Introduction

An old *bhajan* (a devotional song) blares from the speaker of a jeep on the busy streets of Udaipur. As the jeep heads towards the outskirts of the city, the man hanging from the jeep's side shouts to people waiting on the sides of the road, in quick succession: Chandpur! Chandpur! Chandpur![1] There is still some space left in the jeep and the driver notices two women ahead, one of them waving. The jeep stops to pick them up across the road from a white-walled building with a big blue sign announcing Satya Hospital, written in Devanagari, where Satya is a Sanskrit term for 'truth.' Two women rush towards the jeep. One woman, older, wearing a simple chiffon sari, helps the other woman, younger, in a *ghagra choli* (skirt and blouse), to step into the jeep. She tells other passengers on one of the sideways-facing back seats to move aside to make space, seats the younger woman in front of me and directs her to rest her head on the side of the jeep. '*So jao* [sleep]', she says. The younger woman – groggy, confused and quietly moaning – follows instructions. She rests her head against the metal bar holding the leather roof of an open jeep and closes her eyes. I notice a bandage across her stomach, then purple ink on her right thumb and then a piece of paper clasped in her hand. I recognize the document – a certificate of sterilization – and the dynamic between the two women whom I have never met before. A motivator, a government-employed community health worker who has an official duty to motivate people to get sterilized, accompanies her case, a woman who agreed to get sterilized under this motivator's name and care, home after the sterilization (or tubal ligation) procedure at a private hospital.

The jeep picks up the pace and, having left Udaipur behind, the asphalt road takes us through the maize and wheat fields, sparse forests, naked hills, mud huts, an occasional dried-out riverbed and small marketplaces at road

Figure 0.1. Landscape in Jhadol tehsil, Rajasthan, and a traditional mud house at the centre, 2012. © Eva Fiks.

Figure 0.2. Landscape in Jhadol tehsil, Rajasthan, 2012. © Eva Fiks.

intersections. We see yellow and white signs painted on the sides of houses, on rocks, on gates and health centre walls. Messages in Hindi encourage healthy habits, children's education, the value of daughters, tree planting and limiting family size. Some are signed by non-governmental organizations (NGOs) or the National Rural Health Mission (NRHM).[2] Other messages remain unsigned, unclaimed, inscribed as 'wisdom' without the author. I wonder if people notice them. These state- and NGO-prescribed ways of living and being-in-the-world are not as vivid as advertisements for phone companies, soft drinks and tyres that cover other walls of the same houses.

Occasionally we see peach-pink-coloured buildings in the distance – government schools – which stand out in the rural landscape. A journey through rural Rajasthan uncovers how 'development' is carried out by

Figure 0.3. Advertisements and social messages in Jhadol tehsil. Besides the Angel submersible water pump's ad on the left, a message from Child Fund reads: 'Get the vaccines and regular check-ups, so that no harm comes to the child'. First message on the second wall reads: 'Leprosy treatment is free'. The second message says: 'Forests drink poison like Shiva and produce wealth like Kamadhenu' (just like Shiva drank poison to save the world, forests absorb carbon dioxide and just like Kamadhenu, a divine bovine-goddess produces wealth through milk and cow dung used as fuel, forests produce wealth by providing food, fodder and oxygen), 2013. © Eva Fiks.

NGOs, Christian missionaries, Hindu nationalist organizations and private companies which often plug the gaps where the postcolonial state fails. An hour into the journey, the older woman taps the driver on the shoulder, and he stops the jeep at the road intersection, next to a small settlement. She gives the driver a few rolled up ten-rupee notes and helps the younger woman to get off the jeep. The jeep speeds away and I look back to see the women turn towards the gravel road.

Half an hour later, the jeep arrives at its destination – Chandpur – and stops in the bazaar, where the single road splits into two. I disembark and pass various shops in the bazaar: the motorcycle repair shop, grocery store, mobile phone shop, a tailor and a ration shop.[3] I do not linger here. I know, by then, that the bazaar is a socially dangerous place: young girls and daughters-in-law find ways to cross the village without passing through the market. Most property in the bazaar is owned by dominant-caste[4] families who are known as having been ruined by money. Meat and alcohol consumption indicate these effects. Most stories of sexual assault take place in the bazaar too.

I turn to the main square, pass the tamarind tree, Mataji shrine and Shiva temple, the office of a local NGO and a small grocery shop where a young widow and her unmarried daughter sell everyday household items. I turn into a small lane and see Lakshmi, one of my main interlocutors, standing in front of her mud house watching me. She knows I would not go home without dropping by to say hello. Lakshmi's twenty-year-old son, Lokesh, plays on his phone on a charpoy (a bed consisting of a light wooden or metal frame woven with ropes or fabric) outside. Lokesh has many expectations firmly placed on his shoulders: he is regularly reminded that he will have to look after his parents in their old age and encouraged to study hard for his college degree to become the first college graduate in the family. Lakshmi's twenty-five-year-old daughter, Arti, sits inside watching a soap opera on TV. Arti's divorce settlement is still ongoing since she ran back to her parents' village from a violent husband and refused to return. Lakshmi's older daughter, Santosh, lives in Kota with her husband and son. I say hello to Lakshmi's husband repairing a bicycle tyre puncture at the entrance of a neighbouring house where he runs a small bicycle repair shop. Lakshmi greets me with an empty metal bucket in her hand, enquires about my trip to the city and moves to the inner yard to give water to the two cows tied in a shed.

Lakshmi, just like the young woman I saw on the jeep, got her tubes tied after the birth of Lokesh, almost twenty years ago, in a private hospital in Udaipur. She takes great pride in her decision to get sterilized. The permanency of the procedure gave her relief from *tension* – a common idiom of distress – that was troubling her during her childbearing years. Sterilization

resolved the uncertainty of her bodily states and the uncertainty of her family's financial circumstances – in the present and in anticipated futures. A few years later, after suffering from heavy vaginal bleeding and abdominal pain, Lakshmi had a hysterectomy in another private facility in Udaipur. I remember Lakshmi's words: 'I am like a man now: I have no period, so I can do anything that a man can.' Due to the hardships that she has endured after her husband lost his leg, and due to her sharp and outspoken character, Lakshmi is feared and respected by her family, neighbours and other Chandpur residents. She is described as being *zordar* (strong). This strength – of character, expression, determination and an ability to head and run a household under a lot of social and economic strain – stands in contrast to *kamzori* (weakness). *Kamzori*, created by joining *kam* (less) and *zor* (strength), is a vernacular idiom of distress which has been described in the literature as a way that social, economic and political suffering finds expressions in women's bodies (Ramasubban and Singh 2001; Rashid 2007; Simpson 2022; Snell-Rood 2015). While Lakshmi does feel weak and tired sometimes, and while living in rural poverty presents endless daily challenges of surviving, arranging children's marriages, dealing with the social consequences of one daughter's divorce and navigating tense relations with neighbours, she fundamentally feels (and is seen as being) strong. In her narrative, and in the narratives of many women like her, getting sterilized was an expression of her strength, not weakness.

I lived in Chandpur for eighteen months between 2012 and 2013 trying to understand how women like Lakshmi experience sterilization and how this biomedical state-sanctioned intervention fits within women's intimate, social and political lives in rural India. I document a practice that touches the lives of many women but which has not been chronicled ethnographically. In 2015–16,[5] 36 per cent of married Indian women aged 15–49 used tubal ligation as their method of permanent contraception. Half of the women underwent sterilization before the age of twenty-six. The median age at first marriage in India is nineteen. Ninety-five per cent of sterilized women have at least two living children and almost 50 per cent have at least three (IIPS and ICF 2017a). One-third of sterilization procedures in rural Rajasthan are conducted in camps (IIPS and ICF 2017b: 63). The camp is a ubiquitous format in India which describes a temporary service provision facility which can be organized by the government, NGOs or private companies. Camps often deliver narrowly defined services (e.g. eye camps provide eye health check-ups; immunization camps provide vaccinations to children; and pension camps provide help with paperwork required to receive a government pension) to populations where these services are not routinely available. Sterilization camps provide clinical teams and equipment to conduct tubal ligation procedures at rural facilities on certain days.

