the state and kin to control women's reproduction – created challenges in regarding contraceptive technologies in any single framework. Lock and Kaufert (1998: 2) argue that women's reactions to medicalisation of their lives and bodies "may range from selective resistance to selective compliance" depending on particular circumstances and, therefore, women's engagements with biomedical technologies can be described as pragmatic. Women are neither passive targets of biomedical or familial power, nor entirely autonomous. Women's engagement with biomedical technologies can be seen as a process of pragmatic negotiation. Despite unequal resources and power, women contest the denigrating practices of more powerful actors, and at times transform dominant ideas and practices to better serve their interests (Ginsburg and Tsing, 1990; Ginsburg 1989).

Ginsburg and Rapp (1995) argue that the politics of reproduction are inherently tied to wider structures of power, kinship, and economic relations. Unnithan-Kumar (2004: 6) in the introduction to the volume *Reproductive Agency, Medicine and the State: Cultural Transformations in Childbearing* refers to reproductive agency as "the ideas, actions, thinking and planning in the domain of human reproduction by women and men who engage in reproductive activities and seek healthcare services, as well as [...] the strategies, compulsions and motivations which inform the actions of medical, clinical and health personnel". In other words, reproductive agency refers to the questions of who has the power to make decisions concerning reproduction and fertility; what social, cultural and economic arguments drive these decisions; who is seen as affected by them; and who is left to bear the burden of failure or success.

Discussing the narratives surrounding the practice of female sterilisation in Brazil, O'Dougherty (2008) argues that academic works usually emphasise that voluntary sterilisation is a myth and that such "choice" arises from powerful and constraining social forces. Authors tend to discuss sterilisation as an example of increasing medicalisation of women's lives, a lack of contraceptive options or the lack of knowledge. As De Bessa (2006: 225) puts it: "scholars have wondered whether the demand for sterilization signifies an attempt at greater autonomy or whether it is a last resort taken by desperate women". O'Dougherty (2008: 420) asks "is it the bodily cutting that makes sterilisation 'radical,' or is it the renunciation of all future motherhood that is radical?"

Dalsgaard (2004: 133 cf O'Dougherty, 2008) argues that "medicalisation is a double-edged sword, both allowing (agency and expression) and alienating, as the active subject willingly entering the medical discourse is simultaneously made subject to the same discourse". Also working on sterilisation in Northeastern Brazil, Dalsgaard (ibid.) contends

that sterilisation meant simultaneous submission to medical authority and a sense of control. For her informants, sterilisation procedure was a strategy to improve relations and commitments within family and community, and to fulfil the ideals of good motherhood. The author concludes that the procedure was empowering for individual women, even though inferred from "contradictory concerns and demands" (ibid.: 175). De Bessa (2006: 221), similarly, argues that sterilisation among low-income women in Brazil represents "women's active struggle to improve their lives and to resist the burdens placed on them by unequal gender relations."

Sangari (2015: 131) argues that the claim to agency and 'choice' lies at the heart of some reproductive practices, such as sex-selection and commercial surrogacy, in neoliberal India, but that these practices create non-emancipatory and non-transformational subject positions. In these contexts, claims to women's agency perpetuate familial hierarchies and state- and market-driven patriarchal regimes. Sangari investigates how women's choice in decisions of sex-selection demonstrates efforts to improve women's position within the family or to improve the family's position through bearing sons. She argues that women's "complicity is formed under the triple sign of familial normativity, visible or invisible familial coercion, and class aspiration" (ibid.: 32). Sangari states that "even when a woman takes the decision 'herself', she practices a relayed, misogynic, classed agency; […] (which) is reappropriated and absorbed back into patriarchal structures" (ibid.: 32-33). Such analysis can be extended to the practice of female sterilisation, which can also be seen as "self-directed violence" alongside sex selection (ibid.), where patrilineal family formations, state's family planning agenda and political economy conspire to make women 'choose' a surgical intervention. However, such a view sits comfortably within studies which consider agency as resistance as the only form of agentive action, and which, in my view, somewhat dismiss women's efforts in survival and resilience in deeply constraining structural conditions. Mahmood's (2012[2004]: x) argument becomes extremely relevant here: "while acts of resistance to relations of domination constitute one modality of action, they certainly do not exhaust the field of human action."

Bledsoe (2002), working on reproductive behaviour in high-fertility context of rural Gambia, narrates how women saw their bodies as "wearing out" due to cumulative effects of certain lifetime events, particularly those of closely spaced pregnancies, difficult childbirths and pregnancy losses. Women try to control the effects of these adversities through ritual, medicine or contraception and, in author's words, create "contingency plans" in order "to smooth the roughest edges of risk" (ibid.: 24). Spacing pregnancies is a way not only to

ensure the highest number of surviving children, which is in the interest of the household and the family, but also a way women exert some control over the way their bodies decline over the life course. Uncovering the multiplicity of agendas women take into account modelling their reproductive careers, Bledsoe highlights multifaceted social and moral dimensions of women's reproductive actions.

Williams, Vira and Chopra (2011: 16) in their Introduction to a special issue on the experiences of the state in contemporary India argue that subaltern agency designates more than acts of resistance and "encompasses practices of resilience and processes of reworking in the context of state and societal power". Contrary to Sangari's (2015) analysis of agency as resistance, I find the framework of agency as creating "contingency plans" or agency as resilience (also see Obrist, 2006) particularly useful in discussing women's experiences of sterilisation. In line with O'Dougherty, De Bessa and Bledsoe, I see sterilisation procedure as a way women simultaneously take control of their precarious and contingent lives, but also, by doing so, submit to existing patriarchal institutions and relationships which, in the context of rural North India, demand women to solely bear the burden of reproduction and contraception.

As stated in the thesis introduction, I avoid framing the research question through the juxtaposition of choice *versus* coercion when discussing female sterilisation as a reproductive technology. The language of choice risks concealing the structural forces and inequalities that shape reproductive decisions. However, the language of violence and coercion also risks concealing the everyday efforts of women to negotiate and navigate these structural forces and inequalities stemming from patriarchal family structures and unequal distribution of resources and access. Trying to understand how and why women make reproductive decisions that suit them at particular points in their lives – and sometimes that decision might be to not take any action in the fear of domestic violence, for instance – does not in any way negate the importance of or the need for efforts to challenge these structural inequalities. Women themselves challenge and accept, negotiate and maintain hierarchies, norms, and structures at the same time. Pragmatic decisions or "common-sense" decisions are not made in a vacuum. According to Gramsci (1971: 325-326), who reflected on the understanding of the "common sense" in rural South Italy, "there is not just one common sense, for that too is a product of history and a part of the historical process". Pragmatic reproductive decisions, as well, are shaped by diverse historical, social, economic and political processes that materialise in particular conditions under which women live their lives.

## Reproductive decisions and gender relations

Throughout my fieldwork, I noticed that asking anyone a question – who decided to do this or that? – constrains the narratives from fully unfolding (also see Jeffery and Jeffery, 1997). Identifying a particular person as the source of a particular decision, thought, or even action hides the circumstances behind all three, and ignores the dispersed nature of agency (Gell, 1998). Lalu (2000: 49-50) suggests that there is the need "to think of the ways in which agency is constituted by the norms, practices, institutions, and discourses through which it is made available". In the corridors of academic life in the UK, I found myself being constantly asked again and again by my colleagues – so *who* makes the decision to get the female sterilisation procedure? The first thing this question masks is a question of gender relations. People want to know whether husbands pressure their wives into this decision. Then the in-laws and the state come into the question of coercion.

Studies on women's agency during reproductive occasions clearly articulate the tensions between reproductive restraints originating from kinship structures, gender relations, biomedical and state authorities, and women's autonomy and resistance to these structures. Jeffery and Jeffery (1997), Säävälä (1999, 2001), Croll (2000) and Van Hollen (2007) wrote about how patrilineal and patrilocal kinship hierarchies influence the reproductive decision-making in South Asia. Jeffery and Jeffery (1997: 122) frames the control that the mother-in-law holds over reproductive decisions of her son and daughter-in-law as an illustration of how "the enhanced agency of older women (as mothers and mothers-in-law) may be at the expense of limited or even reduced agency for their daughters and daughters-in-law". Stories of women's resistance to their husbands and mothers-in-law are also present in the literature. For instance, Säävälä (2001) working on reproductive decision-making in Andhra Pradesh, narrates the story of a young woman who demands sterilisation against the wishes of her husband and mother-in-law, and her tubal ligation scar becomes the evidence of her ability to challenge familial power over reproductive decisions. Säävälä (1999) further argues that even though mothers-in-law exercise significant decision-making power over a couple's reproductive life, young women may push their mothers-in-law towards relative old age by undergoing the sterilisation procedure and entering the post-childbearing age themselves.

During my fieldwork, I encountered occasions when husbands, mothers-in-law and parents were complicit in abortions and the use of contraceptives, as well as occasions when

they were strongly against it. Let me illustrate this with very different life stories of Kali, a middle-aged woman living in Chandpur, and her 25-year-old daughter Deepika.

## *Kali and Deepika*

Kali is a middle-aged outspoken woman, a mother of three – two daughters and one son. Kali's older daughter, Deepika, is married and lives in Udaipur; her younger daughter, Aarti, lives with her parents after getting divorced, and her son, Lokesh, studies in college and is expected to be the first college graduate in the family. Kali's husband runs a small bicycle repair shop next to their house. With her children grown, Kali looks after the cattle, the house and the fields, and effectively runs the household. Kali and her husband's families have been marrying across caste lines for three generations. In a place where caste endogamy is prevalent, this social transgression is ambiguously both a source of family pride and shame in different contexts[73].

Kali got sterilised after the birth of her son, almost 20 years ago, in a hospital in Udaipur. She always took great pride in her decision to stop childbearing through tubal ligation and repeated that it was the permanency of the procedure that gave her the relief from tension that was troubling her during childbearing years. She emphasised that her in-laws had no say in the matter, and that it was an economically motivated decision by her and her husband. Kali's in-laws lived with her husband's brother's family in a house next door, but she did not think that they may have had more say in her sister-in-laws reproductive decisions. According to Kali, it was both the uncertainty of her bodily states, as well as the uncertainty of her family's economic situation and future that troubled her most before the procedure. A few years later, after suffering from heavy bleeding and abdominal pain, she got a hysterectomy in a private clinic in Udaipur. When asked, Kali loudly and wittily exclaims:

[73] Counting the whole extended family, which spreads between Banswara and Udaipur districts, there are men and women of *adivasi*, Rajput, Brahmin, Jain, Nat and other caste affiliations. Kali justified their choices in marriage partners by saying that "if you cut your finger, blood comes out. Whether it is a Brahmin's finger, my finger or yours. We are all human beings and caste is not written in your blood". In spite of this justification and pride in their lack of caste identity, the caste hierarchies were never absent – the family emphasised upper-caste brides and grooms in the kinship network and tended to ignore the ones from lower caste backgrounds. This issue became particularly apparent when the family started looking for a groom for Deepika's sister, Aarti, who was mentioned in Chapter Three. Aarti was once married to an older Brahmin man, but divorced him because he was violent. For her second marriage, the family was looking for a respectful upper-caste groom, preferably Rajput or Brahmin, who did not drink, and my suggestion of a nice *adivasi* boy from an economically secure household was completely unacceptable. The villagers expressed their discomfort with the lack of rules guiding whom one could marry in Deepika's family by calling them *khichdi*, a popular Indian dish made of cooking rice, lentils, potatoes and other ingredients together.

"I am like a man now – I have no period, so I can do anything that a man can".

Kali's husband lost his leg ten years ago, in a road accident while working as a driver's assistant on a truck commuting between Udaipur and Mumbai. It was a simple broken leg, but as the truck was on the road somewhere in Maharashtra, the hospital refused to treat him suspecting he would not have money to pay for the treatment. He was put in a room with other abandoned patients and refused care. Eight days after the accident, Kali found out about the accident, borrowed money from neighbours and kin, and took him to a hospital in Ahmedabad. The untreated broken leg was infected and had to be amputated. When Kali confronted the truck driver's family who denied them knowledge of the accident for eight days, she was beaten up so badly that she barely survived. That was the first case that the Chandpur's Women's Resource Centre, run by Seva Mandir, took to solve demanding compensation on for such violence.

For a few years after the accident, Kali worked for a government secondary school as a helper – she cleaned classrooms and brought water for schoolchildren – for the payment of Rs. 1 per day. She remembers how villagers used to encourage her to leave her husband because he was no longer seen as capable of providing for her and their children, but she decided to stay by his side. According to Kali, she had three children and did not want to leave them with a disabled man and his parents, and could not expect anyone to look after her children within the second marriage. Even though Kali did not mention it, her inability to bear more offspring after tubal ligation may have been one of the factors for her to stay with her husband instead of remarrying. To this day, she is feared and respected by her own family and by the villagers for providing for her family through hard work as well as for her sharp character (*tej*) and outspokenness.

Kali's 25-year old daughter, Deepika, has a very different experience of how her proximity to her in-laws, class aspirations and control over her own reproduction intertwine. Five years ago, Deepika had what she calls an arranged love marriage with her father's brother's wife's sister's son from Udaipur, also from a family of inter-caste relatedness. They fell in love during a family function and their partnership was approved by both families. After the wedding, Deepika moved to live with her in-laws in an aspirational middle-class neighbourhood in the outskirts of Udaipur, where the mother-in-law ran a small faux jewellery store around the corner from the house, the father-in-law had a tailoring shop and her husband ran a small-scale trading business. During my time in the field, Deepika was pregnant for the first time and gave birth to a baby boy. During pregnancy, she visited Chandpur often, and for extended periods, because it was an opportunity for her to rest from

the duties in her in-laws' house that continued until the very last days of pregnancy. She often complained that her mother-in-law did not help with work in the house because she was lazy and fat. Cooking, cleaning, washing clothes and serving her in-laws and their guests occupied all of Deepika's time.

Deepika gave birth in the main government hospital in Udaipur, where the family had connections. She received a bed and attention from the medical personnel, which was rare in this overcrowded but highly regarded healthcare facility. I visited her and the newborn at the hospital in the morning, a few hours after delivery. She was lying on one of the 20 beds in the middle of a crowded maternity ward. Deepika's husband, in-laws, mother, father, brother and sister were spending time on the side of or around the bed, occasionally leaving to get *chai* and to walk around the corridors, while Deepika herself, exhausted after the delivery, was lying passively with a little cotton scarf tied around her head. The baby was next to her. Everyone was joyful and the baby was an object of repetitive fascination and admiration by all present. At one point, the baby started crying, and the women collectively, and vocally, decided he was hungry. There were no men around the bed at the time, and before Deepika was able to take her breast out of her blouse to breastfeed, her mother-in-law stood up from the chair, roughly took her breast out, started massaging the breast for the milk to appear, and in no way gentler or with any more care, pushed the baby's face into her nipple. Nobody in this situation, including Deepika, seemed to mind. Deepika's body did not belong to her; her mother-in-law had full authority to intervene and direct her to look after the long-awaited grandson. It was not simply that the mother-in-law was teaching Deepika how to be a mother (this was something that other women at this moment and for the months to come did). Rather, the mother-in-law clearly demonstrated her control not only over Deepika's behaviour in the house, mobility and money, but also her control over Deepika's breasts, nipples and milk.

At some point, Deepika's mother-in-law left the maternity ward, leaving only her mother, sister and I. Deepika turned to her mother and me and said "Have you seen how roughly [*zor se*] she squeezed [*dabaana*] me and grabbed the baby? She is always like that. I do not like that". Then, Deepika began telling me a story about her struggles to conceive. The pressure that a new bride faces in North India to give birth within the first year of marriage has been widely documented (e.g. Jeffery, Jeffery and Lyon, 1989). Deepika could not get pregnant for three years after her marriage and it caused a lot of concern and tension for her, her husband and the in-laws. About a year ago, her in-laws asked her to get dressed and told her they all needed to go somewhere for some business. She did not know why but followed

instructions. Without a warning or consent, they took her to a hospital, put her in a bed and a doctor gave her an injection. That was the last thing she remembered. She woke up after a few hours in the same bed with pain in her stomach. It turned out that a doctor performed surgery to "open up blocked fallopian tubes". Deepika emphasised that it was planned and implemented by her mother-in-law. When narrating it, Deepika was looking for comfort for having not been warned about what was going to happen. However, she assured me, now she was happy because this procedure helped her to get pregnant and give birth to a boy. Deepika's mother, Kali, was always very concerned for her wellbeing and critical of Deepika's mother-in-law's behaviour, but at the same time, she acknowledged that the life of a young daughter-in-law was always going to be difficult.[74] She understood it, partially, as the price of social mobility. Kali always emphasised that Deepika's husband was good and caring, and that Deepika now lived in a financially secure household in Udaipur city, and the mother-in-law was the only bad thing in her life, a quite familiar narrative in India.

Even though it is not clear what procedure was performed on Deepika, nor how the decision was made, the incident itself seems important in trying to understand how Deepika's role as a wife, her body, agency and reproductive expectations play out in the context of relationships between her and her in-laws. Especially telling is the fact that the mother-in-law seems to play a central role in claiming control over Deepika's body, both as far as organising an invasive medical procedure and breastfeeding are concerned. Deepika's story illustrates how women, as primarily responsible for conception, tend to bear the consequences of the failure to conceive and are subjected to a variety of measures in dealing with that failure. Contraception falls into similar constraints: as already demonstrated in Chapter Two, the responsibility to end childbearing also has, as history bears witness, fallen mainly on women's bodies.

When I met Deepika two years later, during a post-fieldwork visit, she was caring for her second son, two months old at the time. She said she did not want the second child as the first one was giving her enough trouble, but her mother-in-law did not allow her to take contraceptive pills and demanded another grandchild. Playing with her newborn, she giggled and proclaimed she wanted to get her tubes tied just like her mother did, but was not sure that her in-laws would allow her. The pride and assertiveness with which Kali retrospectively

[74] The struggle between a young daughter-in-law and her mother-in-law over resources, influence, and power is one of the central concerns not only for the academics working on women's agency and kinship in India (Jeffery, Jeffery and Lyon, 1989; Jeffery and Jeffery, 1996; Uberoi, 1993; Wadley, 1994, 2010), but also serves as the main story line for many popular Indian soap operas.

speaks about her tubal ligation and the way the same procedure stands as a hardly attainable aspiration for her daughter Deepika represents two very different sets of kinship structures and levels of control over reproductive processes. Furthermore, it also represents the diversity of circumstances that women around Chandpur encounter in their reproductive struggles.

Kali and Deepika's stories illustrate that women in nuclear households had much more freedom to make reproductive decisions than women in joint households, where the in-laws had more control over women's mobility and decisions. My informants' accounts seem to contradict other studies which often emphasise the constraints that are placed on women's reproductive choices by patrilineal and patrilocal kinship structures. During our conversations and in their retrospective accounts of tubal ligations, many of my informants spoke similarly to Kali and strongly emphasised that they made the sterilisation decision on their own or in an equal agreement with their husbands, and were not forced by their husbands, in-laws or the state. To emphasise this point, some women stressed that they made the decision to get sterilised against the wishes of either their parents or their in-laws. Due to methodological limitations of being unable to observe negotiations within the household as part of the process of reproductive decision-making, I restrain from making claims about how reproductive decisions are made. Instead, I am interested in how women frame their reproductive dilemmas and decisions post-operation.

### *Bindu*

Let me illustrate this with an extract from my conversation with Bindu, a woman in her mid-thirties from a *Meghwal* caste, the only and quite populous caste of *dalits* in Chandpur. Bindu's family is one of the very few *Meghwals* who has a *pakka* house and is economically relatively better-off. Her husband runs a small painting business in Jhadol, and Bindu herself recently started selling vegetables in the *bazaar*. She had an operation after delivering three children about eight years ago. Consider Bindu's narration of how the decision was taken:

> "My parents did not want me to get the operation because they were afraid that something might happen to me. So I did not tell them; only my in-laws knew. They were worried only for complications of the operation. They thought I was weak already and operation gives even more weakness, or I might die. So I did not tell them. My son's father was also forbidding me to get the operation. But I said I need it no matter what you say. If I die, just burn me but I am getting the operation because I do not need any more children – I told him. He did not even come with me to the hospital".

Bindu presents herself as having the ability to make a decision to get her tubes tied completely on her own, against the disapproval of everyone in her natal and in-law households. Her family was not against the procedure because they wanted her to produce more offspring, but because they were worried about Bindu's health and wellbeing. Jimli Bai in the opening narrative also told how she avoided meeting her father-in-law on the day of the operation because he was strongly against it. Even though she had discussed getting sterilised with her husband previously, on the day of the operation he was working in Ahmedabad, which provided her with autonomy to take the final decision on her own. The fact that my informants emphasised that decisions about sterilisation were made independently from their parents and in-laws resonates with other researchers' findings. For instance, an edited volume *Negotiating Reproductive Rights: Women's Perspectives across Countries and Cultures* (Petchesky and Judd, 1998) discusses seven country studies from Brazil, Malaysia, Egypt, Mexico, Nigeria, the USA and the Philippines, and investigates women's strategies for reproductive control. Petchesky and Judd's (1998) collection found that many women presented themselves as sole decision makers in reproductive matters, including contraception. Petchesky (1998) summarises that women saw themselves as sole decision makers because these decisions were concerned with their bodies and health, and with the wellbeing of their existing children. In such a way, women "both carry out their intentions and reconcile them normatively with centuries of patriarchal culture and socialisation, that define women as caretakers who ought to think of everyone else's needs before their own" (ibid.: 188). This clearly resembles women's narratives in rural North India, where women are anxious to be seen as good mothers, but simultaneously put efforts to decrease the burden that the bearing of children place upon them (Unnithan, 2003: 190). Bindu, then, presents herself as a sole decision maker in getting her tubes tied but reconciles it through the idea of self-care and an implicit ideal of good motherhood – to care for the existing children. The family planning slogans about a small family provides her a framework to take full control over her family's wellbeing, while at the same time perpetuating the gendered burden of contraception.

Later in her narrative, Bindu invoked the ideas of modernity, social change and changing gender roles. When I asked her whether there was any stigma attached to female sterilisation, she replied:

> "Nowadays it is easy to tell your neighbours, friends or doctors that you had the operation. This topic became open. Before, women used to feel ashamed

> to speak to male doctors about pregnancies or abortions, but not nowadays. In those days, they used to fully cover their faces and would not even wear shoes. When I got married, I did not wear my slippers in front of my in-laws also. I used to carry slippers in my hand all the way until that house [she points to the last house in her *gali*] and only then would wear them to go to the market. I did not speak to my father-in-law directly at all;[75] if I needed something from him I had to ask somebody else. But then it all changed".

Many of my informants spoke about the past and the present as two very different times. Whereas the past was romanticised in some contexts and accounts as the time of, for instance, wealth and abundance, it was also demonised in other contexts as the time when women had to abide to much stricter gender roles than today. It is not clear which particular processes and social changes Bindu is referring to in this narrative exactly, but a similar discourse of changing gender roles was prevalent amongst many of my informants from various caste and class backgrounds. Bindu acknowledges that these changing gender roles and kinship rules are paramount in creating conditions within which she is able to make a decision to get her tubes tied against the wishes of her entire family. Such decision, even though perceived as risky by her family and Bindu herself, was the only reliable way for Bindu to stop having children, and she was willing to take that risk. She made such a decision because the existing gender roles prescribed that the burden of reproduction and contraception fell on her shoulders, but also because the changes in gender roles allowed her to negotiate this burden according to her own terms.

Jimli Bai in the opening narrative also said that she and her husband made a decision to stop having children together, but she was the one who decided to get the procedure that particular day when the health worker came over. However, she further elaborated on the constraining structural conditions within which this decision was made. Jimli Bai referred to the time, most probably the time around the Emergency (see Chapter Two), when it was her father, not her mother, who got the procedure. In that way she acknowledged that the burden of family planning today fell on her shoulders and it was her body that had to bear the burden of medical intervention. Jimli Bai further questioned the reasons behind this gender imbalance

[75] A variety of embodied expressions of hierarchy, in this case between *bahu* (daughter-in-law) and the in-laws, is practiced in Chandpur as well as throughout many parts of India (e.g. Jeffery, Jeffery and Lyon, 1989; Vera-Sanso, 1999). Even though there are some similarities and differences in the way these practices manifest across caste lines, some of these gendered embodied hierarchies are used in the contexts outside of kinship also. For instance, many young *bahus* stand up when a father-in-law or other male relatives enter the room, and would not sit down at all or sit down only on the floor when the male relative sits down on a *khat* or a chair. The same practice of standing up was employed by the nurses and ANMs in Chandpur's hospital whenever a (usually male) doctor entered the room.

and the division of labour within the household. The idea that the husband had to do work outside in order to earn money and, therefore, needed his strength which might be compromised by the vasectomy[76] was not taken for granted by Jimli Bai. She, like many other women I overheard fighting with their husbands, questioned the quality of hard work men were said to do outside the house, and also demanded acknowledgement that the work she did at home and in the fields was as hard or even harder, and required as much strength as the work men pretended to do. Many women, if they did not confront their husbands about it, at least mocked men's "work" in women-only spaces. Jimli Bai's reflections on the gendered division of labour, or rather on the unjust valorisation of gendered labour, was a way to acknowledge that the decision concerning the means to end childbearing was made within tight social, economic and cultural constraints.

This was not the only time when women tapped into the memory of Emergency as a resource to negotiate and contest the existing gender relations. One day I met Indira, an ANM working in Kolyari who was proud to tell me that she brought in 23 cases from her work area to get the sterilisation procedure in the past year. I asked her how she convinced so many women to get the procedure, and she provided me with a simple answer: she tried to make the women understand that they did not need more children because it was difficult to feed them. She told me she had three children of her own, and I asked her whether she had an operation. Surprised, she replied with a question:

> Indira: "Who? Me? No no! My husband had it".
> Eva: "How did you convince him to have it?"
> Indira: "We are *samajhdaar* [sensible, sober-minded]".
> Eva: "How many years ago was it?"
> Indira: "My daughter is seventeen now, so count it. My father also had the operation himself and not my mother".
> Eva: "Oh but that happened during the Indira Gandhi times?"
> Indira: "Yes! They grabbed him from work and chopped it off".

[76] The metaphorical link between vasectomies, masculinity and virility is overwhelmingly present in everyday discourses, and, in an effort to increase the prevalence of vasectomies, is addressed by the doctors in the sterilisation camp as well as in public discourses. A public service announcement on television in the 1990s featured a man in a rural setting who had had the operation, clarifying to his friend that this ability to perform sexually would not be compromised on his getting operated. More recently, the state of Madhya Pradesh has offered free gun licenses as an incentive for vasectomy replacing the earlier offer of Rs. 1,100. This has reportedly raised the number of voluntary vasectomies dramatically. This strategy was adopted after a survey found that most men refused vasectomies because they did not want to lose their "manliness". "We decided to match it with a bigger symbol of manliness: a gun license", said Manish Srivastava, the chief administrator of Shivpuri district, where the scheme was announced (Washington Post, 2008). For the discussion on the metaphorical significance of semen in India, see Alter (1997), Busby (1997), John and Nair (1998), Srivastava (2001).

At that moment Indira laughed wildly and gave me a high five. I was left puzzled with Indira's enthusiastic high five and somewhat evil laughter. This burst of complex emotions provided a brief insight into the history of forced vasectomies as well as the construction of discourses about modernity in India. According to Indira, the fact that it was her husband who had a vasectomy, and not her, was the main proof that they were the family of *samajhdaars* [sensible, able to understand and comprehend]. According to Wadley (1994: 66), this capacity to understand in rural North India stands as the basis for hierarchies among genders, families, castes, or, in the author's words "'understanding' or knowledge is the primary attribute of those who are dominant, while those who are oppressed lack knowledge and understanding". The idea that the motivators' job is to make women understand what is good for their children and families is the most prevalent narrative. However, whereas the poor women's decision to get sterilised is considered to be sensible, such a decision is not sensible for the motivators. In Indira's narrative, the fact that it was her husband who got an operation stood as evidence of how different they were from the poor. Here, a decision to get a vasectomy instead of female sterilisation was an expression of a more gender-equal understanding of modernity. Indira invoked her father's operation as further evidence for her family's long-standing sensibility. However, when further probed, she disclosed the fact that her father was forced into getting a vasectomy during the Emergency, but that did not stop her enthusiasm. Her laughter can partially be read as a critique of the historical period of Emergency, but also, and maybe even more importantly, as a critique of prevailing unequal gender relations. Indira stripped the context of coercive nature of vasectomies and used the fact that it was her father who had the procedure, and not her mother, as facts illustrating their position as *samajhdaar*. The narrative of vasectomy, here, was selectively used as a positive experience which allowed Indira to critique the prevailing trend of women bearing the burden of contraception today.

## Negotiating the idea of a small family

Like many other women in Chandpur, Jimli Bai reasoned her decision to end childbearing after three children with the logic strongly embedded in the long history of India's family planning efforts (see Chapter Two). The political language of economic development and progress through limiting population growth translated into the local ways to think about one's life. Official family planning slogans propagating a small family, such as *chhota parivar, sukhi parivar* (a small family is a happy family), popularised through a variety of

communication methods, such as puppet shows, pamphlets, writings on house walls, radio and TV, throughout the decades (Chatterjee and Riley, 2001; Conly and Camp, 1992; Dharmalingam, 1995), have become a part of everyday vocabulary in rural areas. More than that, these slogans and their logic have become a way to think about social mobility and economic prospects. The main argument for ending childbearing is the wellbeing of existing children. According to Jimli Bai, she did not want more children because she wanted to provide more materially to those she already had. The same logic, over and over again, was repeated by almost all women who did not want more children, no matter how many they already had. Women who had the operation, their motivators, as well as women who did not have an operation but due to other reasons had only one, two or three children, all agreed that the fewer children there were, the better life for them one could provide.

