Matters of the Womb: Muslim Women’s Narratives of Fertility, Family, and the Indian State

by

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Abstract

India’s population control policy has long narrowly focused on curtailing reproduction, even after it was rebranded in the late 1990s as family planning. It continues to prioritize a target-oriented approach limiting birth rates instead of promoting the well-being of families. In particular, deep-seated class prejudices against the low-income Muslim community have led to academic debates and policy interventions to curtail what is considered to be the high fertility rate of Muslims across the nation. Against this backdrop, my dissertation examines the ways that low-income Muslim women imagine, embody, and negotiate family planning in the context of their everyday lives. Drawing on fourteen months of ethnographic fieldwork in Delhi, I explore how women limit fertility and build families. Their narratives provide a critique of the neoliberal framework of choice that celebrates freedom, autonomy, and individual rights in the pursuit of reproductive goals. In contrast, women’s decision making reveals how reproductive choice is embedded within the context of social, familial, and kinship relations, gendered dynamics inside and outside the household, neighborhood and migration histories, and state-imposed programs.

Through a feminist analysis, I foreground the relational and contextual aspects of family building practices. I argue that women challenge the state’s classed, gendered, and prejudiced discourses through their pragmatic family building rationales, which they commonly refer to as *samajhdari ki yojana*, or wise planning, especially within the context of scarce resources and infrastructural constraints. Women cultivate an ethos of judiciousness and responsibility; they understand their own physiological and mental health to be intrinsically connected to the well-being of their families. Thus, women navigate state and familial institutions while negotiating the use of both invasive and non-invasive contraceptive technologies such as sterilization, intrauterine devices, and oral pills. In this regard, I illustrate how their willingness to use IUDs is intertwined with their hopes for the safe delivery and immunization of their infants; how familial, medical, and social anxieties compel them to seek different contraceptive pathways to avoid failures and side effects; and how contingent circumstances and relations with community health volunteers motivate them to adopt or evade sterilization. This dissertation contributes to an understanding of women’s challenges and contradictory and ambivalent negotiations with care arrangements within both familial and institutional settings. It also contributes to an understanding of how social ties and the dynamics of neighborhood building shape the parameters of intergenerational family building.

**Keywords:** family building and planning; contraceptive technologies; Muslim community; India
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Chapter 1.

Introduction

Across India, deep-seated prejudices against the Muslim community have triggered academic and policy debates about the drivers of high fertility of Muslims. This concern with the "problem" of "Muslim fertility" represents generalized Islamophobia, which in turn shapes the social context in which family planning occurs. Any discussion of family planning necessitates an inquiry into both the private domain of familial life and the public domain of policy prescriptions, institutional arrangements, and neighborhood dynamics. Population control policies in India, even after being rebranded as family planning, saturate and structure both the provision of health care and the consciousness of people in all walks of life. Against this backdrop, my goal in this dissertation is to examine how low-income Muslim women imagine, embody, and strategize with relation to family planning programs and population control policies, especially in the context of religious prejudices and class biases?

How do women in an economically underprivileged Muslim community in Delhi experience and conceive their own projects of family building? Rather than examining fertility behaviour as an aggregate of individual choices—as demographers usually do—I carried out ethnographic research to document how low-income Muslim women see their reproductive lives as an integral part of their social lives in an urban context. Invasive and non-invasive contraceptives are provided in the state-run maternity centers, dispensaries, and hospitals. What do women’s stories about both contraceptive- and non-contraceptive-related trips to these institutions reveal about policy implementation and medico-institutional practices?

Low-income Muslim women navigate a myriad of institutions to avail themselves of contraceptives, which in turn are primarily structured by coercive and interventionist family-planning policies. What, then, are the pathways they chart to evade or adopt a particular contraceptive based on the knowledge they glean from their community about

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1 I deploy the concept of reproduction by drawing on the insights of Susan Greenhalgh (1995: 14) who goes beyond understanding reproduction merely as a biological event, as evident in the analysis of demographers, by emphasizing how it is a socially constructed process.
the success and danger of using particular kinds of contraceptives? As I show, the women’s own accounts express ambivalences and contradictions that undergird their choice of contraceptive technologies. In this context, the familial, kin, and neighborhood arrangements become contingent and variable components that factor into how women give birth, limit fertility, or build families. Against the official narratives that portray low-income Muslim women as irresponsible and noncompliant, my ethnographic research illuminates how women cultivate an ethos of judiciousness in their family planning and family building practices.

Because reproduction is not merely a biological event of childbearing but, rather, a process in which personal, kin, and community relations are entwined within specific gendered and classed contexts, I use the term “family building” as an alternative to the term “reproduction” in order to go beyond an individualist framework and foreground the relational aspects of kin and community networks, especially in order to understand the aspirations and future orientations of family building. In other words, I seek to understand the complex social phenomena of reproduction by focusing on women’s decision making in the dense networks of social relations, community ties, neighborhood arrangements, and state policies. In doing so, I reject the naive view of “choices” that characterizes current reproductive health discourse, instead using the concept of decision making to encompass actions that orchestrate forms of power, agency, and resistance with regard to procreation, contraception, and sterilization as well as the cultural and symbolic meanings attached to procreation and gendered conceptions of the body. To go beyond investigating reproductive choice in isolation, I document the reproductive practices of Muslims in their everyday lives by means of household histories, family sagas, and oral biographies.

My research draws on and underscores anthropological arguments that the approaches to family formation occurring through reproduction are processual, relational, and contextual. The processual approach suggests that reproductive decision making is an ongoing process throughout the reproductive life cycle and not a periodic act (Carter 1995). That is, decisions regarding childbirth, contraception, and sterilization are constituted, negotiated, and strategized throughout the life course. The relational approach emphasizes that reproductive decisions are embedded in the intersection of personal, kin, and community networks. The cultural and symbolic meanings attached to procreation are shaped within the domains of kin and community. The contextual
approach lends primacy to the particularities of the local and situated lives of women by foregrounding their differential engagement with issues of reproduction, especially the bodily experiences of conception, birthing, and contraception.

The Political History of Population in India

Population control policy has been the *sine qua non* of the post-independence Indian state. The Famine Inquiry Commission (1946) and the Bhore Committee (1946) instituted by the Indian state provided the platform for shaping population policies. The different policy approaches to fertility control can be broadly characterized by their means of intervention: a clinic approach that witnessed the establishment of family planning clinics to impart information on contraception; a information, education, and communication approach that created the motivation for small families; a health department-oriented, incentive based, target-oriented, time-bound, and sterilization approach that promoted female sterilizations through IUDs; and a camp approach that shifted focus to male sterilizations due to the failure of IUDs (Ledbetter 1984; Srinivasan 2000; Rao 2004). These approaches, phased between 1951 and 1979, led to the implementation of monetary incentives and disincentives promoted by the state (which peaked during emergency period of political upheavals from 1975 to 1977) in order to fulfill sterilization and contraception targets.

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2The Famine Inquiry Commission (1946) linked the Bengal famine of 1943-44 to food shortages as a result of overpopulation and recommended information on birth control. The commission particularly recommended instituting maternity and child welfare centers to impart information on birth control. For instance, it was envisioned by the commission that women could adopt birth control strategies during health emergencies and for spacing children (Famine Inquiry Commission 1946: 172). Likewise, the Bhore Committee (1946) instituted to assess the health conditions of people also recommended information on birth control to be imparted through a national program that was geared towards improving the health of the population (Bhore Committee Report 1946).