The poor quality of care in sterilization camps has been an ongoing concern (Bali, Yadav and Alok 2020; Ramanathan, Dilip and Padmadas 1995) but the attempts to ban them resulted more in new vocabularies rather than different service delivery mechanisms.

In this book, I offer a thorough examination of intimate and institutional relationships which hide behind these statistics and intertwine in rural women's experiences of ending childbearing through sterilization. Sterilization becomes a window into women's relationships with partners, children, neighbours, state functionaries and healthcare institutions in contemporary rural India. Positioned at the intersection of medical anthropology and the anthropology of the state, this book describes women's everyday lives in the area stuck between poverty and intervention (Pinto 2008), in the space between structural violence and state-led care. Sterilization illustrates the ambiguities and fragilities of care in postcolonial rural India: care that is available to rural communities may provide temporary relief but inevitably deepens chronicities which characterize rural lifeworlds.

History of Population Management in India

The management of reproduction has been a preoccupation of the Indian government since the country's independence in 1947. In 1952, India became the first country in the world to introduce family planning as an official national programme. The neo-Malthusian concern that overpopulation threatens economic development and causes poverty was a key driving force in introducing such a policy. In the name of national development, increasingly coercive population control measures were undertaken at the recommendation of the World Bank, the Ford Foundation, the Population Council and other international organizations (Connelly 2006; Mamdani 1972). The national population control programme started by advocating a rhythm method in the early 1950s which suggested avoiding conception by restricting sexual intercourse to the times of a woman's menstrual cycle when ovulation is least likely to occur (Ledbetter 1984). Priorities quickly shifted to include contraception available at the time (condoms, diaphragms and vaginal foaming tablets) available at newly opened birth control clinics but waiting for people to come to clinics to pick up contraception soon proved ineffective and led to the introduction of an outreach programme of family planning workers starting to make home visits (Harkavy and Roy 2007). Family planning targets (for IUDs, sterilizations and condoms) and incentives were introduced in the mid-1960s (Satia and Maru 1986). The camp approach, with a strong state functionaries' pres-

ence 'lending a coercive element in the process', was introduced in the 1970s (Harkavy and Roy 2007: 311). These developments slowly but steadily were building towards the forced vasectomies which continue defining the period of National Emergency declared by Indira Gandhi in 1975. From 1975 to 1977, between eight and eleven million people – mostly illiterate, economically and politically disadvantaged men – were forcefully sterilized as part of a programme attempting to limit population growth and bring economic development.[6] Even though scholars demonstrate that the methods employed during the Emergency were not that different from what was happening throughout India before or after (e.g. Jaffrelot and Anil 2020; Williams 2014), the Emergency is still remembered as *nasbandi ka vaqt* (a time of vasectomies) in much of north India (Tarlo 2003). The memories of the Emergency and the development of laparoscopic surgery techniques contributed to tubal ligation becoming one of the most prevalent methods of contraception by the 1980s. With the return of programmes focusing on women as preferred users of family planning (Basu 1985), '[t]he pressure to meet quotas, the obsession with efficiency, and the urgency to defuse India's population bomb' cemented the reliance on laparoscopic sterilizations[7] (Olszynko-Gryn 2014: 164). Discourses on reproductive health and rights that proliferated in the 1990s continued to suggest reducing poverty and population growth by controlling women's fertility (Qadeer 1998).

According to the results of the National Family Health Survey (NFHS–4) (IIPS and ICF 2017a), around the time of fieldwork 43 per cent of rural married women in Rajasthan aged 15–49 used tubal ligation as their method of contraception. Soon after fieldwork, fifteen women died after undergoing the procedure in a camp in Chhattisgarh. The subsequent Supreme Court judgement argued that 363 women died between 2010 and 2013 during or after surgery in sterilization camps and ordered the government to shut them down within three years ('Devika Biswas v. Union of India' 2016). Despite the judgement, journalists report that sterilization camps continue to be held similarly throughout India (Agrawal 2017; Dash 2021; Ghosh 2021; Verma 2022) while temporarily stopping during the nationwide lockdown in 2020 during the COVID-19 pandemic.

The Indian government regularly disavows a population control discourse and highlights the narrative of choice and voluntarism as cornerstones of its family planning initiatives, illustrated through the abandonment of targets in 1996 and an attempted conceptual transformation from population control to reproductive health and, later, to an integrated reproductive, maternal, new-born, child and adolescent (RMNCH+A) health framework (Ministry of Health and Family Welfare 2022a). However, neo-Malthusian sensibilities continue to guide policy and action (Hartmann and Rao 2015). For instance, the Ministry of Health and Family

Welfare (2013a: 122) in its Annual Report for 2012–13 continued to perpetuate neo-Malthusian dispositions by stating that the decline in fertility rate 'spurs the economic and social progress'. In 2012, another international partnership was launched by the Bill & Melinda Gates Foundation and was joined by the UK Department for International Development (superseded by the Foreign, Commonwealth and Development Office in 2020), the United Nations Population Fund and the US Agency for International Development to increase contraceptive use worldwide by 120 million users in the world's poorest countries by launching FP2020, which later became FP2030. The quantitative goal has been used to mobilize resources and leadership to simply increase contraceptive use throughout the world. India has joined the initiative enthusiastically. The total fertility rate in India dropped from six births per woman in 1951 to replacement fertility of two in 2020 (Ministry of Health and Family Welfare 2022b) which made the journal *Science* declare that 'India defuses its population bomb' (Pearce 2021). However, in India, the declining fertility rate does not correlate with a reduced focus on family planning. In 2015, a letter circulated to all National Health Mission Directors states that besides a focus on postpartum IUD insertions, there is 'a pressing need to look into the matter of limiting methods in terms of postpartum sterilization by the Minilap mode and NSVs [no scalpel vasectomies]' (Ministry of Health and Family Welfare 2015a). The letter further outlines how to generate professionals able to perform the procedures and how to prepare healthcare facilities for these procedures to 'stimulate demand'. The enthusiasm to return to permanent methods of contraception and targets for contraceptive uptake – key features of FP2020 and FP2030 – do not align with huge gains in lowering fertility achieved since the introduction of family planning as a national policy in India. The international global health and development industries consider the concept of 'unmet need' for family planning to be an indicator of access to reproductive health. But behind the concern with reproductive health lies the numbers-driven logic which defines goals, measures progress and has the capacity to undermine all other concerns, including informed consent, reproductive freedom and an understanding that reproductive decisions are grounded in couple dynamics and wider social and political contexts (Ampofo 2004; Nandagiri 2021). Preoccupation with health metrics in the field of global health may distort how healthcare is funded and provided (Adams 2016) and quantitative reproductive goals which drive interventions and measure success run the same risks. Furthermore, the idea of an 'unmet need' for family planning services creates, defines and prepares 'a ready market for contraceptives' (Ampofo 2004: 115–16) which solidifies neoliberal rationality – rather than a concern with reproductive health – as the driving force of the global initiative.

Sterilization in Context

While the prevalence of sterilization in India is often attributed to large-scale often coercive population control programmes, other contexts provide a different view of the most common contraceptive method used worldwide. In 2019, 219 million women (23.7 per cent of women using contraception) relied on sterilization, followed by a male condom (189 million), IUD (159 million) and the pill (151 million) (United Nations 2019). In Brazil, for instance, sterilization is viewed as resulting from individual women's choices and actions albeit situated within powerful and constraining social forces (Dalsgaard 2004; De Bessa 2006; McKenna 2019; O'Dougherty 2008). Working in low-income settings in Northeast Brazil, Dalsgaard (2004: 27) argues that sterilization 'relieves immediate pressures and endows [a woman] with recognition as a responsible mother'. De Bessa (2006: 221) demonstrates that sterilization represents poor women's 'active struggle to improve their lives and to resist the burdens placed on them by unequal gender relations'. O'Dougherty (2008: 420) questions other scholars' attribution of sterilization to increasing medicalization, a lack of contraceptive options or the lack of knowledge and asks: 'Is it the bodily cutting that makes sterilization "radical," or is it the renunciation of all future motherhood that is radical?'