Most women and men agreed that everything was so expensive nowadays, so it was better to provide good food, clothes and education for fewer children. However, one of the biggest concerns was not feeding or dressing one's children but providing land and houses to sons after their marriage. "Land is not made of rubber" was a common idiom, referring to the fact that the more sons one had, the smaller pieces of land they would inherit. This idiom refers to the idea that the amount of land one holds is fixed and does not increase (stretch like rubber). When that fixed amount of land has to be distributed amongst one's sons, then the more sons one has, the smaller plots of land each son inherits. Widely circulating are the stories of the "old times", when newly married *adivasi* men refused the land offered by their parents and moved to the jungle, started working the land, and after years of hard work, were in possession of much more land than their brothers who were too lazy and stuck to the parents' property. Nowadays, people say, nobody can do that because the jungle also belongs to the state or somebody else, and the land is no more like rubber.[77]

Even though people agreed that good parents provided their few children with better material life, there was a big disparity between ideas on how many children one should have and how many children people actually had. A very simplified trend in Chandpur, as well as in some other parts of India, can be summarised this way: the higher the family was on the caste and class hierarchy, the fewer children they tended to have. The idea of a small family was also present amongst *adivasis* – economically disadvantaged and low in caste system –

[77] Such an expression might point to the entrance of the state and the state's insistence on establishing strict land ownership. For the considerations about the distribution of land between sons, also see Jeffery and Jeffery (1997: 73-116); for the detailed discussion on the changes in the governance of village resources in Rajasthan, see Robbins (1998).

but was articulated differently than among the upper-caste and upper-class people. Whereas better-off families had one or two children, for *adivasis* in my fieldwork area[78] three or four children meant a small family. Even though people disagreed on how many children one should have, and for that matter, what and how much needed to be provided for them, most of them agreed that one was supposed to stop childbearing at some point. Female sterilisation, for many in Chandpur, was the only practical option.

## *Jivin and Neela*

In Chandpur, one particular family was often used as an example of failing to care for one's children properly. Jimli Bai also referred to them while talking about her own decision. The family in question was an *adivasi* family, living two minutes away from Jimli Bai, just outside of Chandpur. Jivin headed a family of twelve – his wife, Neela, and ten children, the oldest of whom was already married and with a baby of her own, and the smallest of whom was still nursing. With one daughter married to a village eight kilometres away, Jivin, Neela and their remaining four daughters and five sons lived in a run-down *kacca* house which desperately needed repairment. Jivin was well known in the village for his heavy drinking and fighting his neighbours and wife while drunk (one of these incidents was discussed in Chapter Three). He earned money by helping a travelling blacksmith with heavy iron work in Chandpur itself and spent most of his earnings on local alcohol made from *mahua*[79] flowers. Neela and their children worked in the fields and looked after the household. Neela and Jivin's children were a matter of concern to other villagers. Or rather, it was not so much a concern as a source of disgust mixed with ridicule. People often said things along the lines of: "Look at Jivin Bhai's children – how dirty they are, they do not have clothes, roam around all day on the road. Who needs that many children? If he had less, all of their lives would be so much better". Jivin's family used to be a concern for Padma Devi, Chandpur's ANM, who recalled the time few years ago, when Jivin had only five children. She spoke with his wife almost every week, trying to convince her to have an operation. According to Padma Devi, she saw

[78] *Adivasi* families in some other *tehsils* in Udaipur district, for instance Kotra, were much bigger compared to Chandpur. During one sterilisation camp I attended in Kotra, *adivasi* women reported having five to ten children before undergoing the procedure.

[79] The *mahua* flowers are collected from trees in the villages in the hot season, dried and sold to the shops in the market, which generates a relatively substantial income to the households in Chandpur. Some households prepare the liquor themselves and sell it to the villagers. Amongst the tribals, *mahua* liquor is consumed on regular basis, and especially on various festivals and life cycle occasions. For the material on *adivasis* and alcohol consumption, see Hardiman (1985), Froerer (2007), Lakra (2001), Shah (2011).

how much his family was suffering because he could not provide for them, and that was why she kept suggesting them to consider an operation or any other family planning method. “They did not listen to me, so I stopped coming. How many children do they have now? I stopped counting”, she described her unsuccessful efforts in motivation. Padma Devi and other villagers, both from Jivin’s *adivasi* village and from Chandpur, explained that the reason for their continuous childbearing and refusal to take advice on contraception was that Jivin did not care and did not understand: “*Samajhte nahi, daaruliya hai. Samajhdaar hota hai to kuch karvaate hai* [He does not understand, he is a drunkard. If he was sensible, he would get something done]”. Jivin’s alleged failure to care for the wellbeing of his wife and children resulted in ANM leaving them alone. Jivin and Neela, for whatever reason, managed to refuse the state’s intervention into their reproductive lives and decisions.

When I spoke to Neela herself, she explained to me that she did not get her tubes tied because there was a lot of work to be done in the fields and she did not want to lose her physical strength, a common concern discussed in the second part of this chapter. According to her, “that is how five sons and five daughters happened [*ho gaye*]”. On the day of this conversation, Neela's oldest daughter was visiting with her own newborn son, and both women were breastfeeding their respective sons while sitting on the same *khat*. Such occurrence was usually described as "shameful" by other women in the village, but Neela and her daughter seemed quite comfortable with the situation. Talking about contraception made them both laugh at first, but Neela soon went back to her matter-of-factly mode. She remembered the time, when Padma Devi used to come, but said that nowadays nobody came: “ANM used to tell me to get *nasbandi*, but I have a tumour in my uterus, so I cannot get the operation without removing the tumour first. We do not have money to pay for its removal – you know that their father is drinking every day”. Neela did not trust other methods of contraception either: she was afraid that the copper-T would make her ill, and was sceptical of contraceptive pill. She assured me she did not take any pills even when she was sick, and always opted for injections. Neela suddenly added: “But now children will not come anymore. Some old lady gave me *jangli dawaai* [herbal medicine]. I ate them for five days after the last delivery and now my uterus has closed”. I could never get Jivin’s side of the

story,[80] but it is evident that Jivin and Neela's reproductive choices and socio-economic constraints cannot be clearly separated. The intricate relationship between the lack of material resources, ill health, lack of access to and distrust in biomedicine, and complicated gender relations contributed to the fact that Jivin and Neela had to bear the village's ridicule.

## *Magli*

Negotiating the question of what is a small family can be found in the most unexpected places. One morning, Gunjan, an interpersonal communicator with Marie Stopes India (MSI) and one of the key organisers of a sterilisation camp, sat at a desk outside the hospital registering "cases" – making a list of women who had come for the female sterilisation procedure that day – when she was approached by a woman accompanied by her motivator. Gunjan asked a set of regular questions required for the registration: which village she came from; how many sons and how many daughters she had; and their age. The *adivasi* woman named Magli had a one year-old son and a four year-old daughter, and was in her early twenties. Gunjan quickly stood up and invited Magli to follow her to another room for a counselling session, a step that she would quite often skip, saying that these poor women would not understand the procedure anyway. She was happy for me to observe the session.

Gunjan spent a good fifteen minutes explaining to Magli that her son was very young, and that if anything happened to him, she would not be able to have another one after the operation. She told Magli about other, temporary methods of contraception – the pill, condoms, copper-T – advising her to use them until her son got older. She asked if Magli's husband knew that she would not be able to bear another child after the procedure. Magli was not convinced of using other methods and said she discussed all these issues with her husband, and they had decided that two children were enough – they were already struggling to buy their children good clothes and good food, and wanted to send them both to school one day. "How much money do you think we have from his wage as a daily labourer?" – she asked rhetorically. Gunjan seemed concerned for her, but after trying everything, she could not convince her to delay the operation. Gunjan then spent a few minutes explaining how to

[80] Besides Jivin's general drinking habit which prevented me from finding ways to talk to him about his reproductive life, Jivin and I also had a neighbourly conflict which resulted in a long period of non-communication between us. One afternoon, Jivin, under the strong influence of alcohol, was passing through the fields in front of my house and violently abused a stray dog that I was keeping in my backyard. Since then, our relationship deteriorated and I visited his wife only when he was away.

take care of a young son: "You must feed him well, not only *rotis* but lots of vegetables and fruits also. And do not allow him to play on the road. Keep him next to you at all times. Did you get all the injections for him? It is alright then". With nothing else left for her to say, she allowed Magli to continue with the medical examinations. She turned to me, worried, and said: "What can I do if she does not understand. I know that in the villages they do not look after their children the way we do. Who knows what might happen. And then they might have to live without a son".

It was a particularly interesting moment because it was the first time I observed the sterilisation camp staff trying to advise against the operation. During my fieldwork, quite a few women got rejected for the procedure due to recent abortions or other health problems, such as anaemia or high blood pressure. However, a woman's decision and circumstances were never questioned, except this one time. Gunjan's push against the operation after having one young son and bringing him up in the village contradicted the government's efforts and notions in family planning. She agreed that one should have a small family, but in Magli's case there was a real danger that the family was too small. This is a good example of utopian ideas of the state clashing with the health worker's understanding of local rural realities. Magli, who came for the operation with only a son and a daughter, together with her husband, embodied the state's utopian small family. However, Gunjan could not see how this small, utopian family could cope with and survive the challenges of rural poverty. Even though Magli did not follow the state's propagated idea of a small family blindly, and made a decision based on her own family's situation and calculation of risks, she was not seen by Gunjan as someone who knew what she was doing. Gunjan's concern contradicted the logic that was followed by the health workers throughout my fieldwork.

As mentioned earlier, *adivasi* women who came for the operation were usually seen as those who understand (*samajhte hain*) – the closest one gets to the notions of modernity lived and used locally. Those who insisted on having big families, like Jivin, were regarded as not understanding – and in need of someone to make them understand – which choices were good and which were not. The local health workers, as well as Marie Stopes India staff, saw it as their duty to make the tribal women understand what was good nutrition, proper family size, and how to take care of one's health. However, for Gunjan, Magli demonstrated not the ability to understand that a small family was a way to a more economically prosperous future, an argument employed to justify family planning programmes throughout the decades in India, but instead the inability to calculate the risks of rural poverty. In the fifteen minutes Gunjan spent counselling Magli in a gloomy room in the rural hospital in Jhadol, she tried not

only to convince Magli against the personal decision she had already made, but also negotiated the core idea of the Indian state's family planning efforts, questioning its suitability for the area of Jhadol where she was working, an area affected by deep-rooted poverty, unemployment and strong dependency on yearly rainfall.

In this chapter, I do not place analytical focus on the encounters between the women and the health workers in Chandpur. However, it is important to emphasise that notions surrounding family planning, small family and economic prosperity are constantly negotiated and contested in a variety of settings, including the interactions with the health workers. The ideas that my informants held about their own aspirations for a better future via the path of reducing fertility were, in many ways, products of multiple social and political processes and histories. Gunjan, speaking in the name of the state when it came to the reproductive health matters in her work area, negotiated and contested the idea that two children were enough, when it came to her understanding of a child surviving in rural poverty. The rupture that occurs while implementing top-down programmes and policies is just one example of the multiple negotiations and contestations of official discourses that happen on the ground, in the interaction between women who come for the sterilisation procedure, their motivators, bureaucrats and medical personnel carrying out the procedure.

Most importantly, both Jimli Bai in the example from the opening narrative, and Magli in the encounter with Gunjan above, clearly know what they want. The ideas and decisions about the ideal family size, the method of contraception and the timing of the procedure are all formed in some sort of relationship with the state (a variety of local manifestations of family planning programmes, such as slogans, idioms and health workers). However, both women clearly make choices which suit their circumstances, and in Magli's case, in spite of the MSI nurse's suggestions.

## Tubal ligation amongst other methods of contraception

To understand why female sterilisation is one of the most practical options for women in Chandpur, let me briefly discuss other contraceptive methods and how they are perceived by my informants.

Most women in Chandpur dismissed condoms as a possible contraceptive option without much consideration. They simply acknowledged that it would be difficult to convince their husbands to use them. The few men who were willing to talk to me about such matters provided insights into their strong refusal to use condoms. According to some, a condom

prevented man's juice (*ras*) from entering a woman's body, which erased any point of having sex at all. Here, the concern is not with making a woman pregnant, but rather with creating a relationship with the woman through the exchange of bodily substances. Sex, in this view, creates love and attachment through the exchange of bodily fluids. Such understanding is in line with Marriott's (1976) argument that Indian persons are connected to other people, places and things through sharing of coded substances – blood, food, sexual fluids and milk.

As a circle of Sadhus discussed one sunny afternoon, all *maya* started with sex and extended to the joys and worries about children, the house and the cattle. *Maya*, here, is not simply an illusion, the way the literal translation from Sanskrit would suggest. Rather, *maya* refers to the person's attachments to the everyday and to the world around. As Lamb (1997: 282, emphasis original) conceptualises in her work on aging in West Bengal, persons "viewed and experienced themselves as emotionally and substantially *part* of the other people, places, and things that made up their lived-in worlds". These nets within which people are enmeshed are called *maya*.[81] According to the logic of personhood expressed by the circle of Sadhus that afternoon, using a condom prevented the exchange of sexual fluids that created an attachment to the joys and sorrows of the everyday.[82]

It is important to consider that the men with whom I spoke to in Chandpur could have been arbitrarily tapping into the local cosmologies and ideas surrounding personhood for their own pragmatic reasons, such as legitimising their personal reluctances against condom use. A rural legend widely circulating in and around Chandpur was told to me for the first time by Hema, a Brahmin woman who worked as a local worker for Seva Mandir. Hema worked in the area of women and children's health and narrated a story about a training organised for the villagers of Chandpur a few years back on the matters of contraception. One of the presenters demonstrated how to use a condom by putting it on his thumb. A few months later, one of the men who attended the training turned up at the local office of the NGO complaining that the condom did not work and his wife got pregnant again. When asked, he supposedly narrated that before having sex with his wife, he put a condom on his thumb and proceeded. Hema could not stop laughing while telling this story. Similar versions of this story were retold to

[81] Maya is also the name of one of the manifestations of Lakshmi, the goddess of prosperity, love and wealth, which suggests the metaphorical link between children, kin and wealth.

[82] Besides Daniel's (1984: 163-181) account on the importance of mixing of sexual fluids in the making of a Tamil person, which is in full synchrony with Chandpur's Sadhu's account, similar social and cultural factors influencing women's resistance to condom use in Rwanda were described by Taylor (1990), who argues that the mixing of bodily fluids was necessary for the process of social cohesion and personhood formation in Rwanda, and condoms represented a polluting blockage in this process.

me a few more times by different people in Chandpur. Whether a true story, a distorted version of different events, or a completely made up anecdote, this rural legend circulates widely in Chandpur ridiculing condom use and men who use or fail to use condoms. This story, combined with Indira's enthusiastic high-five and an outburst of laughter while talking about her father's experience of a forced vasectomy during the Emergency I discussed earlier, is, in my view, a way of talking about modalities of power, and about the intersection between the masculine, family planning and the state.[83] Ridicule that connects the narratives about those men who were subjected to vasectomies in the 1970s and men who use condoms nowadays is a way to talk about how incomprehensible it is in local terms that men should bear the burden of contraception. Furthermore, it is a way to express a critique of the state targeting men for family planning by locating the patriarchal "state power in the realm of ridicule" (Mbembe, 2006[1992]: 386).

Most women in Chandpur were suspicious of other contraceptive methods – especially of the contraceptive pill and copper-T – and agreed that there was no way to make their husbands wear condoms. The HealthWatch and CEHAT's studies (2004 cited in Duggal and Ramachandran, 2004: 126) on abortion in India also report some women's perception that abortion is "a 'safer' option than IUDs and other spacing methods". Jimli Bai and her sister-in-law agreed that the contraceptive pill was not good for women's bodies. Even though they could not explain why it was harmful, they both acknowledged that constant use of medicines, just like a daily or weekly intake of contraceptive pills, could not be good for one's body. Jimli Bai further hinted at a much wider suspicion in villages towards any kind of oral pills and the preference for injections (discussed in Chapter Three) by saying that she did not even know where the pill went after swallowing it.

Some women were not simply suspicious of contraceptive pills, but acknowledged a lack of access to the medical knowledge and supply of them. When discussing her reproductive history with my neighbour Bindu, we started talking about the reasons why the health workers themselves did not get the operation and found other ways to stop childbearing. She said:

> "They are doctors, they know about different medicines which stop you from getting pregnant. We do not know anything about that, and that is why we ask to simply close it [uterus] for good. They have access to the medicines all the

[83] For the literature on the patriarchal symbolism and representation of the state, see: Brown (2007[1995]); and in reference to the Indian state, see: Menon and Bhasin (1993).

> time, and if something happens to us, where do we go looking for the meds? If one gets pregnant, it does not fall that easily [referring to abortion]. For some women the abortion pill works, but for me it never does, no matter which or how many pills I take".

Even though Bindu clearly expresses a desire "to simply close it [uterus] for good", it seems that permanent methods of contraception, such as tubal ligation, present a particular challenge to feminist thought. The arguments against permanent methods of contraception range from concerns about women's changing social circumstances, such as the need and possibilities for remarriage; to ideas about the integrity of bodies and their relationship with intrusive medical procedures; to the supposed loss of control over one's body in case the woman changes her mind and decides to have more children. However, for the majority of women I spoke to in the field, tubal ligation's irreversibility and permanence was a desire. Its permanence was exactly the reason why most women opted for sterilisation in the first place. As one of the doctors in the camp once said: *adivasi* women either want more children or the operation; there is nothing in between". Even though her view needs to be taken as the perspective of a middle-class medical practitioner who has a particular way of seeing the *adivasi* women she works with, women in Chandpur from various caste and class backgrounds quite often expressed precisely that notion.

There have been numerous legal cases and a number of judicial decisions from courts across India concerning the failure of a sterilisation procedure and losses suffered by patients due to unwanted children born after the procedure. In the case of State of Haryana v. Smt. Santra, for example, Santra, a poor labourer woman from Haryana, had the procedure in 1988 after giving birth to seven children. After the operation, she became pregnant again and gave birth to a daughter. Medical examinations revealed that the operation was performed on her right fallopian tube only, and the left one was left untouched. The Supreme Court of India (2000) acknowledged Santra as the victim of medical negligence and recognised the economic implications of having an unwanted child, which could have been avoided had the sterilisation operation been successful. The court recognised the liability of the doctor and the government, which promoted family planning as a way to relieve an economic burden the

couple might not have been able to shoulder.[84] The most recent case was won by a couple from Chittorgarh district, Rajasthan. According to the article in *The Times of India* (2015), a woman named Prem Bheel underwent the sterilisation procedure ten years ago after having two children, but gave birth to another son and daughter after the procedure. The court decided that the couple was entitled to a compensation of Rs. 30,000 for their losses (ibid.). The permanence of tubal ligation, then, emerges as the main reason women chose this particular method of contraception.

## The timing of sterilisation

When the decision to get the tubes tied was negotiated within the household, various factors came into consideration deciding the particular timing of the procedure. One of my informants told me about the right times to get sterilised:

> "You always do it during winter; the wound heals better and quicker when it is cold. During the heat you sweat a lot and the wound gets infected easily. But it is the same with any other operation – your body heals quicker in winter but so many times you do not have a choice. Like *uncleji* [her husband] who felt the stomach pain in June, so he had to get the kidney stones removed right away. But with *nasbandi* you can choose".

Female sterilisation is commonly performed during a particular time of the year. There is a specific term used in the place of my fieldwork, both by the villagers and by the health

[84] The courts have also recognised and compensated the non-pecuniary injuries that might result from such negligence, such as mental trauma and distress. In one case the court ruled that the government was liable to pay compensation to a woman who had become pregnant after her husband underwent vasectomy. She faced humiliation, insult and torture as her integrity was doubted by her husband and his family, who were led to believe that after the operation no child would be born (Shakuntala Sharma v. State of UP, 2001). The courts have also granted compensation in instances of death of the patient during a sterilisation operation (Rajmal v. State of Rajasthan, 1996) and when severe complications arose after the operation (Dr. M. K. Gourikutty v. M.K. Radhavan, 2001).

In 2005, the Family Planning Insurance Scheme was launched in response to the exhaustive directives issued by the Supreme Court in its order dated March 1, 2005 in Civil Writ Petition No 209/2003 (Ramakant Rai v. Union of India, 2007). It directed the Union of India and States/UTs to ensure the enforcement of the union government's guidelines for conducting sterilisation procedures and norms for bringing about uniformity in sterilisation procedures. The scheme grants a patient (or family) compensation of up to Rs 2 lakh in case of death due to sterilisation while in hospital or within 7 days of discharge; Rs 50,000 in case of death due to sterilisation within 8-30 days of discharge from hospital; up to Rs 25,000 to cover expenses for treatment of medical complications due to the sterilisation operation (within 60 days of the operation); and Rs 30,000 in case of failure of sterilisation (MoHFW, 2011).

workers, to describe this time – the sterilisation season[85] or *nasbandi ka mausam*. The sterilisation season falls between October and February, when the weather is cold. It is a time when sterilisation camps are organised every week and when the motivators expect to collect the most "cases" for their unofficial annual sterilisation targets. For the women, the sterilisation procedure needs to be performed during that time because the cold weather is believed to speed up the healing process after any operation. Operations during the hot season are avoided, as it is widely believed that the post-operative body heat, combined with the hot weather, stops the body from healing, and the incision has more chances of getting infected. Such an understanding draws on a discourse and everyday practices of balancing "hot" and "cold" qualities in the body through diet, ritual and other daily interactions. Daniel (1984: 70) suggests that each and every person has a uniquely proportioned composite substance and that it is person's responsibility to determine what external combinations of substances suits him or her best, as "there is no *dharma*[86] […], no unit of time, no food or soil that is moral or good for all persons". He also suggests that the uniqueness of one's composition makes the person vulnerable "to the unique conditions of place, time, and other equally vulnerable substances with which he comes in contact" (ibid.: 71-72). One's internal composition continues to change throughout one's life and imbalances of these qualities in the body are seen as resulting in a variety of illnesses and diseases.[87] Women's conscious planning to undergo the sterilisation procedure during the cold season to avoid the consequences of the excessive heat during the summer shows how well the operation is incorporated into the local understandings of the body, illness and healing and local biologies (Lock, 1993). It also supports Donner's (2004: 123) argument that "(t)he medicalised view of women's reproductive bodies fits surprisingly well with the Ayurvedic understanding of the body and its functions as a system of channels and substances which can become unbalanced/blocked".

[85] Besides the sterilisation season, the health workers also sometimes talk about the IUD season – the remaining months of the year when women want to get contraception but do not want to get an operation because it is too hot.

[86] *Dharma* is a key concept in Hinduism, referring to one's obligations, duties, rights and virtues.

[87] It is not simply food that has these qualities. A unique balance of these qualities in one's body are believed to be determined by a variety of factors, such as caste, life cycle and birth place. Particular actions, practices and events also affect this balance, for instance, manual labour, sex, menstruation, pregnancy create the heat within the body. Diseases are also classified as hot or cold as a result of excess of these qualities in the body. Miscarriage is seen as a result of excessive heat, whereas tuberculosis is seen as a cold disease (Pool, 1987). Describing the hot and cold beliefs in South India, Beck (1969 cited in ibid.) argues that excess heat is thought of as "building up within the body" while excess cold is seen as "attacking from without". Cold complaints are usually invisible but painful, whereas hot complaints are visible on the surface of the body but not painful (Beck, 1969: 562 cited in ibid.). Also see Ecks (2014) Lambert (1992), Parry (1989). Other methods of contraception are also conceptualised in the same hot-cold dichotomy. For the discussion of IUD understood as hot, see Van Hollen (2003: 159-162).

Pinto (2008: 267) argues that the idea of heat brings together the intersection between moralities, bodily ontologies and the embodied categories of caste and class, and "indexes the body in a web of social relations that are infused with power". Cohen (1998: 155, 269) writing about aging suggests that "(h)eat, particularly in the context of the life cycle, may be read as the externalisation of power" and expresses the disruption in familial ties and care structures embodied by the aging person. Women's concerns with the summer heat as preventing post-operative healing can also be read along similar lines. Besides the concerns related to the speed of recovery, the seasonality of the procedure is strongly linked to the demands of agricultural labour cycles. The cold season is also a time when there is less work in the fields, which occupies a lot of women's time in summer and after the rains. Less work in the fields means women can find time for the procedure more easily and can also take more time off to recover after the procedure. Bearing in mind that women always get help from their kin or neighbours to help out with the household duties after the procedure, summer is a difficult season to find other women who would have time to help out in another household. In the same way, the heat of the summer also represents the possibility of disrupting the household affairs if a woman undergoes the procedure during the time of the year when there is a lot of work. The heat of the summer is thus seen as unsuitable for the sterilisation procedure and also stands for the lack of support structures required by the women after the procedure.

Besides concerns about the seasonality of the procedure, the women often had vague convictions about the concrete time to start using contraception, including getting the operation. As in Jimli Bai's narrative, she decided to stop having children and get the operation a year before she actually underwent the sterilisation procedure. That approach was often repeated in other women's narratives. Often, the decision not to have any more children did not result in an immediate action. Between the decision and an actual procedure, some women gave birth to another child or underwent abortions.[88] According to various ethnographic accounts, the main reason for seeking abortion in India among married women is to limit family size or space children (Patel, 1994; Unnithan-Kumar, 2001, 2004b). According to some qualitative studies, the majority of women reported knowing about various

[88] It is important to emphasise that one of the findings from the case study of Rajasthan states that "(a) wide range of providers in the state includes those that provide clandestine, but safe abortion services" (Iyengar et al., 2004). From my informants' narratives and widely used words for medical abortion (e.g. MCwalli pill or menstruation pill, Rs.500walli pill or the pill that costs Rs.500) it is clear that medical abortion is increasingly available to the rural women, even though stories of other methods for abortion (ranging from herbal teas to the insertion of foreign objects into uterus in order to cause infection and subsequent abortion) are also circulating.

methods of contraception; however, their concerns for health, discomfort, pain, husbands' approval and irregular supply prevented them from using any of the methods (HealthWatch and CEHAT, 2004 cited in Duggal and Ramachandran, 2004). In my field site, abortion was primarily sought to limit family size, particularly before a woman found time to get the operation. Some women delayed the procedure for other reasons: their smallest child was too small to provide them with enough time to recover after the procedure; their female kin was away with no one else to help with housework during the post-operative recovery period; or they just did not manage to get it organised. This is where the health workers seemed to play an important role.

According to Jimli Bai, whose story opened up this chapter, she got the procedure that particular day just because the health worker came over to invite her to the camp, and she did not have any other work in the house or business in the market that day. Whereas the decision to get the operation seems to be made within the family – Jimli Bai also says she discussed it with her husband before, in spite of father-in-law disagreeing – the timing of the procedure itself is very clearly influenced by the visit of a health worker. This in some way resonates with Van Hollen's (1998, 2003) argument about "moving targets". Van Hollen writes about the routine insertion of IUDs by nurses and doctors in the public maternity wards in Tamil Nadu following childbirth and abortions. The health workers in large government hospitals in urban areas – operating in the system of official family planning targets[89] – routinely inserted IUDs without women's consent because they viewed the women as "moving targets". That is, the women were difficult to reach after they left the hospital. Similarly, the women in and around Chandpur who did want to get the sterilisation operation needed to be "caught" by the health workers at the right moment in time. Thus, they were "moving targets", but not in a sense of distance, the way Van Hollen's informants conceptualised women's distance from health facilities, lack of regular check-ups and a general lack of possibilities of surveillance of rural women. Rather, women in Chandpur were "moving targets" in terms of time: the uncertainty of when exactly a woman would decide to get the procedure, if at all, created obstacles in health workers' agendas (discussed in Chapter Four).

[89] Van Hollen carried out her ethnographic research in 1995, when the official family planning targets were in operation before being officially abandoned in 1996.

## Women's weakening bodies

The decision about sterilisation procedure is related to the concerns with livelihoods, political economy, gender relations and desires for a better future as discussed above, but that is only part of the picture. These social and economic concerns materialise through the conversation about one's body. The fact that women bring their concerns with the body at the centre of their narratives of sterilisation gives them an opportunity to take full responsibility for the decision to end childbearing, at least in their retrospective accounts.