3To achieve sterilization targets, the state promoted incentives in the form of gifts and awards. In particular, people employed in government services could qualify for subsidized housing, promotion, or holiday pay if they produced sterilization certificates (Vicziany 1982: 373). Further, disincentives too were adopted by some of the state governments. One of the appalling measures was to discriminate against families having more than two children. As one of the report states, women were denied maternity benefits if they birthed a third child (GOI 1974: 329).

4The period of political upheaval during 1975-1977 (under the prime-ministership of late Mrs. Indira Gandhi) when the state was autocratic in implementing measures that violated the democratic rights of people (one of them being forcible sterilization of the poor, that included a large number of Muslims). As Rao (2003: 3452) argues, “...the emergency period also witnessed
Due to a backlash against coercive measures, especially during the period of emergency, planners shifted away from a myopic focus on birth control alone. In the 1980s, family planning was integrated with anti-poverty programs like female literacy, education, and employment and other schemes of social restructuring (Ravindran 1993; Qadeer 1998; Rao 2004). In the mid-1990s, a paradigmatic shift in the ideology and structure of family planning programs occurred. Following the international ratification of the reproductive rights approach after the International Conference for Population and Development in Cairo in 1994, the Indian state implemented the Reproductive and Child Health program in 1997. Its planners defined this program as a target-free approach that seeks to recognize the overall health needs of women and children such as child survival, safe motherhood, safe abortions, and enhanced community participation (Rao 2004; Simon-Kumar 2006). However, the program is imbued with a neoliberal agenda and donor-driven policies of the Indian state (Hodgson and Watkins 1997; Qadeer 1998; Rao 2004); it is far-removed from the ground realities and the structural conditions that impinge on women’s decision-making with respect to contraception, abortion, and child-delivery services.

There are several explanations for the adoption of these policies. Scholars have argued that planners in developing countries have adopted fertility limitation policies—although with the purported agenda of enhancing the overall welfare of the nation—that reflect an eugenicist and a neo-Malthusian philosophy\(^5\) (Banerji 1985; Rao 1994, 2004). The elite and the middle class have campaigned against what they consider to be the problem of the “population explosion” among the poor by advocating for birth control measures (John and Nair 1998; Chatterjee and Riley 2001; Ahluwalia 2008). And population policies are infused with patriarchal assumptions that conflate women and reproduction, whereby women are primarily conceived as responsible citizens, imbued with a sense of agency to fulfill nationalistic goals, through the subjection of their bodies.

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\(^5\)Eugenics is the belief in the harnessing of the desirable human genetic stock through selective breeding. Often, it has meant racist, classist, and sexist labeling of what is considered genetically ‘fit’ with the aim of preventing the procreation of less desirable or what is considered ‘unfit’ populations. While neo-Malthusian debates focus on the interlinkage and issues around the growth of population and depleting resources. Family planning programs are often envisioned within a neo-Malthusian framework: the policy-makers attempt to control the fertility (through forced sterilizations and contraceptive delivery) of the poor who are perceived as a threat to limited resources within any particular nation-state.
Since independence and partition in 1947, the Indian state has often treated Muslims as the Other within the nation-state and thereby discriminated against and targeted them while enforcing population policies. This bias came to the forefront especially during the emergency period, when Muslims in particular were forced to undergo sterilizations. In Delhi, the family planning policies were interlocked with housing policies during this period (Tarlo 2003). As Emma Tarlo illustrates, Muslim couples were forced to produce more than one sterilization certificate to acquire a single plot of land in resettlement colonies. The government authorities justified demanding multiple sterilization certificates by arguing that Muslims were reluctant to participate in the family planning programs of the state. In other words, an attempt was made to normalize what was considered to be deviant communities by selective targeting and intensifying pressure to undergo sterilization. The continuation of similar population control policies in recent decades has intensely affected the most marginalized population of India.\(^6\)

**Census Controversies**

The 2001 census initiated debates, discussions, and controversies concerning the uncontrolled fertility of Muslims in India.\(^7\) The census numbers were interpreted in an Islamophobic and xenophobic context, creating a public sentiment that the very bodies of Muslims were threats to the social order. The 2001 data recorded growth rate of Muslims in the decade between 1991 and 2001 as 36 percent and that of Hindus as 20.3

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\(^6\) Scholars (for example, Rao 2003; Buch 2005; Visaria, Acharya, and Raj 2006) have been critical of disincentives promoted by state governments, one of them being the disqualification of people to contest in the elections of local bodies who did not adhere to the two-child policy of the government. The Supreme Court of India, the highest legal body, too has supported the implementation of this policy of disincentives. Monetary incentives like educational scholarships or fee concessions are also routinely promoted by the Indian state to motivate people to restrict their number of children. Alarmingly, the implementation of such policies, in a social context of son preference over daughters, have resulted in higher incidences of female foeticides and increase in the frequencies of unsafe abortions.

\(^7\) According to the census of 2001, Muslims, the second largest religious community, comprise 13.4 percent (approximately 138 million) of Indian population (Bhagat and Praharaj 2005: 412). Whereas one-third of Muslims live in urban India, only one-fourth of Hindus live in urban India (ibid.).
percent. These data were challenged by demographers, who questioned the estimation of these fertility differentials (Bose 2005; Rajan 2005; Kulkarni and Alagarajan 2005; James and Nair 2005). For instance, the demographers argued that the growth rate among Hindus and Muslims was not strictly comparable with respect to the difference in the overall population, that is, comparing 827 million Hindus to 138 million Muslims (Rajan 2005).

They questioned the comparison of these population figures of Hindus and Muslims and emphasized the importance of taking note of the socioeconomic, cultural, regional, and demographic diversity of religious communities in India. Nevertheless, demographers like P N Mari Bhat and A J Francis Xavier (2005) have contended that fertility of Muslims is 25 to 30 percent higher than that of Hindus and that the so-called high fertility of Muslims can be attributed to their resistance to sterilization. In response, critical scholars have argued that the idea of Hindu-Muslim fertility differentials foregrounds “pernicious myths” that serve the interests of what they label as “saffron demography” (Jeffery and Jeffery 2005: 447). Instead, they emphasize that there is a gradual decline in Muslim fertility as a result of an increase in literacy and the adoption of practices limiting fertility.

The discourse of high Muslim fertility has generated communal tensions in India especially after the publication of the census data, however, demographers have asserted that such sectarian propaganda related to the fertility differentials are advanced by non-demographers who are unable to accurately interpret the data. For example, S. Irudaya Rajan (2005) argues that fertility differentials need to be understood in the context of specific socio-economic variables, state and district wise composition of Muslims and Hindus, cross-national migration of Muslims, and specifically both Muslim and Hindu demography in urban and rural areas. So the challenge remains in

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8 As the demographers argued, the exclusion of the Muslim dominated state of Jammu and Kashmir in 1991 census recording but its inclusion in 2001 created the false impression of an unusually high growth rate for Muslims (Kulkarni and Alagarajan 2005: 403).

9 The articles (published in Economic and Political Weekly, Vol. 40, No. 05, 2005) provide an extensive discussion on Hindu and Muslim fertility differentials and determinants with respect to the 2001 census.