Contraception can both help women assert reproductive control and place 'their bodies under the control of powerful state and medical establishments' (Greenhalgh 1994: 3). Contraception as birth control and as population control demonstrates these opposite effects (Russell 1999). Birth control indicates personal decision-making, a form of (self-) care. Population control – underpinned by eugenic and neo-Malthusian sensibilities – sees procreation as a (national) problem to be solved through fertility control, regardless of the desires of individual women. Such dichotomy fails to see that women navigate both birth control and population control discourses and arrangements to suit their everyday life demands in such a way that birth control can disempower while population control can be felt as care.

Women actively negotiate the means and conditions under which powerful structures attempt to control their reproductive lives. Medical historian Dyck (2014) examines women's reproductive struggles in Canada in the mid-twentieth century, during the co-existence of the eugenics programme and the Catholicism-inspired ban on contraception.[8] Dyck demonstrates that in the shadow of the official eugenics programme, which coerced men and women considered to be 'unfit' to undergo sterilization procedures, some married middle-class women pressured their physicians to provide them with the sterilization procedure as a method of contraception, which

remained illegal at the time. 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' (Dyck 2014: 183). This historical account destabilizes the link that is often explicitly made between sterilization and eugenics (Bashford and Levine 2010; Dikötter 1998; Weindling 1999).

Sterilization lurks in the background of many ethnographic accounts of women's lives in India (Jeffery, Jeffery and Lyon 1989; Pande 2014; Pinto 2008; Van Hollen 2003) but it has rarely been the focus of anthropological research. The existing accounts explore women's agentive capabilities in relation to the wider structures of power, mainly kinship and the state. Säävälä (1999, 2001), for instance, explores women's perceptions of sterilization 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 old age and less power by undergoing sterilization and entering the post-childbearing age themselves (Säävälä 1999). Cohen (2004, 2005) argues that sterilization allows the poor to secure participation in the project of citizenship and the state by becoming *as if* modern citizens through tubal ligation. Brault et al. (2015) demonstrate that women in a low-income neighbourhood in Mumbai see sterilization as providing them with greater freedom and improving emotional health while acknowledging that family planning policies, socioeconomic factors and gender relations constrain their choices. This resonates with López's (2008) suggestion that Puerto Rican women in New York chose to end their reproductive lives by sterilization in response to their social and economic conditions and saw this decision as liberating. Building on these scholars' work, I aim to move conversations about sterilization beyond discussions on agency, victimhood and reproductive freedom by focusing, instead, on tensions, uncertainties and contingencies they encounter in their everyday lives through the concept of care.

Care and Reproductive Chronicity

Throughout this book, I ask questions about the relationship between care, chronicity, power and violence and how these are experienced by women through surgical intervention. I use the concept of care and its ambivalent dimensions to investigate how women engage with a population control programme and the wider state practices. Sterilization is often discussed as a form of violence against poor marginalized women (Wilson 2018) or reproductive injustice (Nandagiri 2022), especially because it is entangled

in coercive, incentive- and target-driven state-sanctioned population control efforts (Tarlo 2003; Williams 2014). My interlocutors, however, talk about sterilization as a form of care, not violence (and as an expression of their strength, not weakness). I, therefore, employ the framework of care as an opportunity to see how sterilization fits into women's everyday lives and relations which often focus on managing arising everyday challenges in conditions of structural disenfranchisement and increasing state-led medicalization.

Mol, Moser and Pols (2010: 14) define care as 'persistent tinkering in a world full of complex ambivalence' and encourage us to investigate the mundane practices of care that people carry out in their everyday lives. The initial interest in care as an inherently moral act and practice (Kleinman 2009; Livingston 2012) represented a shift away from anthropology's preoccupation with suffering to a new anthropology of the good (Robbins 2013). But anthropologists have also highlighted various ways in which care can be ambivalent or violent (Biehl 2012; Garcia 2015; Gupta 2012; Han 2012; Ticktin 2011). While care can be defined 'as a concrete work of maintenance, with ethical and affective implications, and as a vital politics in interdependent worlds' (Puig de la Bellacasa 2017: 5), what care means and what it involves depends on particular institutional, political and social settings. Understandings of care are culturally specific, as demonstrated by Van Hollen (2018) on cancer care in south India, Świtek (2016) on Japanese eldercare by Indonesian workers and Stevenson (2014) on the clash between Inuit and postcolonial state's understandings of care. Even when ambivalent, care remains central to people's everyday attempts to make their lives liveable (Guell 2012; Han 2012; Mol 2008).

The ambivalent dimensions of care – and the relationship between care and violence – have been investigated by anthropologists from many ethnographic locations who highlight how conversations about care often involve conversations about power, inequality and violence. Discussing the failure of social welfare programmes in India to relieve persistent poverty, Gupta (2012: 24) argues that these programmes are arbitrary and succeed unevenly, and calls it 'violence . . . enacted at the very scene of care'. He demonstrates a strong relationship between violence and care inherent in the postcolonial Indian state and its relationships with its citizens: state care can be yet another form of structural violence. Besides structural violence – a form of violence that is built into the social, economic and political structures and systems producing systemic harms and perpetuating the suffering of certain groups within society (Farmer 2003) – direct violence can also be deeply entangled with care in people's everyday lives. It can manifest as an attempt to care in mundane married life which crosses religious lines in the context of the potentiality of violence (Das 2010) or in

healing contexts where violent interventions constitute an integral part of care and healing (Garcia 2015). Care in power-infused contexts becomes capable of simultaneously looking after and 'sustain[ing] patriarchal inequities, an exploitative global economy, and state violence' (Arnold and Aulino 2021). Caregiving is entangled in local hierarchies and informal economies and is not always 'in accord with an ethics of justice' (Praspaliauskiene 2016: 584). Care is intrinsically 'caught up with structural violence in many forms' (Arnold and Black 2020: 575), and I attempt to unpack this entanglement throughout this book.

The anthropology of chronicity (Ecks 2021; Estroff 1993; Manderson and Smith-Morris 2010; Manderson and Warren 2016; Weaver and Mendenhall 2014) continues anthropology's interest in documenting suffering (Robbins 2013). Care and chronicity are closely linked, but this link often remains implicit. In the context of chronicity – a persistent fluctuating ill health that is closely entangled with chronic changing structural conditions of people's lives – care does not simply seek to make lives more habitable but also involves endless efforts to 'make suffering liveable' (Kleinman and Hall-Clifford 2010: 249). Just as chronicity is embedded in everyday lives, political economies, biomedical regimes and cultural systems (Estroff 1993; Manderson and Smith-Morris 2010), so is care. A focus on the ambivalent dimensions of care highlights that care is not simply an antidote to chronicity; rather, the relationship between care and chronicity requires ethnographic attention. Both everyday caregiving practices and everyday experiences of chronicity are always locally situated, and so is their relation.

Sterilization – through its location within the population control programme and its history, in its target-based strategies, in its reliance on cultivated intimacy between health workers and rural women, in the mundane acts taking place in the camps and, most importantly, as women's attempts to make their lives better for themselves and their children – functions in the space where 'care can do violence, and violence can also be felt as care' (Arnold and Aulino 2021). In this book, I argue that sterilization – from the rationalities behind women's reproductive decisions to their engagements with health workers and camp personnel – illustrates how ambivalent and fragile care is in postcolonial rural India: care that is available to rural communities may temporarily provide relief but inevitably deepens reproductive and other chronicities. The way structural inequalities of caste, class, gender and geography intertwine with the kind of care that is sought and provided unravels the relationship between violence and care, which, in some contexts, become ambiguously indistinguishable. Moving between reproductive experiences situated within homes and domestic relations with partners, children and kin, encounters with biomedically trained personnel and state functionaries in sterilization camps and relationships

with community health workers for various reproductive concerns, I ask how sterilization becomes part of everyday life. Women's narratives of sterilization – experiencing, refusing or desiring it – demonstrate how women's everyday concerns unfold in the backdrop of wider social, economic and political forces. While the topic of this project is indeed intimate, it is not a subject that is considered to be sensitive or surrounded by taboos in rural Rajasthan. People discuss sterilization in a matter-of-fact way, which is one of the reasons I was drawn to this topic. The Indian state has used intimacy as a tool and target of governance for many decades, which allowed conversations about sterilization to become daily, almost public concerns.