In the conversations with my informants, it became clear that the decision about female sterilisation hinged on balancing concerns for one's body becoming weak due to childbearing and regularly practiced abortions against the fear of becoming even weaker after the operation. Rashid (2007; 2010: 181-182), working with young married women in a slum in Dhaka, Bangladesh, argues that *chinta rog* (worry illness), *durbolata* (weakness) and white discharge "are metaphors for the economic, social, and political deprivation in poor women's lives". In the narratives provided by Rashid, women talk about their weak, worried and thin bodies breaking and wasting away, with tensions and burdens stemming from difficult relations with husbands and kin, unemployment, financial instability, and pressures of being a good wife and mother. Following Scheper-Hughes and Lock's (1987) suggestion that social relations and inequalities are embodied in individual, social and political bodies, and that sickness is a way to speak about individuals as well as society, Rashid (2010: 186) argues that "(t)he gradual deterioration of their [poor women's] bodies communicates the social, structural, and physical inequalities in their lives". Similarly, Bledsoe (2002), working on reproductive behaviour in high-fertility context of rural Gambia, narrates how women saw their bodies as "wearing out" due to cumulative effects of certain lifetime events, particularly those of closely spaced pregnancies and pregnancy losses. Women try to control the effects of these adversities through ritual, medicine or contraception and, in author's words, create "contingency plans" in order "to smooth the roughest edges of risk" (ibid.: 24). Cohen (1995), working on perceptions related to aging in Banaras, also writes about the embodied weakness associated with getting old and with a fear of becoming a burden as well as a fear of inadequate support. The concerns with women's weakening bodies enter the narratives and considerations of ending childbearing and choosing a particular method of contraception in Chandpur in similar ways. The fear of becoming a burden, the possibility of ill-treatment by the in-laws, and the lack of support due to one's incapacity to carry out work in the house highlights uncertainties young women faced in the context of my fieldwork.

In Chandpur, women spoke about two processes that made their bodies weak: childbearing and tubal ligation. Jeffery, Jeffery and Lyon (1989: 167-175) demonstrate that childbearing is seen as making women lose their strength, draining their spirit and making women old. Women's concern for their weakening bodies is expressed in a variety of narratives concerned with various stages of their lives and various activities. A common idiom used widely and in a variety of situations and contexts in the village is "*paanch minute mazaa – nau mahine sazaa"* which can be translated into "five minutes of pleasure/fun – nine months of punishment". This saying clearly demarcates gender roles implied in a sexual encounter – men's quick pleasure translates into women's long bodily suffering of pregnancy. In many narratives, pregnancies and abortions were seen as part of the same process. Bindu spoke about her experience using the contraceptive pill for a year before undergoing the operation, abortions and the consequences of these reproductive technologies on women's bodies:

> "And if you forgot to eat the tablet, you need to go to the doctor every time and pay him money and your body suffers every time [*sharir se nuksan*]. Why would you do that? Just close it for good. I had my children, didn't need more and this is why I got an operation. Men's bodies do not get weak, it's our bodies which deteriorate [*bigar jata*]. How long can we run around with children on our hands; how long can we wash their dirty clothes? I have never seen more blood than when I got an abortion; I do not want to go through anything like that again. That is why I got an operation. And now my children got big, now we are waiting for the time to arrange their marriages".

The weakness so widely spoken about and feared by the women in Chandpur includes tiring quickly, and not being able to walk long distances or carry heavy items. Carrying water from sometimes far away water pumps and bringing wood from the forest for food preparation formed women's daily chores. The same concern was expressed by an *adivasi* woman, Tiya. Tiya is in her early forties and a mother of three – a sixteen-year-old son, a fourteen-year-old daughter and a ten-year-old son. She was fifteen when a teenage boy, Mukesh, from a neighbouring village came over to visit her natal household to see Tiya and her sister and decide whether he liked any of them to marry. He spent the whole day helping Tiya's father with building a shed and left in the evening. Tiya followed behind him to his house, three kilometres away. When he saw her entering his house and demanded her to leave because he was not sure whether he liked her, Tiya threatened to jump into a well on her way back, because she could not return to her parents' home after having left for a boy she liked.

Mukesh and his parents allowed her to stay. Tiya says that they did not live "like wife and husband" at first, but after a few months Mukesh started "coming to her". They never got properly married – through ritual and village celebration – but cohabitation and the birth of the first child made their family legitimate in the eyes of the village and her natal kin. After the birth of their first child, Mukesh built their own house, a few kilometres away from his parents. Throughout the years, Mukesh worked on various construction sites in Udaipur and other parts of Rajasthan and Gujarat, while Tiya looked after the children, the house, kinship responsibilities and the fields. Currently, Mukesh does irregular and low-paid jobs on construction sites around Chandpur. Tiya says that whatever she grows in their fields gets them through the year – if the rains are good, they have enough maize, wheat and lentils to sustain the household. Their buffalo, cow and several goats provide them with milk and irregular cash, when sold. Their oldest son works on an industrial farm in Gujarat and occasionally sends them money. When there is no cash in the house, Tiya works on NREGA projects around Chandpur.

Tiya tells me that besides her three surviving children, she had one more, another boy, Naran, who would have been around twelve now. He died in the arms of his father, when he was around seven, from an undiagnosed illness. Tiya tells me that they decided to stop having children after Naran, their third child, was born, but did not get the procedure organised in time and she felt pregnant with the fourth son. She sought advice from a *bhopa* (local healer) on how to induce abortion and was given herbal medicine, as the medical abortion pill – a combination of Mifepristone and Misoprostol – was not widely available ten years ago. The child did not fall (*girna*) and she carried him to term. Several months after his birth, Tiya was approached by the local *anganwadi* worker and was taken to the camp to get her tubes tied.

When I met Tiya that day, she had just visited the Chandpur market and got the household essentials – soap, oil and sugar. She dropped by the house of another *adivasi* woman, Paru. Paru, in her mid-twenties, had an arranged marriage in her late teens and was already the mother of three young daughters and one son. Her husband ran a tea stall in the Chandpur market, but spent a lot of his income on drinking. Paru looked after the children, the fields and around 15 goats. On that particular day, Paru's mother-in-law, who lived in a house nearby, met Tiya and me at the *angan* to Paru's *kacca* house and said that Paru was in bed and in pain because she took the *MCwalli* pill (*lit*. the menstruation pill, referring to a combination of Mifepristone and Misoprostol). That day she was going through post-abortion bleeding after taking the pill given to her by Padma Devi, Chandpur's ANM. Later on, Paru explained that she did not have time to get the operation organised, but neither she nor her

husband wanted another child, as they were already struggling to feed the four existing children. Without much consideration, Tiya immediately replied: "That is why I had the operation, now it is *chutti*[90] [holiday, vacation] – I do not have such problems anymore. I do not have to hurt my body anymore".

Undoubtedly, there is a sense of relief when Tiya uses the term *chutti* to describe the ending of her childbearing. She feels free from the bodily suffering that seems to be inevitable in a woman's life. It was not the only time when Tiya used *chutti* to describe her current situation as a woman of post-childbearing age. A few months before, I entered the kitchen where Tiya was making *roti* while sitting on the floor next to the fire in her own house. We talked about her operation before and I remembered the ease with which she talked about it: "I had four children and then I had an operation and then *chutti*. Four is enough. My family is happy, so I am happy too". These words are clearly based on the slogan used by the Indian government during various family planning campaigns, "A small family is a happy family". When I asked Tiya if she was at all scared before or during the operation, she agreed that she was, but said, "it took as long as smoking a *bidi*.[91] You know, you light the *bidi*, it takes three minutes and it is over. That is how long the operation took; I did not even realise and it was over". It seems to me that *chutti* in Tiya's narrative also signifies the certainty which came with the operation. Women of reproductive age experience their bodies as uncertain, as they do not know when they would get pregnant and when they would decide and acquire the means to terminate those pregnancies. Tiya, on the other hand, knows what she can expect from her body after the operation.

Looking after one's children and dealing with the consequences of unwanted pregnancies are considered to be harmful to women's bodies. Tiya's expression that if she had not had the operation, she would have had to go through regular abortions shows how common abortion is in the village. My conversations with women from various socio-economic backgrounds show that it is a common option amongst women of all castes. Even though there is no agreement of how many children are enough for a family, there is a clear understanding that somewhere along the way, the family had enough offspring. Rather, the conversation about sterilisation rests with deciding which way to prevent childbearing is the

[90] Tiya uses the word *chutti* which can be used in many situations. A direct translation of *chutti* is holiday or vacation. It also means termination of something: one can get *chutti* from marriage (divorce) or from work (getting fired). *Chutti* can also mean a break from school, household chores and so on.

[91] *Bidi* is a thin, Indian cigarette filled with tobacco flake and wrapped in a leaf, tied with a string at one end. It burns quicker than a regular cigarette.

best. Temporary methods of contraception, including abortion, are considered as contributing to the deterioration of women's bodies.

The sterilisation operation, however, is not considered to be the best or easiest way to end childbearing by all women. The biggest and the most common concern for women when deciding whether to have a sterilisation procedure is the same fear of becoming weak, of not being able to carry out the work required of them. The women who were against the operation expressed their concern this way: "I need to bring water, to wash clothes, to make food. Some women become weak after an operation. Who will do all the work in the house if I become weak?" The weakness associated with tubal ligation (and with vasectomy) has been rather widely noted by anthropologists and other researchers (e.g. Ramasubban and Rishyasringa, 2001; Wadley, 1994). For instance, Wadley (1994) in her *Struggling with Destiny in Karimpur* briefly discusses the dilemma of undergoing tubal ligation faced by the women in Karimpur. The author cites one woman saying: "I'm scared of the operation. I get scared, as I feel there is no life in my body. My body gets weak. I don't know what an operation does. Whether it does good or bad to one's life or finishes it. That's why. With an operation you get nothing but weakness" (ibid.: 114). The concern with losing one's strength is the same as in the case of vasectomies, but due to the fact that women's work in the house and the fields is not valued as much as men's paid work, it is seen as a lesser of two evils.[92]

There are two main reasons why the operation is seen as weakening women's bodies. The first reason is related to the understanding of the laparoscopic procedure, which is known in the village as *lightwalla*, *karantwalla* or *doorbeenwalla* operation. The laparoscope is seen as working through electricity and every time women spoke about its way of working they pointed to the nearest working fan. One woman told me once when pointing to the fan: "this is how *karantwalla* operation works, through the current of electricity. The way the water is sucked up the pipe, that is how the blood is sucked out with the *doorbeen*, would you not become weak after it?" This understanding refers to the local understanding of anaemia or a lack of blood (*khun ki kami*), which is supposedly caused by the technology of a laparoscope. A laparoscope is seen as having not simply the power to *see* inside the body (*doorbeen* as binoculars), but also to suck out the blood from the woman's body through the work of electricity. Through such a conceptualisation, wider conditions causing anaemia, such as poor nutrition and, inherently, gender inequalities in the distribution of food within the household,

[92] The link between the operation and sexual drive also persists in discussions on female sterilisation. Women were seen as wanting and needing less sex because they had the operation.

agricultural cycles and shortages, and broader socio-economic restraints in access to food, are overshadowed by placing the blame on the medical instrument. A laparoscope, and by extension, medicalisation of reproductive processes and women's bodies, then, emerges as a single perceived cause of weakness and anaemia in this particular context.

Another reason why the operation is seen as weakening women's bodies is expressed in a concept articulated amongst the women in the village as *operation ka sharir*, or the body of operation(s). This idea of an operated body refers to any kind of intrusive medical operation (like kidney stone removal or sterilisation), and its weakening of the body. Tubal ligation was usually listed as one among many operations a woman had in her life – among kidney stone removal, C-section, hysterectomy.

I found Simran, a woman from whom I was renting a room at the time, sitting on her *khat* and sewing her old *saris* into a duvet cover that day. At the time, I had spent a few months in the field already and knew that sterilisation procedure in the village was usually referred to in a generic term: operation. I asked Simran, a respectable and rather strict Brahmin woman in her mid-thirties who had two sons, fourteen and sixteen years of age, if she had had an operation herself. Simran told me she could not lift heavy water buckets anymore because her body was a body of operations. She showed me scars on her body as the memory of all the operations and narrated:

> "I had three operations altogether and *uncleji* [referring to her husband] had only one. I had a formation on my breast which had to be taken out, another one was an operation that stops children [*bacce band karnewalla operation*] and a big operation when my uterus was removed because I was bleeding too much. And *uncleji* had a kidney stone which was removed in a hospital".

It is clear from this encounter that tubal ligation is not seen as an extraordinary procedure, a traumatic or shameful or regrettable one. It is just one amongst many operations that marks one's body and self, as well as becoming markers of different time periods in one's life. However, it is not simply that women's lives are inscribed on their bodies and the scars their bodies bear (Turner, 1980), but also that the national history of progress and development through family planning is inscribed on their bodies (Das, 1996; Pandolfi, 1990). Women's bodies have to bear witness to the state's interventions. All of the operations seem to be functional or performed in order to make one's body function better. The capacity of the body to function properly has been reduced by illness (in this case breast formation, uterine bleeding and kidney stones); or the body's "natural" ability to keep producing children

became socially unacceptable in new times of economic scarcity and different socio-cultural norms concerning family, its size and wellbeing. Even though the concept itself, the body of operation(s), is not necessarily gendered – Simran also mentioned that her husband had a kidney removal surgery – women tended to experience many more operations throughout their lives, especially having in mind the prevalence not only of tubal ligations but also hysterectomies, and slowly increasing prevalence of C-sections. It seems that the notion of the body of operation(s) is a way to speak about the increasing medicalisation of women's lives in rural Rajasthan. This medicalisation is partially a solution to women experiencing their bodies as constantly weakening due to reproductive cycles, but also partially contributes to their further weakening. This contradiction represents the main dilemma that women face when making a decision to get their tubes tied.

## Conclusion

In this chapter, I discussed particular concerns related to female sterilisation – the idea of a small family, the timing for the procedure, women's understanding of their bodies as weakening through continuous reproductive cycles – which contextualise the tubal ligation procedure within women's everyday lives, socio-economic constraints and reproductive demands. The burden of reproduction – whether conception, the consequences of failing to conceive, or the ending of childbearing – fell exclusively on women and their bodies. By employing a number of diverse ethnographic vignettes, I demonstrated the diversity of women's reproductive experiences and concerns. All of these broader reproductive concerns influence how ending childbearing through the female sterilisation procedure is conceptualised. It is important to emphasise that even though this chapter is intended to be read as an account of women's own experiences and considerations, set against the backdrop of the narratives and discourses of the state that I presented in the previous chapters, it is difficult to separate these two sides of the story. When narrating their reproductive histories, women almost always invoked references to and experiences of encounters with health workers and institutions, whether those of the state or state-like NGOs.

Even when explicitly and implicitly acknowledging reproductive restraints within which the decision to get sterilised is taken and when talking about their weakening bodies, most Chandpur women who have been sterilised speak about the procedure as a positive experience (Säävälä, 1999; Brault et al., 2015), and as something that has made their lives easier. Furthermore, tubal ligation is seen as a positive experience precisely because of the

wider economic, social and reproductive constraints women face in their everyday lives. Throughout this chapter, I showed how the decision to get tubal ligation was an expression of agency as resilience while navigating precarious economic conditions, unequal gender relations and constantly weakening physical bodies. Even though the relationship between reproductive agency and constraints is a complex one, the women were actively reflecting on and negotiating the conditions under which they make reproductive choices. Reproductive agency, then, is enacted through, rather than despite, engaging with discourses and practices of increasing medicalisation of reproductive cycles and women's bodies, pressure from kin to conceive and pressure from economic demands to stop childbearing. Women are able to take full responsibility for the decision to get sterilised precisely because the concerns with the body are placed at the centre of sterilisation narratives.

Having explored the local embodiments of the state and its discourses on family planning, and women's own conceptualisations of reproductive agency and restraints in the chapters so far, the following chapter provides an ethnographic account of a sterilisation camp. A sterilisation camp is a politico-medical space where many of the issues discussed in the previous chapters come to light. It deals with the contradictions, peculiarities and failures of biomedicine and the state in the place where care is at the centre of negotiation. The following chapter also continues the ethnographic exploration of women's efforts to negotiate power relations with health workers, doctors, nurses and bureaucrats within a very particular temporary facility.

# Chapter Six
# Encounter in the clinic: ethnography of a sterilisation camp

## Setting the scene – first impressions of the sterilisation camp

The very first time I came to a sterilisation camp was by accident. It was the end of July 2012, World Population Day, on which, as I was to find out later, a mega camp was usually organised. But it was still the end of summer, with a late monsoon just arriving, and I did not expect the camp to happen, as had been the case on so many Tuesdays before when I had been disappointed to see no sign of it. That Tuesday I happened to visit the Chief Medical and Health Officer (CMHO) office, yet again asking when the camps would start. "It is happening right now, go to the hospital and see", one of the officers directed. While walking from the office to the hospital, I was balancing on the line between excitement over finally witnessing what I came to study in the first place, and fear of some medical practice that in many reports by human rights organisations was described as inhumane and brutal.

I entered the hospital, asked the nurse which way to go, and followed the instructions to "go down the corridor, then turn right and *see*". Having passed the women's ward on the right, where a few women were lying down with their newborns, and a few older women were sitting on the floor, I had only a small space to walk forward, as mattresses on the floor on the left side were taking most of the space in the corridor. I did not count how many women, covered with blankets from head to toe, were lying down on these mattresses but there were more than a dozen. I passed them in order to see where the action was happening. An open door on the right led to an Operating Room (OR), a small painted sign on the wall indicated. There was a small corridor with two doors on the left and a young man sitting at the end of it, as if guarding the door to the second room. It was so much hotter and humid here than outside. I looked around and saw a huge iron pot of boiling water on the gas cylinder, slowly bubbling away. The sweat from the heat, excitement and fear slowly dripped down my face.

I decided to introduce myself and explain the reasons for me being there to somebody, as the feeling of invading into something private, sensitive and highly medicalised was bothering me. I felt like somebody intervening into medical spaces that were meant for either doctors or patients. The young man sitting at the end of the corridor, next to the door into the

OR seemed like a gatekeeper. I squatted next to him and introduced myself. “One second, talk to our *Madamji*”, he said, opened the door on the left, into the OR, and through the half-open door loudly announced my presence. In a few seconds, a woman, still wearing her surgical mask, cap and gloves, appeared in the doorway. “What is happening?” she asked. I explained my situation quickly as it seemed she was in the middle of something. “Are you studying to become a doctor?” she asked. After hearing I was a social scientist, she proclaimed, “Then you cannot come inside the Operating Room but you can talk to patients and observe outside”, and turned to the young man who called her before: “Suraj, help her and answer her questions”. She went back inside. At that time they did not know that I was here not for a one-off visit, but would continue coming to observe their work for a whole year to come.

I tried to make sense of what was happening there – that bubbling boiling water filling the air with steam, one woman is taken into the OR, one taken out, moaning and disoriented. I asked Suraj to see the papers he was holding and scanned through, as if these written records would have the power to explain what was going on. “It is a Female Sterilisation Case Card, it is very important, so be careful”, he proclaimed with an authoritative voice, giving me a few pages stapled together. On the top of the form, the blood pressure, pulse and a short note of “no operation” was scribbled in doctor’s writing in English. Haemoglobin and sugar levels, a negative pregnancy test were written below the limited bio-data on the patient – her name, husband’s name, caste, village, number of children and the sex of the children. It looked like an official document, with several blue ink stamps, including those that said “Marie Stopes India”, and blue ink thumbprints in several places. At that time, my status as an anthropologist had not been established properly yet and I wondered if ever I would be allowed inside those doctor–patient spaces where health check-ups were conducted, and doctors interacted with patients directly. It seemed to me at the time that the medical world was strictly closed to outside observers, just like that door into the OR and *Madamji’s* decision that the door clearly marked what was meant for the medical professionals and what was a public domain accessible to others.

I was wrong. A sterilisation camp turned out to contain much more than just a straightforward interaction between doctors and patients. It was home for the contestation of tribal and caste identities, the encounter between the medical and the bureaucratic worlds, and the doctor–patient relationship which was mediated through nurses and family members. A medical encounter in this setting turned out to be a very social experience and issues of privacy were guarded much less than I expected. Therefore, an anthropologist’s presence did not seem to bother anyone in particular, it was simply a bit strange.

## A sterilisation camp as a clinical setting

Anthropologists working in clinical settings and producing ethnographies of hospitals and clinics tend to focus their attention on understanding the relationships between doctors and patients, experiences of pain and suffering, and the constructions and enactments of diseases. The specificity of a sterilisation camp presents us with a different set of questions. First, a camp can be understood only through investigating relationships not only between doctors and patients, but between doctors, patients, motivators and state officials. Given that government hospitals are crucial sites in which people encounter the state in rural India, for instance, how does the intersection of medical and state authority articulate in a sterilisation camp? Second, a sterilisation camp allows us to investigate an experience of a hospital without the experience of illness, as tying one's tubes is an elective procedure, and, as it will become clear shortly, women have to prove that they are healthy and strong, rather than embody or demonstrate the symptoms of illness. Even in these specific circumstances, a sterilisation camp is one of several state-governed and systematically organised institutions to administer population groups and collectives, and an ethnography of its processes sheds light on the nature of biopolitics and governmentality in this particular context.

In this chapter, I briefly outline the process women go through in the camp, from registration to surgery. Then I focus on distinctive sets of relationships and encounters experienced in the camp, such as an articulation of the state in the clinic through bureaucratic registers at the registration desk, the construction of women as strong, healthy and fit for the procedure via medical examinations and recording of their health history, and engagements with the intimate and sexual selves in the encounter with the gynaecologist. Discussing every stage of the camp in detail allows me to focus on one main aspect of the camp in reference to that particular stage. However, this does not mean that particular processes discussed in reference to one stage are contained within that one stage. For instance, while discussing the period when women wait for the anaesthesia to take effect before being taken into surgery, I focus on micro-hierarchies[93] and inequalities visible and maintained between the poor women and the rest of the camp staff, but it does not mean that those inequalities articulate *only* in this particular stage of the camp. Even though those hierarchical relationships are constantly

[93] Micro-hierarchies refer to those everyday interactions which articulate and reproduce hierarchies on a micro-level, such as the system of address, turn-taking in speech, slipper wear and so on.

maintained throughout the camp, I find it useful to discuss them in reference to the waiting period.

"Camp" is a regularly used term to describe a temporary service provision facility, either by the government or a non-governmental organisation, in India. According to Cohen (2011), health camps emerged in colonial rural India as a way to care for the mass body of the population in a time-effective manner. Cohen (ibid.: 125) calls camps "the periodic and regular time of the civic gift […] [that] presume(s) a mass population that chronically lacks both access to information about appropriate health resources and that depends upon the gift of these resources through a form – the camp – able to treat the mass in its entirety". Camps "are usually rationalized into discrete problems" (ibid.). Besides a sterilisation camp, there can be other thematic camps, such as a health camp, eye camp, education camp, IUD camp, immunisation camp, pension camp, land records camp,[94] and so on. A sterilisation camp is an alternate service delivery mechanism, when the "operating team located at a remote facility […] conducts sterilisation operations at a sub district health facility, where these services are not routinely available" (MoHFW, 2008: 3). In Jhadol *tehsil*, sterilisation camps were organised in two existing Community Health Centres (CHC)[95] in the towns of Jhadol and Phalasia.[96] Jhadol CHC accommodated 50 beds and Phalasia CHC accommodated 11 (NRHM, 2013). During the sterilisation season, the camp in Jhadol was organised every Tuesday and the camp in Phalasia every Friday. However, there was never a guarantee that the camp would be held that particular Tuesday or Friday. In the words of Suraj, "*koi fixed nahi hai* [nothing is fixed]". As nobody could predict or know for sure how many cases were to come that day, the team left Udaipur only when Suraj informed them that some cases were coming for sure.

The number of women turning up at any particular camp differed significantly depending on the weather, upcoming festivals and weddings, and ranged anywhere between two to 34 during the time of my fieldwork. It is important to emphasise that the organisation of the camps was different depending on how busy it was. On a quiet day at the end of February my fieldnotes from the camp say: "It does not feel like a factory when there are only

[94] For an ethnographic account on a pension camp see Gupta (2012), on Hindu Nationalist paramilitary camps see Sehgal (2007), Sehgal (2009), on health camps in Nepal see Citrin (2012).
[95] Rural health care infrastructure in India consists of the following institutions, starting from serving the smallest population and staffed and equipped accordingly: Sub-Centre (SC), Primary Health Centre (PHC), Community Health Centre (CHC).
[96] I mention the camp in Kotra only sparingly as I have visited it very few times and the situation in Kotra *tehsil* is rather different from the *tehsil* of Jhadol.

three or four women". The doctors and nurses were more relaxed on a slow day, the desire for order and its techniques were not enforced, the team had plenty of time to conduct their respective roles and procedures, perform operations and, before heading home, to have their lunch somewhere on the outskirts of Jhadol, where the landscape of the hills and the river opened up to be enjoyed by the local tourists from Udaipur and around. Even though a day with many operations to be performed was considered to be a good and productive day, it was also more stressful to the members of the clinical team who wanted to make their way back to Udaipur before dark.

In Jhadol *tehsil*, the organisation of sterilisation camps was outsourced to Marie Stopes India (MSI).[97] This outsourcing of family planning programme is a feature of the regime of neoliberal governmentality in India which has been developing since the 1990s and is characterised by the emergence of new mechanisms and institutional forms of governance which take over the functions formerly assigned to the socialist model of the state (Sharma, 2006). According to their website, Marie Stopes International is a private not-for-profit social enterprise delivering quality family planning and reproductive services, in this case in India, with their headquarters in Udaipur.[98] Marie Stopes India is a subsidiary of Marie Stopes International with a vision of *A world where every birth is wanted* and a mission statement, *Children by choice not chance*. In 2014, Marie Stopes India was presented with a fourth annual award as the best NGO in Rajasthan working in family welfare and recognised for its contribution to increasing contraceptive use. The Health Minister from the Government of Rajasthan presented the award on World Population Day. At that time, MSI operated their services in 90 locations across 14 districts in Rajasthan via mobile clinical teams (MSI, 2014). Every mobile clinical team had about four scheduled visits to different locations every week. The team serving Jhadol consisted of six members: a woman surgeon also trained as gynaecologist, an anaesthesiologist, female nurse, male nurse, a driver and another helper who both helped with non-medical stuff in the OR – carrying the equipment from the ambulance into the OR and setting it up, getting women from a chair onto an operating table and back, and sterilising the surgical equipment with boiling water. Besides the clinical team,

[97] In August 2013, before I left the field I heard from MSI staff that they took another block in Udaipur instead of Jhadol and the government would be taking over the organisation of camps in Jhadol from then on. Suraj said to me: "You should attend the government-run camps and see how badly the things are done there". I had to leave the field before this was implemented and had no opportunity to compare the MSI and the government-organised camps.

[98] Male and female sterilisations were performed at the MS India office as well, usually serving the urban or semi-urban population in and around Udaipur.

two other members of MSI staff were an integral part of the organisation of the camps: an interpersonal communicator, Gunjan, whom we met in Chapter Five, and an organisational supervisor, Suraj, who appeared in the opening narrative of this chapter. Gunjan's duties included counselling during the camps, postoperative field visits and maintaining relationships with the motivators. Suraj was in charge of the general organisation of the camp and liaising between the CMHO office, the clinical team and the motivators.

## Outline of the life in the camp

Before moving on to discuss specific encounters in the clinic, let me briefly describe the timeline and the activities taking place in the camp. The hospital in Jhadol is conveniently located on the road leading through the market between the bus stand and a *tehsil* office. A big gate leads to an open square, with a building on each side. The building on the left is a government hospital, CHC. The ground floor of the building on the right is also part of the hospital, whereas the first floor accommodates the offices of CMHO and its staff, a big meeting room and a row of toilets, only one of which is usually open. The open square


**IMAGE 10: IN FRONT OF THE CHC IN JHADOL ON TUESDAY, A DAY WHEN STERILISATION CAMP IS HELD.**

between the hospital and the offices was rarely empty – pregnant women, their *daimas* and family members who came with them, patients who came for check-ups and medicines, and the *mazdoors* who were constructing the second floor of the hospital, all sat in this area. Gunjan and Suraj were the first people to reach the CHC early in the morning. Gunjan set up the registration desks outside the hospital or CMHO office, and Suraj put up big MSI posters on the hospital walls and gates letting everyone know that the camp was held that day. The posters contained a welcoming message from Marie Stopes India and an Indian version of their mission:

| |
|---|
| अभी नहीं या कभी नहीं, पसंद आपकी<br>चांस नहीं लेना, जब बात हो परिवार की |
| *trans*. not now or never, it is your choice;<br>don't leave it to chance when your family is concerned |

The posters, fit well on the hospital wall, were filled with short educational messages concerning health, which I briefly discussed in Chapter Three:

| |
|---|
| अस्पताल में प्रसव कराओ, जननी सुरक्षा योजना का लाभ उठाओ |
| *trans*. deliver in the hospital and take advantage of Safe Motherhood Intervention |
| क्षय रोग का उपचार 6 से 8 माह तक डॉक्टर विधि द्वारा लेना आवश्यक |
| *trans*. it is necessary to take the treatment for tuberculosis for six to eight months according to doctor's directions |

In the morning, Gunjan and Suraj already knew an estimated number of cases to be expected that day because the motivators called them the previous evening to make sure that the camp was being organised and to inform them about their intended arrival and the number of cases to be brought the following day. The motivators, the women coming for the procedure, their relatives and smallest children arrived by buses or jeeps and reached the hospital. The first thing they needed to do was to get registered at the desk, where the Female Sterilisation Case Card was filled out and a pregnancy test was conducted. After registration, the motivators stayed at the registration desk or nearby for a little while and gossiped with the staff and

amongst themselves, whereas women were left alone with their children and their mothers, mothers-in-law and other family members who accompanied them. Everybody had to wait for the clinical team to arrive from Udaipur. Officially, the team was supposed to reach the CHC at 10 am on the scheduled day, no matter whether cases came or not. However, that never happened.