10 Saffron demographers emphasize the ‘high’ fertility of Muslims compared to that of the Hindus, especially raising anxieties that the Muslims will soon outnumber the Hindu majority in India (Jeffery and Jeffery 2005). In doing so, these demographers reinforce preexisting stereotypes of the “over-sexed Muslim man and his over-fertile Muslim wife/wives” (Jeffery and Jeffery 2005: 447).
interpreting and understanding how the state collects statistical data and whether a holistic understanding is taken into account while interpreting the fertility differentials. Rather than focusing attention on the Hindu versus Muslim fertility differentials and invoking communal hatred, the above intersecting factors need to be considered. Female literacy, according to S, Irudaya Rajan (2005), has a strong correlation with the differentials of the total fertility rates of Hindus and Muslims. States that have high Muslim female literacy levels show a low total fertility rate. In addition to social development and socio-economic variables, demographers also emphasize that state and district wise data also alerts us to levels of fertility transition. K. S. James and Sajini B. Nair (2005: 375) argue that the “fertility in both Hindus and Muslims have similar pace of transition with the accelerated fertility decline in India since the 1980s.” For instance, the decline of child mortality is also a factor that could have contributed to this decline.

Given how the census has focused on the singular axis of religion to understand differentials in fertility among communities also negates our attention on the important logics of how families arrive at reproductive decision-making. Rather than a straightforward claim of lack of contraceptive use among Muslims contributing to high fertility, there is a need to understand why families choose to have a specific number of children in the first place. Through my ethnographic study, I argue that reproductive goals of families constantly change in the context of their lived realities. For example, even after adopting contraception to delay or limit fertility, families are compelled to rethink their reproductive decisions when there is a contraceptive failure. At times, the prevailing rate of child mortality is a significant factor that underscores why families decide to have a specific number of children. In some families, women also have to navigate pressure from the elder members to refrain from contraceptive use, which affects their decisions of reproductive planning. Nevertheless, fertility differentials among religious communities could vary depending on the composition of the population and the socio-economic variables in particular states, districts, or neighborhoods. But do we have data that account for fertility levels in varying settings, say at the scale of a neighborhood? In other words, the large datasets miss accounting for these lived realities that shape reproductive trajectories of communities irrespective of the dimension of religion.

Reports on fertility differentials between Hindus and Muslims created a furore among the sectarian and communal forces, which contributed to heightened prejudices
against Muslims. The media too contributed to the controversies generated by the right-wing Hindutva extremist organizations, including Rashtriya Swayamsevak Sangh, Bajrang Dal, and Shiv Sena, which routinely injected saffron demographic discourse into the public realm to stir communal sentiments arguing that high fertility is rooted in the practice of polygamy and the reluctance to use contraception among Muslims. These assertions fueled the paranoia that the Muslims’ aggressive reproduction rate will eventually endanger the Hindu religious majority in India.

In my thesis, I go beyond the mechanistic analysis and cultural characterization of Muslim women as irresponsible individuals who did not adopt fertility control measures. Instead, I develop a layered and nuanced understanding of social relations, lived practices, contraceptive negotiations and resistances, and experiences of conception and birthing through close attention to the contexts and contingencies of their lives.

**Beyond Aggregates**

To begin with, I challenge the claims of the Islamophobic saffron demographers. Through their data aggregates, these demographers have raised concerns about high fertility rates of Muslims without taking into consideration the salient contexts and contingencies of reproductive decision-making. I argue that family building and planning are intimately connected to material, affective, and emotional conditions that structure life. My research draws on the perspectives of anthropologists and critical demographers in departing from a purely demographic analysis that focuses on population aggregates to explain reproductive decision making. Instead, I attempt to underscore the process of embodied decision making as a framework to investigate women’s negotiations of contraceptive technologies and how such negotiations are embedded in personal and kin relations as well as neighborhood and community dynamics.

Demographic studies conceptualize reproductive behavior through certain variables referred to as socioeconomic status, which suggest that indicators such as income, education, work, or occupation can solely explain fertility and family planning practices. In other words, the field of demography emphasizes merely population aggregates that take those variables into account for statistical representation of data (Kertzer and Fricke 1997) by eliding the social contexts, relationships, power dynamics,
and gendered inequalities that affect crucial decisions concerning reproduction (Riley 1999). As a result, critical demographers have argued for the reevaluation of the positivistic orientations of mainstream demographers (Kertzer and Fricke 1997). Moreover, critical demographers also question the emphasis on individual behavior because it fails to account for the significance of gender in shaping behaviors (Riley 1999: 377). Rather, they insist on a reflexive approach that recognizes “gender as an organizing principle” of inequalities and power difference in society (Riley 1999: 377-378).

In a similar vein, anthropological critiques have focused on social structures that impinge on fertility or mortality rates rather than relying on quantitative methodological paradigms. They have called for a critical interpretive approach and underscored a meaning-centered (Scheper-Hughes 1997) analysis of demographic events and their embeddedness in kin, community, neighborhood, and state structures.

My research contextualizes the messiness of everyday lives that demographic data rarely capture. For instance, the implicit assumption of demographers that women who do not work outside their home spend more time with their children is often unfounded. As empirical evidences show, women struggle to care for children for an extended period due to their time-consuming everyday chores (Desai and Jain 1992 cited in Riley 1998: 524). Further, demographers tend to base their analyses on generalizable data rather than on nuanced empirical evidence or research. For instance, the oft-repeated viewpoint that women increasingly invest in “family welfare” if they control economic resources stereotypes them as “inherently altruistic and caring” (Basu 2000: 23). As Basu shows, the demographers ignore both the particular social construction of gendered roles in a given context and the significance of empirical research before making connections between women’s economic empowerment and family welfare. Rather than relying on generalized patterns that make universalist claims, I draw on empirical arguments to understand the complex, embodied, and experiential processes related to family-building life events.

**Arguments on Reproduction**

Anthropologists emphasize that biological reproduction must be conceptualized as a social process to attend to the different meanings, dynamics, and relations that
affect family formation. Scholars conceive of reproduction as a locus of power inequality (Ginsburg and Rapp 1991, 1995); as deeply gendered social matters involving men and women, kin, community, and state (Feldman-Savelsberg 1999); and as both the biological and the social act that is intrinsically connected to social inequalities (Unnithan-Kumar 2003).

While studies demonstrate how class, region, religion, gender, literacy, and organization of work shape family structure and reproductive outcomes at the macro-level (Mamdani 1972; Schneider and Schneider 1995; Jeffery and Jeffery 1997; Johnson-Hanks 2006), scholars have also focused on how micro-level factors including kinship networks, friendships, sibling intimacy, and conjugal relationships assist people in fulfilling their reproductive agendas (Fuchs and Moch 1995; Weiner 1995; Unnithan-Kumar 2003). Furthermore, modern technologies and the medicalization of childbirth have altered indigenous and local birthing techniques and women’s experiences of childbirth and mothering (Ram 1998; Van Hollen 2003a). Evidence from a variety of settings has illustrated how demographic policies, discourses, and ideologies control women’s bodies and their sexual and reproductive lives (Anagnost 1995; Kligman 1998; Asdar Ali 2002a; Tarlo 2003; Greenhalgh and Winckler 2005). Scholars have focused on the local-global interface in their analyses of the implementation of reproductive health and family planning programs in specific local contexts and the consequent acceptance, resistance to, and modification of these programs (Pearce 1995; Bledsoe et. al 1998; Asdar Ali 2002b; McKinley 2003; Foley 2007).