Discussing the experiences of women who got sterilized alongside perspectives of different generations of women who did not, this book makes several key conclusions. Many rural women experience sterilization as a form of care despite its ambivalent dimensions. In the context of structural conditions which contrive women to experience reproduction as a form of chronicity – which I call reproductive chronicity – sterilization emerges as a desirable solution to women's chronic reproductive suffering. Rural women speak of their bodies as chronically ill due to various ordinary and adverse reproductive events, reproductive labour, social and economic conditions shaping their everyday lives and various interventions they undertake to tend to their bodies. Suffering and care are intimately and ambiguously intertwined in women's experiences of reproductive chronicity. In this context, I use 'chronicity' to refer to the state of chronic-ness and long-lasting suffering and ill health of persons, communities and institutions. The meaning this term has gained in medical anthropology departs from its usage in other contexts, where it may simply denote something long-lasting or enduring without any negative connotation. Reproductive chronicity is just one type of chronicity that characterize life in rural India. I suggest that reproductive chronicity is key to understanding how women engage with sterilization. Reproductive chronicity encapsulates a cycle in which women find themselves looking for relief for their recurring reproductive suffering, even as available therapeutic options, poor healthcare infrastructure and fragile social and institutional relations offer temporary care. The long-lasting, yet fluctuating nature of women's reproductive suffering that is temporarily relieved by ambivalent care options characterizes reproductive chronicity. When navigating biomedical and state settings which systematically perpetuate hierarchies based on gender, caste, class and geography, rural women remain driven by their search for pragmatic modalities of care that suit their everyday life demands and arrangements. Acts of resistance – in everyday encounters with community health workers, through mundane acts in the camp and in the critique women express when discussing vasectomies – are built into narratives of

sterilization and do not simply articulate as a refusal to end childbearing through this method. While discourses of convenience which strip sterilization of its historical context and capacity to harm are employed by the Indian state and biomedical discourses, women resist such narrative – but not the procedure itself – through insisting on local understandings of the laparoscope as capable of healing and harming – caring and violating – simultaneously. Rural women know how violence is built into care and provide a nuanced understanding of how to successfully navigate it.

Research Setting: Chandpur

This book draws on ethnographic fieldwork that was carried out over eighteen months in 2012–13 in Chandpur, a mixed-caste village located in the Jhadol tehsil (sub-district) of the Udaipur district of the north Indian state of Rajasthan. Being the largest Indian state by area, Rajasthan is only

Map 0.1. Field site: Udaipur district in Rajasthan, India. Modified version of a map by Milenioscuro, CC BY-SA 3.0.

Table 0.1. Demographic profile of India and Rajasthan. Data retrieved from https://censusindia.gov.in/census.website/.

	India		Rajasthan	
	2011	2020	2011	2020
Population and demographic indicators				
Area (sq km)	3,287,240		342,239	
Population (million)	1,210	1,380	68	81
Population density (per sq km)	382	420	200	237
Sex ratio	940	907	928	911
Crude birth rate	21.8	19.5	24.8	23.5
Maternal mortality ratio	178	97	255	113
Infant mortality rate	44	28	52	32
Total fertility rate	2.2	2	3	2.4
% rural	69	—	75	—
Literacy rate (%)	74	—	66	—
Male literacy rate (%)	82	—	79	—
Female literacy rate (%)	65	—	52	—

the eighth largest by population. It is often joined together with Bihar, Uttar Pradesh, Madhya Pradesh and Chhattisgarh as high fertility states. Rajasthan performs poorly on various social and economic development indicators, including low gross state domestic product, high poverty rates, poor access to quality healthcare and high rates of crimes against women.

The southern Rajasthan district of Udaipur is bounded by the Aravalli Range in the north-west (which helps the district to avoid the inhospitable Thar Desert), the Rajsamand district in the north, the Chittorgarh district in the east, the Banswara district in the south-east, the Dungarpur district in the south and the state of Gujarat in the south-west. Like some other tehsils in the Udaipur district, the entire tehsil of Jhadol is designated as a scheduled area, where special protection is promised to Adivasi (indigenous) communities who constitute 75 per cent of the tehsil's population of almost 250,000 people. Tehsil's headquarters, Jhadol, is an hour away from Chandpur. Chandpur's nearest city, Udaipur, is two and a half hours away by bus on a curvy, single-lane asphalt road leading through the Aravalli hills.

Chandpur functions as 'the margins of the state' (Das and Poole 2004a; Tsing 1993) in many ways. Local state functionaries interpret and implement formal rules and policies according to this geographic and political imaginary of the margins (Corbridge et al. 2005): in unexpected, often contradictory and arbitrary ways (Gupta 2012). Political and geographic marginality also provides Chandpur with the special status of being perpetually

Figure 0.4. A view from a rooftop in Chandpur, 2012. © Eva Fiks.

stuck between chronic poverty and chronic intervention (Pinto 2008). Chronicities and interventions take many forms but are often united by nebulous and financially sustainable concepts of 'development' and 'empowerment'. Government agencies, local and international NGOs, Christian missionaries and Hindu nationalist organizations continually attempt to lift Chandpur out of chronic failure into the aspirational good life.

Chandpur's population of over 1,700 residents belong to many different *jatis* (castes) without any single caste dominating numerically. Chandpur is surrounded by Adivasi villages, some of which are only a few minutes away, which represents a wider tendency for Adivasis to live in scattered villages outside larger residential centres while caste Hindus concentrate in bigger villages and towns.

Larger villages have seen relatively rapid construction of brick and cement – or *pakka*[9] (solid, permanent) – houses in recent years, a practice signalling class-based aspirations and another form of hierarchy work alongside the lines of caste and class (Menon 2023). In 2015–16, 56 per cent of households in rural Rajasthan lived in *pakka* houses (IIPS and ICF 2017b). Adivasi villages continue to consist primarily of houses made of mixing mud, grass, stones and other locally available materials with roofs made of hand-moulded fired mud tiles or thatch. Mud houses, referred to

Figure 0.5. A view of one of the lanes in Chandpur, 2013. © Eva Fiks.

as *kaccha* (flimsy, impermanent) houses, despite the translation, are long-lasting structures which are easy to maintain and repair and which keep cool in the summer and warm in the winter, are built on hillsides and next to the fields cultivated by their owners. The in-between arrangements are ubiquitous too: some *pakka* houses have a *kaccha* kitchen (unlike the rest

Figure 0.6. A traditional mud house and *angan* in Jhadol tehsil, Rajasthan, 2012. © Joshua Taussig.

of the house, the kitchen has a porous roof or even mud walls) or a separate area outside to enable cooking on a *chulha* (mud cookstove) which requires burning wood and cannot be done inside conventional *pakka* structures.

Adivasi Imaginaries

The term 'Adivasi' (indigenous people) has been employed by scholars and activists to describe the groups classified as 'Scheduled Tribes' under the Indian Constitution. The colonial projects of administration and governance employed and solidified the lens of a tribe to distinguish diverse groups and communities from caste Hindus. Such differentiation was based on the colonial administration's view of a more 'civilized' Hindu society and the 'primitive' groups in the social and geographic peripheries of the country. Based on an often rebellious relationship to historic state projects, cultural and religious practices distinct from the mainstream norms and the relationship with the land – sometimes historic (autochthonous) and often symbolic (hills and forests are often imagined as home to *jangli* [wild] tribes which live in harmony with nature) (Moodie 2015) – the tribe in India has been defined not only as distinct from caste but also fundamentally marked by 'backwardness', a term which continues to be employed in popular and government discourses to describe geographical areas and communities (e.g. Bakshi, Chawla and Shah 2015). After independence,

Figure 0.7. Mud cookstove or *chulha* in rural Rajasthan, 2009. © Joshua Taussig.

Figure 0.8. Charpoy in the *angan* in Jhadol tehsil, Rajasthan, 2012. © Joshua Taussig.

social welfare provisions and protection of 'tribal' communities have been written into the Indian Constitution. Special provisions for groups which were listed as historically in need of affirmative action include reservation of seats in legislatures, government employment and education. The post-colonial 'Indian state treats adivasis as backward and needing paternal protection, and simultaneously as oppressed and dangerous – the "Other" of the "mainstream nation"' (Sundar 2014: 472).