Around noon, the team reached in a van decorated with MSI logo and full of equipment for the procedure. Both doctors sat at the front of the minibus, next to the driver, whereas nurses and other staff sat at the back of the minibus, facing sideways. The minibus stopped just in front of the entrance to the hospital, and at the sight of it coming, everyone – registration staff, motivators, women and I – made our way across the square and into the hospital. Both doctors were greeted by other staff, asked the usual questions of how many cases had come and went inside the rooms where examinations were to take place. The rest of the team – a driver, a male nurse and an assistant – started unpacking the equipment and taking it inside the hospital, through its corridors and into the OR.

The next stop was to see the nurse and anaesthesiologist for blood and urine tests and an outline of one's health history. After that, women met with the gynaecologist for questions and examinations to determine if they had had a recent abortion or other gynaecological problems. After the medical examinations, women were put to sleep on mattresses near the OR and given a small dose of local anaesthesia and a tetanus injection. After approximately half an hour given for the anaesthesia to work, a woman was taken to the nearest toilet to urinate and taken into the OR for the procedure. The operation took about five minutes and the woman was rolled out in a chair out of the OR and put to sleep in her spot on a mattress. After all the operations were performed, the doctors left the OR and, on their way to the other room, checked whether women were breathing and asked those who covered their faces with blankets to uncover to see that they were conscious. After less than an hour, the women were woken up by their motivators and taken to the other room to receive a couple of strips of medicines, certificate of sterilisation and a financial incentive of Rs. 600 given out by Suraj. After that, the women accompanied by their relatives and motivators left the camp and returned back to their homes.

## Registration: bureaucratic registers and the production of the state in the clinic

Many women I spoke to in and around Chandpur provided me with a piece of paper to prove that they had a sterilisation procedure. It was a sterilisation certificate given at the end of the camp which women kept in plastic bags and metal chests inside their houses, together with other documents and certificates, such as the Below Poverty Line (BPL) cards, land records, and bank account paperwork. Even though only few of them could read what was written in this particular piece of paper, and even though its actual relevance or usefulness in everyday life was highly debatable, the sterilisation certificate was kept safely away from children, dust and other possible damage. This certificate is one of the ways in which the state articulates itself to the rural poor in India. It is not to say that the state is powerful, but rather that the state is seen as an official body, something that is and, at the same time, produces important effects. The forms of writing which circulate both within the state agencies and institutions and outside of them, to put it in Gupta's (2012) words, are not simply records of action but rather are constitutive of action itself. Besides discussing the materiality of documents (Bear, 2001; Hull, 2008; Mathur, 2012), anthropologists have also discussed paperwork as central to engaging with and experiencing the state in South Asia (Corbridge et al., 2005), and as a


राजस्थान सरकार

चिकित्सा, स्वास्थ्य एवं परिवार कल्याण विभाग

नसबंदी प्रमाण-पत्र

प्रमाणित किया जाता है कि श्री/श्रीमती _____ आयु _____ वर्ष

पुत्र/पत्नी श्री _____ पता _____

व्यवसाय _____ विभाग/संस्थान का नाम _____ जिला _____ का निवासी है तथा

जिनके हस्ताक्षर नीचे प्रमाणित है, का पुरुष/महिला नसबन्दी ऑपरेशन इस संस्थान _____ में

दिनांक _____ को चिकित्सक डॉ _____ द्वारा किया गया। केस कार्ड क्रम संख्या _____ है।

क्रमांक _____

दिनांक _____

हस्ताक्षर चिकित्सा अधिकारी

केन्द्र/कैम्प _____

जिला _____

हस्ताक्षर/अंगूठा निशानी
नसबन्दी कराने वाले का

"छोटा परिवार, सुखी व स्वस्थ परिवार"

**IMAGE 11: A FEMALE STERILISATION CERTIFICATE**

technique through which people make themselves visible to make claims to the state (e.g. Street, 2012, 2014). Furthermore, anthropologists have investigated a variety of actions and processes enabled and constituted by and through paperwork. A sterilisation certificate may not trigger processes, responses and actions, especially on its own, but, when placed together with other "paper truths" (Tarlo, 2001, 2003) in metal chests and plastic bags, it produces the state as a real, concrete and graspable unit.

Those metal chests held written documents not necessarily produced by government agencies, but also certificates of participation in certain NGO activities, bank account documents and vehicle loan contracts. All of these point to the perceived power of the written word and the performance of authority through writing and texts (Messick, 1993), however multiple and heterogeneous their sources. My own work of writing fieldnotes at the end of the day in the field was understood by the people of Chandpur to be much more serious and important than the process of talking to people or recording interviews during that day. Truthfully, only my visits to institutions – the hospital, sterilisation camps, *anganwadis* – and occasional attendance in meetings were seen as work by the villagers, and every other interaction in non-institutional settings was interpreted as my social life. The significance given to the process of my writing can be illustrated not only by the fact that it was the only time people agreed I should not be disturbed, but also with the way in which my notebook was looked after and placed away from the arriving cups of tea.

The sterilisation certificate that the woman received after the operation is only one of the products and articulations of the state. The registration process at the sterilisation camp is an elaborate encounter with Indian bureaucracy. Gunjan, Suraj and another person from CMHO office waited for the motivators and cases at the registration desk. Their main job was to register the cases and their motivators on the MSI and CMHO registers, to fill in the Female Sterilisation Case Cards, counsel the women on the procedure, its effects and postoperative care, perform pregnancy tests and wait for the team to come from Udaipur. The questions in the Female Sterilisation Case Card and registers were basic: motivator's name, woman and her husband's names, village, caste, religion, education, her approximate age, number of sons and daughters and the age of the youngest child. The information for the registers was always filled in by one of the MSI or CMHO staff, but the Case Card was filled in by either the staff or the motivator. The motivator would usually answer all of these questions herself, only sometimes asking the woman directly. The motivators worked in these areas for years and personally knew the women they brought in as cases, so, in most instances, could provide the basic biodata. The case number, according to the order in which

they reached the camp, was written on top of the Case Card with a marker. The same number was written on the plastic cup which was given to all women for urine. At the end of registration, a woman was asked if she could sign her name or would simply give her thumbprint. Most of the women have never learned to write or read, so would simply giggle at the question and show their thumb. Gunjan or Suraj would open an ink box and guide their thumb from the ink to the paper. The signature was needed on many of the registers and pages of the Case Card, so their thumbprint would be placed in seven or eight places. Women's signatures and thumbprints are essential in producing the legitimate paperwork that can produce effects. Nayanika Mathur (2012: 167) discusses the implementation of National Rural Employment Guarantee Act (NREGA) in the government offices in rural Uttarakhand and argues that "transparency is officially achieved by the Indian state through the production, transaction, circulation, and exhibition of certain key documents". In a similar manner, the registers and Case Cards signed by women themselves produced the discourse of choice in the family planning programme haunted by the history of forced sterilisations during the Emergency.

The process of filling in the paperwork was not, however, as straightforward as it might seem at a first glance. Let's look into this brief encounter at the desk. Suraj was filling in a form about Kanku, an *adivasi* woman standing in front of him who came for the procedure. He needed to write down the number and age of her children, so the conversation went like this:

> Suraj: Your three children, how big are they?
> Kanku: Two are big, and one is small.
> Suraj [trying to determine the age of the older two]: Are you planning the marriages for the two?
> Kanku [laughing]: No no, they are not that big.
> Suraj: So what age are they? Are they six or four? And how small is the small one?
> The motivator [intervened at that moment]: One is four, one is two, and one is six months old.

This ethnographic moment shows a disjuncture between the language of the state required to fill in the paperwork and the language used in the village. Whereas the state demands to count the age of persons through the numeric system of years, the age and birthdays are not relevant to the understanding of the person in the village and, therefore, are rarely written down or celebrated. From the years of experience of working for MSI, Suraj knew that men and women did not know their own or their children's age, so he asked whether it was time to

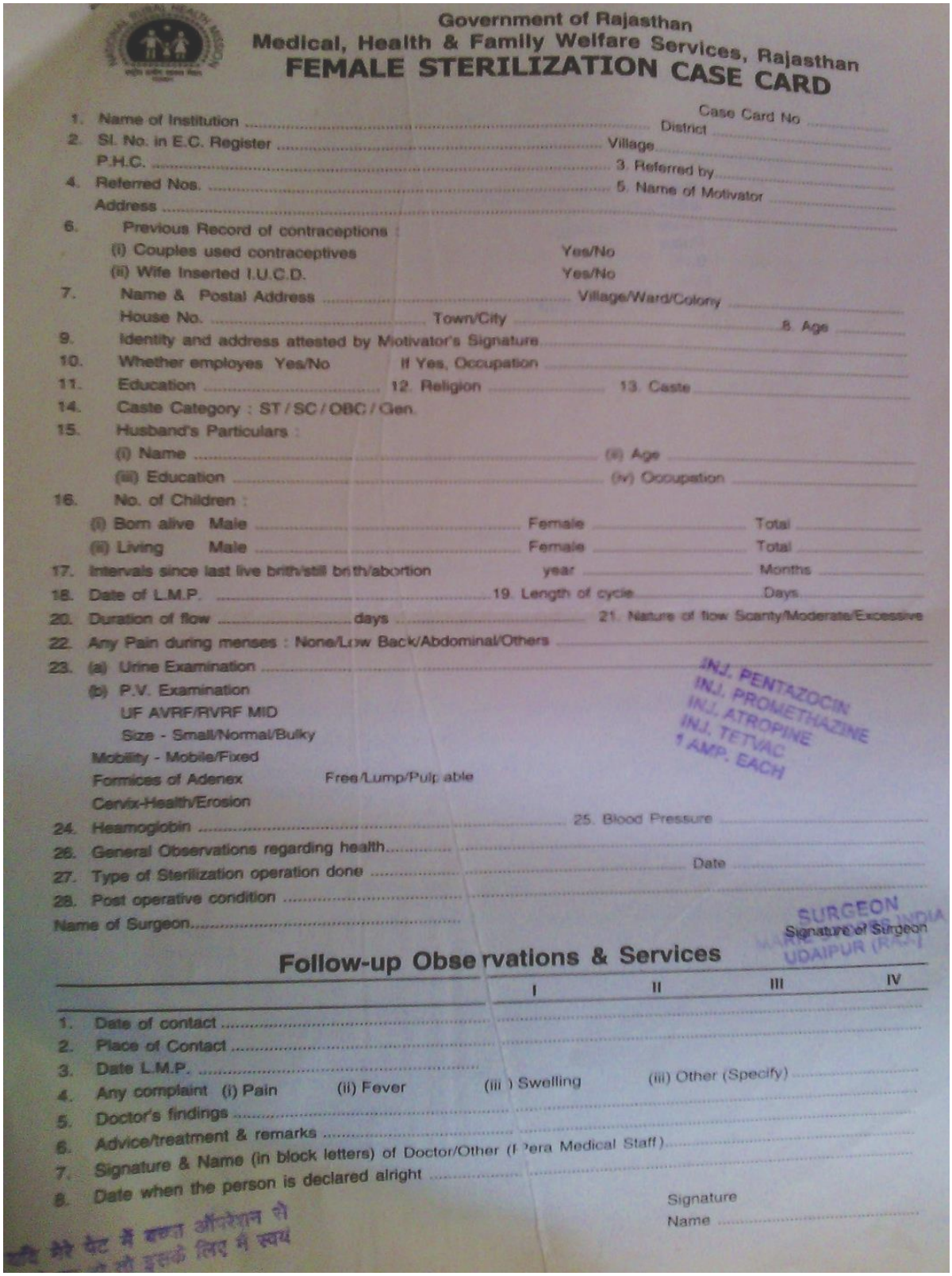
arrange the bigger children's marriages which would mean they were in their teens, and such an approximation would be enough to satisfy the state's need for numeric evaluation. However, what was a big child for Suraj was not the same for Kanku. The big children in the eyes of the woman turned out to be four and two years old, when Suraj assumed they would be teenagers. This disjuncture may partially be understood by the differences in ways in which the intersections of class, caste and rural/urban distinctions influence the understandings of childhood, children's independence, necessity for supervision and political economy of childbearing. Cole and Durham (2007: 14) argue that age is "implicated in divisions of labour within and beyond households", which, in this case, means that children's age – big or small – is defined by the care work required to attend to them by Kanku. Age, categories such as childhood and youth, and their experiences, then, are not simply historically contingent and culturally diverse, but also relational and "part of pragmatic and situational social practice, put to work by people in social and political settings" (Durham, 2004 cited in ibid.: 14).

In this instance, the motivator bridged the gap between the language and the world of the state and that of the patient. Having a long-term relationship with the woman, the motivator knew, approximately, the ages of her children. The disjuncture that occurred in most of the interactions in the camp was mediated by the motivators. The motivators sometimes translated the jargon and rules of the state to the women, sometimes provided answers to the state, based on their previous knowledge about the women and their families, and other times shaped and adjusted the facts to fit what the state wanted to hear in order to proceed with the procedure. The state's tools and techniques of simplification of social worlds made women intelligible. Here, to be intelligible was to make sense, to be easily describable and classifiable; it was to have experiences reduced to categories. For instance, Female Sterilisation (FS) Case Card was filled in with "facts" which were produced at the very encounter between the paperwork, women and those mediating this encounter – the camp staff and the motivators. Kanku's Case Card had her children's numeric age inscribed in it as facts and hid the process through which this estimated age was established. Her own answer "two are big, and one is small", which articulated a subjective experience of children's independence as a mark of their age, was unacceptable in the world which functioned through numbers that could be compared, grouped together and classified. Similarly, a woman's age also was approximated by the camp staff from her appearance and from the number of

children she had[99]. The process of registration, therefore, was a process of translation and representation, both of which were instruments of legibility and simplification of the kind that Scott (1998) described as enabling modern institutions to "see like a state".

The FS Case Card is an example of how different registers operate in the camp simultaneously. On the one hand, as shown above, the card is a tool and an effect of the state, in the sense that it produces the effects of the government to the officials who have, later on, to produce tables and data sets using the cards, keep their copies in archives, and present the data in their monthly meetings. However, a bureaucratic simplification and classification of a patient and her social world is not the only function that the card plays. Starting with the registration desk, the card travels with the motivator everywhere her case goes and at every step nurses and doctors inscribe their findings into it. The given importance of this document is demonstrated by the very fact that the women were rarely trusted with it, and, instead, their motivators were the carriers of the card. Therefore, on the other hand, the card also serves as a medical record in the camp which produces patients who can be explored and operated upon and which allows the doctors to act (Berg and Bowker, 1997; Heimer, 2006; Rees, 1981). The Case Card, as a collaboratively constructed patient file, facilitates the connections between multiple bureaucratic and medical encounters (Berg and Bowker, 1997; Moreira, 2004). The intersection of bureaucratic and medical records is a perfect illustration of how inseparable these two registers are in the camp, and how difficult it is to distinguish where bureaucratic tools and logics end and the biomedical ones begin. In *The Birth of the Clinic* (1973), Foucault was concerned to understand how medical knowledge and practice produced the body and appropriated it within a network of institutions that functioned at the micro level to establish medical power. In a sterilisation camp, I argue, both medical and state power functioned together at the micro level in a variety of intersecting, contradicting and sometimes competing ways. On the one hand, both bureaucratic and biomedical tools were used by the state authorities in order to make the rural women legible, standardised and definable (Scott, 1998). On the other hand, the biomedical team embraced some aspects of bureaucratic order while denying others. Health workers and poor women's encounters with the power of the state were usually mediated through biomedical techniques, logics and interventions and vice versa – women's encounters with the biomedical world were mediated, or at least negotiated through that of the state.

[99] According to the 2005-2006 National Family Health Survey (IIPS and Macro International, 2007), the median age of women getting the sterilisation procedure is 25,5.



Government of Rajasthan
Medical, Health & Family Welfare Services, Rajasthan
FEMALE STERILIZATION CASE CARD

1. Name of Institution ..... Case Card No .....
2. Sl. No. in E.C. Register ..... District .....
P.H.C. ..... Village .....
4. Referred Nos. ..... 3. Referred by .....
Address ..... 5. Name of Motivator .....
6. Previous Record of contraceptions :
(i) Couples used contraceptives Yes/No
(ii) Wife Inserted I.U.C.D. Yes/No
7. Name & Postal Address ..... Village/Ward/Colony .....
House No. ..... Town/City ..... 8. Age .....
9. Identity and address attested by Motivator's Signature .....
10. Whether employes Yes/No If Yes, Occupation .....
11. Education ..... 12. Religion ..... 13. Caste .....
14. Caste Category : ST / SC / OBC / Gen.
15. Husband's Particulars :
(i) Name ..... (ii) Age .....
(iii) Education ..... (iv) Occupation .....
16. No. of Children :
(i) Born alive Male ..... Female ..... Total .....
(ii) Living Male ..... Female ..... Total .....
17. Intervals since last live brith/still brith/abortion year ..... Months .....
18. Date of L.M.P. ..... 19. Length of cycle ..... Days .....
20. Duration of flow ..... days ..... 21. Nature of flow Scanty/Moderate/Excessive
22. Any Pain during menses : None/Low Back/Abdominal/Others .....
23. (a) Urine Examination .....
(b) P.V. Examination
UF AVRF/RVRF MID
Size - Small/Normal/Bulky
Mobility - Mobile/Fixed
Formices of Adenex Free/Lump/Pulpable
Cervix-Health/Erosion
INJ. PENTAZOCIN
INJ. PROMETHAZINE
INJ. ATROPINE
INJ. TETVAC
1 AMP. EACH
24. Heamoglobin ..... 25. Blood Pressure .....
26. General Observations regarding health.....
27. Type of Sterilization operation done ..... Date .....
28. Post operative condition .....
Name of Surgeon..... Signature of Surgeon
SURGEON

Follow-up Obse rvations & Services

| | I | II | III | IV |
|---|---|---|---|---|
| 1. Date of contact ..... | | | | |
| 2. Place of Contact ..... | | | | |
| 3. Date L.M.P. ..... | | | | |
| 4. Any complaint (i) Pain (ii) Fever (iii ) Swelling (iii) Other (Specify) ..... | | | | |
| 5. Doctor's findings ..... | | | | |
| 6. Advice/treatment & remarks ..... | | | | |
| 7. Signature & Name (in block letters) of Doctor/Other (Para Medical Staff) ..... | | | | |
| 8. Date when the person is declared alright ..... | | | | |

Signature
Name .....

मेरे पेट में दर्द ऑपरेशन से
को इसके लिए मैं स्वयं

**IMAGE 12: AN EMPTY FRONT PAGE OF A FEMALE STERILISATION CASE CARD.**

The co-production of facts that covered the first page of the FS Case Card was only one way in which women were made intelligible in the camp. Their case number following the order in which they reached and were registered at the camp, was written on top of the Card and inscribed on the inner side of their arms with a thick black or blue marker with a circle around the number. For the most part of the remaining time in the camp, women were known by their case number, and only occasionally were they addressed by their names. The registration desk was a place where women were literally reduced to numbers; not only in the way that they circulated in a variety of data sets of achievement or underachievement of family planning targets when sub-districts and states were compared later on, but also in the way that their social persons were reduced to numbers on their arms. The number on women's inner arms also allows us to open up conversation about various practices of exposure, concealment and visibility in the sterilisation camp. One of the doctors once explained to me why this marking was used. According to her, because the team wanted to proceed through various stages of the camp as quickly as possible, they needed a way to easily *see* whose turn it was to go to which station. According to her, the visible number on women's hands allowed the staff to see and order patients more quickly than if there was a need to see their Case Cards or ask for their names all the time. *Seeing*, here, is not a simple act or ability, but rather yet another bureaucratic tool of organisation and simplification.

The numbers on women's arms are also an expression of desire for order shared mainly by the clinical and bureaucratic team and constantly ignored and rebelled against by the poor women and their motivators. In one instance an anaesthesiologist refused to perform his checks on the woman seated in front of him because a number 18 on her arm was written with a pen and not a marker that was regularly used. He angrily and dramatically threw her Case Card on the table making the stapled papers fall apart and shouted to the crowd of motivators and the camp staff asking who wrote the number on her hand. The woman's motivator came forward with a confession of having written the number herself because it was overlooked at the registration desk. She acknowledged breaching the unwritten structure of power and authority, and endured the doctor's rant on how difficult it was to work in these disorderly conditions. Within a minute or two, the word about the doctor's anger reached other corners of the hospital and Gunjan rushed in with the marker. Once she wrote down the same number 18 with a marker over the already scribbled writing in pen on the woman's arm, the anaesthesiologist gathered the pages of the Case Card and started his checks. After this woman's check-ups were done, another woman came in with a number 21 written on her arm. The doctor again became irritable and angry because patients were coming in randomly and

not in the ascribed sequence. He performed the checks on the patient in front of him anyway but shouted to the crowd outside to form a queue according to the case numbers. The queue outside was formed by the motivators but seemed to work for a few minutes after this incident only, and later on dispersed back into the initial crowd.

From the very first moments in the camp, a relationship of regulation was established between the women and the camp staff. For the time in the camp, the camp staff took over almost complete control of women's movements, actions and bodies. After the questions in the Case Card were answered, women were asked whether they could sign their own names or needed to put their thumbprints. Suraj or Gunjan took control over a woman's thumb, dipping it into ink and then into paper, back into ink and pressing it hard onto paper, repeating six or seven times in different places in the card. Some women could sign their own names, but even then Suraj found ways to claim his temporary regulative authority. When Rangili came and signed her name holding her two-year-old son, Suraj argued that he cannot read the signature and demanded: "Give your baby to somebody else to hold and then sign again, because your name is one and your signature is another". Rangili's motivator standing beside her tried to explain that this was how they signed in the village. Suraj disagreed and repeated that the signature was wrong because she was holding the baby. Rangili gave her son away to her mother standing nearby and signed again, in an exactly the same way and handwriting as before.

After the Case Card was filled in, women were given plastic cups with the same case number written on them. They were directed to the nearest toilet or, if it already had a long waiting line, motivators directed their own cases to go around the corner of the hospital to fill the cup up with urine for a pregnancy test. As we will see from the following sections of this chapter, women were not only told when and where to urinate, but also when and where to sleep, where and how to sit and so on. This is a very clear example of poor women's reduction to the "bare life" (Agamben, 1998) in the sterilisation camp and its complete regulation and control by turning them into docile bodies (Foucault, 1977).

## Comparing the camp and *HariOm*

Women's reduction to numbers does not end there. One day, a man from the CMHO office was crossing the square between the hospital and the office and shouted to Gunjan on the first floor: "*kitne case aaye?* [how many cases came?]" "Two!" she shouted back. The information on how many cases came that day seemed to be the concern of many hospital and office staff,

who would always casually enquire about the number while passing by, whether nearby or across the yard. Soon after starting to attend the camps, I easily took over the language used by the camp staff as well. "How many cases came today?" became the first question to ask the first couple of people I met at the camp. Gunjan always presented me with the number of women who had come already and another number of how many more were on their way. That number seemed to be significant not only as a way of opening a conversation, but also as some sort of indicator of performance. It was difficult to figure out whose performance this indicator referred to – the area and their residents or the health workers – but it was clear that the bigger the number, the better the performance. The same man from CMHO office, whose responsibility during the camp was to provide tea to the doctors and to take women into the OR and to push them out of it in a chair, asked one day in December, when a big number of cases was expected to show up but only four came: "*Case thande pad gaye, kaise nahi aa rahe hain*? [cases became cold, how come they are not coming?]" Everyone in the CMHO office, as well as other camp staff, was concerned with the performance of the camp on any given day. In part, it was related to the constant pressure to achieve family planning targets. However, not everyone cooperated in the effort to achieve as high number of cases as was possible. Throughout the following sections it will become clear that some members of staff and some biomedical investigation tools stood in the way of achieving the maximum number of cases.

Discussing the low numbers of attendance opened up opportunities to compare the provision of sterilisation services in different facilities. The previous conversation about cases becoming cold continued. "The most cases are done in Badgaon",[100] replied Gunjan. "Cases now spread between Jhadol, Phalasia and Udaipur, that is why. In *HariOm*, motivators get Rs. 500 instead of Rs. 250 that they get here", contributed Gunjan. *HariOm* is a private hospital on the outskirts of Udaipur where many motivators took their cases for the procedure instead of the camp. Interestingly, bringing women to the private hospitals still counted towards their yearly family planning targets and the incentives were paid to both the motivators and the women undergoing the procedure. This is another example of emergence of new forms of public-private partnerships[101] (PPPs) in a healthcare sector in neoliberal India. According to

[100] Badgaon is another *tehsil* in Udaipur district, situated just outside of Udaipur and considered a semi-urban area; many people who work in Udaipur, buy land and build houses in Badgaon.

[101] I do acknowledge that the PPP phenomenon is a critical and very problematic formation in the healthcare sector and in the development industry, and that the comparison between the government camp and the *HariOm* hospital is simultaneously about the reconfiguration of biopolitics and the development industry. However, the discussion about its implications is beyond the scope of this thesis.

the Ministry of Health and Family Welfare (MoHFW) (2015: 146), "PPPs in Family Planning Services are intended to utilize the reach of private sector in increasing the access to Family Planning services". According to the Annual Report 2014-15 of the MoHFW (ibid.), the accredited private facilities in the high focus states, including Rajasthan, received Rs. 2,000 for every female or male sterilisation case they performed, and the "acceptors" were compensated with Rs. 1,000 for undergoing the procedure in that facility from the government's budget. According to my informants in the CMHO office, *HariOm* as a private hospital made plenty of profit by providing sterilisation services because even though the sterilisation procedure was free and was followed by a financial incentive to the women, the service of providing abortion before sterilisation cost women Rs. 1,500. Such service was not provided in the camp or government hospitals, and that is why *HariOm* was a rather popular choice for the procedure. "But in *HariOm*, they do not perform haemoglobin or urine tests, give only one injection of anaesthetics and make the cases leave after 15-30 minutes after the operation", added Gunjan. "There are no rejections in *HariOm*, that is why women choose to go there. Also, they perform an operation even on pregnant women – first they do *safaai*[102] [abortion], and then they do the operation", another person from the CMHO office explained.

The MSI and CMHO staff together with the motivators discussed these matters frequently. They discussed the reasons why some women and their motivators preferred going to *HariOm* hospital instead of the camp, which was closer to their villages. The MSI and CMHO staff tended to emphasise the lack of responsibility of this private hospital and the lack of care for women's health. The medical examinations rather thoroughly conducted in the camp and strict criteria for rejection were seen as necessary tools to ensure women's quick recovery after the procedure. The camp staff drew a clear opposition between the camp where these procedures were followed, and the *HariOm* hospital where, according to them, procedures were skipped in order to speed up the process. However, this was not a clear distinction between the state and the private sector. On my very last visit to the MSI office in Udaipur for the monthly meeting, Suraj notified me that MSI got a contract to deliver family planning services in another *tehsil* of Udaipur and, therefore, they had to stop organising the camps in Jhadol due to the lack of resources. With a sarcastic tone of voice he said that I should stay in the field longer in order to see the difference in how the camps were organised in Jhadol by the government without the help from MSI. He implied that the quality of services provided by the MSI were incomparably better than the ones provided by the

[102] *Safaai* literally means cleaning and is commonly used to refer to abortion, or cleaning of the uterus.

government. I did not get a chance to continue my participant observation in the government-run sterilisation camps in the area, but Suraj's comment provided me with some perspective on how to interpret the previous demonisation of services in *HariOm* and romanticisation of quality of services in the MSI-run camps. Even though there is a clear sense of competition between the state and the private service providers when it comes to the family planning, the public-private partnership between the state and MSI is portrayed as an ultimate answer to the quality of services.

From the perspective of the motivators, *HariOm* was not a bad choice for the sterilisation procedure and they tended to emphasise the advantages of taking cases there. According to many motivators, the process in *HariOm* was much quicker than in the camp and there were significantly fewer rejected cases. Furthermore, the motivators were not asked to help out during the preparation for the procedure; they simply helped to fill in the Case Card and waited until the women were ready to be taken home. One of the ANMs told me:

> "They have good arrangements [*vyavastha*] there, women do not come out as dizzy as here after an operation and we, nurses, do not have to do anything. And here everybody is telling you – do this, do that. Everything is much faster there – you leave the hospital after half an hour".

As seen in Chapter Four, the motivators negotiate the terms of engagement with the particular facility and their staff. Another ANM I met on the jeep from *HariOm* bringing her case back home after an operation, spoke about the lack of rejected cases in *HariOm* as the main reason to go there:

> "I brought my case to the camp once, last year, and it got rejected. So now other women do not trust me anymore. That is why I take them straight to *HariOm* nowadays, it is better. Also, when a woman decides to get *nasbandi*, she should be taken for an operation immediately, because if you wait for the camp to be held, she might change her mind".

The surgeon at the camp confirmed this ANM's experience with rejections at the camp last year. According to her, a number of rejections depended on the surgeon operating that day. It was his or her choice to take the responsibility of a successful sterilisation operation considering particular woman's physical condition. She emphasised that "last year, if a little bit of white vaginal discharge was detected or haemoglobin level was a little low, they used to reject. This year, we reject less. Patients are not happy if they get rejected – they come only once. Second time they will not come".

The MSI staff clearly distinguished themselves from both services provided by the government, and those provided by private hospitals. The MSI portrayed themselves as concerned mostly with patients' health, wellbeing and convenience. This stood in contrast to the way the MSI staff spoke about the government-organised sterilisation camps as sites where the main concern was achieving the largest number of "cases". The private facilities, on the other hand, were portrayed by the MSI staff as places driven by the concern to maximise profit. In the sections that follow it will become increasingly clear how the MSI staff employed the idea of acting in the name of women's health and wellbeing, and how this very idea legitimised the government's efforts in family planning.