These anthropological studies emphasize the significance of the historical, cultural, and political-economic processes that are inextricably linked to the process of reproduction (Jeffery and Jeffery 1997; Feldman-Savelsberg 1999; Unnithan-Kumar 1999; 2003). Ethnographies illustrate how the process of reproduction is embedded within local contexts and shaped by structural arrangements and cultural logics and metaphors of procreation. For instance, the process of procreation is connected to the economic value of children, to the status and prestige linked to motherhood, and to an ability to find an appropriate sexual partner (Bledsoe 1998; Feldman-Savelsberg 1999; Unnithan-Kumar 2003). Bodily conceptions of infertility and reproductive disorder are associated with a wide variety of factors including illnesses, harmful health policies, economic crisis, spirit possession, and gender inequality (Boddy 1989; Inhorn 1996; Feldman-Savelsberg 1999). Thus, reproductive experiences are multi-layered and
reproductive subjectivities are differentiated in terms of gender, age, class, caste, region, and ethnicity.

Reproductive decision-making is not a periodic act. Caroline Bledsoe (1998, 2002) argues that the western conception of chronological time cannot be deployed to chart an individual’s reproductive life course. Individuals do not make fertility decisions once and for all; rather, they make reproductive adjustments throughout their lives. Issues of conception, birth spacing, and use of contraceptives are shaped by specific socioeconomic and cultural settings. In Gambia, for instance, women accept contraception not to delay births but to let their bodies heal from the wear and tear of frequent childbirths (Bledsoe 1998; 2002). Thus, sociocultural norms and gender relations affect women’s abilities to make autonomous reproductive choices (Mamdani 1972; Ginsberg and Rapp 1995; Lopez 1998; Bledsoe 2002).

The disciplines of anthropology and gender studies have drawn on the lived experiences of women to question the binaries between victim and perpetrator and between agency and oppression (Abu-Lughod 1990, 1993; Mahmood 2001, 2005; Das 2007). Scholars have argued that subjects are simultaneously powerful and vulnerable in various contexts. In this vein, ethnographies have highlighted how sterilization could be a source of freedom in the context of social constraints (Lopez 1998).

Since the 1970s, feminist scholars have focused on ways in which women both strategically and unwittingly use the instruments of their own oppression to counter or subvert hegemonic practices and patriarchal arrangements. They have demonstrated how collective, organized, or unorganized forms of resistance occur in the form of gossip, lament, trance, and poetry (Scott 1985; Boddy 1989; Abu-Lughod 1993). Although most scholars recognize the salience of this analysis, Saba Mahmood (2001: 206) has questioned the universal desire to resist and the “naturalization of freedom as a social ideal.” By questioning the “analytical and politically prescriptive project of feminism” (Mahmood 2001: 206), she suggests, “uncoupling both the notion of self-realization from that of the autonomous will, as well as agency from the progressive goal of emancipatory politics” (Mahmood 2001: 208). As she contends, “how we might think of agency not only as the capacity for progressive change but also, importantly, as the capacity to endure, suffer, and persist” (Mahmood 2001: 217). Here she draws on the theoretical formulations of Veena Das, who has forcefully articulated that women’s
negotiation and survival of pain in the context of violence inflicted on them during the partition of India can be understood not solely as “defiance” but rather as “the doing of little things” that does not have the sense of “passive submission but of an active engagement” (Das 1999: 11-12; also see Das 1995 cited in Mahmood 2001: 217). Inspired by Michel Foucault, these analysts argue that resistance is never exterior to power, nor is it always designed to overthrow any given regime or institution.

Through his concept of biopolitics, Michel Foucault (2003) has shown that the state practices of regulating populations not only involve the disciplining of bodies but also contribute to the process of subjectivation and self-formation. Individuals internalize the norms of discipline and of regulation, which in turn shape their subjectivities. Similarly, inspired by Foucauldian analysis, Kalpana Ram (2001) and Cecilia Van Hollen (2003a) have argued that the population policies have interpellated Indian women into the ideas of carving a modern identity and contributing to nation building through family planning. In turn, family planning discourses to accept contraception and restrict family size are aimed at creating rational subjects who could then enact the role of responsible mothers and wives by making judicious decisions with regard to family formation.

Reproduction and its Distinctive Meanings

The concept of “reproduction” has distinctive meanings: firstly, it is associated with birthing, raising children, and the care work rooted in building families; secondly, the socially necessary reproductive labor that women are usually burdened with in order to sustain their families (Federici 2012; Winders and Smith 2018). Scholars have argued how reproductive labor not only contributes to biological reproduction but also constitutes the range of activities that replenish or renew the labor power of the working members of the family on a daily basis (ibid.). Women replenish labor power by carrying out everyday household chores such as cooking, cleaning, caring and sustaining emotional relationships and solidarities with kin members. Feminist scholars have noted that this domain of work within the intimate or private domain of the household is largely invisibilised and unpaid (ibid.). The social reproductive labor is considered subordinate to productive labor: the wage earning member, usually the male member, is considered the breadwinner and a productive member of the society, while women’s care work is not valued in economic terms. Feminist scholars (Hochschild 1989, 1997; Glenn 1992) have foregrounded a nuanced analysis of how women experience the double burden of
productive and social reproductive labor when they participate in the workforce as wage earners. Further, scholars (Romero 1997; Parrenas 2000) have shed light on how women of color from the Global South, who are socially and economically marginalized, offer care work and domestic services for the rich or the middle-class families of the Global North. Through the notion of ‘global care chain’, Arlie Hochschild (2013) has analyzed how the women of the Global South are connected with people in the Global North through a range of services they offer (see also Parrenas 2000).

Extending this framework, Shellee Colen’s (1995) concept of ‘stratified reproduction’ foregrounds how reproduction and social reproductive labor that encompass birthing and care work including mothering, parenting, fostering, and raising children raise critical questions of social inequality based on the axes of class, gender, race, sexuality, ethnicity, nationality, migration status, and religion. The concept of ‘stratified reproduction’ has disrupted and challenged the normative and ideal cultural construction of motherhood, care work, and family building. Colen’s analysis shows how racialized and immigrant women are overburdened with social reproductive labor. Despite the significant contribution of this transnational labor, the powerful symbolic imagery of mothering and care work, according to Colen, still rests on the biological mother among the privileged white families. Further, this concept also amplifies the inherent inequalities in such transnational labor, when racialized women subsidize the lives of privileged rich white families through their care work by relying on the support structures of their kin and family members back home who primarily raise their children in their absence (see also Parrenas 2000).

Such care arrangements also call into question what constitutes normative heterosexual families, especially when the lack of state resources and economic insecurities compel women to undertake transnational migration to care for the children of the privileged in different contexts. These strategies adopted by marginalized immigrant families to support their families back home resonate with family building strategies among Black women in North America, which in turn exemplify the interplay of colonialism, race, gender, and class. For instance, the concept of ‘othermothers’ by Patricia Hill Collins (1987) sheds light on how biological mothers in Black families relied on extended and intergenerational family and also community members such as grandmothers, aunts, sisters, and neighbors to raise, educate and provide overall guidance to their children when they were unable to do so. These support networks,
according to Collins, provided economic resources as well as emotional care that were central to Black families. At times, ‘othermothers’ also took on the responsibility of long-term adoption of the children whose families struggled with economic uncertainties, incarceration, or deaths of parents resulting from slavery, and also those who were born out of rape (Collins 1987: 5).