The inadequacy and political history of the term in the Indian context have been widely discussed both historically and ethnographically (Béteille 1986, 1998; Skaria 1997; Sundar 1997). The main points of critique are the origins of the term in the colonial project of governmentality (Bates 1995; Ghurye 1959; Guha 1999), the difficulties of distinguishing Adivasis from caste Hindus (Sundar 1997; Unnithan-Kumar 1997) and a disregard for complex and diverse identities of different communities as a source of political exclusion (Rao 2018). The colonial project of designating Adivasi communities as 'backward' continues today in new forms. Adivasi communities throughout India tend to be the most deprived in terms of livelihoods, food security, education and health. Dispossession of Adivasi lands for various industrial projects, such as mining, dams and factories, contributes to further marginalization. The colonial oppression continues 'in more systematic and aggressive ways . . . in the name of development', argues Virginius Xaxa in an interview for *The Week* (Sharma 2022).[10]

Despite the scholarly problematization of the concept, the term 'Adivasi' has been taken up by various groups to define themselves – particularly when making claims to the state in contexts of land and

resource dispossession – and serves as a source of identity and subjectivity. It is the lack of protection of rights to the land and natural resources and the multidimensional exploitation of already marginalized groups which has led to the idea of indigenous people or Adivasis becoming an important way to assert identities and take part in local and global political projects (Xaxa 1999). Moving away from claims to a separate Adivasi identity and rights to resources, some Adivasi groups embrace the Hindu nationalist organizations and their rhetoric and deploy their political claims to indigeneity against Christian Adivasi and Muslim communities (Baviskar 2005; Froerer 2007).

Fieldwork in a mixed-caste setting uncovered various tensions surrounding identities and subjectivities of both Adivasis and caste Hindus living in an 'Adivasi area'. Some Adivasi interlocutors take pride in their identity and speak joyfully about being *jangli* (wild or from the jungle),[11] some invoke their Adivasi identity to highlight complex processes of marginalization they encounter while dealing with state agencies and caste Hindus in the past, present and anticipated futures. Caste Hindus often speak the word 'Adivasi' only in whispers and express a combination of mistrust, ridicule and fear. Udaipur district has seen significant mobilization efforts by Hindu nationalist groups since the 1990s, which resulted in increasing electoral support for the Bharatiya Janata Party (BJP) in rural Adivasi areas (Lodha 2004). Udaipur district has also seen increasing activities by Christian organizations, particularly the Pentecostal movement, which resulted in increasing numbers of conversions to Christianity amongst rural Adivasi communities (Sahoo 2018). Since the 2000s, anti-Christian violence has increased significantly in Rajasthan and is often carried out by members of Hindu nationalist organizations, such as RSS, VHP and Bajrang Dal; many incidents have been reported in Udaipur district too (Kalra 2015; Sahoo 2018; Srivastava 2004). My Adivasi interlocutors who support Hindu nationalist ideology often employ anti-Christian rhetoric to support their political indigeneity claims (Baviskar 2005).

Neighbourhood Imaginaries

Jhadol tehsil shares a border with Gujarat and two other tehsils: Kherwara and Kotra. Chandpur's residents consider Kherwara and Kotra as representing two different development trajectories. On the one hand is Kherwara, where a new highway connecting Udaipur and Gujarat's capital Ahmedabad stimulated the growth of many businesses, lifted the levels of education and employment and led to increasing rates of labour migration to the Gulf, generating relatively high household income through the

transfer of remittances. In Chandpur, Kherwara is known as an ambiguous place 'where Adivasis are richer than Brahmins', indicating that hierarchies between castes are somewhat dwindling (Jodhka and Manor 2018). On the other side of the development story is Kotra tehsil, characterized by the presence of a 90 per cent Adivasi population and 'commonly known as *Kalapani* (black waters)[12] – extremely remote and inaccessible – where the government officials are sent as a "punishment posting"' (Sahoo 2013: 4). A British Army cantonment was situated in Kotra during the colonial period, but it was abandoned by the official development efforts after India's independence. Many consider Kotra to be a dangerous place where shops and restaurants close early and where it is not advised to travel after dark.

Jhadol is located somewhere in-between these two development trajectories: not as poor, dangerous and remote as Kotra, but not as socioeconomically developed as Kherwara. In official and resident circles, Jhadol continues to carry the label of 'backwardness:' a generic term used by caste Hindus and the postcolonial state to refer to more than material poverty and economic marginalization of Adivasi communities (Baviskar 2005). The contemporary discourse on 'backwardness' continues to articulate the colonial constructions of wildness which are constitutive of the very distinction between caste Hindus and Adivasis (Skaria 1997).

Livelihoods, Poverty, Health

Life in Chandpur is precarious for most residents, except for a few wealthy and well-connected households. The majority of households around Chandpur are small landowners. Most Adivasi households 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: *urad* (black gram), *tur* (red gram) and *chana* (Bengal gram or chickpeas). The region depends on rainfall for its agricultural needs, and water scarcity is a major challenge, which makes Chandpur particularly vulnerable to the climate crisis and its longer-lasting and more frequent extreme weather events. Households with installed irrigation can cultivate rice and green vegetables, but such arrangements are rare. Livestock rearing – mostly goats and buffaloes – contributes to daily consumption needs and household income. Many families are considered to live Below Poverty Line (BPL)[13] and receive subsidised food through the Public Distribution System.

Due to low agricultural productivity, wage labour is the main source of income. Many oppressed-caste men migrate to Udaipur and other localities

in Rajasthan and neighbouring Gujarat in search of employment, mainly in the construction industry. People working in Udaipur commute daily while those working further away migrate for periods of two to four months at a time. Income from such labour is low and irregular. During the period of my research, the average daily income for manual labourers in the construction sites in Jhadol ranged from ₹70 for carrying and sieving stones, usually done by women, to ₹300 for a supervisory role and mixing cement. The rates were higher in Udaipur, but daily commuting costs added a considerable expense. Some households practice traditional occupations like pottery, goldsmiths and blacksmiths and cater to the needs of local markets. Many dominant-caste men, and occasionally dominant-caste women, run shops or hold government and NGO jobs. Few oppressed-caste men have degrees and even when they do they are often chronically stuck waiting for government jobs (Jeffrey 2010) which do not materialize due to an inability to pay financially significant bribes.

Men's increasing labour migration to cities, and increasing labour migration of children to work in cotton fields in Gujarat, put increasing pressure on women to tend to their fields. Adivasi women are 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[14] (NREGA) projects. Collection of forest produce – *mahua* flowers, firewood, bamboo, honey and berries – also forms a source of income and contributes to household consumption. Many caste Hindu women are also involved in agriculture but rarely participate in NREGA projects.

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 (Farmer 2003; Scheper-Hughes 1992; Singer and Baer 2018). 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 2003: 40).

While the quality of public healthcare in rural India improved with the introduction of the NRHM in 2005 (Gopalakrishnan and Immanuel 2017), the bleak picture that existed before the scheme (Banerjee, Deaton and Duflo 2004a) did not disappear. Both health and healthcare provision in rural Rajasthan remain poor. Sixty-two per cent of children aged 6–59 months and 49 per cent of women are anaemic (this number rises

to 63 per cent amongst Adivasi women). The infant mortality rate is 44 per 1,000 live births while the under-five mortality rate is 54 per 1,000 live births, down from 75 and 98 respectively in 2005–6. The maternal mortality ratio (the number of maternal deaths per 100,000 live births) in Rajasthan remains high but has been declining: 244 in 2011–13 (167 in India) (Ministry of Health and Family Welfare 2018). Fifty-eight per cent of households in rural Rajasthan have no toilet facilities and practice open defecation (IIPS and ICF 2017b). Fifty-three per cent of children aged 12–23 months had all basic vaccinations, defined as fully vaccinated with BCG, measles and three doses each of DPT and polio vaccines. Public healthcare infrastructure in rural Rajasthan focuses on maternal and infant health, and most government interventions target women of reproductive age and seek to govern various aspects of their lives through a network of biomedical and state institutions.