## Counselling: the disjunctures between the official and on-the-ground realities

After the registration and before the clinical team arrived, women were given shorter or longer counselling sessions. Conducting counselling sessions was the job of MSI's interpersonal communicator and was supposed to include making sure women were aware that tubal ligation was irreversible, explaining the procedure as well as ways to take care of oneself after the operation – what food and drinks to have and what to avoid, how long to rest and how long to abstain from sex, so that one's body recovered fully and quickly after the procedure. However, the length and clarity of a counselling session provided to women depended on how busy the interpersonal communicator was during that day, her mood, and whether any outside visitors were planning to visit that particular camp. Gunjan acknowledged that most often the counselling session was conducted in order to follow the necessary procedures of the camp, outlined in the "Standards for Female and Male Sterilization Services" (MoHFW, 2006) provided by the Ministry of Health and Family Welfare. According to her, counselling was not beneficial to the women themselves because "they would not understand anyway and might run away afterwards". Here, Gunjan, acting as an agent of the state and biomedicine, evoked the very fact of the illegibility of her language about the medical side of the procedure to the women because they were poor, illiterate, ill-informed and tended to panic (Das, 2004: 245, also see Cohen, 2011). In this way, Gunjan constructed the structures that she aimed to represent, the state and biomedicine, "as rational in opposition to a credulous public" (Das, 2004: 251). However, there were some exceptions.

Halfway through my fieldwork, the surgeon became concerned with the quality of counselling before the procedure and started asking the women who came to see her later on whether they were told anything about the operation when they got registered at the desk. Most of the women shook their heads and the surgeon had a conversation with Gunjan about her skipping the counselling. Ever since the incident, Gunjan made sure to have shorter or longer conversations with women about the series of medical examinations and procedures to be expected in the camp and the permanence of the procedure. On one of the days, I heard the last few moments of the counselling session where Gunjan ended with the statement "If you are pregnant, it is your responsibility. If your period does not come after the operation, you have to go and see a doctor". Later on I asked Gunjan why would it be their responsibility if a pregnancy test was done in the camp anyway. She replied: "Some of these women hide these things. For us, if period is late one or two days, we stress about it. But these people do not think like that, for them if it comes, it comes; if it does not come, it does not come. They do not pay attention". The ideas surrounding the differences projected onto the bodies of poor *adivasi* women as patients, or folk sociologies,[103] will be explored in the following chapter, but here it is important to emphasise that the constructed differences in the way poor women are seen and in the way poor women's bodies are treated are the basis on which the medical examinations are performed and hierarchies enforced. The assumption that women were hiding the truth about their bodies, selves, pregnancies and abortions was carried into other stops of medical examinations in the camp.

During the last months of my fieldwork, Gunjan got transferred to a different district in Rajasthan, to the area where her parents lived and could look after her children. Jaya was hired to replace Gunjan. During her third week in the job, I had the chance to record one of the counselling sessions she conducted with one woman. She started speaking in Hindi and after realising that the woman in front of her could hardly understand it, switched to Mewari, one of the dialects of Rajasthani. She spoke with a kind and friendly voice and asked: "Are you scared of me?" When the woman giggled shyly, Jaya assured her that she was her friend: "you can hold my hand, you can talk to me". After taking the woman's hand, she asked her a series of questions, to which the woman either nodded or shook her head, and Jaya herself vocalised her answers: "Where do you live; when did you get married; what work does your husband do? Have you gone to school? You did not. Do you work outside the house? No.

[103] Folk sociologies are employed to explain the behaviour and characteristics of others, particularly the behaviour of members of other classes which are considered to be problematic (Sayer, 2005: 4).

How many children do you have?" Jaya asked if she knew about any other *saadan* (methods of contraception), and explained *Nirodh*, contraceptive pills and copper-T. "Do not be scared, just talk to me. A small family is a happy family, is it not? How much expense do you have nowadays? If you keep increasing your family, you will become unhappy (*dukhi*)". Jaya showed a picture of reproductive organs and explained that a child was conceived when the man's seed (*beej*) met with the seed or the egg of the woman. She explained that an incision would be made in her belly button and that two *nas* (fallopian tubes) would be tied with a plastic ring:

> "After that, the man's seed will come, but woman's egg will not make it through the fallopian tube. They will not meet, so the child will not happen. We call it *nasbandi*, not operation. Operation is very big, when they cut you open. And here the incision is so small. So you can eat everything, there is nothing you need to avoid. After this procedure, you will not have any more children. You have one girl and one boy now, so you need to look after them [*dhyaan rakhna*]: in winter, in summer, during the rains; feed them well and if they become sick, you need to take them to the hospital. You will not have another child in your life. Even if you decide to have more, these two will be the only ones you have. This is a big family decision. If you have copper-T, you can take it out; you can stop taking *Mala-N*, but *nasbandi* is permanent. If you go out for work and the children are alone at home, you need to make sure that no harm comes to them because you will not have more. You need to make your husband understand also. Does he beat you [*maar-piit karta hai*]? Does he drink? Have you told him that you are coming here today?"

The woman shook her head to Jaya's question about domestic violence and her husband's drinking, and replied that they both decided they did not want any more children. Jaya continued:

> "You need to do checks-ups after *nasbandi*; if you have fever or have pain when urinating, you need to see a doctor. Take the phone number of your nurse and I will give you my own phone number also. Do you or your husband have a phone? Whatever difficulty [*takleef*] comes to you, give me a call. In a week, the nurse will come to take out the stitches and then you will be able to do all the work in the house. You can breastfeed after the procedure, you can look after your children, make food and sweep the floor. You do not need to tell anyone that you got the operation, nobody will get to know. Did you understand what I said, my language? Do you want to ask me anything? How much does your husband earn? Does he bring enough to get the household items and clothes? Who came with you today, is it your mother-in-law? Does all of your family know that you are closing your uterus for good?"

This counselling session ended in a couple of minutes, when Jaya asked the woman sitting in front of her what she needed to remember from this conversation. The woman replied: "That I need to take care [*dhyaan rakhna*] of myself". Jaya repeated her suggestions about taking rest after the procedure, eating good food and abstaining from sex for a few weeks. Compared to the counselling sessions conducted by Gunjan, Jaya seemed to be much more approachable, put efforts into connecting with women and explaining the procedure, other methods of contraception as well as suggesting how to recover after the procedure better. Even though in this session Jaya did sound somewhat patronising and inquisitive about women's personal lives, the women were rather comfortable with her. I cannot be sure that Jaya's enthusiasm and efforts remained the same since she started, but it is important to acknowledge the diversity of counselling sessions I observed. The quality of the counselling session, then, depended on the interpersonal communicator's personal efforts and mood, rather than followed official procedures in "Standards for Female and Male Sterilization Services" (MoHFW, 2006).

## General health check-ups: constructing the healthy *enough* body

Unlike the usual encounters in hospitals and clinics, where patients have to produce and articulate symptoms in order to receive the diagnosis and treatment, women who come for the sterilisation procedure have to prove to doctors that they are healthy and that their bodies can handle the procedure and easily recover afterwards. There are certain health conditions for which women get rejected for the operation, such as low haemoglobin or sugar levels, a positive pregnancy test, a recent abortion after which the next natural period has not come yet, previous C-sections or other operations in the abdominal area, tuberculosis, epilepsy, or high blood pressure. In the context of a sterilisation camp, women's bodies need to be unmarked by other medical interventions or diseases. Therefore, after registration and counselling, a woman goes through three or four examinations by different nurses and doctors in order to establish that she is healthy and fit for the sterilisation procedure. However, doctors and MSI staff see the women who come for an operation and their motivators as those who cannot be trusted fully. As rejection is usually disappointing to the woman herself as much as to her motivator, one of the underlying assumptions for at least half of these examinations usually is that a woman is trying to pass as healthy and cover the fact that she is either pregnant or has had a recent abortion, whether out of her own will or under misguidance from her motivator. It is a process through which doctors and nurses employ tools of medical examinations,

questioning and confession in order to find the truth about a woman's body. In other words, a series of medical examinations is a way the biomedical and state authorities employ the pervasive medical gaze seeking out and demanding truths embedded in the human body (Foucault, 1973) and these medical examinations are considered to be concrete procedures of knowing. The requirements for the woman to be healthy, not pregnant and to have no history of previous illnesses and operations are some of the eligibility criteria and belong in the realm of biomedical authority; during the registration, however, the woman has to prove other criteria as well – being married and having enough children. In this section, I demonstrate how women's status as "healthy" is constituted.

As mentioned earlier in this chapter, after registration at the desk where the Case Card is filled in, a woman is given a plastic cup and directed to the toilet or, in some cases, behind the hospital, to urinate in it: "*pesab leke aana* [come back with urine]". She is then asked to come back to the figure held by Gunjan/Jaya who takes a pregnancy test stick out of the plastic packaging, asks a woman to open the plastic cup, dips the stick into the urine for a second and directs the woman to close the cup. If a pregnancy test is positive, a woman is immediately rejected for an operation, sent back home and asked to come back next month. If the pregnancy test is negative, the woman is asked to follow her motivator inside the hospital, into a room where an MSI nurse has set up her work station with few pieces of equipment brought from Udaipur.

The nurse seats the woman, asks her to open the urine cup and puts a stick into it for a couple of seconds. It is a glucose level test and the end of the stick turns into different colours. She compares them with the colours on the box of sticks and decides if these match. She directs the woman to throw away the urine cup into a rubbish bin next to the window: "Close the cup first, open the rubbish bin, put it in there, slowly, don't spill it and come back here". She scribbles something into the woman's card, takes a piece of cotton and dips it into an antiseptic and cleans the woman's fourth finger. "Don't worry, it will not hurt", she comforts the woman and breaks her finger's skin with a recently unpacked new blade. The nurse takes a piece of blotting-paper and squeezes a drop of the woman's blood on it. She waves the paper in the air so that it dries quicker, and compares it with the haemoglobin level test kit – the redness of blood on the blotting-paper has to match with one of the shades of red on the kit. If a nurse decides that woman's haemoglobin level is 7 or lower, she refers her to the anaesthesiologist who checks her tongue, eyes and palms in order to confirm the diagnosis. If the tongue and palms are too pale, she is rejected for an operation and is given iron tablets or syrup with an advice to come back for an operation next month. If haemoglobin and glucose

levels are normal, she is asked to continue with medical examinations. Sometimes the nurse turned to me and asked:

> Nurse [while showing me the blotting paper and the kit]: Do you think it is 8 or 10?
> Eva: It is not as dark as 10 but also not as light as 8.
> Nurse: Ok, then it is 9 [she confirms the result and writes it down on her card].

We see that the decision on the diagnosis of anaemia is taken collaboratively (Berg, 1992; Mesman, 2010; Mol, 2002) – the blood test interpreted by the nurse and sometimes those around her is combined with the tongue, eyes and palms' paleness read by the anaesthesiologist. The results of medical tests are arbitrary and constantly interpreted by nurses and doctors involved who make a decision on what the particular numbers *mean*. The truth that supposedly hides behind the numbers is exposed as the articulation arising from contestations and articulations of power amongst medical staff. Doctors sometimes disagreed on how to interpret the test results and what was a healthy enough body for the procedure. When the nurse was ready to reject case 3, because the redness of her blood on the blotting paper looked like an unquestionable 7 to her, a government doctor taking part in the team that one time questioned her decision. She said she was not sure 7 was too low for this *adivasi* area and asked Suraj to find the guidelines for female sterilisation online. He reminded the doctor that another woman was rejected for the operation just last week because her HB level was 7 so he was sure that this was the correct threshold. She did not approve the rejection until the anaesthesiologist authoritatively said her HB was definitely too low. The hierarchies among different doctors and nurses also play a significant part in the process of interpreting the test results and making the decision on who is eligible for the procedure and who is not.

What is also interesting here is how the idea of health itself is arbitrary and constructed. The government doctor acknowledges that HB level 7 is really low for them, the doctors and other people from the city and those who are generally better-off economically. She is not sure, however, whether 7 is normal or low for the people living in poverty in Jhadol subdistrict. This points to an arbitrary and fluid definition of health which is not only gendered but also classed. According to this logic, a person experiencing symptoms of anaemia due to insufficient food intake, exhaustion after hard and regular manual labour and otherwise affected by a variety of consequences of poverty would be declared either healthy or healthy enough, whereas the same test result would bring a diagnosis requiring treatment and intervention for a person from a more economically secure environment. This is not

simply to state that the threshold for ill health is different depending on a person's economic and social background. Rather this contradiction gains importance when discussing the government's interventions in health and welfare in poverty-ridden areas.

The next stop is at the anaesthesiologist's desk, just across the desk from the nurse. His job in the process of overall medical examinations is to check the woman's blood pressure, heartbeat and lung function and ask if she ever had any operations, including a C-section, or "big illnesses", such as high blood pressure, tuberculosis, or epilepsy. Any of these conditions gets a woman rejected for laparoscopic operation but she might still be referred to a hospital in Udaipur for a tubectomy. A stethoscope and a mercury sphygmomanometer to measure the blood pressure, which he has brought from Udaipur, are the only pieces of equipment on the side of his desk. A woman sits down on the chair in front of him and he is one of the very few people to refer to her by her name, not only by the case number. "What is your name?" – he asked and looked at the form. "Kanku?" A woman shyly gave a positive answer. Her motivator or the doctor himself puts the inflatable cuff on her upper arm and pumps it with air. "You did not have any long illnesses, did you? Children came out easily? None were taken from above?"[104] asked the doctor while measuring her BP, with the woman giving short answers to the posed questions. "Take a deep breath [*lamba saas le*]", he continued while listening to her lungs. The anaesthesiologist's tests were not as straightforward as one would expect. The women constantly ignored his request to take a deep breath in order to hear their lungs properly, and continued sitting in front of him in the previous posture and breathing rhythm. After repeating his request the second or third time, he sometimes lightly slapped a woman on her back and asked her to take a deep breath in a raised voice. Other times, he gestured to the woman's motivator to make her take a deep breath and the motivator spoke in Mewari or whispered in the woman's ear. Once the woman complied and the tests were done, the doctor scribbled the blood pressure result on the top of the case card, noted no big illnesses, no operations and gave the form back to the woman's motivator.

Certain symptoms and test results are constantly negotiated not only between nurses and doctors, but are also contested by patients and their motivators, revealing alternative explanations of visible bodily signs. When the doctor proclaimed that Rupali's palms' paleness was a clear symptom of anaemia and was about to write down REJECTED on her Case Card, she started laughing and said that it was the turmeric that coloured her palms as

[104] *Upar se lena* (*lit*. *trans*. to take from above) refers to a C-section.

she participated in the *Haldi* Ceremony before her niece's wedding.[105] Her motivator quickly approached the doctor's desk from the corridor, took a good look at her palms and loudly repeated that the paleness was actually left by the turmeric paste. However, the anaesthesiologist did not want to take a risk and chose to trust neither the woman herself nor her motivator, and asked them to come back next month, after the supposed stains from turmeric wore off.

Another woman was rejected for the operation after being diagnosed with hypertension or high blood pressure, in her case 210/110 mm Hg.[106] Her motivator came back with the woman herself after the doctor performed the check-ups on all the remaining women and sipped his tea waiting for the time to start preparations for surgery. The motivator argued that the woman is scared of doctors and the hospital and that is why her blood pressure was so high. In response, the doctor explained that the *uparwalla* measure or systolic pressure could get higher due to the fear and anxiety of the hospital environment, but the *neechewalla* or diastolic pressure never got so high unless there was a serious problem. He suggested taking the woman to another doctor to get properly diagnosed, consume the given medication and bring her back to the camp next month. The disappointed motivator then recalled another incident of rejection for the operation last year. Her case was diagnosed with jaundice because her eyes were yellow but, the motivator emphasised, this woman's eyes were still yellow after the whole year and there was no other sign of disease. In this way she questioned and undermined the doctors' skills and authority to diagnose women properly and expressed her disappointment with supposedly unnecessary and wrongful rejections. The doctor replied:

> "We come all the way from Udaipur to do this; do you think it is fun for us to reject cases [*ham maza le rahe hain aapko lagta hai*]? If there is any problem tomorrow after the operation, we are not there, we go home; it is you who will be there every day, they will eat your head [*aapke sir khaa jaaenge*]".

There is an inherent contradiction in the doctors' effort to prove that women are healthy and strong in the context of them living in persistent poverty, structural violence and inequalities (Farmer, 2005). Considering the poverty-ridden area of Jhadol specifically, doctors do not look for general experiences and indicators of being healthy, but, rather, look for proof of

[105] Turmeric (*haldi*) symbolises fertility and prosperity and is used in a *Haldi* ceremony before Hindu weddings. Turmeric powder is mixed with water to form a paste and is applied on the bride and groom's faces and bodies.
[106] There are obvious problems with diagnosing hypertension in the camp. The condition is supposed to be diagnosed through medical observation over extended period of time and recording complete health history, and one medical test at the camp does not provide conclusive medical diagnosis.

women being *healthy enough*, a notion supposedly specific to this particular area. Being healthy enough, defined by the lack of sickness, stands in contrast to the World Health Organisation's (WHO) definition of health. According to the WHO (1946), health "is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Doctors use biomedical tools to establish that poor women's bodies are *healthy enough* according to a narrow biomedical understanding of health as absence of disease and through biomedical testing of their anatomical bodies. However, these particular circumstances do not simply mean that women go to the hospital to be named as being healthy. As we will see in the following section, the health and strength of the poor women's bodies serve as evidence of their capacity to reproduce.

## At the gynaecologist's: intimacy of the self and becoming a patient

The last stop of medical examinations is seeing an experienced gynaecologist and surgeon in her late forties, who is feared and respected by the staff and has the last word in most of the affairs in the camp. Her role is to ask a woman a series of questions trying to determine if she has had an abortion within a month and if she has any other gynaecological problems. If the doctor is convinced that the woman has had an abortion, she is asked to come back next month, after her next natural period. Women with the smallest child below one year of age are not probed much. Women whose smallest child is two or three years old or older, on the other hand, are questioned more, mainly trying to determine the reasons and conditions under which they have not got pregnant for such a long time. When a doctor is not sure, and sometimes as a routine procedure, she performs a vaginal exam to detect traces of recent abortion or gynaecological problems. Once I decided to ask the gynaecologist why sometimes she performed pelvic exam routinely and sometimes only as a follow-up on women she had doubts about. She replied: "I get to know if there is any problem. If the smallest child is three years old, why she did not get pregnant afterwards? There will be some problem". These insistent intimate questions about women's sex lives and reproductive experiences are attempts to objectify the intimate self. The objectified intimate self is, then, prepared to be investigated by the medical personnel in the name of health and wellbeing, and, by extension, in the name of population control.

Anju, a woman in her late thirties and a case number 26, came into the room for a pelvic exam. The gynaecologist looked at her card, which stated her age as 35, looked at the woman, and back into the card. Her motivator was peeking into the room behind the halfway

closed door. The doctor, partially to herself, partially to the motivator who was not supposed to be peeking, and partially rhetorically said: “she is older than 35”. Her motivator agreed and Anju giggled. The doctor directed her to lie down on a leather bunk bed and it took a minute for her to slide down the bed, with her legs dangling down. The doctor asked her to lift her skirt and put the bent legs on the bed just like during a delivery. Out of a habit, the doctor reached her hand with a plastic glove to enter vaginally and was thrown out of the routine when she saw a woman wearing skin-coloured underwear. Irritated she asked the woman to remove it. She put her hand inside and immediately asked: “What happened here? Have you just delivered?”

Anju: Yes.
Doctor: How many days ago?
Anju: One and a half month ago.
Doctor: Where did you deliver?
Anju: At home.
Doctor [turning to me]: How many children?
Eva: Five.
Doctor: How many girls and boys?
Anju: Two boys and two girls.
Doctor: So how does it become five?
Anju: The last one died.
Doctor: Was he born alive? How many days did he live?
Anju: Three or four days.

The doctor took out her hand from Anju’s vagina, removed and threw away the glove and quickly wrote something down in the card. She directed Anju to proceed and get an injection, and Anju left clenching her underwear in her fist. In this way, the gynaecologist did not simply extract the knowledge hidden deep inside Anju’s body, but her probing questions also demanded Anju’s confession and the truth about her intimate self. Even though this knowledge serves the purposes of determining whether the operation would be safe, it is still a process of extraction of intimate truths legitimised through the power given to the medical gaze and authority. This tension between the medical authority extracting truths and its justification through appealing to safety is something that runs through all medical and bureaucratic encounters in the camp.

The truth is not simply something the doctor looks for passively lying inside one’s body. Rather the truth is more about negotiating power and voice while interpreting bodily signs and confessional answers. When Alka, a case number 7, came into the room, the doctor probed her on how and why she did not conceive in four years since her last child was born,

and asked about abortion in a variety of different ways. The doctor encouraged her to confess saying: “tell me the truth; harm might come to you, not to me”. Alka shyly acknowledged that she ate the tablet. She got rejected for the procedure straight away and left the room. A minute later, her mother-in-law came into the room to tell the doctor that Alka meant the tablet for fever and not the abortion pill. The doctor authoritatively rejected mother-in-law’s alternative explanation and emphasised that Alka talked to her openly, so she had no doubt about her answer. That moment Alka herself and her motivator came into the room as well, and the motivator proclaimed that “she did not eat the tablet; she is saying that madam did not understand”. The doctor laughed and addressed the motivator: “after they talk to you [the motivators], they are afraid and they change their stories. She should not experience any harm. We had an open conversation: she did not get her period and this is why she took the tablet”. The doctor added: “bring her next month, it is not a big deal”.

A few minutes later, Mr. Sharma, the CMHO officer-in-charge, came into the same room and told the doctor that number 7, Alka, ate the fever pill and was rejected by mistake. The doctor completely dismissed his intervention, and he left the room to go outside of the hospital without arguing with her. Alka, her motivator and mother-in-law gathered around him outside, and he offered a solution: “Take them to Udaipur. If you leave right now, you will reach in an hour and will get it done immediately”. It seems that even though Mr. Sharma’s office lost one sterilisation case by sending the woman and her motivator to Udaipur instead of suggesting to come back to the camp next month, he did so according to the logic of rejection described above: if some women do not get the procedure the day they arranged it, they would never come back.

As mentioned previously, the *madamji*, the gynaecologist and the surgeon, was feared and respected by everyone in the camp, including Mr. Sharma. Even though different camp staff reserved a right to believe in different versions of events, everybody acknowledged that the gynaecologist’s word and decision were final and unquestionable. It is clear that similarly to how the results of medical tests are negotiated and contested by the members of the clinical team, by women who are being diagnosed and by their motivators, the intimate truths extracted by the gynaecologist are also contested by a range of actors in the camp. And in the end, the doctor makes a decision about which version of the truth she chooses to inscribe on the Case Card and act upon. She acknowledges the powerful influence that the motivator and the mother-in-law might have on Alka’s version of events and tries to put Alka’s wellbeing at the centre of the decision. She also considers the CMHO officer’s interest in performing as many procedures as possible. However, she fails to acknowledge her own position of power

in the process of demanding the confession in the first place. Interestingly, the doctor in this situation has the power to decide who gets rejected for the procedure even when all the other parties involved, including Alka herself, make efforts to get the procedure done. In such a way, the biomedical authority competes with and stands in the way of implementing the desires and agenda not only of the agents of the state, but also of the women who come for the procedure and their kin. The power of the biomedical authority, here, is legitimised through concerns related to health, safety and women's wellbeing during and after the procedure.

The biomedical mode of inquiry sometimes experienced difficulties in acquiring the desired knowledge about women's bodies. Just like the disjuncture between the official language required to fill in the paperwork and the language used by the patients at the registration desk, the doctors also experienced various incidents of miscommunication with patients. In North India the encounters with the medical authorities are "explicitly moments of revelation" (Pinto, 2008: 171) because one does not go to see a doctor but "shows to the doctor", in Hindi *doctor ko dikhaana*. It can easily be illustrated with ethnographic moments from the camp, where women come expecting and ready to be seen by the doctor. Throughout my time in the room with the surgeon carrying out the examination before the procedure, when women were asked to reveal the intimate history of themselves, one particular incident of miscommunication between the doctor and the patient caught my attention. One of the doctor's goals during this examination is to make sure that the patient has not had a recent abortion. There are a few ways to ask about it. One of the expressions for abortion in Hindi is *safaai* and to abort is *saaf karna*. Both of these expressions are used in everyday vocabulary and refer to cleaning or clearing. When referring to abortion, it is meant to indicate the cleaning of the womb. When the surgeon once asked the patient if she had *safaai* recently, she shyly but assertively answered positively. Her response was different than expected for both me and the doctor. Whereas other women tended to be either unwilling or at least not be so forthcoming with this confession, this particular woman responded in a way as if this was what she was expected to do and simply acknowledged that she had done it. The doctor, already suspicious of her reply, asked when she had it done and the woman replied: "two days ago". The doctor quickly said, "oh no, not that", and rephrased her question using another expression for abortion – *giraa dena* or to make it (the foetus) fall. The woman laughed loudly at the miscommunication and denied having had an abortion. When she left the room, the doctor laughed and explained to me what happened. The patient thought that the doctor was asking if she shaved her intimate parts and answered that she did that two days ago. The

doctor added that "*adivasis* are very particular about these things and they always keep it shaved".[107]

The way this woman assumed that the doctor was inquiring about her cleanliness unravels the expectations women as patients project onto doctors. It also allows us an insight into the process of becoming a patient and preparing oneself for the medical gaze in this particular context. Let me briefly describe what I mean by becoming a patient here. During my stay in Delhi, when I was attending Hindi language classes, one of the women I lived with, Nikhila, told a funny story about her visit to a doctor in London, while visiting the UK for the first time. She was complaining of a painful cough and the GP asked her to take off her top in order to listen to her lungs. When she narrated the story to me, she emphasised that a doctor in India never asks women to remove their clothes, and instead listens to the lungs or the heart through clothes. She felt uncomfortable with the UK doctor's request not because she felt discomfort with taking her clothes off *per se* or because it broke some gender rules. Rather, she said she was embarrassed because she was wearing an old and not visibly pleasing bra. She confided that only if she knew she had to show her underwear to a doctor, she would have worn something more decent. "It is good I do not have to see that doctor anymore", Nikhila exclaimed and laughed. A similar idea of the need to get ready to be seen by the doctor and consciously transforming oneself into a patient is what is happening in the sterilisation camp. Instead of wearing better clothes, women who come to the camp for the procedure employ other techniques of transformation, such as shaving.

Sometimes, efforts were partially made to isolate the women from external influences, such as family members and motivators. In some instances, the family members and the motivators were imagined to pose a threat to the process of extraction of the truth. On one occasion, Gunjan, standing in the doorway, looked for the case that was next in line to enter the room for the examination. A woman was sitting down with her mother-in-law and both of them stood up in order to go and see a doctor. Gunjan stopped the mother-in-law saying, "I will take care of her, she is my sister", and took her inside the room, leaving the mother-in-law puzzled outside. Gunjan's discursive employment of such a kinship idiom was meant to

[107] Women across caste and class lines had very specific ideas and routines about their pubic hair. Even though most of them agreed that removal of pubic hair was hygienic and keeping the hair was dirty, they also acknowledged that they shaved their pubic hair because their husbands scolded them if they did not. Some women, whose husbands worked outside the village and returned only once in a few months, said that they shaved their pubic hair only when the husband was at home. Therefore, even though not shaving was considered to be dirty and unclean, not all women kept the pubic area shaved all the time due to the lack of time or the lack of the gaze. However, being seen by a doctor was seen as requiring similar preparations to as being seen by the husband.

comfort the mother-in-law but, at the same time, to control her and the situation, to make it easier for the doctor to examine the patient and to extract the truth.

Another example of how medical and state authority demanded a woman to "know herself" and denied her access to her social relationships as a source of that knowledge is this short encounter. A case number 10 came into the room accompanied by her husband, a rather rare sight at the camp because the camp was seen as a women's space and business. The gynaecologist asked her about her last period and the woman immediately looked at her husband for an answer. The doctor angrily shouted: "What does your husband know?" "During the last full moon", the woman replied in a couple of seconds, intimidated. This situation raises a few questions. In most of these medical examinations a woman's body is understood by the doctor as a completely independent entity, knowledge and control of which should belong to the woman herself, and, therefore, should be easily taken over by the camp staff for the duration of the camp. Motivators and sometimes women's family members often accompanied women through every step of these medical examinations in an attempt to provide care and support, but, as demonstrated here and above, their presence was constantly questioned by doctors and bureaucrats. In the example above, the possibility that a husband might remember his wife's last period was denied due to the assumptions that a woman should know her own body and that a menstrual period is a woman's concern. It was completely ignored that even though a menstruating woman tried to hide this fact from male family members, a husband would usually know about her menstrual cycles because abstinence from sexual relations and restraint from food preparation during menstruation was widely and rather strictly practiced in the area, as well as across India. The doctor's insistence on isolating the woman from her social world for the period of examination shows an inherent assumption in biomedical discourse about the individuality of the patient. Searching for the truth within the woman's body and self and denying her access to her social relations in this biomedical setting contradicts the notions of South Asian personhood, discussed in Chapter Five.