Thus, one needs to understand these nuances of ‘stratified reproduction’ to clarify how social reproductive labor and care work do not solely rest on blood mothers, biological families, and hetero-normative parenting. In other words, these family building arrangements also underscore how extended families and neighbors take on additional responsibility rather than abandon or desert children in the context of racial injustices in the United States. Similarly, fostering and childcare responsibilities are shared among families who live in poverty and conflict-ridden situations, who care for non-biological children due to the untimely deaths of biological parents in Brazil (Goldstein 2003).

Furthermore, the introduction of assisted reproductive technologies (ARTs) has redefined the normative understanding of familial and kinship relationships related to genetic and blood lineages. Despite these technological advancements, it is crucial to shed light on the differential access to biogenetic materials, that is, sperm, eggs, embryos, and wombs because it rests on purchasing power (Riley 2018) and also claims to citizenship rights (Deomampo 2015) of individuals and families struggling to become parents after long periods of personal battles with infertility, chronic ailments, or non-hetero-normative relationships. For instance, Nancy E. Riley (2018: 126) asserts that although there are “positive outcomes”, ARTs can be conceived as a form of stratified reproduction. There are clear economic and class distinctions as to who can access donor eggs, sperms, and wombs. In countries like India, working class women’s bodies have become commoditized, since they are usually the donors of these biogenetic materials. Furthermore, the buyers of donor eggs or sperms build perceptions around what constitute desirable and idealized bodies in these processes of commodification and economic exchanges. For instance, it is not uncommon for the buyers to look for special attributes in genetic makeup, as they are willing to pay more for intelligent, athletic, and beautiful traits. Thus, investing in such traits exemplifies the differences in social location, class privileges, and thus a more advantageous position to seek what is considered ‘superior’ quality of biogenetic materials (also see Riley 2018: 126-130).
In this light, Deomampo’s (2015) study of transnational surrogacy in India and Norway demonstrates the complexities of nationality and legal rights of the genetic mother, surrogate or birth mother, and the child born out of such surrogate arrangements. Thus, it is important for us to understand who has the power and leverage to navigate the bureaucratic and official paperwork of renegotiating citizenship and parenthood rights, and who stands to lose her rights or entitlements in this process. Deomampo argues that since the birth mother is legally conferred parenthood in Norway, the case of Norwegian parents who are seeking the services of the surrogate in India to birth their genetic child struggle to prove their relationship ties to their genetic child to the Norwegian government. In this context, the Indian surrogate or birth mother (who is considered the legal parent given the Norwegian rules) has to provide a “written statement that she has consented to transfer all her parental rights to the commissioning parents” (Deomampo 2015: 10). Such specific cases reinforce how privileges of nationality, citizenship entitlements, and purchasing power strip the gestational surrogate of any legal rights to the child.

Similarly, Holly Donahue Singh (2014: 826) asserts that ARTs have exacerbated “more and more intimate exploitation of inequality” (cited in Riley 2018: 129). Singh observes that in cases of domestic surrogacy “the middle class citizens in India conceive the labor of the surrogates who birth their genetically unrelated child as mere ‘labor’ – a naturalized category of people who can be hired and let go at will, for whose well-being employers bear minimum responsibility, and who can be easily exchanged for others eager to take their place” (Singh 2014: 826, cited in Riley 2018: 129). Thus stratified reproduction highlights how discourses around the dispensability of certain forms of reproductive labor get manifested and how particular forms of reproductive labor is valorized or discounted. In this light, stratified reproduction provides us a lens to critically understand whose bodies are conceived as capable to reproduce, nurture, and undertake caregiving work and whose bodies and sexualities have been sites of disciplinary state policies of control and regulation because they are considered as irresponsible ‘breeders’ (see Ginsburg and Rapp 1995: 3). Furthermore, this analytical framework sheds light on deep-seated prejudices and how they shape our perception of specific communities. For example, Ginsburg and Rapp (1995: 3) argue, “that on one hand, low-income African-American mothers are considered irresponsible ‘breeders’ who are a burden on state resources due to their demands on welfare, however, on the
other hand they are viewed as ‘good enough’ nurturers to undertake childcare responsibilities of the rich and privileged class and ethnic groups.”

In this similar vein, my study contributes to this analysis of ‘stratified reproduction’ as I demonstrate through case illustrations how low-income Muslim women are perceived as irresponsible and non-compliant related to their adoption of contraceptive technologies. In other words, low-income Muslim women, who primarily carry out social reproductive labor in middle class households in Delhi, are targeted for their high fertility. The prevailing prejudices historically have led the state authorities to target them during mass sterilization drives. However, in this dissertation, I also show how low-income Muslim women counter such prejudices and carry out pragmatic family building rationale in making a convincing case that it is in fact the state that acts irresponsibly towards them, often hampering their ability to make healthy choices for themselves and their children.

Challenging Gendered Subordination

As Kumkum Sangari and Sudesh Vaid (1989) have argued, in recent decades in postcolonial India women are further marginalized as a result of the lop-sided development model that devalues their significance in the production sector and limits them to invisibilised social reproduction roles. In addition, the resurgence of communal tensions and “ politicization of religious identities” have led to “ patriarchal practices under religious sanction” (Sangari and Vaid 1989: 2). In this light, the scholars assert “the inter-relation of patriarchal practices with political economy, religion, law and culture – in sum questions about the politics of social change” (ibid.). Furthermore, the subjectivity of women in familial relationships is often construed in a homogeneous and conservative manner (Tharu and Niranjana 1989: 247). For instance, the ideology of Indian family planning programs and advertisements that promote contraception assume that women do not actively negotiate pregnancy with their partners (ibid.). As Bina Agarwal (1998) argues, institutions such as family, community, and media play a significant role in reinforcing prevailing ideological norms with varied outcomes across classes and regions.

In this respect, it is crucial to challenge the social construction of gender and the process of subordination. For instance, we need to interrogate the well-established
discourse of subordination of women that reifies patriarchy, religious customs, and traditions among Muslim communities. Scholars have contested the stereotypes and myths that portray Muslim women as passive victims in Islamic countries (Abu-Lughod 1990, 1993; Mahmood 2001, 2005). In this light, Lila Abu-Lughod (1990) attends to the complexities of power, structures of domination, forms of subjection, and modes of resistance among Awlad Ali Bedouin women in Egypt. As an example, she shows how women resist structures of domination by defying male authority through their refusal to accept marriage proposals and how older women exercise power by making demands on younger women to live with honor and modesty (Abu-Lughod 1990).

As Abu-Lughod (1990: 49) illustrates, older women are able to persuade their younger counterparts to not give in to the pressures of consumerism by purchasing lingerie—attire perceived to accentuate a form of “sexualized femininity deployed in the pleasing of husbands.” Her analytical challenge is to capture how Bedouin women both resist and support the existing systems of power. In a similar vein, my research aims to understand the significance of these power structures and how women embody it.

In this dissertation, I focus on narratives to reveal a wide range of situations and dilemmas through which I uncover how important contingent family biographies are for understanding how and why certain reproductive pathways are taken. By treating population policy documents as a source of information and as representative examples of larger discursive frames, I show how the members of the socially underprivileged Muslim community understand, interpret, and receive the terminology of choice, rights, and autonomy imprinted in policy reports in their lives. In this context, so-called choices are undertaken in dynamic situations connected to work arrangements, coercive state policies of contraceptive promotion, familial relationships and extended kin networks, and the histories of urban immigration and evolution of neighborhoods that shape family-building decisions. I structure my narratives around what women consider as important and worthwhile in matters of family building and family planning.