Marriage and Motherhood

Marriage and motherhood form a central part of women's lifeworlds in Rajasthan.[15] Adivasi marriages follow patrilineal clan and village exogamy and tribe endogamy, and the distance within which brides are found is usually less than twenty kilometres. They often reside in nuclear households, with sons building their own houses after marriage. Caste Hindus practice caste endogamy and patrilineal clan exogamy. They often reside in joint households, where parents live with at least one son and a daughter-in-law. 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 fifteen. Even though both Adivasis and caste Hindus practice arranged marriages, various alternative arrangements, while all rare, can be found: these include an informal settling into a lover's house before marriage, arranged inter-caste marriages, inter-caste love – court – marriages, informal live-in arrangements without marriage and polyamorous arrangements.

Gender inequalities and exclusions are deeply engrained in everyday life in Rajasthan. The son preference forms part of the everyday fabric across castes but peaks amongst dominant-caste families. The lack of non-familial sources of old-age support, the need for labour power, the continuation of a family line, the performance of funerary rites and property inheritance are often invoked to explain son preference. Allocation of resources – food, money and care – is often informed by the son preference, which can also lead to sex-selective abortions and infanticide. In 2015–16, the overall sex ratio was 973 females to 1,000 males and the sex ratio under seven years of age was 887 (IIPS and ICF 2017b). The birth of a son is celebrated in a vis-

ible and institutionalized manner while the birth of a daughter may be celebrated to some extent but may also go unnoticed, especially among caste Hindus. Daughters are breastfed for shorter periods than sons. Concern with daughters' modesty and piety, the requirement to help with housework and the devaluation of girls' education encourage some parents to remove their daughters from school early. Medical treatment is delivered promptly to sons but is often delayed for daughters.

Starting with colonial imaginations but perpetuated in postcolonial academic settings, scholarship often portrays Adivasi communities as governed by more egalitarian gender roles and relations when compared to caste Hindus (Sinha 2005: xxix). This egalitarianism is primarily based on less constraining marriage practices, including rules governing divorce and remarriage (Deliège 1985: 119), fewer restrictions on girls' and women's mobility and the presence of a bride price instead of a dowry. This egalitarianism has been challenged by scholars demonstrating that Adivasi and caste Hindu women's roles and experiences, especially in matters of kinship and economy, are fundamentally similar (Unnithan-Kumar 1997), some practices which are seen as benefitting women, such as bride price, can disadvantage them (Nongbri 1998), that class and religion have significant effects on gender norms in different households, and that gender norms vary greatly amongst different Adivasi groups (Xaxa 2004).

Methods, Positionality and Ethics

I first came across the topic of sterilization in rural Rajasthan while working on a small research project with a local NGO in Udaipur in 2009. While examining the declining sex ratio in an Adivasi village nearby with the help of a young dominant-caste man as my translator, I made day-long journeys to the village interviewing people about why they thought the village's small population was disproportionately skewed in favour of men in all age groups. Son preference is prevalent among different communities in north India and finds many articulations (Purewal 2020). However, some NGO workers maintained the discourse that gender relations in Adivasi communities are more egalitarian than among caste Hindus. The statistics on the declining sex ratio among the Adivasi communities, therefore, pointed to either the falseness of this discourse or a change in gender relations. The most common answer given to us by the residents of the village was that the main reason for the declining sex ratio was sterilization. Most respondents suggested that the sex ratio was declining because women got sterilized after having sons without waiting for the birth of a(nother) daughter. Differential stopping behaviour, also known as son-targeting fertility

behaviour or male-preferring stopping rules, has been shown to have various demographic effects but does not affect the sex ratio at birth (Basu and De Jong 2010). However, my interlocutors' worldviews do resonate with wider scholarly arguments that there is a link between family planning policies and small family norms and sex selection and devaluation of daughters (Kaur 2020). The ease with which both men and women talked about sterilization – and were quick to see it as a simple answer to what I saw as a complex question – got me interested in the topic. There was no taboo in talking about sterilization. There were no hushed voices, no giggles, no fear and no concern. It was an ordinary topic to discuss.

To explore the absolute ordinariness of sterilization, I returned to rural Rajasthan for my doctoral fieldwork. During the eighteen months that I lived in Chandpur, I resided in three different localities. I first lived with a dominant-caste family related to a local NGO worker who helped me settle into the village. I then moved into a house rented to various meat-eating families. Meat-eating is considered to be impure within Brahminical Hinduism,[16] thus the house was primarily rented by oppressed-caste families. Finally, I moved to an Adivasi village adjacent to Chandpur. With each distinct location, unmistakably different but overlapping local moral worlds were unlocked. In each locality, I formed relationships by getting to know my neighbours and their kin and I broadened my social and trust circles from there. To understand reproductive lives and concerns and to contextualize sterilization in women's lifeworlds, I spoke with women and their families whenever and wherever I met them: in their homes, fields, shops; while cooking, travelling or waiting – for buses, rations and doctors. I participated in many aspects of village life whenever I was welcome. I became familiar with many aspects of everyday rural affairs but maintained a clear focus on women's reproductive experiences and how reproductive concerns intertwine with social and kin relations, livelihoods and institutional lifeworlds. Besides discussing women's joyous and sorrowful reproductive experiences related to pregnancies, childbirths, childrearing and ending childbearing, we widely touched upon various other topics of neighbourly intimacy. Besides village ethnography, I carried out participant observation in weekly sterilization camps held in two Community Health Centres (CHCs). The Indian state outsourced the organization of these camps to Marie Stopes India (MSI), a subsidiary of Marie Stopes International (since 2020, known as MSI Reproductive Choices). In the camps, I observed encounters amongst women who came for sterilization, MSI clinical and organizational teams, community health workers and the Chief Medical and Health Officer (CMHO) office bureaucrats. I built relationships with camp personnel whom I met regularly, whereas patients arrived from villages across the tehsil and attended a camp just once so I built only short-

term rapport. The focus on the mundane practices involved in sterilization camps – bureaucratic registration, medical examinations, waiting for the clinical team and preparations for surgery – provided a nuanced understanding of how practices of care, neglect and violence intertwine and mask each other's effects.

The permission to conduct observations in the camps was granted by Udaipur district and Jhadol tehsil's CMHO offices and the MSI team. Biomedical personnel provided me access through their explicit invitations and permissions to observe registration, counselling and most medical examinations, except surgery. After gaining formal access, I sought permission from patients at every encounter. Building on my readings and reflections on power, ethics and positionality in hospital ethnography and the developing understanding of social and cultural norms of the area which I gained through ethnographic enquiry undertaken before entering sterilization camps, I used my discretion of when to stay/leave, where to position myself within the room and acted on my sensibilities of how my presence affected women's experiences.

To understand how sterilization fits within wider institutional frameworks that medicalize rural women's reproductive lives, I attended Chandpur's Primary Health Centre (PHC) and got to know the biomedically trained staff, community health workers and numerous *dai-mas*[17] (traditional midwives). I also observed women's engagements with health workers in *Anganwadis*[18] (preschool centres), immunization camps and outside of institutions. I interviewed various NGO workers and government officials at district and sub-district levels.

My presence in Chandpur drew curiosity, which subsided through extensive time spent living there. Even though I never blended in, being a tall white woman, my consistent presence in village life, fluency in Hindi and increasing understanding of Mewari and my persistence in trying things out allowed me to create trusting long-lasting relationships. Building long-term trust in the village and short-term rapport in the camps relied on breaking down embodied hierarchies at every encounter, staying keen to hear everyone's perspectives and an ability to communicate in a mixture of Mewari and Hindi. While residents of Chandpur and camp personnel got used to my presence over a prolonged period of fieldwork, my positionality in already power-infused contexts of the camp had effects I could not avoid. I remained continuously reflexive of how my presence may alter patients' experiences and attempted to document the practice in an unintrusive way. Following the doctoral fieldwork, I returned to Chandpur for two post-fieldwork visits in 2015 and 2016 and I continue to keep in touch with some interlocutors via social media and telephone, receiving regular updates on various matters in the village. Even though the arguments

I make in this book draw from a specific ethnographic moment, they reflect wider social and institutional relations and processes that continue to be salient to understanding rural realities in India.