The surgeon's insistent questions about why a patient did not get another child after her 3 year-old in the example above also illustrate an imagination of poor women's reproductive strength. Generally, a woman's status as healthy and strong in biomedical terms would be considered to be a positive thing. However, the fact that these women are healthy and strong while living in poverty and in "backward" areas provides an opportunity for the biomedical personnel to constitute women's health and strength as problematic. These characteristics of women's bodies, that doctors have established through various tactics

locating the truth within these bodies, become to be defined as a threat to the wellbeing of women themselves (and, according to the population control discourses, to the nation in general) precisely because healthy, strong and fertile women live in problematic social, economic and cultural circumstances. Whereas the health, strength and truth are constituted by doctors as residing within women's bodies, these characteristics become problematic in their social context. In the view of the doctors, the strength of the woman's body demonstrates its capacity to be dangerous in conditions of poverty and "backwardness". Furthermore, women's reproductive strength is seen as both an outcome and a vehicle of "backwardness", and the operation is meant to create what Cohen (2005) called *as if* modern citizens. Such logic, as part of the development discourse, depoliticises poverty by depicting it into a problem that is technically manageable (Escobar, 1995; Ferguson, 1994), in this case through the female sterilisation procedure.

## On the mattresses: micro inequalities and hierarchies waiting for the procedure

After the medical examinations, women are taken by their motivators to the end of the corridor, where mattresses are laid down on the floor, in front of the operating room. The nurse is already waiting for them with injections and a pen. Women are told to lie down and three injections are given to them, one on the right arm and two on both buttocks. The place where the injection is put on the arm is marked by putting a circle around it with a pen, in order to see later on if a woman is allergic to the anaesthetic. The first woman to get an injection also gets the time of injection written on her arm.[108] The power of writing (Derrida, 1976, 1978), discussed in reference to the process of registration above, gains new forms in this context. Here, the woman's body is a site where social reality is literally, though temporarily, inscribed (Csordas, 1994: 12; Foucault, 1977). Women's bodies are inscribable with biomedical, political and bureaucratic power, and literally markable like paper, in the case of having numbers written on them. The power of the state is, again, masked as a biomedical procedure and a necessity. These bodies contain the details of individual patient histories, histories of collective bodies (the first woman's body contains information about all

[108] When there are less than ten women getting the procedure that day, then the first woman to get an injection also gets the time of injection written on her arm. When there are more than ten women waiting to get their tubes tied, then every tenth woman gets the time of injection written.

the women in the camp that day) as well as temporary histories of the nation (Das, 1996) and family planning.

Without removing her shoes, the nurse steps over the women's waists to reach every patient lying down. The motivators or the nurse put the blankets over women's bodies, from head to toe, and instruct them to sleep. If any member of staff or an ANM passes by and see women looking around, talking to each other, laughing, they instruct them to sleep: "*so jaao, baat mat karna, dekhna mat* [go to sleep, do not talk, do not look]". An ANM passing by would come, wave her hand to get rid of the mosquitoes buzzing above her case's head and put a blanket over her: "close your eyes and sleep will come". An effort to silence women in this waiting period by ordering them to sleep is clearly combined with motivators taking over their agency to act. Even though it can clearly be seen during other encounters in the camp already discussed, motivators taking over women's bodies as an expression of their ownership and achievement reaches its most visible forms in this period when anaesthetics are taking time to work. The women often rebelled against these strict orders to silence them and I could hear them giggle from under the blankets and whisper to each other.

Doctors wait around for almost half an hour, giving the anaesthetic time to take effect, and make their way into the OR. The surgeon shouts from the inside of the OR that they are ready and Suraj stands up from a tiny chair that he has placed next to the door into the OR, just like the very first time I met him. He shouts to the crowd of motivators standing around in the corridor: "Bring the first and second cases to urinate *phataaphat* [instantly] and bring the first case in!" There is a little bit of whispering amongst the motivators: "Who does the first case belong to?" It is a motivator's job to wake the woman up, as the effects of anaesthesia have taken place, and the woman is dizzy and disoriented, take her to the nearest toilet in the Women's Ward and bring her to the entrance to the OR. Sometimes Gunjan comes and whispers to the women squatting in the corridor waiting for their call to be taken into the OR: "They will give you another injection and will put a small machine inside. Do not make any noises. If you scream, operation will take more time". Gunjan once explained to me why she told women not to make sounds in the OR:

> "Let's say I cut my finger and you tell me not to make a sound. But if it hurts, I will shout and cry no matter of what you told me. But I have to tell them because if they shout, then others will get scared and then the team will have to take time calming them down. I tell them everything once but it does not stay in their minds and they forget. They come for the operation, so there are so many issues on their minds. No matter how many times I tell them not to scream, but they still do. And then madam thinks we do not tell them".

Here, we see how the women's pain does not receive acknowledgement; it is denied (Das, 1996), and written off as yet another aspect of their "backwardness" and inability to understand and contain themselves. Taussig (1980) reflects on the story of a middle-aged woman suffering from polymyositis – an inflammation of many muscles, – whose pain and other signs of distress were transformed by doctors into a physical disease of the brain, and the patient was denied authorship of the symptoms and a sense of certainty. Contrary to Taussig's account, nurses denied the women in the sterilisation camp the authorship of their pain not by reducing it into a symptom of a certain biomedical condition, but by constructing the pain as not contained within or originating from the woman's body at all. Rather, pain was interpreted as an expression of women's social and economic circumstances, and located within the social, not the individual body.

Even though the OR door is open, none of the motivators are allowed to enter inside. The threshold to the OR clearly separates the world of doctors, technology and skill on the one hand, and that of patients, health workers and the social on the other. The motivator of the first case helps her to stand up and takes away her *odhni*,[109] and sometimes the whole *sari*, leaving the woman standing in her blouse, stained with breast milk, and *ghagra* (skirt) or petticoat. *Odhni* is a see-through wrap worn together with *ghagra* and *choli* by many *adivasi* women and women from some other castes in Rajasthan and symbolises woman's modesty and piety. When the motivator forgets to remove the woman's *odhni* and passes her fully dressed on to Suraj, he removes it himself and throws it to this woman's motivator. The motivator rarely held onto the woman's *odhni* herself and, having expressed her disgust with the supposedly dirty garment, threw it either in the corner or onto the empty mattress. A few moments later, the woman is taken into the OR. Suraj continues his directions to motivators: "Seat the second case here, bring the third one to urinate and seat her here as well". The second and third cases are told to squat in the small corridor leading to the OR and wait for their turn, while their motivators stand chatting to each other in the same space. The motivators calm women down if they look anxious, put shawls over their faces and heads and

[109] *Odhni*, literally translated as wrap, is a part of women's dress in the area and is generally a long piece of cloth worn together with a skirt and a blouse (*ghagra choli* or *lehengas*). One end of it is tucked into the skirt, draped across like a *sari* and taken to cover the head in a short veil; the other end is tucked into a blouse or skirt. *Odhni* stands as a mark of female respect and modesty (Raheja and Gold, 1994), and protects men from overexposure to women's power and protects women from undesirable men's attention (Papanek and Minault, 1982 cited in ibid.: 47). Raheja and Gold (ibid.) problematise *odhni's* symbolism by showing that in many Rajasthani women's songs, *odhni* also marks eroticism and dalliance.

direct them to sleep for a little while longer. “Why don’t you seat them on chairs?” I asked, familiar with people’s discomfort if guests squat or sit on the floor. “They do not know how to sit on a chair”, Gunjan provided an unexpected answer and continued: “they are dizzy, so they will fall down from the chair. They are used to sitting like this in the village because they do not have chairs there”.

The camp staff often commented on different levels of dizziness women experienced after the anaesthesia. The dizzier the woman was, the better the procedure was predicted to happen. One woman found it very difficult to stand up from the mattress and Gunjan rhetorically asked: “*Chakkar aa raha hai*? [are you feeling dizzy?]” and turned to me and the motivators: “*iska operation badiya hoga* [her operation will be great]”. Here, the power of anaesthesia and the woman’s dizziness symbolises her complete surrender to the rules and hands of the medical team and the camp. Her body is taken over not only by the anaesthetic drug but also by the regulative efforts of the bureaucratic and medical procedures of the camp.

On another occasion, I was squatting in the corridor leading to the OR, where a couple of women were seated to wait for their turn to get in for the operation. Shanti, an *adivasi* woman from Kolyari, another area in Jhadol *tehsil*, was seated next to me. She did not have any trouble walking, was making jokes with her motivator, and was inquisitively looking into the room, where the water for the sterilisation of instruments was bubbling on a stove, the same pot of steaming hot water I described in the opening narrative. I asked her if she did not feel dizzy at all. Shanti gave a negative answer and I looked at her motivator who was standing in front of us. Gunjan joined us at that very moment after hearing snippets of our conversation and explained to me that local anaesthesia does not work on those who use a lot of *nasha* (direct translation is intoxication; in daily use it refers to the use of alcohol, nicotine, marijuana and opiates). The ANM asked her if she consumed alcohol. Shanti said that she sometimes did and giggled. Another woman was taken out of the OR in the rolling chair after the procedure and Shanti was taken into the OR. The moment she disappeared behind the OR door, the ANM told me that she and her husband drank every day and that now she was lying: “I worked there for so many years; I see everything that is happening. I know they are drinking, every day”. Here, this woman’s body’s resistance to anaesthesia not only symbolises the lack of surrender to the rules of the camp but also her rejection to be subjected to a certain morality. The concept of intoxication, once again, is seen not as a condition within the body, where biochemical elements create reactions and alter perception and behaviour. Rather, intoxication refers to social conditions and relations, and, therefore, *adivasis* are “expected” to drink, because they are “backward”. In the eyes of Gunjan and health workers,

this woman's operation would not be easy and "great" because she transgressed the moral boundaries of what was appropriate for a woman, and exemplified what was expected from a "typical" *adivasi*.

It takes less than five minutes and one of the staff pushes the first case out of the OR on a small rolling chair. She seems much dizzier than before, eyes closed, a head fallen backwards, the lower part of her breasts not covered by the blouse, a bandage covering her belly button, her *ghagra* untied but still held tight by the clasp of the woman's hand. The man pushing the chair shouts out for the woman's *odhni*, her motivator finds it and tries to cover the woman's exposed body from those few who have not seen it yet. When the chair reaches the mattresses, her motivator is called to help to put her to sleep. She carefully helps the woman to stand up, leads her to the middle of the mattress, helps her to lie down and covers her with the blanket. By the time she lies down, the second case is already in the OR and the cycle goes on. Between the moment the motivator deprives the woman of her *odhni* until the moment she returns it, the woman is completely exposed, physically and socially, to the power and the hands of those who hold the *doorbeen* (literally translated as binoculars and referring to a laparoscope). However, it is not simply the *doorbeen* that allows the doctors to see within one's body. Rather, there is a much longer process of making oneself seen, becoming naked, losing one's moral codes of behaviour in order to be accessed by the doctor and the *doorbeen*. This process involves both woman's own efforts in becoming a patient and the rules and procedures of the camp discussed previously.

## The operating room: the power of the *doorbeen*?

The surgeon had very clear and strict ideas about what was allowed and what was not allowed for me to do in the camp. Just like taking photographs in the premises of the camp, the operating room was something outside of these lines. Interestingly, the inside of the OR was also something to wait for because she kept saying that one day for one time only she was going to allow me to step into the OR and observe the procedure myself. Such a promise and its constant reminder was one of the ways to construct the OR as an extraordinary space completely removed from the everyday life of the hospital within which it was placed (Goffman, 1961; Foucault, 1973; Moreira, 2004; Wilson, 1954). It was defined as a space for only medical staff and patients, separated from the rest of the hospital and its life by special attire, such as scrubs, masks, caps and shoe covers, as well as protected entry inside, not only to me but also to the motivators and other non-medical personnel. However, the surgeon also

once told the medical team a funny story about the time when she brought her eight-year-old daughter to the camp and allowed her to observe the procedure inside the OR. The doctor's daughter was shocked that "the hole [incision] was so small, but the instrument [laparoscope] was so big!"

The doors of the OR remained closed to me throughout the time that this particular surgeon was in charge. The surgeon herself was the embodiment and the symbol of how specialised, strict and sometimes even magical the OR was portrayed to be. Other members of the clinical team talked about her very special surgical skills and almost magical powers in diagnosing women's reproductive health issues, and expressed these comments almost like "hero worship", which characterises many doctor-patient relationships in contemporary India (Bharadwaj, 2006). In the context of the camp, however, this admiration was coming from other staff, rather than patients. Gunjan was one of the biggest admirers of the surgeon's skills. She often emphasised that the *madamji* needed only two minutes for each sterilisation procedure and no other surgeon could pull it off in such a short time. Gunjan once also said that the *madamji* could detect a one or two day pregnancy just by putting her hands on the patient's stomach. She explained further that after tying one's *sari* or *ghagra*, woman's fallopian tubes became tight and visible and this was how the doctor got to know about a very early pregnancy.

One day when Suraj was seated at the entrance to the OR directing which case needed to be getting ready, his voice was louder than usual and anger was spilling through his facial expressions, bodily language and vocabulary. One of the motivators standing beside him jokingly addressed him: "Speak gently, the cases barely come, everyone will run away". Gunjan replied that their *madamji*, the surgeon, also shouted a lot. I asked Suraj if he shouted because the surgeon shouted? His reply surprised me: "She is our *guru*, she is allowed". Even though his answer was not fully serious, it still provides an insight into the way the surgeon is seen by the staff in the camp.

One of the ways to refer to the laparoscopic sterilisation procedure – *doorbeenwalla* operation – invokes the gaze as the central defining characteristic of the procedure. As noted in the Introduction, *doorbeen* is a Hindi word for binoculars or a telescope, an instrument used to see things that are far away. It refers to the laparoscope which allows the doctor to see the inside organs of a human body through the lens on the top of the instrument or the screen. Such a conceptual understanding of the procedure immediately suggests that the conversation about vision and gaze has to take place in trying to understand how medical technologies in general and female sterilisation in particular are thought about and imagined in local moral

worlds. Calling the operation *doorbeenwalla* invokes powerful hierarchies inherent in the concept of the medical gaze and opens up the conversation about power and visibility (Foucault, 1973, 1980). *Doorbeen* highlights the increasing surveillance of the individual body, and the localisation of power within those controlling the medical technology, the laparoscope. Another way to refer to the same procedure is *karantwalla* operation, where *karant* refers to the electricity which enters and potentially transforms one's body. Both of these concepts referring to the procedure invoke power to see within and to act inside the body. It is, therefore, of extreme significance to keep in mind the work of power (to see and act, as well as to be seen or remain hidden) in the process of getting one's tubes tied, both in the process of interacting with health workers prior to the procedure or the process of motivation, and the interactions with doctors, health workers and bureaucrats within the sterilisation camp.

Gunjan told me that the villagers referred to the operation as *karantwalla* and those who were more educated – mainly health workers of various levels – referred to it as *doorbeenwalla*. Even though it turned out not to be particularly true (women and men in the village referred to the operation in a variety of ways, including *doorbeenwalla*), Gunjan's statement is interesting in itself. According to her, *doorbeenwalla* operation is a more accurate title for the procedure referring to a particular piece of equipment and, therefore, available only to those with a particular amount of technical/medical knowledge and education. This is an example of how Gunjan projects socially and economically disadvantaged positions of the women who get the procedure and the villagers in general through the language they use. A choice of vocabulary, in her view, holds the potential for symbolic power, and differences in social and economic status are reproduced through access to legitimate language (Bourdieu, 1991). Gunjan's statement implies the power of the medical gaze being unintelligible to the men and women who are the targets of that very procedure it describes. Furthermore, the making of such a distinction makes Gunjan a part of medical professionals and other educated people. Gunjan herself is a Brahmin woman from the city, educated till tenth standard, without proper medical education but holding a rather steady job related to rural women's health. It is a way to assert her own social status through taking part in a group which holds the *doorbeen* and has the power to see within one's body. The doctors themselves rarely referred to the procedure as *doorbeenwalla* or *karantwalla* operation, unless speaking to health workers and patients and using the language that was supposedly understood by them. Rather, they referred to the procedure as a laparoscopic surgery when talking amongst themselves or with me.

The madam surgeon resigned from her position at MSI and took a job at a private hospital a month before I left the field. During my last few visits to the camps, a newly hired surgeon was in charge. The second time I met him, he instructed the staff to give me a surgical mask, cap and shoe covers, and invited me to observe the procedure inside the OR. Nervously standing in the corner, I observed how a woman was led into the room and lifted by the male nurse onto the operating table. She was given more anaesthesia, and a nurse, who performed HB and glucose tests and administered injections before, made a small incision in her belly button. The woman moaned when her abdomen was inflated and a laparoscope inserted. The surgeon navigated the instrument for a few seconds and called me to take a look at the magnifying lens on top of the instrument. I apprehensively moved across the OR and stood next to the operating table. I looked through the lens on top of the laparoscope, and saw a white plastic ring clipped on the pink flesh, a fallopian tube. I gave the surgeon a sign that I have seen enough, and returned to the corner. He removed the instrument, inserted a second ring into it, returned the instrument into the incision and, a few seconds later, removed it. The nurse put a single stitch onto the incision and placed a bandage across her abdomen. The male nurse lifted the woman from the operating table, seated her into the rolling chair and pushed her out of the OR. I left the OR behind them. The surgical mask, placed between the pages of my fieldnotes, still reminds me of this uncomfortable scene. There is no denying the violence of any surgical intervention, and the necessity for the complete surrender of the patient to the power and skills of the surgeon, the medical team and the *doorbeen*. However, I felt finally relieved that the previous surgeon did not allow me into the OR earlier. The discomfort I felt in the OR – an anthropologist intruding into a clearly medical space and, by gazing into the laparoscope lens, inside the woman's body – could have completely altered my reading of events and encounters in the camp, should it have happened sooner.

## Conclusion

In this chapter, I discussed a complex interaction between the state, biomedicine, class and gender in various encounters in the sterilisation camp. Long, Hunter and Van der Geest (2008) in their *Introduction* to a special issue of Anthropology and Medicine focussing on hospital ethnography describe a hospital as a highly ambiguous space, both part of the everyday social and cultural lives and removed from them at the same time. In this chapter, I uncovered some of the complexities and multifaceted relationships that unfold and structure the life in a very particular politico-medical space – a sterilisation camp. Partially, the camp is

a liminal space (Turner, 1969), where women are removed from their everyday lives and brought to be medically examined, questioned, operated upon and medicated (Long, Hunter and Van der Geest, 2008: 73). However, the camp is not completely isolated from the everyday hierarchies and inequalities, but is a place where these inequalities find new ways to be articulated and negotiated. Furthermore, the camp is not a purely clinical space where the interaction between doctors and patients could occupy the central focus. Rather it is a space where the intersecting clinical and bureaucratic worlds constantly compete and negotiate each other's legitimacy and authority. In the context of sterilisation targets – for health workers, but also for the MSI team of doctors, nurses as well as CMHO bureaucrats – the camp staff members operate within conditions of uncertainty. They speak about the lack of women agreeing to come for the procedure or women's choice of a private hospital in Udaipur, such as *HariOm*, instead of the camp. Such uncertainty, however, does not result in a unilateral agreement between the medical and bureaucratic realms to perform the sterilisation procedure on every single woman who showed up at the camp that day.

Women who come for the procedure find themselves stuck between various agents – motivators, nurses, doctors and bureaucrats – negotiating and contesting each other's methods, reasons and ways to know "the truth". Starting with simple questions in the FS Case Card about the number of children, their sexual composition and then moving onto the biomedical examination and questions about women's history of abortions and contraceptive use is a way to establish supposedly objective criteria for the woman's suitability for tubal ligation. These set bureaucratic and biomedical rules about eligibility for the operation serve as the legitimation for the state's family planning agenda and methods. The team of doctors are not interested in the conditions under which women came to the hospital for the procedure. However, they trust neither the patient nor her motivator, who supposedly acts in the name of the Indian state, and acknowledge that there are various reasons and socialities behind a woman making a decision to get her tubes tied, and all these reasons are acceptable in the doctors' view. However, the team of doctors creates barriers for the decision that was made outside of the hospital to be implemented by making rules on who is eligible for the operation. It is not as simple as the interaction between women as patients and the authority of biomedical institutions, established through doctors and nurses' control over medical procedures, language and rules of behaviour. The team of doctors and nurses challenge the authority of the state to implement the family planning agenda by creating and negotiating rules for women's rejection for the procedure by looking for and multiply constituting a healthy *enough* body. During all of these interactions, doctors, nurses and bureaucrats see

women not as merely bodies that contain indicators of health and solutions to the supposed problem of fertility, but also as products of their social and economic circumstances. According to the camp staff, women's bodies are constituted by their poverty and, in essence, being *adivasi*. The following chapter provides a deeper look into the process of marking poverty and class on women's bodies and how poor women themselves negotiate these projections.

# Chapter Seven
# The operable bodies: negotiating social status through female sterilisation

I was on a crowded jeep leaving Udaipur and heading to Chandpur, when the jeep stopped on the outskirts of the city to pick up two women outside of a big private hospital called *HariOm*. The older woman wearing a simple *sari* helped the younger woman in a tribal *ghagra choli* (skirt and blouse) into the jeep, seated her on the back seat just in front of me, and directed her to put her head on the side of the jeep and try to sleep. I recognised this internal dynamic from the very first look. It was a very familiar view for me at that time – the younger woman, slightly intoxicated and quietly moaning in pain, a bit lost in her surroundings, with a bandage on her stomach, her right thumb covered with ink, and a certificate of sterilisation in her hand, followed instructions. They were travelling home from the hospital after sterilisation – a younger woman was sterilised and an older woman was her motivator, bringing "the case" back to the woman's house. Although I had never visited *HariOm* hospital, I had been visiting government sterilisation camps for four months by the time of this encounter which informed my ability to read this situation.

This chapter is about the bodies which are inscribed and marked by female sterilisation procedure. After discussing some ways in which class is marked on women's bodies, I introduce a concept of the operable body recognisable in this brief encounter in the jeep. I discuss Cohen's concept of operability and appropriate it to the context of my ethnographic encounters. From this brief interaction on public transport it is clear that understanding social status dynamics is central to understanding this relationship of operability. A government health worker – a motivator – is at the centre of providing the clinic and the state with the bodies of mainly poor *adivasi* women for the procedure of sterilisation. She is not only one of the main agents who facilitates the conditions for the operable body to emerge, as discussed in Chapter Four, but also the relationship between the motivator and the woman highlights the importance of class and status in the creation of this operable body. Besides the relationship between the health worker and "the case", the intersection between caste, class and gender in the conversation about female sterilisation also comes into the picture when we discuss women's relationships with one another. Here, I follow Petchesky's (1983: 223) warning that "(b)y collapsing class into gender, the notion of

sex as class ignores the obvious, piercing differences – of power, authority, and resources – among and between women". In this chapter, I unravel the contradiction that even though the sterilisation camps served mostly *adivasi* women, the tubal ligation procedure itself was prevalent among women across various caste and class backgrounds. I demonstrate that female sterilisation becomes a field within which women mark and negotiate their social status, and, in a way, delineate their relationships with each other. Overall, I show that a conversation about a woman's body – its limitations, appropriate use, strengths and weaknesses – and its relationship with a particular biomedical intervention – female sterilisation – is a conversation about class, caste and social status.

## Women's bodies marked by class

The notion of "local moral worlds", as defined by Kleinman (1995: 27), is concerned with "moral accounts […] of social participants in a local world about what is at stake in everyday experience". In Chandpur, concerns over one's social status and place within various intersecting hierarchies – gender, class, caste and age amongst others – are at stake during most of the interactions in everyday life, be it seeking healthcare, food preparation, clothing, or dealing with neighbours. Social status is gained, learned and marked on and through bodies, and people are distinguished by the way they use their bodies (Bourdieu, 1984, 1993; Douglas, 1996[1970]; Mauss, 1973[1936]). These bodily practices are given meaning and made intelligible within complex networks of power relations.

It was late morning when I came to the primary health centre (PHC) in Chandpur that day. At least some of the hospital staff were supposed to be found at the hospital every day (except on Sundays) between 9 am and 1 pm. That day, I walked through every office and delivery room in the hospital and could not find any staff anywhere, except for a couple of women with their newborns next to them in the maternity ward and their male kin sharing tea from a plastic bag on the stairs to the unfinished second floor of the hospital. Only on my way back out of the door did I see a lab technician, standing in the doorway looking outside and chatting with some passers-by. He was not a permanent staff member at the hospital, but was hired on a project basis to conduct blood, urine and tuberculosis tests. He spent his days either conducting these tests or chatting with other staff while waiting for the patients to come. That day, I asked him who would deliver children if any pregnant woman came, bearing in mind that no other staff were around and I had never seen him conducting deliveries himself. "You will", he said smiling and continued:

> "It is not difficult at all – the body does it itself. You just hold the baby on its head, cut the umbilical cord, put some medicine to disinfect and that's all. Women here, they work so much, at home and as daily labourers [*mazdoori*] throughout the whole pregnancy period. That's why their bodies are strong [*mazboot*] and the delivery is easy. Also, these women can handle pain much better. Women in cities are different, they do not work hard, during pregnancy they refuse to lift heavy things, they just lie in bed and wait for the baby to grow and come out. And then they get C-sections because their bodies are too soft [*naram*] and they cannot handle pain".

This brief extract from our conversation demonstrates several things. It illustrates that poor *adivasi* women's bodies are seen as physically different and capable of different things from the bodies of women of higher social status. The reason for that difference is the work that their bodies do, the manual labour that transforms them. There is an implied understanding, in the words of the lab technician, that this labour is not a choice but an economic necessity. The physical strength of the body gained through manual labour makes the process of childbirth quicker and easier for rural women. This resonates with Van Hollen's (1998, 2003) findings while working with lower-class women in maternity wards in Chennai, Tamil Nadu. Van Hollen's informants narrated the strengthening effects of normal childbirth and a strong relationship between childbirth pains and *shakti* (female power). Lastly, due to their strength rural women's bodies are seen by the lab technician as closer to the "natural" condition of the body (Ortner, 1972), the condition in which childbirth is a natural and easy process during which the body requires the very minimum of external help and intervention.

Women's bodies in Chandpur are significantly marked not only by gender, but by class and caste as well. Just as notions of femininity, fashion and appropriate behaviour are performed and embodied, so are social hierarchies and inequalities. Bodies are products of these hierarchies and inequalities; this is evident, for example, in the idea that *adivasi* women's bodies deliver babies more easily because they have to work hard in the fields due to living in poverty. If class and caste are understood as an ongoing process of articulation (Mookherjee, 2008), then the body is not only the result of this process, but also the means through which class and caste is constantly articulated and negotiated. This process is particularly visible in the encounters in the sterilisation camp, and here I briefly return to the ways in which class is marked on women's bodies in this particular politico-medical site.

## The partial decontextualisation of the body in the clinic

In conventional medical anthropology, the medical gaze is generally understood as treating the body as a completely abstract and decontextualised entity, the container of diseases and their symptoms (Foucault, 1973). Some anthropologists and sociologists of health and illness have ethnographically illustrated the processes through which a patient is transformed into a body in particular biomedical contexts (Fox, 1992; Gross, 2012; Hirschauer, 1991; Katz, 1984; Mol, 2002). For example, Gross (2012) writes about the process through which a patient is stripped of everything that makes her a person, made into a body and then into a brain on her way to the operating room for brain surgery. This "stripping process", during which the distinctions of class, status and other everyday roles are wiped out in order for the anonymous body to emerge (Van der Geest and Finkler, 2004), does not, however, fully resonate with processes in the sterilisation camp.

Women in the sterilisation camp do go through a process of decontextualisation, but only to a certain degree. After leaving home, the woman arrives at the hospital with her motivator, her smallest child and another woman, either kin or neighbour. By the time she is called to the registration desk to sign the registration forms and the Female Sterilisation Case Card – which were filled in by the Marie Stopes team with information provided by her motivator – her female kin is sitting down in the meeting room with her child. She gets a number written on her arm, and she becomes that number for the rest of her stay in the clinic. She fills a cup with her urine and from that moment this cup contains many of the answers to questions about her body's current condition, including whether she is pregnant or not, as well as the information that will establish whether or not she has wasted this day, by determining if she will be accepted or rejected for the operation. After that, she is taken for the blood and other tests, and her blood seems to hold other answers – is she anaemic or not, does she suffer from high blood pressure or not, and then her heartbeat – is there a problem with her heart? The clinic, in this case, is a space where the woman is separated from her family, reduced to her heartbeat and qualities of her blood and urine. All of these biomedical techniques, in other words, transformed the body into a visible, intelligible and appropriate form, creating conditions for the medical intervention (Mol, 2002; Street, 2014).

However, when the woman meets with the "madam surgeon" who will perform the procedure, she is commanded to speak; she is more than her body or a combination of some qualities of her body. The madam demands to know about her fertility and contraception history, menstruation cycle and sexual activity patterns, as discussed in Chapter Six. I argue

that, contrary to the conventional anthropological view, the medical gaze in the sterilisation camp does not see the body of the woman who comes for the procedure as a completely abstract, decontextualised entity. The process of medical examinations and the interaction with the surgeon, even though decontextualising women, constitutes and defines the body according to its health, strength and capacity for fertility, as demonstrated in Chapter Six, instead of its pure depersonalised materiality.