**Methodology**

This dissertation draws on fourteen months of field research in two low-income neighborhoods in southeast Delhi. I have used pseudonyms, Radha Nagar and Noor Nagar, for both these neighborhoods to protect the privacy and confidentiality of my
research respondents. Initially, the pradhans or chiefs of both these settlements introduced me to a few key and articulate women in both neighborhoods. These women worked as community health volunteers and ‘dais’ in the neighborhoods. The nature of their work involved everyday interactions with women who sought their advice about safe and reliable contraceptive technologies, immunization of their children, vitamins and foods to take during pregnancy, and assistance at the time of birthing and postnatal care.

The pradhans perceived that the health volunteers and the ‘dais’ could explain my research project to women residing in these neighborhoods. In my initial days in my field sites, they became my key informants and introduced me to families that had sought their assistance. They also introduced me to their neighbors and extended family members who resided in these neighborhoods. During my first meetings with these women and their families, I spoke in detail about my research project, and at the time of follow-up conversations it became easier to discuss about their experiences in the health care institutions.

My research involved participant-observation, in-depth unstructured and semi-structured interviews, and informal discussions. I spoke to women in ages ranging from sixteen to sixty. I conducted sixty in-depth interviews with Muslim women and their families residing in both Radha Nagar and Noor Nagar. Given the practical considerations of the time frame for this research, I limited my research respondents to thirty families in each of these neighborhoods. My aim was to learn about and understand women’s reproductive experiences and their perceptions with regard to the shifts in population policies.

I first determined a local history of turning points—phases or crucial moments—in order to develop a periodization. This involved looking at documents to determine important policy transitions or shifts in family planning services, interviewing key informants in the community to capture local history and change; and interviewing women in order to get a sense of their life course, that is, how they themselves would organize their life into phases.

I also had extended conversations with at least fifteen health volunteers and registered medical practitioners. In so doing, I paid particular attention to the existing
hierarchies among these health care providers in order to gain an understanding of their varying expertise and training.

**Field Sites**

Radha Nagar was a low-income neighborhood made up of approximately five thousand families at the time of my fieldwork. It was gradually established since the 1980s. The elderly residents told me that initially the place was filled with shrubs and bushes, and that the vast empty spaces without vegetation looked like a desert. People were not inclined to set up temporary shelters here because there was no source of water in sight. However, new migrants to the capital city who struggled to find work started living in this area, because they could not afford to rent a house in the low-income neighborhoods. As more people settled here, they took up the responsibility of clearing the overgrown bushes and built shelters with sundry materials like corrugated tin, cardboard, plastic sheet, gunnysack, and straw mat.

Gradually, over the years, residents turned these temporary shelters into small huts supported by bamboo poles with a thatched roof above. At the time of my fieldwork, people had built concrete houses, and none of these early huts remained. The residents also told me that during those days there were more cases of theft so that they had to guard their shelters and their belongings. They hesitated to sleep in their shelters at nights due to the fear of wild animals. But they had to stay in their newly constructed shelters because other people forcefully occupied these shelters with their sheer display of strength. To avoid such hostile relations, the old residents lived in this neighborhood despite their difficulties.

Over the course of time, residents brought some order to the chaotic state of everyday affairs in this neighborhood. As people found work in the nearby garment export factories, they planned their lives and organized themselves. For instance, they hired a person to guard their belongings when they went to work. After a few months, they brought their families from the villages and constructed wells and tubewells to have a constant water supply. They built a community as more people settled in this neighborhood. Most people had migrated from the adjoining state of Uttar Pradesh, but the recent migrants were from Bihar, Madhya Pradesh, and Rajasthan. It is a mixed neighborhood comprising of both Hindus and Muslims. Most of the Muslim residents
claimed that they belonged to subaltern castes such as weavers, oil pressers, and butchers.

The older residents had at least two houses in this neighborhood, which they had occupied in the initial days of settling down. At that time, they did not have to pay any money to buy the plots. Once they started living on these plots, they owned them. In the present context, they profited from these plots by renting them out. Some of the residents had sold the plots when they were in need of money in crisis situations such as spending on a marriage or repaying debts in case of health emergencies. While some residents entitled their children to these plots especially if they planned to settle in their native villages.

The residents often recalled unfortunate incidents of fires, which were not very frequent now. Families had lost infants and children during these outbreaks along with their property and belongings. Children suffered the most, as they could not escape when a fire rapidly spread across the entire neighborhood. Usually, the parents worked in nearby factories and the elder siblings took on the responsibility of caring for infants and toddlers, and thus children could not seek any help in the absence of their parents. People often mentioned one of the major fires that had completely destroyed the huts in the early 1990s. Many people had lost their lives. Though newspaper reports had documented twenty-five deaths, I was told that there were more casualties. People had received some compensation—2 USD$—from a nongovernmental organization. This organization had also distributed tarpaulins, straw mats, and bed linens to the families to help them reconstruct their shelters.

Most of the residents affirmed that almost three thousand shelters had been gutted, which drew the attention of political leaders and ministers. Though some of these ministers promised to provide certain amenities, these promises were never fulfilled. However, the residents reiterated that the erstwhile Prime Minister V. P. Singh had

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11 Vishwanath Pratap Singh (V. P. Singh) was the Prime Minister of India for a short period between 1989-1990. Before being elected as the Prime Minister, he was a cabinet Minister in the Congress government under the leadership of Mrs. Indira Gandhi. However, he quit the Congress Party due to differences and had subsequently formed the Janata Dal. He had won the Prime Ministership while being a member of Janata Dal. He is remembered for implementing reservations for the Other Backward Classes in public services. He consistently worked on issues of social justice and was particularly involved in stalling demolitions of low-income neighborhoods in Delhi. He had issued V. P. Singh cards to the residents of these neighborhoods to ensure their
visited the neighborhood and ensured basic provisions. As a result of his involvement, the residents of Radha Nagar were allocated block and house numbers and also provisioned with basic infrastructural facilities. The V. P. Singh cards issued in 1990 and 1991, the residents argued, were a form of identity card that validated them as residents of Delhi.

The house and block numbers entitled the residents to own an address; this was a significant benefit for proving their identity and residency status for bureaucratic purposes. In the late 1990s, the Delhi Development Authority initiated demolitions in Radha Nagar. The neighborhood is considered an illegal slum settlement. In the context of these demolitions, only the residents who can prove their identity and residency status can claim resettlement plots. The demolitions have occurred over the past two decades; however, they have been successfully stalled due to the interventions of influential ministers. In 1990s, when the initial demolitions occurred in Radha Nagar, only those residents who had V. P. Singh cards received resettlement plots on the outskirts of Delhi, although they had to pay 120 USD$ for these plots. Some of the residents also claimed that a private health dispensary was established in Radha Nagar due to the intervention of V. P. Singh.

During my fieldwork, the residents were collecting necessary documents to receive resettlement flats in case of evictions and demolitions. Though Radha Nagar still exists today, the residents are anxious about the impending reality of losing their homes and livelihoods as a result of evictions. As one of the residents noted, the Delhi Development Authority “is constructing multi-storeyed flats nearby to accommodate evicted families; and we have heard that only two thousand families will reside in these flats. Thus most of us have to be prepared to live in flats built on the outskirts of Delhi.” Given this present context, the residents fear that their identity documents could be rejected, or that they will have to wait for a long period to receive their resettlement flats.