Ethnographic Knowledge Co-Production

This book represents my interpretation of the lifeworlds I encountered and became part of during fieldwork. This interpretation 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 country and village far away from my family received mixed reactions from my interlocutors. I was seen as both privileged and cursed with the freedom to roam the streets of the village (and the world) with much fewer restrictions and repercussions than them. 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 interlocutors and contributed to the types of spaces I frequented, the types of conversations I had and the types of things people disclosed to me or decided to hide.

This book draws on my observations, experiences and understandings, which I recorded in detail in my fieldnotes. I made notes 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 some interviews and encounters in hospital settings. 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 book – 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 interlocutors and myself in navigating different languages. The process of translation is one of the central and crucial tasks of fieldwork itself, where both the interlocutor and the anthropologist must interpret their own culture and that of the other (Baviskar 2005: 5105). While acknowledging my own limits in ethnographic inquiry and writing, I follow Scheper-Hughes' (1995) suggestion 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 resources we have at hand: our ability to listen and to observe carefully and with empathy and compassion' (Scheper-Hughes 1995: 417–18). Therefore, my interlocutors' voices and experiences that I recreate and represent in this book should be read as produced in collaboration between my interlocutors and myself as an ethnographer through sharing a subjective space and having been parts of each other's lives (Sluka and Robben 2007: 24).

Reflections on Hospital Ethnography

In many ways, this work is a product of a multi-sited (Marcus 1995) patchwork ethnography (Günel, Varma and Watanabe 2020). 'Fieldwork is about looking for coherence and finding it even where there is none', a note in my fieldwork journal from post-fieldwork days says. Writing this book – years after writing the doctoral thesis (Lukšaitė 2016) and perpetually postponed by teaching commitments, writing blocks and various personal circumstances – compels me to think differently. Drawing on the recent thinking surrounding patchwork ethnography and 'research as working with rather than against gaps, constraints, partial knowledge, and diverse commitments' (Günel, Varma and Watanabe 2020), I wonder, instead, about how to weave stories together not into a forcefully coherent narrative but into a fragmented story that unfolds in the same time and place, simultaneously as different things. We can only know others through fragments of their shared thoughts and institutionally prescribed scripts – and when they slip – only through fragments of histories that surround geographical places and their people, only through fragments of their encounters with neighbours, doctors, lovers. What people choose to reveal to each other and what people allow to slip depends on the relationships that they have with the ethnographer and with these hidden scripts that do not form part of the official narrative. Writing time and process, too, are rarely given institutional protections and, instead, occur in fragments and in-between other obligations. The idea of patchwork ethnography makes space for the notion that fragmented writing about fragmented stories is the conventional, rather than exceptional, way ethnography is conducted and written.

I aim to rethink the methodological boundaries defining the practices and challenges of hospital ethnography (Finkler, Hunter and Iedema 2008; Inhorn 2004; Long, Hunter and Van der Geest 2008; Street and Coleman 2012; Zaman 2005). How to create possibilities of patching together an understanding of the social, moral and political worlds that unfold through fragmented encounters in clinical settings not only to an ethnographer but also to interlocutors navigating these settings? How do we develop a

comprehensive understanding of social and political processes through fleeting encounters within institutions? How is this view different from doctors who see their patients in fleeting moments unless there is a long-term illness or care? How can we study and write about 'institutions' which become something for a day – as a sterilization camp does – which is different from more 'stable' fields such as a hospital, a ward or a government office, defined by buildings, clinical teams and working hours. How do we conduct ethnography when the site itself is constituted through gaps, fragments and institutional incoherences? How do we document a practice when the sterilization camp materializes in front of one's eyes and then dissolves back into an inconspicuous part of the hospital?

I often met women as patients for a brief, fleeting, temporary moment in the camp only: does it not go against the method of long-term engagement and trust? But does it not also correspond to the way biomedical personnel from urban settings see patients in the camp and other rural healthcare facilities? Many every week but never the same one twice, unless the woman returned to the camp after being rejected before. The view is very partial, but it is always partial anyway. By living in the village, observing various state institutions (*Anganwadis*, school, PHC) and engaging with traditional healers and *dai-mas*, I aimed to patch together a view of how women's lifeworlds unfold in different contexts.

Inhorn (2004: 2096, emphasis original) argues that '[w]hen those who are not physicians attempt to penetrate the hospital clinic in order to apply an "ethnographic gaze *on* the medical gaze" (in part to examine structures of power), their ethnographic penetration may 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, yes, read'. I did not encounter many of these restraints. The camp staff welcomed me to observe life in the camp. The operating theatre (OT) was the only restricted site. I built relationships with biomedically trained personnel, state functionaries and community health workers who regularly attended the camps.

The rural healthcare facilities that I describe throughout this book are spaces rather different from clinical settings in the global north. The doors of the PHCs and CHCs, labour rooms and examination rooms were always open and regularly crossed by patients, their family members, passers-by and chaiwallahs (people serving tea). The privacy of the patients during various examinations did not seem much of a concern to either the healthcare staff or the patients themselves. The only exception was the pelvic exam by the gynaecologist in the sterilization 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 (gender was the only criterion 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. The doctor always 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 the 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, frequent visitors from MSI offices in Jaipur and Delhi investigating the quality of provided services, plus state bureaucrats and community health workers. But an anthropologist seemed to be the most confusing. I was allowed to observe medical examinations and was sometimes asked for an opinion or to help with simple tasks, such as marking the injection spot on women's arms or handling case cards. The camp staff also regularly joked that I should convince women in Chandpur to undergo the procedure and bring in cases as well, and in that way reciprocate their help during my fieldwork.

Precisely because the camp is a temporary facility, I built long-term relationships with the camp staff and community health workers but managed to build only a short-term rapport at best with patients who attended the camps. Women arrived at the camp from different villages, and most had never met me before. It often felt too intimate to approach and talk to patients in the camp – it was already an unfamiliar setting involving multiple encounters with the biomedical team. I did not want to intrude; I did talk to patients sometimes when there was some sort of fleeting rapport: if we happened to laugh at the same comment by the motivator; if we were squatting next to each other and smiled at each other; if they saw me seeing them being told off for chatting to one another and giggling. It is difficult to build trust and break down hierarchies in a setting like the camp. Breaking hierarchies is one of the most important things to do during fieldwork and yet one of the most difficult tasks to do in rural India where the intersecting hierarchies of class, gender, caste and age are woven into everyday relations. Hierarchies are particularly noticeable in healthcare settings. Hierarchies among the MSI team members, between biomedical and bureaucratic personnel, between doctors and nurses, between biomedically trained personnel and community health workers

and between the camp staff and patients were expressed in multiple obvious and nuanced ways. Soon after entering these power-infused clinical settings, I realized that my positionality carried much stronger implications in the camp than it did in the village, where ideas about my background, wealth and habits were dispelled or established through everyday relations and interactions. Due to these challenges, I refrained from interviewing patients in the camp, which would have been both biased and inconvenient to the patients.

Patients at the camp were at the bottom of the hierarchical lifeworld of the camp. They were mostly Adivasi, rural, uneducated women removed from their daily surroundings and placed in the medico-political environment, where the community health worker who cared for them also spoke for them, where they were told to go to sleep when their active participation in providing consent or answering questions as part of medical examinations was not needed anymore, where they took off their shoes while entering the doctor's office but a staff member did not take their shoes off while stepping on a mattress where they were 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 camp staff would do in clinical settings. These were simple things like squatting in general,[19] squatting with patients who were waiting to be taken to the OT, queueing with patients and, of course, note-taking. The camp staff soon got used to my presence, but patients remained somewhat curious, sometimes suspicious, often entertained.

The Chapters

Chapter 1, 'The Camp', opens the book by delving into the most obvious institutional world where sterilization takes place in rural settings: the sterilization camp. It explores a complex politico-medical world through a detailed discussion of bureaucratic and biomedical processes involved in the camp: registration, counselling, medical examinations, preparations for surgery and post-operative care. This highly ambivalent space contains multiple negotiations amongst biomedically trained personnel, state functionaries, community health workers and patients about rural women's health, eligibility for the procedure, identities and social relations and who holds the power to define these. Carried out in the name of care and safety, these practices reveal how care is structured by prevailing social distances between camp personnel and patients thus contributing to overlapping chronicities. The chapters that follow provide the reader with the pieces necessary to contextualise the processes that happen in the camp.