Besides the body's health, strength and capacity for fertility, there is something else in and about the body that is never taken away in the camp, even in the OR. It is acknowledged that the reason for the necessity of the procedure does not lie within the materiality of the body, as there is no medical problem that the operation tries to fix. Rather, the operation is seen as necessary precisely because of the body's social, cultural and structural conditions – because it is a poor *adivasi* woman's body. "*Adivasi* people do not understand what is good and what is bad for them, having few children is good and having many is bad", was a common expression among motivators and nurses. These conditions are often simplified into such buzzwords, stripped of their complex meanings and reasons in such a way that poverty, remoteness, "backwardness" and lack of education come to be used as self-explanatory de-politicised descriptions. Staples (2012) makes a similar argument when discussing lay and professional understandings of disability in South India, where less-abled people from rural, uneducated and economically poor backgrounds are seen as careless, lacking understanding of the medical condition and relying on non-biomedical healing traditions. At the same time, these complex social and economic conditions are inscribed on their bodies. In the sterilisation camp, the women who come for the operation are never treated simply as women. Rather, they are always treated as women and bodies marked by their caste and class. The deeply rooted hierarchies between doctors and patients are even further deepened by the overlapping hierarchies of class and caste. The body in the camp is always the poor, rural, *adivasi* body. The first two characteristics defining the body in the camp – its relative health and fertility – are established through medical examinations, such as reproductive history, blood and urine tests. The third characteristic of the body – its socioeconomic status – is established not only through bureaucratic procedure of registration, but is also implicitly conceived by the team of doctors, nurses and bureaucrats, as well as by the other women, through observing the ways in which the body is carried around the camp.

Class is embodied, performed and visible in everyday life interactions (Bourdieu, 1984, 1993) including the sterilisation camp, where patients take off their shoes before entering the doctor's office, but the health workers refuse to remove theirs when stepping on

the mattresses where women lie before and after the procedure. The camp is also a place where the health workers embrace visibility to mark their difference from the patients in a variety of ways, the most straightforward one of which is the aesthetics of the health worker. In the place where I did my fieldwork, there are two conventional ways to tie a *sari*. In *sidha pallu* (straight stole), or Gujarati style, the *sari* is draped over the right shoulder; the stole comes in front, is spread across the chest and tucked on the left side at the back. In *ulta pallu* (reverse stole) or over the shoulder style, the stole is draped over the chest, pinned on the left shoulder and left hanging at the back. These different ways of tying a *sari* carried very clear social status connotations. The most commonly worn *sari* by women across different castes in the village is a straight stole style. However, every time I was tying my *sari*, every single woman suggested I should wear it over the shoulder, "like a *madamji*". A *madamji* usually refers to a teacher or another educated woman. It turned out that doctors, nurses, teachers and health workers, as well as NGO workers living or working in villages, wore their *saris* over their shoulders. *Ulta pallu* asserts one's social position of being educated and holding a steady government or NGO job, whereas *sidha pallu* marked one as rural.

All motivators I met in the camp also wore their *saris* over their shoulders and, when I asked them about it, one ANM replied: "I wear it straight at home because it is much more convenient to do my housework, but when I am on duty, I always wear it over the shoulder". When it comes to the motivators, the aesthetics of an educated woman works in different domains. The way the motivator ties her *sari* reflects her education and a middle-class standing when visiting villages and women's houses to motivate for immunisation, sterilisation and other interventions. A *sari* tied over the shoulder is a common denominator of educated women who accompany *adivasi* women in their *ghaghra chole* or *sidha pallu saris* to the sterilisation camp. Therefore, in the camp, the health workers' *saris* tied over their shoulders separate them from the poor *adivasi* women as patients. For health workers, the hospital is a place where they perform a particular type of the self and are ready to be seen by poor women, other health workers, doctors and bureaucrats. Unlike the health workers who tie their *saris* in ways that embody status, and the team of doctors and nurses who wear white coats, the women who come for the procedure are seen as embodying their rurality and "backwardness" – their wear the same clothes they wear at home, bring their little children to the camp, and sit or squat on the floor.

Through the characteristics described above – women's health, fertility and markings of social status – the poor woman's body in the sterilisation camp becomes partially contextualised and embedded in social relations and hierarchies. Within the population

control discourse, perpetuated by the Indian government and international development agencies and discussed in Chapter Two, poor women's bodies in the sterilisation camp come to stand as embodiments of the poverty and "backwardness" of Jhadol *tehsil* and *adivasi* communities in general. However, through the process of sterilisation those same bodies also contain the primary solution to this poverty: ensuring that a woman does not have "too many" children. Inherent in this is a tacit acknowledgement that alleviating the structural conditions of poverty through social interventions such as education or the redistribution of resources is far beyond the current capacity of the state. Therefore, the body is viewed not simply as the container of symptoms of poverty and inequality, but also of solutions to it. This is an example of how medicalising women's bodies and everyday lives is a global process through which poverty, illiteracy, maternal mortality and morbidity come to be viewed as caused by biological factors, such as excessive fertility. In this way, poverty itself is medicalised (Arnold, 2012), and is treated with biomedical interventions, instead of addressing the structural conditions of political economy and son preference that underlie it (Scheper-Hughes, 1992). In other words, the population control discourse depoliticises social issues of poverty and inequality by offering a technical solution (Ferguson, 1994) – a biomedical intervention of female sterilisation. The concept of operability reflects some of these dilemmas and provides an opportunity to look deeper into the processes that constitute woman's bodies in particular ways. Here, once again, I turn to the way female sterilisation is often portrayed in the media.

## The operable bodies

I start this section with a brief discussion on one example of the visual material used in the articles reporting on various human right abuses and unhygienic health conditions in sterilisation camps in India. I find this visual representation useful in trying to unravel the disjuncture between how the practice of female sterilisation is discussed in public domains, and how it is spoken about by the women who had the procedure themselves. For example, in the article reporting the tragic deaths in a sterilisation camp in Chhattisgarh in November 2014, entitled "Rat poison linked to India sterilisation deaths, with death toll expected to rise" in *The Guardian*, the following image was the only one used in the story. Four women in *saris* with bandages on their abdomens stand in line while the camera focuses on their bodies between shoulder and knee, cutting out their faces and surroundings (see Image 13).

**IMAGE 13: A PHOTO USED FOR THE ARTICLE "RAT POISON LINKED TO INDIA STERILISATION DEATHS, WITH DEATH TOLL EXPECTED TO RISE" BY *THE GUARDIAN* ON 14 NOVEMBER, 2014.**

The visual is ambiguous without the narrative. Here, I want to ask: what are the implicit messages associated with the image? How does the visual convey these meanings? What power differentials shape the interpretation of the image? The image above depicts parts of women's bodies that are marked (and from the context of the article, supposedly violated) by a state-organised medical intervention. Four women standing in line show the scope of the intervention, but also portray the mass body of the homogenous "poor", and, at the same time, a homogenous "bare life" (Agamben, 1998). The women, without their faces and stories, are reduced to being poor, exotically clothed brown bodies, stripped of their agency. Big white bandages, differently placed on their abdomens, and contrasting with their brown bodies, stand for the contradiction between high levels of medicalisation and the poor quality of medical services. This image is an example of "visually constituted 'grand narratives' of poverty and suffering" (Shankar, 2014: 342), directed at middle-class readers across the world. In line with other discourses in development industry, it depicts poverty as powerlessness, marginality and despair (ibid.), and this powerful gaze, or an ideologically constituted "way of seeing" (Berger, 2008[1972]), makes more sense if placed within the historical context of orientalism and colonialism (Mbembe, 2001; Said, 1978). The tendency to portray Indian women as voiceless and powerless has a long history (for instance, for the debates surrounding *sati* see Mani 1985, 1989), and has been interpreted as providing a

rationale for the colonial intervention by the British (Chatterjee, 1989). Whereas in colonial accounts Indian women were transformed "into a sign of the inherently oppressive and unfree nature of the entire cultural tradition of a country" (ibid.: 622), the image above conflates "the patriarchal Indian culture" and the government into one oppressor. In many ways, such a portrayal of Indian women by *The Guardian* reproduces the essentialised differences between the powerless colonised and saviour colonisers (Said, 1978) in a postcolonial context. The state-organised biomedical intervention, here, replaces the "barbaric" and "backward" practices, like *sati*, but seems to serve exactly the same purpose.

## *The concept of operability*

The reduction of women to their bodies and signs of state-organised medical intervention, depicted in this image, brings us to the concept of operability as introduced into anthropological discourse by Cohen. Cohen (1999, 2004, 2005) makes an analytical link between government-organised sterilisation campaigns, kidney transplantation and the castration of *hijras* (transgenders) in India through the concept of operability. Even though his main work focuses on kidney transplantation in Tamil Nadu, when interviewing kidney donors from urban slums in Chennai, Cohen (1999) found that every one of the almost 30 women who sold their kidneys with whom he spoke had already had a tubal ligation procedure. He emphasises that early on in the process of enlisting for the kidney donation women were informed that, in order to donate a kidney, they needed to have a tubal ligation for health reasons. Interestingly, every woman narrated that "she had already had *that* operation" (ibid.: 138, emphasis original). Cohen (2004: 166), therefore, concludes that sterilisation not only "produces a body that performs *as if* it had undergone a transformation of reason [emphasis original]", but also that "(t)he operation becomes not only a technique and a site instantiating the state but also a form marking the possibilities and limits of belonging for persons hailed as [the masses]". Rephrasing Van Hollen's (1998) work on the use of reproductive technologies amongst poor women in Tamil Nadu, Cohen emphasises medicalisation as central to women's engagements with the state, and tubal ligation as one of these instances. He makes a connection between operation and citizenship, and defines operability "as the degree to which one's belonging to and legitimate demands of the state are mediated through invasive medical commitment" (Cohen, 2005: 86). Discussing Agamben's (1998) notion of "bare life", where subjects are stripped off of their civic and political rights and are left with the only right to life, Cohen argues that some marginal subjects – *hijras* or

poor women and men – may sometimes deliberately become "bare life" or operable bodies in order to claim civic and political rights that are denied to them. In other words, for Cohen (2004: 167), to be operable is to be part of the project of citizenship. He suggests that in this context female sterilisation procedure becomes one of the ways through which poor and marginal subjects can secure places in the project of the nation state (ibid.: 172).

In a way, Cohen's conceptualisation of operability as a form of engagement between the state and its economically and socially marginal subjects also portrays the poor undergoing sterilisation procedure as a homogenous group, supposedly desperately looking for ways to be included in the project of the state. Desperation – for belonging in the project of the state and citizenship, for being modern, and for financial resources in the case of kidney donation – seems to be the core characteristic of operability. Furthermore, a female sterilisation operation, in Cohen's argument, is meant for and, at the same time defines, the poor body. The surgical procedure marks the poor body and subject with signs of belonging to the project and discourse of the state, and provides it with further options and possibilities which, implicitly, put further restraints on already desperate and marginal subjects. Cohen's ethnographic work does not directly focus on women's experiences of sterilisation, and his conceptualisation of operability remains an analytical exercise, at least in the context of tubal ligations. My ethnographic findings resonate with some aspects of Cohen's concept, but also critique it in some ways.

Whereas Cohen's concept of operability marks one's belonging to the political, social and economic margins and demonstrates one's vulnerability and desperation, the concept might also be used in a slightly different manner. Schriempf (2009) writes about the conditions within which articulateness determines and enables subjectness, and uses Cohen's concept when writing about her own suitability for a hearing aid. The author suggests that in the social world where speaking is considered the most valued form of articulation, she herself "(a)s a profoundly and congenitally deaf person for whom speech and articulateness did not come 'naturally' but arrived through the aid of technology, science, and perspiration, [was] highly aware of how articulateness enables [her] subjectness" (ibid.: 279). A specific characteristic of her body – a specific quality of her inner ear and an indicated kind of residual hearing – indicates that she could respond well to hearing aid amplification which could help her speak. According to her, this particular quality of her body makes her operable and her "social, moral, political, epistemic life hinges on having an operable body" (ibid.: 284). Her inner ear's qualities and the operability that follows give others access to rehabilitate her; also, "being operable means that I can be a subject in the fullest sense, that is, to be someone

with choices" (ibid.: 284). As set out in Schriempf's article, certain qualities of her body make her operable, and this operability provides her with a particular set of further options, such as the possibility to speak and, therefore, to participate in society in constituted, particularly normative ways. She acknowledges, then, that her deafness as disability is constituted socially rather than biologically (Staples, 2011; Thomas and Corker, 2002; Tremain, 2002). Whereas for Cohen operability refers to options which further extend one's marginality, Schriempf's interpretation of operability seems to refer to much more positive options, even while acknowledging the constraints of the world where verbal articulation bears more acknowledgement than other forms.

The concept of operability as defined by Cohen is not an ethnographically nuanced one, but it has been used ethnographically by other anthropologists. For instance, Towghi (2012) writes about the increasing prevalence and normalisation of hysterectomies, procedures to remove the uterus, amongst women in Balochistan, Pakistan. Hysterectomies, largely medically unnecessary procedures, are considered to be a normal treatment by the medical personnel "because people are 'poor' and live in 'remote' areas" (ibid.: 244). According to Towghi, Baloch women have their uteri medically removed precisely because they do not subject themselves to other biomedical interventions. Using Cohen's work, she conceptualises hysterectomies as an example of the "operability of in-operability". Medical practitioners' "vague concern about the structural conditions and constraints of the lives of women provides the social, and not the medical, rationale" (ibid.: 244) for the procedure. In other words, the failure of medicalisation in a context where "women prefer homebirths to hospital births, herbs instead of pharmaceutical drugs, and treat their infertility with nonbiomedical and biomedical means" (ibid.: 234) is precisely the reason for a surgical intervention to remove women's uteri.

This is rather different from my field site, which, even though considered to be remote and poor by both medical practitioners from urban settings and the rural residents alike, is an area where women's lives and bodies are medicalised to a comparatively higher degree. The practice of hysterectomies is very common amongst relatively older caste Hindu women, but not amongst *adivasi* women in Chandpur. However, the majority of women who had undergone hysterectomies previously also had sterilisation procedures, whether in government camps or in private hospitals. The prevalence of tubal ligation, the increasing numbers of institutional childbirths, the presence of overwhelming numbers of private medical practitioners and the reach of government's maternal and reproductive health services are exemplary of a high level of medicalisation, no matter the quality of these services.

Therefore, the prevalence of hysterectomies in my field site, contrary to Towghi's ethnographic findings, marks the increasing degree of accessibility of rural women's bodies to biomedical tools and interventions, and of their operability manifesting through a series of normalised intrusive medical procedures. In this regard, the operation as form does imply governmentality, disciplinary technologies, and the construction of women into docile subjects of biomedicine (Foucault, 1977), but not necessarily with the state as its source. Even though women do become subjects of the state and its family planning agenda by getting sterilised, the project of the state, or one's belonging or demands to it, does not figure in the conversations about the sterilisation procedure or hysterectomies. Rather, being operated upon once (tubal ligation) seems to mark the options, possibilities and limits for further engagement with one's body, illness and biomedicine. In other words, undergoing a sterilisation procedure opens up and limits the options and choices concerning the treatment of one's body. A hysterectomy procedure becomes a conceivable and valid option of treatment for gynaecological issues, from both women's and medical practitioners' perspectives, only if a woman had had a previous tubal ligation procedure.

In this chapter, I use the concept of operability and operable bodies as a tool to explore women's experiences of their bodies and the subsequent choices of treatment made for their bodies, in this case methods of contraception. I aim to understand how women's experiences of their bodies are related to their experiences of their social and economic conditions, as well as how choices concerning biomedical interventions act as ways to negotiate these social and economic statuses. How and to whom does a sterilisation procedure become a valid option, and what further options and limitations does this procedure present? Even though tubal ligation is mandated to poor and low-status women whenever possible by the agencies of the state and biomedicine (Cohen, 2004: 170), as illustrated in Chapter Two, my ethnographic explorations of women's engagement with biomedical interventions, especially tubal ligation, reveal the multiplicity of meanings and ways in which women in rural India negotiate social status. Therefore, I seek to ethnographically explore the idea that operability marks socially, economically and politically marginal bodies.

I argue that the concept of an operable body is useful in analysing what is happening where women's engagement with the sterilisation procedure, biomedicine and the state is concerned. Whereas the definition of, or a word for, a body that has the potential to be operated upon is not used in the field, there is a very clear idea of what type of person and body is suitable for an operation. In other words, there is a very clear idea of whom I should and should not have asked whether or not she had had an operation, and a pool of potential

suspects. Through the conversations I had with health providers in the field, ranging from local health workers such as ANMs and accredited social health activists (ASHA) to nurses and surgeons from Udaipur, it became clear that an operation was seen and understood as something that poor *adivasi* women went for. Every time I posed a question "did you have an operation yourself?" to a health worker, it did not make sense to her and was received as a joke. Let me go back to something Bindu said in Chapter Five in reference to why ANMs themselves did not get an operation, and found other ways to stop childbearing:

> "They are doctors, they know about different medicines which stop you from getting pregnant. We do not know anything about that, and that is why we ask to simply close it for good. They have access to the medicines all the time, and if something happens to us, where do we go looking for the medicines? If one gets pregnant, it does not fall that easily [referring to abortion]. For some women the abortion pill works, but for me it never does, no matter which or how many pills I take".

Bindu's narrative captures Cohen's statement and further elaborates on the idea that operation is an option only for certain women and bodies marked by poverty, tribal belonging and rurality, which in the narrative above is illustrated by lack of access to medical knowledge and alternative medical choices, such as pills. However, the relationship which suggests and defines one's operability in Bindu's narrative is not the one with the state, or at least not directly implicating the state. Rather, one's operability seems to be related to the relationship with biomedicine and concerns with class. As discussed in Chapter Three in reference to the biomedical landscape and economy in the village, the state is not seen as a privileged site where biomedicine is practiced. The villagers' refusal to use the Primary Health Centre for free biomedical treatments and resort to private biomedical practitioners with limited or no training shows that biomedical interventions are quite often seen as separate from the state. According to Bindu, one's access to medical knowledge and resources has more to do with one's education, rather than with one's participation in the project of the state.

My own experiences in the sterilisation camp can be given as another example illustrating a clear understanding, in this case amongst the medical practitioners, of who the tubal ligation is meant for. During the camp, it was usually Suraj who took the biggest pleasure in teasing me about everything. The joke that he used most often, actually in almost every sterilisation camp I attended, was that he could not wait for the day when I would be sitting on the chair on which women are pushed out of the Operating Room after the procedure. Another was that because there were not enough women coming for the procedure,

partially due to the failure of my imagined efforts in motivating women in Chandpur, I should make the sacrifice and get the procedure done myself, so that Jhadol *tehsil* could achieve a higher number of its sterilisation targets. The basis of this joke is the juxtaposition between the poor *adivasi* women who should get the operation, and me, as a white educated woman from abroad, indicating a much higher social status, getting it instead. In the discursive field within which this regular joke was made and laughed at, its humour was derived from how overwhelming the difference in social and economic conditions between us was, and how unimaginable such a swap in position would be.

This discursively constructed link between the sterilisation procedure, poverty and vulnerability, inherent in the very concept of operability and also discussed in everyday encounters in the sterilisation camp, does not, however, fully correspond with women's own experiences of the procedure. Contrary to Cohen's analysis, I demonstrate below that women who get the operation do have choices, however limited and constrained by social and structural conditions, and clearly demonstrate their agency in making them.

## Negotiating class through female sterilisation

The use of technologies always includes choices made on the basis of values, beliefs and unequal opportunities and the appropriation of some technologies over others is an interesting lens through which to look at ways in which people's ideas surrounding health and reproduction change over time. The use of technologies to achieve goals of healthy pregnancies and babies as well as limited family size that have reached Chandpur, or that the residents of Chandpur can access in cities like Udaipur or Idhar in Gujarat, are not that scarce: an ultrasound, C-section, sterilisation, hysterectomy, even infertility treatments, to name the most common ones. However, whereas an ultrasound is a rather common practice among better-off families in Chandpur, rarely does any *adivasi* woman ever use the service herself, even though the knowledge of a "TV that shows the baby inside" is common. The sterilisation procedure, on the other hand, has been commonly used among the villagers for a longer period of time and is used across families with more diverse socio-economic and cultural characteristics. Whereas nowadays women who come for an operation in the camp are mostly *adivasi* women, many other women – from both lower and upper caste backgrounds – also have undergone the procedure.

Women's relationship with biomedical technologies and interventions have been discussed widely in the anthropological literature (e.g. Ginsburg and Rapp, 1995; Greenhalgh,

1995; Martin, 1987, Unnithan-Kumar, 2004). Medical care becomes another arena for anthropologists to discuss and for people to mark and negotiate class, caste, gender and other subjectivities. Anthropologists discussed various ways in which gender, class, and race affected options of medical care and people's treatment in these spaces (e.g. Martin, 1987; Lazarus, 1994). One's socioeconomic status manifests itself and is constructed through one's relationship to medical interventions, especially through tubal ligation. Caste and class become relevant to the analysis of female sterilisation practices not only where structural inequalities of accessing healthcare (Drèze and Sen, 2002) or the fact that family planning programmes target poor rural *adivasi* women are concerned. Caste and class become important even more when practical considerations on the ground are discussed. For example, class relations and social status considerations are involved in the way women choose to access medical care. Women in the village choose a particular method of contraception, medical treatment, or method of childbirth depending on their class and caste affiliations, limitations and aspirations. In other words, their gendered bodies marked by class and caste are exposed to "appropriate" and desired medical interventions in different ways.

Investigating the different choices of contraceptive measures among women in India, Basu (2005) asks "(a)re the IUD, the pill and sterilization increasingly the poor woman's methods, while her rich, educated, urban counterpart prefers to trust withdrawal, rhythm and perhaps a combination of these in conjunction with the condom?" The author makes a clear link between the methods of contraception used and women's social status and access to options. However, in a village setting these choices are much more subtle and complex than can be grasped by a simplified juxtaposition between different choices made by and accessible to rural and urban women. From the first glance it seems that the health workers and socially and economically better-off women use contraceptive pills, condoms and IUDs to space or end childbearing, or proudly speak about their bodies "closing up" on their own without any medical intervention[110], and female sterilisation is seen as something meant for poor *adivasi* women. A deeper look shows that tubal ligation is performed on both poor and rich, as well as on *adivasi*, other lower-caste and upper-caste women. What is interesting is how the differences in the way the tubal ligation is performed features in women's narratives.

My conversations with women in the field reveal the ways in which the female sterilisation procedure can be carried out becomes an arena to negotiate, maintain and perform

[110] For the ways upper-caste middle-class women in Bengal "cooled down" their bodies and controlled their fertility by refraining from sex with their husbands through vegetarianism, see Donner (2008).

one's social status by women in ambiguous socio-economic conditions. I want to discuss extracts from conversations with two of my informants. I describe two women in this section – Sunita and Bindu – as being in ambiguous socio-economic circumstances because of the effects of the intersection of class and caste in their particular life situations. Sunita is a higher-caste woman but struggles with economic and financial security, whereas Bindu is a lower-caste woman with increasing economic stability and relative wealth. These ambiguities provide them with wider possibilities to negotiate their fluid and uncertain social status.

## *Sunita*

Sunita is a Brahmin woman in her mid-thirties and a mother of three – two teenage sons and a five-year-old daughter. Her husband is employed by a small restaurant in Chandpur to make *samosas* and *kachoris*. Sunita's husband is from Udaipur, but they returned to Sunita's paternal village, Chandpur, a couple of years ago because life in Udaipur was too expensive and economically harsh. With no property of their own, Sunita and her husband rent an unfinished and run-down *pakka* house next to the beer and meat shop in one of the notorious *galis* of the village. Besides being polluting, alcohol and meat shops also gather crowds of men at the late times of the night and, therefore, their neighbourhoods are not considered as respectable places to live for the upper-caste Hindus. The location of Sunita's house also marks her lower economic status. Without the land of their own, Sunita works on a small patch of rented land and cultivates wheat and maize, which barely sustains the household through the year. She also earns some cash for making *puris* (thin deep-fried bread) during the wedding season and other occasions. She got sterilised soon after her daughter was born. After a long conversation about her understanding of a small family, her struggles with a husband who drinks, her experience in the hospital during the sterilisation procedure, her efforts to help her body heal quicker through food and avoiding heavy work, I asked her about her decision to get the tubal ligation procedure in a private hospital in Udaipur instead of the camp in Jhadol. Sunita articulated her discomfort with the camp in these words:

> "In the camp, they do not do the operation well. There are too many people there, we want to go separately. If you go separately, you get good facilities, it is better that way. In the camp, they do the operation very quickly [*phataaphat*], it fails sometimes and that is why we do not go there. *Adivasis* work in the fields, cut grass, they go to the hills and jungles, and then they come to the camps. I do not know where the *adivasis* come from, how they are,

> that is why we do not go to the camps. We go to clean places, to big hospitals and we listen to doctors' instructions about food and work".

Sunita's narrative is based on two sets of juxtapositions: between the government camp and a private hospital, and between *adivasis* and caste Hindus. The government camp, just like other government services and facilities, is imagined to be a place that lacks quality care, whereas the private sector, like the private hospital *HariOm* that was discussed in Chapter Six, is seen as a place where facilities are much better if one can afford them. This is a rather common understanding in the context of North India. What is interesting for me here is something much more complex than that. The second juxtaposition adds a different layer to the public-private opposition. The camp is seen as a place where *adivasi* women go, and, therefore, some women of upper-caste or upper-class upbringing choose not to go there precisely for that reason. What is interesting here is that tubal ligation itself – even though it is promoted by the government, which is seen as an agent failing to provide proper care and to be avoided at least in matters of healthcare – is not necessarily seen as a method just for poor *adivasi* women. The procedure does not necessarily carry the potential to mark social status and identities. Rather, the site where the procedure is performed, instead of the method of contraception, becomes a way to mark one's social status. Sunita did not go to the camp to get her tubes tied because she, as an upper-caste woman, did not want to mingle with *adivasi* women in a crowded government hospital. In this narrative, the choice between the private and the public facility for the sterilisation procedure becomes a way for the upper-caste woman to distinguish herself from the imagined crowd of lower-caste women occupying the government hospital spaces. Donner (2004) writes that the relationship between the middle-classes in India and private healthcare sector is ambiguous – the use of reputed private institutions carries social status implications while the profit orientation provokes contempt. However, for the aspirational middle-class women I worked with in Chandpur, private healthcare institutions do not provoke such ambiguity and mostly remain sites carrying social status.

## *Bindu*

The site where the procedure is performed is not the only way in which some of my informants mark their social status. One of my neighbours, Bindu, lives on the outskirts of Chandpur. Bindu's family belongs to a *Meghwal* caste, the only and quite populous caste of *dalits* (untouchables) living in the village. Bindu's family is one of the very few *Meghwals*

who have a *pakka* house and is generally better-off: Bindu's husband runs a small painting business in Jhadol and Bindu herself has recently started selling vegetables in the Chandpur *bazaar*. She had the operation after delivering three children, about eight years ago. She invited me into her bedroom and seated me on a single *khat*. By that time, I had been promising to take a formal interview from her for some time, and she was quite excited to have me there. She made us cups of tea, sat in front of me and happily told me a story of her childbearing and efforts to end it:

> "I have three children – the oldest daughter and two younger sons. When my smallest child was five years old, I got an operation. First I took some medicine that others told me would close my uterus but that did not happen, so I got pregnant again, but we did not need another child so I got an abortion in Udaipur. Three are enough, it is difficult enough to take care of them; who wants to run after another young one?"

Instead of a more common laparoscopic tubal ligation, or *doorbeenwalla operation*, Bindu underwent a tubectomy, or a big (*bara*) operation, in a private hospital in Udaipur and here she explains why:

> "I did not go to the camp; I told the nurse I want to go straight to the hospital in Udaipur. The camps are crowded, mostly *adivasi* women go there. Nobody else goes there; nobody from the *bazaar* would go. It is for *adivasi* women. You go there so you know that out of a hundred there will be four-five other people, but the rest will be tribal".

Bindu's account shows that her choice – not simply of contraception or a private hospital instead of the camp, but of a method of tubal ligation – was informed by the concerns related to class and status. There are a few things that are important to note from her narrative here. Firstly, a decision about where to get an operation for Bindu was a way to assert who she was and who she was not. She did not get the operation in the government sterilisation camp to show that she was not an *adivasi*. This is particularly interesting, bearing in mind that Bindu is a lower-caste woman and that the disagreement of who is lower in the caste hierarchy –

*dalits* or *adivasis* – is in a process of constant negotiation in an everyday life in Chandpur.[111] Secondly, just like in Sunita's narrative above, the biomedical facility – a government sterilisation camp or a private hospital in Udaipur – is a site in which one experiences oneself as a particular type of person. It was not simply that Bindu tried to avoid places where *adivasis* went; for instance, non-*adivasis* use buses to go to Udaipur in spite of the fact that buses are crowded and most passengers are *adivasis*. There is something about the hospital and the camp that enables people to assert and experience themselves as one or another type of person, and the hospital becomes a site for the construction and negotiation of subjectivities. And thirdly, such an assertion requires symbolic resources – both Sunita and Bindu felt that they had the power to ask the nurse not to take them to the camp, which might have been the nurse's first choice. Many *adivasi* women expressed their full surrender to the ANM's decision to go to a particular medical facility for an operation, according to the nurse's choice and not theirs. Bindu's narrative clearly demonstrates that the way the sterilisation procedure is performed – whether in a government camp or in a private hospital, and whether laparoscopically or as an open surgery – becomes one of the ways she negotiates her class and caste status, and reproduces the idea that the government facilities are for poor and illiterate *adivasi* women.