The second field site, Noor Nagar, is a low-income neighborhood, which is also identified as an illegal slum settlement by the Delhi Development Authority. However, the history of the neighborhood and the composition of its initial residents differ from that of Radha Nagar. Most of my respondents in this neighborhood are low-income and migrant residency status in Delhi. The V. P. Singh cardholders were mostly migrants from adjoining states like Uttar Pradesh and Bihar. These migrants mostly belonged to landless families and had left their villages in search of work opportunities in Delhi.
Muslim women from the state of West Bengal. As recounted by one of the elders, since the land was vacant, few Gujjar families who owned buffaloes had settled in Noor Nagar. Apart from financially sustaining themselves with the domestic cattle they owned, they had also started selling surplus milk of their buffaloes gradually to the middle class residents living in the vicinity of Noor Nagar. Earning an income through cattle-raising primarily helped them to sustain themselves in the capital city of Delhi. The Gujjars had migrated from the neighboring states of Haryana and Rajasthan. They were able to build concrete houses within a few years. During my fieldwork, the Gujjars did not live in temporarily constructed shacks like some of my low-income Muslim respondents in Noor Nagar. Some of the Gujar families had also increased their stock of buffaloes. But very few families remain in Noor Nagar now. My respondents relayed the information regarding the Gujjars to me during our discussions of the history of the neighborhood of Noor Nagar.

The Gujjars had relocated to the new suburban neighborhoods, since the national capital region of Delhi had expanded with the construction of housing societies and real estate developments in the adjoining states of Uttar Pradesh, Haryana, and Rajasthan. In the past two decades, Gujar families had used their savings to invest in the land in the vicinity of these new housing societies because the increase in their domestic cattle and expansion of families over the generations required an expanse of land or open space. Further, the families presumed that there was a possibility to earn more money by catering to the residents settled in new suburban townships. In addition to the stories of Gujjars residing in Noor Nagar and then rebuilding their lives in new townships, my respondents also offered a different perspective. They revealed that the Gujjars were exploitative and had accumulated savings through unscrupulous ways.

Families of my respondents in Noor Nagar were initially compelled to pay the Gujjars money on a daily basis to dwell on this vacant land. From their meager daily wage earnings, a substantial proportion had to be handed to the Gujjars who asserted their authority on the basis of being initial dwellers on this unclaimed land in Noor Nagar. As I understood, the Gujjars perceived that they had territorial rights to this land, thus the precarious migrants who had recently traveled to Delhi in search of work opportunities had to submit to their imposed rules, as they lacked shelter and employment stability. Since the migrants had to first seek permission of Gujjars to inhabit, this particular narrative demonstrates how this community of milk-sellers symbolized power by either
offering or denying a plot of land for the migrants to subsist. My conversations with the respondents also revealed another dimension to this narrative of monetary exchanges. Some of my respondents were of the view that this monetary arrangement at times benefitted them because the Gujjars protected their dwellings and plots from being claimed by outsiders if they desired to go back to their native villages either for a brief or long period. Gujjars also acted and mediated conflicts related to ownership of properties among neighbors.

Usually, the migrants worked as daily wage laborers at construction sites, but they were not always fortunate to find employment in this sector. So they gradually started to venture into sorting and selling of scrap or waste in the neighborhood. They collected scrap and wastes such as paper, plastic, and discarded household appliances made of metals, ceramic, and glasswares from the middle class neighborhoods in the vicinity. The scrap collectors sorted and sold the waste to scrap contractors to earn an income each month. My respondents, especially women, found gainful employment in sorting and storing these materials in Noor Nagar. I often came across both women and men sorting and filling huge gunnysacks or polythene bags with discarded scrap or junk until late in the evening in Noor Nagar.

Petty thefts of scrap materials were common. Moreover, during the monsoons, the collected junk got damaged, as it got soaked with rainwater and overflowing drains. Stormy weather also littered the junk around the neighborhood, and residents often noted that accidents were common when they stepped on rusty metals and broken glasswares. Thus, in order to avoid turning the neighborhood into a dumping ground of waste, residents constructed warehouses with roofs and walls made of brick and concrete that worked as a storage facility. A few of the residents who had spent considerable years in this trade had turned into entrepreneurs of wastes in Noor Nagar.

The residents share similar conditions of precarity with their counterparts in Radha Nagar, especially related to the threat of losing their homes and sources of livelihood in the event of demolitions. Many residents told me that they had received notices from the concerned authorities that they could reside in the neighborhoods for only another six or eight months. At the time of my fieldwork and while I visited them a few years ago, panic-stricken residents of Noor Nagar were busy collecting the
necessary documents that could help validate their residency in the city and render them eligible to receive resettlement plots or one-room apartments in suburban areas of Delhi.

In this respect, the informal healthcare practitioner, Mohammed Abdul— who is referred to as daktar sahib in Noor Nagar (discussed in Chapter 6)— offered advice to residents and even filled their forms to procure documents to demonstrate their eligibility for resettlement. During one of my visits to his makeshift health cabin, a pile of forms was stacked on his table. In the midst of prescribing medicines and following up with his patients, he was also engrossed in explaining to people that they needed to enclose particular documents, passport photographs, and also cash that needed to be deposited for the documents.

Though the residents had received notices that the demolition would be carried out in the next six to eight months in Noor Nagar, a few houses including Dr. Abdul’s cabin were demolished in a week of this demolition notice. According to daktar sahib, such hasty decisions of razing the houses without any prior notice flouted legal rules. As I understood, the residents knew about this imminent demolition, however, none of them were prepared for this sudden eventuality. The demolitions had happened because the neighboring middle-class residents had complained that some of the houses that were built close to the drain (nallah) obstructed it in Noor Nagar. The residents, who lost their homes, ended up renting one-room houses from those who owned two or three houses in Noor Nagar. They rented these tenements by paying 50 $USD each month. Dr. Abdul managed to find a spot to set up his cabin, but it was awkwardly constructed below the large water pipeline in Noor Nagar. The cabin was damp year-round and the pipeline obstructed it from receiving any sunlight.

Noor Nagar is located adjacent to a middle-class Hindu neighborhood. Both Hindus and Muslims live in Noor Nagar. The infrastructural facilities in Noor Nagar are worse than those in Radha Nagar. This neighborhood lacks sewage and garbage disposal facilities and functional public toilets. Although an NGO had built public toilets, the lack of maintenance had rendered them dysfunctional in the neighborhood. Residents also claimed that the Pradhan (chief) of Noor Nagar, who collected money from residents for maintaining the toilets, did not regularly pay the hired staff who cleaned the toilets. As a result, the residents were compelled to defecate in the open during the early hours of the day in the vicinity of the neighborhood. The residents also
defecated near an adjacent uncovered drain that flooded the neighborhood during the rainy season. In recent years, however, the residents had received piped water supply in their houses.

At the time of my fieldwork, approximately two thousand families resided here. Men worked as scrap sellers, rickshaw-pullers, vendors, electricians, and daily wage earners in construction sites. Women were employed as domestic maids in nearby middle-class neighborhoods. People hardly had the means to pursue formal education. Most of these residents knew how to write their names in Hindi and English. Only a few residents were well versed in Urdu and Arabic and usually taught their children to read the Quran. The residents are mostly migrants from the northern states of Uttar Pradesh, Bihar, and West Bengal. Unemployment and landlessness had motivated people to migrate to the city. There is not much variation in terms of income and the nature of employment sought by the residents of both these neighborhoods. People make a living with a monthly income that ranges between approximately 30 USD$ to 130 USD$.