Chapter 2, 'The Laparoscope', investigates how the biomedical artefact employed in sterilization camps – the laparoscope – is entangled in the history of population control in India, global exchanges, national policies, institutional arrangements and local moral worlds. While wider biomedical discourses perpetuate the narrative of safety and convenience, people's everyday lives inform their understanding of technology that is widely known but rarely seen. In the context of troubled population control histories, the concept of convenience surrounding laparoscopic tubectomies in state and biomedical imaginaries emerges as a form of care towards rural populations, but local understandings of this technology demonstrate that ambivalence and power are key aspects of this care.

Chapter 3, 'The Motivators', explores a network of government officials who implement the family planning programme through the process of motivation for sterilization. Focusing on relationships between community health workers and the women they motivate – and ways in which both are entangled in wider networks of kinship, political economy and the state – this chapter discusses strategies for cultivating intimacy as a state relation. Some women use this intimacy to achieve their reproductive goals, some find it a nuisance while others employ various avoidance techniques. Driven by power relations, targets and other concerns, these often fragile social and institutional relations offer temporary care but further deepen chronicities.

Chapter 4, '*Jugad*', explores the everyday life of an institution at the forefront of state-funded public healthcare infrastructure: the PHC. By examining daily interactions amongst biomedical personnel, patients, birthing women, traditional midwives and unregulated biomedical providers, this chapter conceptualizes the unfolding everyday state in clinical settings. It proposes that the everyday state in rural India is constituted through *jugad*: a colloquially used polysemic Hindi word referring to creative problem-solving in contexts of limited resources. While *jugad* allows the state to thrive at its margins – stuck between overlapping chronicities and never-ending interventions – it represents the broader politics of disgust that the postcolonial Indian state reserves for its rural populations. Such ambivalences at the heart of healthcare infrastructure offering care further deepen overlapping chronicities but are well-known to rural communities.

After exploring institutional worlds in the chapters thus far, Chapter 5, 'Reproductive Chronicity', turns to women's experiences to understand why women engage with these institutions in such ways. The chapter develops the concept of reproductive chronicity and contextualizes sterilization within women's everyday lives and reproductive concerns. Cumulative effects of adverse and ordinary reproductive events and exhaustion from caregiving are often seen as chronic reproductive suffering while sterilization emerges

as an act of care towards women's ever-weakening bodies. Where women see their reproductive bodies as chronically ill, they describe sterilization as an act of care despite the ambivalence it carries in institutional contexts. Sterilization emerges as one of the temporary care options often requiring further interventions. Reproductive chronicity lingers across generations and captures how reproductive suffering can be transmitted.

Chapter 6, 'Hierarchy Work', starts by briefly returning to the sterilization camp where this book began, giving the reader the opportunity to re-read the same site. The chapter focuses on investigating how hierarchy work is carried out through sterilization. Besides being a site where histories of violence can be reproduced on marginalized women, care emerges as a site for the same women to negotiate their social positions. Resisting discourses of victimhood and marginality, women actively draw hierarchies amongst themselves through various aspects of sterilization. In a moral world where 'the poor' are seen as having no care to give, sites, practices and definitions of what constitutes care emerge as part of the everyday negotiations of power relations. Care materializes not only as ambivalent but also as capable of reproducing social hierarchies and maintaining social inequalities. Instead of being an antidote to chronicity, care has the capacity to further deepen reproductive suffering by sustaining hierarchy-rich lifeworlds.

In the conclusion, I bring together the arguments of each chapter and use ambivalences surrounding sterilization to reflect on care, power and violence in contemporary rural India and to highlight how the concept of reproductive chronicity captures significant experiences of reproduction in a resource-poor and hierarchy-rich setting perpetually stuck between overlapping chronicities and care.

Notes

1. I use pseudonyms to refer to villages and people who feature in this book. Anyone familiar with the region or anyone who knew me during fieldwork, however, may be able to see through these pseudonyms.
2. The National Rural Health Mission (NRHM) is an initiative launched by the Government of India in 2005, which seeks to provide accessible, affordable and quality healthcare to the underserved rural areas.
3. A public distribution shop that distributes subsidised food to people below the poverty line.
4. Throughout this book, I avoid using terms 'lower caste' and 'higher caste' in order to avoid legitimizing the caste hierarchy. Instead, I use the terms 'oppressed caste' and 'dominant caste' to highlight oppression and domination as key aspects of the caste system. I also avoid using a binary opposition between 'oppressed caste' and

'oppressor caste' because local rural realities demonstrate that oppression is not contained within one caste group. The term 'oppressed caste' includes Dalit and Adivasi communities and other caste-oppressed groups.

5. While some results of the latest National Family Health Survey conducted in 2019–21 (NFHS–5) are available, I primarily provide the results of the previous survey (NFHS–4) conducted in 2015–16, which reflect the situation during fieldwork the most accurately.
6. Women also got forcefully sterilized during the Emergency but in much smaller numbers (see Scott 2017).
7. I use the terms 'laparoscopic sterilization', 'laparoscopic tubectomy' and 'laparoscopic tubal ligation' interchangeably to refer to a minimally invasive surgical procedure to block the uterine tubes as a method of permanent contraception.
8. It was illegal to sell or advertise birth control in Canada between 1892 and 1969. Two Canadian provinces performed compulsory sterilization programmes in the twentieth century: Alberta (1928–72) and British Columbia (1933–73).
9. *Kaccha* and *pakka* are two opposites that can describe food, houses and roads, amongst other things. *Kaccha* means raw, uncooked, incomplete, incoherent, and *pakka* means cooked, proper, substantial, solid, coherent. In Rajasthan, *kaccha* house refers to a mud house and *pakka* to a brick/cement house; *kaccha* road refers to an unpaved road and *pakka* to an asphalted one.
10. For a more in-depth discussion on the history and politics of indigeneity in India, see Banerjee (2016), Sen (2017) and Shah (2010).
11. Whereas most of the academic literature discusses the negative connotations of being *jangli*, some older ethnographies (e.g. Carstairs 1957 cited in McCurdy 1964) stress the positive and romanticized meanings of being *jangli*. For instance, Carstairs (1957: 134–35 cited in McCurdy 1964: 474) writes about Bhils, one of the Adivasi groups in the nearby Kotra tehsil: '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.'
12. *Kalapani* – black waters – is a metaphor referring to a place overseas (literally over-the-seas) where during colonial times political prisoners, mainly anti-colonial nationalists, were sent, with no hope of return.
13. BPL is an economic benchmark related to threshold income used by the Indian state to indicate economic disadvantage and the need of government assistance.
14. The 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.
15. For an in-depth account of contemporary marriage practices in rural north India, see Chaudhry (2021).
16. For an in-depth discussion on how political ideologies, historical interpretations, class positions and environmental concerns impact the everyday politics of meat consumption in India, see Staples (2020).
17. Anthropologists often use the term '*dai*' to refer to traditional midwives or women who support other women through birth in north India. In Chandpur, '*dai*' was

always followed by an affix '*ma*' (mother). Therefore, alongside Chattopadhyay, Mishra and Jacob (2017) I use the term '*dai-ma*'.

18. *Anganwadis* were started by the Indian government in 1975 as part of the Integrated Child Development Services programme to combat child hunger and malnutrition. They can be found in almost every village around Chandpur and throughout India. It is often established in or near a government school, where children between one and six years of age are invited to come, play, learn, eat nutritious meals and give their mothers a chance to work a few hours a day, either at home, in the fields or as labourers outside the home.
19. Class is inscribed on the body through bodily movements and positions. I found how strongly deep squatting marks one's lower-class status in north India when I was drinking tea on a lawn in Udaipur with a good friend from a dominant-caste and middle-class family. Due to a persistent lower back pain, I shifted from a cross-legged position to a deep squat. He instantly protested such a move and said that this is how the villagers sit. He insisted that I change my position or else he would leave.