Socially or economically better-off women who refused to go to the camps for the procedure provided an array of different reasons for such a choice, most often not directly articulated as an issue of caste or class. For instance, some said it is because the camps were staffed with medical personnel who were students, learning the procedures, instead of experienced doctors in private hospitals. Others said that they refused using government services altogether and chose private clinics and hospitals for everything from the common ailments, to childbirth and tubal ligation, because government hospitals were places where nobody cared, whereas doctors and nurses properly looked after their patients in private

[111] A considerable amount of anthropological literature on identity politics and affirmative action tends to conflate *dalits* and *adivasis* into the same category of SC/ST or the "subaltern" (e.g. Kapoor, 2011; Shah and Shneiderman, 2013). Shah and Shneiderman (2013: 5) argue that these groups experienced oppression and marginalisation "at the hands of the upper castes": *dalits* on the purity-pollution scale, and *adivasis* for being 'wild' and "backward". However, Srinivas (1987: 10) suggests that "the dominant castes are not the only practitioners of inequality" and that it occurs, sometimes even more prominently, amongst various lower castes towards each other. In Chandpur, *dalits* and *adivasis* perpetuated the same notions towards each other: Meghwals refused water and food from *adivasi* households, and *adivasis* refused water from Meghwals. This process is a complex one of negotiating caste hierarchies within the "subaltern". Many Meghwals from poor households spoke openly about their poverty and struggles to feed their children. They saw themselves as poor, but never as "backward", an adjective reserved to *adivasis*. *Adivasis*, on the other hand, saw themselves as culturally distinct and somewhat "wild", but not untouchable.

hospitals due to the money transactions involved. Here, a very clear juxtaposition between public and private healthcare facilities is evident.

In some way, Sunita and Bindu's stories and the reasons provided resonate with Roberts' (2012) work on the increasing prevalence of C-sections in private clinics among the middle-class and, increasingly, working-class women in Ecuador. Roberts investigates the intersection of political, race and corporeal class relations and discusses the ways in which medical intervention becomes a tool to mark women's bodies and selves as whiter and socioeconomically better-off. She argues that "(s)cars and the bodies that carry them enact a racialized relationship to the nation. Browner bodies can withstand vaginal birth within the disciplines of public maternity care" (ibid.: 215). She further continues:

> "This surgical cut [C-section] indexed a woman's sociomaterial attempt to gather enough resources to seek and receive care in a private clinic, thus avoiding public medical facilities. The scar was a result of her ability to cultivate a corporeal state of worthiness within private care, precisely because she did not take resources from state institutions. This worthiness constituted corporeal class relations in Ecuador, inseparable from political and race relations. The scars received by these women, at least in the early 2000s, made them whiter" (ibid.: 216).

Just like in Roberts' (2012) account of Ecuadorian women, both Bindu and Sunita avoided public medical facilities and, in Bindu's case, chose a more complicated procedure in a private hospital to assert their aspirational social status, aspirational middle class in Bindu's case and an upper-caste position in Sunita's. Neither of them is privileged in both class and caste terms, however, and both of them try to assert and emphasise one privileged axis of their social situation through the same means – using private healthcare facilities in nearby Udaipur – and through the same boundary work – the juxtaposition of themselves as socially and culturally different from *adivasis*. *Adivasis*, here, stand as a descriptive category that also stands for poor and illiterate, or, in Pinto's (2008: 261) words, "(i)t refers to ways of being that encompass habits and praxes bearing the stain of caste but extending to class and beyond". It is clear, then, that reproductive practices such as the conditions in which women give birth and stop childbearing allow them to mark social differences and make identity claims. If we define agency as a "socioculturally mediated capacity to act" (Ahearn, 2001: 112), or simply acting in ways that can produce effects, then both Sunita and Bindu clearly demonstrated their agency by choosing not to go to the camp and, therefore, asserted their respective aspirational social status. Both women's decisions to subject their bodies to

particular, status-generating spaces, technologies and activities arose from a particular combination of social, cultural and political conditions affecting their lives (e.g. Desjarlais, 1997), within a particular set of power dynamics and deeply embedded relations of inequality. They enact agency through their bodies and these bodies are the bearers of their respective aspirational social status.

For women from ambiguous social situations, like Sunita and Bindu, their operability and their bodily integrity are not at stake when the concerns with female sterilisation are discussed. Rather, it is the conditions within which these biomedical interventions are undertaken that carry the potential to perform and negotiate social hierarchies and subjectivities. Even though there is no denying that women's bodies and health become sites of overt and covert discipline, control and struggle (Rapp and Ginsburg, 1991), the same women are able to shift the symbolic meanings of that control to their own ends. Both Sunita and Bindu are "engaged in the exercise of power in the sense of the ability to bring about effects and to (re)constitute the world" (Karp, 1986: 137 cited in Ahearn, 2001: 113), no matter how local these effects are. Even when the family planning programme with its slogans, motivators and camps impose overarching moral frameworks on the local moral worlds, the women of Chandpur use the female sterilisation procedure to express their own visions and aspirations of class, caste, and morality.

## Conclusion

It is hardly surprising that the negotiation of social status is at the centre of everyday interactions in a hierarchically complex site like mixed-caste Chandpur (and it most certainly reflects similarities with rural and urban places across North India). Various intersections between gender, class, caste and age, together with other social markers which become relevant in particular contexts and situations, construct overlapping and competing local moral worlds. Women and men embody, perform and negotiate social status, and these markers constitute a significant part of what matters, or what is at stake, in local moral worlds. Engagements with biomedical technologies provide yet another arena where what matters is not simply an outcome of an experience of good health and quality care received, but also how biomedical technology, the type of procedure, or the biomedical site produce and constitute social status. The female sterilisation procedure becomes yet another one of these sites, where Chandpur women's considerations about caste and class materialise in very particular and unexpected ways.

Some media discourses on the female sterilisation procedure in India portray the procedure as a brutal attack on poor Indian women by the powerful state. One particular image that followed an article on women's deaths in a sterilisation camp in Chhattisgarh reduces Indian women to their bodies, which carry signs of poverty, exoticism and the marks of having been violated by the government-organised politico-medical intervention of tubal ligation. Being operated on is portrayed as being a passive victim and part of a homogenous category of "the poor". Cohen's concept of operability does not fully challenge this portrayal of homogenous "bare life". However, his argument that the poor may choose to become "bare life", rather than being simply subjected to it against their will, in order to seek recognition from and participation in the project of the state, challenges some of the assumptions inherent in critiques of population control discourses. The conversations I had with women in Chandpur reveal that operability does not necessarily mark women with the signs of vulnerability and desperation that are inherent in the very concept of operability itself. For some women, operability also provides opportunities and possibilities to negotiate their socially ambiguous positions, which are seen as sources of this vulnerability and desperation. In conversation with Cohen, I argue that when it comes to female sterilisation, some women choose to become "bare life" in very particular circumstances – in a private hospital like *HariOm* (instead of a government camp) or through a tubectomy (instead of a laparoscopic surgery) – in order to claim recognition. However, women do not demand recognition from or participation in the project of the state, but rather, demand recognition from other women (and men) within their local moral worlds. In other words, if and when women can control conditions under which to become "bare life", they deliberatively do it in particular ways in order to produce social effects. From the women's perspective, the female sterilisation procedure partially transforms their bodies into a different state, as has been argued in Chapter Five. However, the transformation is economic (the promise of upward social mobility and less financial stress on the household), physical (bringing relief to women's wearing bodies) and social (negotiating caste and class status), rather than political (making claims to the state).

In this chapter, I have demonstrated how considerations about social status, caste and class enter women's decisions to have the sterilisation procedure. Reproductive decisions are classed not only in the sense that women's access to particular medical spaces and procedures is constrained by their socio-economic background, but also that poor women choose from the available options with very particular considerations in mind. All in all, the way women negotiate their ambiguous social positions – privileged in terms of caste but marginalised in

terms of class, or vice versa – unravel some of the tensions and contradictions that are inherent in women's efforts to negotiate and redefine their engagements with biomedicine, neoliberalism and the state.

# Chapter Eight

# Conclusion

My primary concern in this thesis has been to give an ethnographic account of women's experiences of the female sterilisation procedure in order, in turn, to investigate the intricate relationship between poor women, the state and biomedicine in rural North India. The specific questions of the thesis were shaped by the increasing presence of projects of governmentality (see the discussion of a Foucauldian concept of governmentality in the Introduction) in rural North India and people's efforts pragmatically to navigate structures and networks of power, within which these projects operate. The female sterilisation procedure encapsulates not only people's engagements and negotiations with the power, practices and discourses of the state, but also with other forms of authority, such as biomedicine, and intersecting structures of gender, caste and class.

The thesis approached the main research theme – the relationship between the state, biomedicine and poor women in rural North India – by examining various relationships and power struggles within these domains as much as between them. An ethnographic investigation of the state, biomedicine and poor women as categories which are not homogenous but rather are constituted through multiple internal and external contestations allowed a deeper and more complex understanding of how increasing medicalisation of women's lives in rural North India is experienced in various different ways. Furthermore, acknowledging the multiplicity of agendas, discourses and experiences within the categories of "the state", "biomedicine" and "poor women" provided an insight into how power is contested and articulated on multiple levels and by multiple actors, resulting in theoretical contributions to the existing theories of power, governmentality and biopolitics.

The structure of the thesis reflects an effort to move from wider historical and political processes to local concerns, constantly highlighting the connections between these different levels. Chapter Two outlined the historical shifts in the programmes concerned with family planning in India, and Chapter Three set out an ethnographic account of how the state articulated itself in Chandpur, specifically focusing on the Primary Health Centre (PHC) as a site where the state is experienced directly. Chapter Four discussed a network of local embodiments of the state and family planning discourse, the motivators for female sterilisation. Chapter Five discussed women's own concerns relating to various reproductive

occasions which set out a social, economic and cultural context within which a decision to undergo the female sterilisation procedure was undertaken. Chapter Six provided an ethnographic account of the sterilisation camp, where women encountered the world of the state and biomedicine before undergoing the tubal ligation procedure. Finally, Chapter Seven investigated women's efforts to negotiate their social status through undergoing the female sterilisation procedure in very particular conditions. In the pages that follow, before closing, I wish to summarise further the main arguments I have made throughout the thesis and to draw out larger theoretical themes and implications that were raised throughout the chapters.

## The role of the state

The intricate history of family planning in India – with the exception of the Emergency in the mid-1970s – demonstrates that women continue to be conceptualised as primarily responsible for contraception. The population control discourse, as discussed in Chapter Two, conceives contraception not in terms of women's autonomy, freedom and agency, but as part of an official family planning programme with the primary goal of facilitating economic development. However, in the eyes of my informants, this history is still dominated by the memories of the Emergency in the 1970s, its coercive vasectomies and the link between vasectomies and various social and economic benefits. Such a disjuncture between two interpretations of history forms a context within which female sterilisation today is seen by the people in Chandpur as representing choice and efforts in securing one's economic stability, and is contrasted with the coercive measures employed in a rather unique historical attempt to subject men to bear the burden of contraception.

Family planning discourses permeate the everyday lives of my informants in various forms. I ethnographically illustrated Partha Chatterjee's (2012: 318) argument that "India has never been more governed than it is today", and dealt with another question arising from the literature on Foucauldian concepts of governmentality and biopolitics. Does the increasing presence of various governmentality regimes in rural North India mean that "the state" holds an ultimate power and authority? My ethnographic explorations in Chapters Three and Four demonstrated that the state and its local embodiments, the motivators, were not seen by my informants as having much power in matters related to female sterilisation. Instead, women and men in Chandpur employed a variety of techniques to get rid of health workers, to appropriate the idiom of "a small family is a happy family" to their own understandings and

needs, and to negotiate conditions under which one underwent the female sterilisation procedure or refused it. "The state" articulated itself through a variety of competing and contradicting practices, narratives and agents that extended way beyond the official institutions of the state, such as the Primary Health Centre or the sterilisation camp. The agents of the state, in this case the health workers who motivated women for the procedure, also challenged official family planning discourses and a small family norm in their own reproductive lives and in conversations with women in their work areas. "The state" that emerged in Chandpur, then, was an ambiguous assemblage of institutions, discourses, agents and narratives which attempted to constitute themselves as a coherent entity, but constantly failed through being negated by its own employees and the people it was supposed to serve. Even though the narratives and agents of the state constantly and unavoidably entered women's narratives of their reproductive histories, none of the women saw themselves as having undertaken the sterilisation procedure because they were pressured by the power of "the state" in its various forms. Rather, women utilised the gaps in state power that became evident through the disjunctures between official policies and their operation by local agents on the ground to engage with what was made available to their own ends.

The institutional figure of a motivator – who has family planning targets to achieve and whose livelihoods depend on the achievement of these targets – has been an integral part of the Indian government's efforts in family planning for a few decades, and might sound like a clear embodiment of coercion. However, realities on the ground reveal that motivators are much more complex figures, and that their relationships with poor women in their work areas, other motivators, as well as doctors and nurses in the camp, contain various overlapping and contradicting power struggles. The motivators are seen by women in the village as both those who embody power through education, a government job and access to the government's resources (the ability to get things done and social connections), and, at the same time, as those whose opinions in matters of reproductive and maternal health carry weight only when it is in line with the particular family's views. The class and caste distance between the motivators and the poor women and men in the village translates into a contradictory relationship of power. When it came to the practice of female sterilisation, the motivators, especially ANMs, were listened to by those who wanted the procedure because ANMs were educated, seemingly trustworthy and had access to biomedical sites, knowledge and experience. At the same time, they were ignored, distrusted and mocked by those women and families who did not want the procedure.

I demonstrated that the institution of a sterilisation camp, where mostly *adivasi* women underwent the tubal ligation procedure, was a politico-medical site rather than a purely clinical one. Bureaucrats from the Chief Medical and Health Office (CMHO), Marie Stopes India's team of doctors and nurses, as well as motivators, negotiated each other's intentions and methods of examination. These different actors competed for patients' trust and demanded to know "the truth", using various tools available to them. The bureaucrats made women intelligible through simplifying their lives into numbers and categories that could circulate as statistical data. Doctors and nurses employed various biomedical techniques – blood and urine tests, taking of health history, vaginal exams and questions about sexual and reproductive choices – to determine whether women were *healthy enough* to undergo the procedure. Motivators constantly intervened in doctor-patient interactions in order "to clarify" patients' supposedly unintelligible language and narratives, and were, more often than not, distrusted by doctors. The doctors carried out most of their examinations in the name of women's health and wellbeing. Simultaneously, the MSI doctors and nurses, motivators and the CMHO staff constituted and reproduced women who came for the procedure as poor and "backward" and, therefore, needing the surgery. In such a way, the concern with women's health and wellbeing legitimised the Indian government's overt and covert efforts in primarily targeting poor women for the family planning agenda.

## Reproductive agency

Nguyen and Peschard (2003) in an article reviewing anthropological approaches to the relationship between inequality and poor health discuss an interesting contradiction. The common-sense understanding that conditions of persistent poverty and inequality produce social distress and a feeling of emergency are rebutted by ethnographic accounts which document that "these situations are remarkable for the apparent normalcy that reigns" (ibid.: 463). This contradiction captures one very significant aspect of my ethnographic work, one that has been troubling me since embarking on fieldwork. This is that in the history of family planning in India, the persistent targeting of vulnerable sections of society for the acceptance of contraception and insistence on the use of permanent methods of birth control points to female sterilisation as a politico-medical intervention that at the very least borders on coercion. However, according to most of my informants, the persistent poverty of rural Southern Rajasthan, as well as the structural violence of caste and class and patriarchal gender

relations constitute the world within which having one's tubes tied is a sensible decision. The women in Chandpur, *adivasi* as well as caste Hindus, laughed at my regular question of whether anyone or anything was forcing them to undergo the female sterilisation procedure. They acknowledged the social and economic constraints in their lives, reflected on and mocked existing gender relations, but, at the same time, always saw themselves as acting in the most pragmatic way possible. Women saw themselves neither as the victims of the state's family planning agenda nor as the victims of their husbands. Getting sterilised, for most of my informants, was a demonstration of their pragmatically oriented agency and of their ability successfully to navigate various economic, social and cultural constraints that women faced in their daily lives.

Investigating the practice of female sterilisation allowed me to untangle the multi-layered and multi-faceted relationships of power that constitute how people make sense of the procedure. India's official family planning policy, its historical forms and accompanying narratives, as well as its implementation through a network of local health workers within the context of target-setting and incentives, is only the most visible form of power. My ethnographic explorations demonstrated much more nuanced frameworks within which concerns about the female sterilisation procedure are negotiated and constituted through invoking idioms and relationships of power. The conceptualisation of the laparoscopic tubal ligation as *doorbeenwalla* or *karantwalla* operation points to how power is seen by my informants as inherent in the very practice of biomedicine. The power of the *doorbeen* to see and act within one's body, the almost magical powers of the surgeon holding the *doorbeen*, as well as more subtle forms of hierarchies between those who have access to the world and sites of biomedicine, and those who do not, add additional layers of complexity.

Women who do undergo tubal ligation negotiate gender relations and domestic responsibilities with their husbands and kin; they also engage in everyday interactions with auxiliary nurse midwives (ANM), the most active motivators for female sterilisation, in trying to negotiate the best conditions under which to undergo the procedure. When *adivasi* women went to the sterilisation camp, they subjected their bodies and intimate selves to be investigated by both bureaucratic and biomedical techniques, but also challenged doctors' diagnoses that did not suit their own narratives. Other women, who refused to undergo the procedure in the sterilisation camp and deliberately chose private hospitals and/or an open surgery instead of a laparoscopic one, negotiated their social status and power in relation to other women in the village. The specificity of an ethnography in a mixed-caste village was a necessity to acknowledge that women from different socio-economic backgrounds had

different means at their disposal to negotiate the conditions of ending childbearing. However, throughout this thesis I demonstrated that all women contested the narratives and patronising suggestions from health workers, doctors and bureaucrats when these discourses contradicted what women themselves wanted.

## Operable bodies

Cohen's (2004, 2005) concept of operability has been extremely significant in understanding the female sterilisation procedure in this thesis. In Chapter Seven, I suggested that instead of discussing operability and operable bodies as inherently vulnerable and somewhat homogenous, it was much more theoretically fruitful to see how the intersection of gender, caste and class influenced how women subjected themselves to different operability options. Some women refused to be marked by the female sterilisation procedure in any homogenous way. For them operability provided opportunities and possibilities to negotiate their socially ambiguous positions.

For those women who had some control over the conditions within which to become operable – such as a choice of a biomedical facility or even of a procedure – these particular choices reflected women's efforts to negotiate the way caste and class was inscribed on their bodies. Instead of marking women's bodies with signs of poverty and vulnerability, the female sterilisation procedure provided some women opportunities to demarcate their aspirational social status. In other words, if and when women had control over conditions under which to become "bare life" (Agamben, 1998), they did it in very particular ways in order to produce social effects. Such conceptualisation of female sterilisation challenges some of the prevailing discourses on tubal ligation as a necessarily brutal and inhumane practice which is prevalent in India only because the powerful state coerces poor women to undergo it.

Throughout the thesis, it has become clear that some women's submission to the programmes of biopolitical governmentality, such as family planning, does not necessarily mean their acknowledgement of or surrender to the power of "the state". Rather, their articulated biological vulnerability, referring to the cycles of births, abortions and childrearing, is the ground for seeking what the state provides – a permanent method of contraception. Female sterilisation was seen as a way to care for one's ever weakening body. Every conversation I had with the women who had the operation or were thinking about

having it, was about women's pragmatic efforts to navigate through a variety of everyday life demands.

## Theoretical implications

As is evident from the above discussion, the contributions that this thesis makes revolve around deepening current anthropological understandings of the concept of power, politicising reproductive agency and South Asian personhood, and blurring the sub-disciplinary line between the anthropology of the state and medical anthropology.

The ethnographic accounts narrated throughout the chapters challenge the Foucauldian notions of power, governmentality and biopolitics in multiple ways. The thesis highlights how these concepts are inherently ambiguous and are regularly employed by various actors – by government officers as much as by poor women themselves – in order to achieve pragmatic outcomes. Pragmatism in everyday life itself, rather than efforts to gain, maintain and articulate power, is what drives most people to act in contradictory and conflicting ways. Therefore, subjecting one's body to the intervention of the state does not result in the recognition of the state's power.

When it comes to projects of governmentality, their effects and use in people's everyday lives, I argued that they are not simply characterised by violence enacted through the politics of care. Institutional forms, discourses and personal interactions between health workers and poor women in the context of female sterilisation can be characterised by the intricately linked and simultaneously enacted care and structural violence – a seemingly contradictory presence which characterised the institutions of the state, as well as those of biomedicine. Here, I am reworking Gupta's (2012: 24) argument that social welfare programmes in India demonstrate how "violence [is] enacted at the very scene of care". Throughout the thesis I argued that the practice of female sterilisation and particularly the institution of a sterilisation camp shows how it represents not simply violence that is enacted at the scene of care, but also the care that is enacted at the scene of (structural) violence. Projects of governmentality, then, are not simply legitimised through concerns with health and wellbeing of the population, but are, simultaneously and ambiguously, sites where care is enacted in ways that do not necessarily serve a political purpose.

I deconstructed categories of biomedicine (construction of biomedical authority, ways of knowing and seeing, competition amongst biomedical personnel) and the state (its local

embodiments, family planning discourses, and institutions and schemes through which the state is known by "the poor" in rural India). I demonstrated that both categories are multiply-constituted through constant contestations of power relations, social status and competition for recognition within and beyond these categories. Therefore, it becomes increasingly difficult to see where "the state" and "biomedicine" begin and where their contours and power end. In this way the thesis blurs the line between the anthropology of the state and medical anthropology by providing an ethnography of a politico-medical site – a sterilisation camp – which cannot easily be interpreted as either a biomedical or a political site. A recent interest in hospital ethnographies amongst medical anthropologists makes this thesis particularly relevant in challenging the understanding of the hospital as either a part of the wider society or as completely isolated from it. It becomes increasingly clear that it is not possible to understand biomedicine as separate from the state and the state as separate from biomedicine.

This thesis has also been an investigation of a particular new kind of governance in the area of reproductive health. Marie Stopes India (MSI) – a private not-for-profit contracted to carry out the function of the state and to organise sterilisation camps – is a perfect example of neoliberal governmentality. Exploring how it is implemented, articulated and thought about is a way to investigate the changing nature of the state and its efforts in governing its rural population in new ways.

Finally, by deconstructing the category of poor women – who contest each other's social status, negotiate the prominence of caste and class, distinguish each other on the basis of reproductive choices – I problematised the concept of reproductive agency. In a way, I attempted to problematise it by politicising the notion of South Asian personhood, where women's bodies are not simply part of other bodies and processes, but are also controlled by those other bodies. However, women's own narratives challenged discourses of victimhood and women emerged as active agents acting pragmatically in structurally restricting conditions.

In closing, this thesis has attempted to examine the lives of politically, socially and economically marginalised women and men in neoliberal postcolonial India through the lens of female sterilisation. The stories that unfolded in the preceding chapters have challenged wider assumptions about gender and the body, about the state and about social identities in rural North India.

# Appendix A

# A glossary of Hindi terms and phrases

| ***Hindi*** | **English** |
|---|---|
| *Aapko kya lena-dena* | A common idiom meaning "how is this your business", and directly translated as "What is there for you to take and give?" |
| *Adivasi* | A widely used term for a member of one of India's indigenous groups, officially classified as Scheduled Tribes by the Indian Constitution |
| *Anganwadi* | a pre-school centre started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition |
| *Bahinji* | Sister |
| *Bara ghar* | Big house, which refers to the house of *adivasi* village's chief or village community house. |
| *Bazaar* | Market |
| *Bidi* | A thin, Indian cigarette filled with tobacco flake and wrapped in a leaf, tied with a string at one end. It burns quicker than a regular cigarette. |
| *Bigar jaana* | To deteriorate |
| *Chai* | A sweet milky tea made by brewing black tea with water, milk, sugar, ginger and other spices. |
| *Chaiwalla* | A person selling and serving *chai*. |
| *Chakkar* | Dizziness |
| *Chhota parivar, sukhi parivar* | A family planning slogan meaning "A small family is a happy family" |
| *Choli* | A traditional short blouse worn with ghagra and odhni in North India |
| *Chutti* | Break, holiday, vacation |
| *Copper-T* | A small intrauterine device |
| *Daal baati* | A dish comprising lentils and hard wheat rolls. |
| *Dahi* | Yogurt or curd |
| *Daima* | A midwife |
| *Daaruliya* | Alcoholic |

| | |
|---|---|
| *Dharma* | A key concept in Hinduism, referring to one's obligations, duties, rights, virtues |
| *Dhyaan dena, dhyaan rakhna* | To care, to look after |
| *Doorbeen* | Binoculars or telescope, and refers to the laparoscope, an instrument with which laparoscopic surgeries, including female sterilisations but not limited to them, are performed. |
| *Doorbeenwalla operation* | Literally operation with a telescope, refers to a laparoscopic procedure |
| *Dukandaar* | Shopkeeper |
| *Gali* | Street, lane |
| *Garib log* | Poor people |
| *Garibi hatao* | A slogan meaning "Remove poverty", used during the Emergency as part of pursuing an agenda of economic development |
| *Ghagra* | A traditional skirt worn in North India |
| *Ghee* | Clarified butter |
| *Gud* | Unrefined sugarcane sugar |
| *Ghunghat* | A veil pulled over a head or face with a loose end of a sari or odhni |
| *Haldi* | Turmeric |
| *Ham do, hamare do* | A family planning slogan meaning "We are two, ours also two", associated with Sanjay Gandhi |
| *Hathwalla operation* | Literally operation with hands, refers to a tubectomy |
| *Iccha (se)* | By choice, by will |
| *Jabardasti* | Forcefully, against one's will |
| *Janani Suraksha Yojana* | A Safe Motherhood Initiative |
| *Jugaad* | A polysemic word that refers to making arrangements in the broadest sense of the word, solving problems in a context of scarce resources, recombination and the ability to combine forces to make a specific goal attainable. |
| *Jungli* | Wild |
| *Kacca* | Raw, uncooked, unpaved, made of clay (in the context of housing), |
| *Kachori* | A spicy deep fried snack, made of flour filled with lentils, gram flour and spices. |
| *Kamzori* | Weakness |
| *Karantwalla operation* | Literally operation with electricity, refers to a laparoscopic female sterilisation procedure |
| *Katheen* | Difficult |

| | |
|---|---|
| *Khat* | A woven bed consisting of wooden frame and a set of knotted ropes, widely used in rural India |
| *Lakh* | A unit in the Indian numbering system equal to one hundred thousand |
| *Lightwalla operation* | Literally operation with electricity, refers to a laparoscopic female sterilisation procedure |
| *Mahua* | A tree whose flowers are used to make local alcohol |
| *Mala-D* | Oral contraceptive pill, promoted by the Indian government and distributed through social marketing organisations at a minimal price |
| *Mala-N* | Oral contraceptive pill, promoted by the Indian government and distributed free in government hospitals and through the health workers |
| *Mandir* | Temple |
| *Matka* | A clay pot used to store and cool water |
| *Maya* | A key concept in Hinduism which refers to the person's attachments to the everyday life and to the world around, and stands in contrast to the spiritual world. |
| *Mazdoor* | Labourer |
| *MC* | Menstruation |
| *MCwalli pill* | Literal translation is menstruation pill. It refers to the medication which induces medical abortion. |
| *Mukhiya* | An *adivasi* village chief |
| *Nai* | A caste in North India conducting the work of hair cutting, conducting deliveries, bloodletting and bone-setting. |
| *Nas* | Vein |
| *Nasbandi* | Vasectomy |
| *Nasbandi ka vakt* | A time of vasectomies, referring to the period of Emergency |
| *Nasha* | A direct translation is intoxication; in daily use it refers to the use of alcohol, nicotine, opiates, and in a clinical context it refers to the effects of anaesthesia |
| *Naukri* | A job, usually refers to a government employment |
| *Nirodh* | A condom |
| *Odhni* | A part of women's dress and is generally a long piece of cloth worn together with a skirt and a blouse. |
| *Pakka* | Certain, cooked, paved, made of bricks (in the context of housing) |
| *Panchayat* | A local self-governance body |
| *Patwari* | A land record officer at *tehsil* level |
| *Phaida* | Gain, advantage |
| *Pregit karna* | To motivate |

| | |
|---|---|
| *Ram Ram* | A Hindu greeting, widely used in rural India |
| *Ras* | Juice, also refers to sperm |
| *Roti* | Flat bread |
| *Saaf-safaai* | Cleanliness, usually of the house |
| *Safaai* | Literally cleansing, refers to abortion or the cleansing of the womb |
| *Samaaj* | Literally translated as community, but in the context of rural North India refers to a caste community |
| *Samajhdaar* | Sensible, sober-minded |
| *Sanstha* | Organisation, institution |
| *Sari* | Women's garment, consisting of a drape wrapped around the waist with one end draped over the shoulder. |
| *Sarkar* | Government |
| *Sarpanch* | An elected head of panchayat and a focal point of contact between government officers and the village community. |
| *Seva* | Service |
| *Shakti* | Female power |
| *Sharir* | Body |
| *Shivir* | A camp |
| *Sui* | Injection |
| *Taankewalla operation* | Literally operation with stitches, refers to a tubectomy |
| *Tehsil* | An administrative division in India, subdistrict |
| *Zor se* | Strongly, loudly |

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