Most of the families lived in one-room tenements, and some of them had already purchased plots in this neighborhood. Recent migrants lived in rented accommodations. None of these neighborhoods had state-run health dispensaries. The registered medical practitioners had set up small shacks in this neighborhood. The many Bengali Muslim residents in Noor Nagar were labeled as illegal Bangladeshi immigrants, and thus the neighborhood was under constant police surveillance. For instance, during one my trips, I had encountered a beat cop while I was returning back from Noor Nagar late in the evening. After walking for some distance from the neighborhood, I had realized that a motorbike was speeding behind me. As I stopped to hire an auto rickshaw to go home, the cop seated on the bike had gestured me to wait for a while, as he wanted to have a short conversation before I left for home. He told me that he has been observing me for more than fifteen days or so during his patrolling duty in and around Noor Nagar. He had seen me talking to informal health practitioners, spending time with families on their verandah, or jotting things down on my notebook during discussions with women in their homes or on the rooftops. Before I could explain the nature of my research, and how I planned to spend my time in the neighborhood, the cop particularly cautioned me to be careful in Noor Nagar. By arguing that he was concerned about my safety, he insisted that I needed police protection while I pursued my field research. I was asked to register my personal details such as name, home address, phone number, and my university
affiliation in the police station within that jurisdiction. He offered his phone number and insisted that I should readily contact him in case I felt any risk or danger while conducting my research. Without hearing out my response he insisted that the residents in Noor Nagar are mostly BCs or ‘bad characters.’

His insistence on police protection, which I declined, clearly demonstrated the moral panic that is associated with the space and the inhabitants of Noor Nagar. In other words, the space comprised of bad characters and was not an ideal space for a middle-class unassisted Hindu woman to inhabit for any reason at any time. However, I did not submit to his moral policing or his over-protectionist discourse concerning my safety while I carried out fieldwork in the low-income Muslim neighborhood of Noor Nagar. I know that if I had sought police assistance during my research, my respondents who encountered everyday intimidation in the hands of the police could no longer trust sharing their stories with me. In other words, the mission of the cop was not to offer surveillance of the space, but also to protect a middle class Hindu woman from the low-income residents of Noor Nagar, who were suspect because of their illegal status of residence, their religious affiliation, and migration histories. It must be reiterated that Bangla speaking low-income Muslims are often touted as illegal Bangladeshi migrants in the city.

Building Trust

Women invited me to their homes during late afternoons when they usually sat on the terrace soon after drying their clothes on the clothesline or especially when winnowing rice or wheat. While they winnowed, they often complained how the subsidized rations of wheat, rice, and sugar had small pieces of stones that had to be carefully discarded before household consumption. In the winter months, they spent extended periods of time on the terrace doing everyday chores and sunbathing after a bath. In the low-income neighborhoods where I conducted my field research, women followed this routine between the months of October and March. Along with seeking a respite from the biting cold, they found some recreational time to chitchat with their neighbors while sipping hot tea. On most occasions they sat on the floor, but they usually rolled out straw mats when babies or toddlers accompanied them.
Women had to constantly supervise their children’s activities because some of the terraces did not have a protective wall or railing to serve as a barrier and prevent children from falling. We all took turns keeping an eye on the children to ensure that they stayed within an arm’s distance. Sometimes grandmothers took on the responsibility of supervision and held the children in their laps, trying to put them to sleep or keeping them engaged through baby talk. When children scribbled on my notebook, their mothers coaxed them to write English alphabets to demonstrate to me that they were invested in their children’s education in the context of limited resources.

Women who were employed as domestic workers and scrap sorters partook in the conversations on the terrace if they returned early from work. They joined in for a few minutes before starting to cook meals for their families and attending to their children’s needs. In the course of their time on the terrace, women extensively spoke to me about their reproductive trajectories, pathways, and coping strategies while encountering the population control agenda of the Indian state in the local maternity centers and the public hospitals of Delhi. Our conversations centered on the fertility limitation motives of the health care service providers during women’s visits to the state health care institutions for regular antenatal and postnatal health checks and at the time of birthing. At times women engaged in detailed conversations, and such moments motivated me to stay for longer hours as I intently listened to their various perspectives. When more women participated, the perspectives were further enriched as they provided details reaffirming or adding to their experiences. The terrace especially served as a space where conversation, gossip, and chat continued for long stretches of time; if one of my respondents left, others took charge and contributed to the ongoing discussions.

The terrace as a socializing space where men thought womanly matters were discussed brought a sense of relief to me, because I did not have to hurriedly leave when men came back from work and needed to rest and relax. Though I introduced my research and myself to men whenever I found the opportunity, they seemed hesitant to speak to me. Some of them suggested that I talk to their spouses or the registered medical practitioners in the neighborhoods since they had significant knowledge with respect to matters of health and well-being. While I met with one of the practitioners in his one room shack, men usually struck up conversations with me and told me about their experiences in the health care settings they had visited to seek treatment when unwell. During these interactions, they also discussed uncertainty related to contractual
and temporary jobs and the lack of basic infrastructure. As a result of my repeated visits to the neighborhoods, men reposed trust in me and talked about the everyday surveillance by the state and, especially, harassment of the Bengali-speaking residents.

During the summer, women spent most of their time indoors cooking meals and feeding their children while watching television serials. Women who worked usually preferred to continue with the conversations late in the evening. These conversations did not happen at a stretch. Rather, they spoke to me in the midst of cooking, serving, and feeding meals to their families. My visits to the neighborhoods over a year helped to build trust with my respondents. I spent more time with some of the families who accommodated me at any hour of the day. With mutual sharing of stories regarding marriage, spouses, and parents and in-law’s families I gradually grew closer to them. We discussed the reasons for my delayed pregnancy and why postponing it provided me more time to do my research. Over the course of a year, I developed friendships as families welcomed me to spend time with them and have random conversations when I struggled to meet my other respondents due to their laborious work schedules. I knew that I could hang around, and this fact comforted me.

On certain days, when women had not returned from work, their children accommodated me in their one-room tenements where I turned my notes in shorthand into proper sentences and reflected on past conversations and formulated specific questions. Children also kept me entertained by dancing to the tunes of popular Bollywood songs. While women bought groceries from the market, they insisted that I tutor their school-going children. Though these children learnt Hindi in schools, women perceived that getting an English education would give them an edge over the vernacular language that might help them get jobs.

Women also invited me to attend special feasts when they celebrated Eid and their children’s birthdays. These get-togethers provided an opportunity to meet with other families in the neighborhoods and introduce my research interests and myself. Such interactions helped familiarize me with the setting, and sharing food especially initiated friendships. Women also took me along with them on their morning trips to the local maternity center, public hospital, and the state office issuing birth certificates.
It was through these many moments that I pieced together the accounts that I call narratives in the following chapters. I rarely recorded women’s stories by staging a formal interview; to do so would have broken the natural conversational flow in which women talk to each other. Instead, I kept notes from the everyday interactions and then later wrote out summaries. Cumulatively, all these interactions taught me about the interactional contexts of families and communities. Sometimes an individual woman would share with me much of her story in one conversation, but then she would add new details and comments in later talks, or other people would add information, or I could infer more from interactions with her family. The narratives I present are reconstructions of tales that were told to me and often repeated and filled in and further explained over more than one conversation. This is the way people speak. This is the way they talk about their lives and themselves to a sympathetic outsider who asks direct questions.

When women talk about their lives with each other, they commonly recount their dukkha, their sadness as a result of unfortunate incidents. In these types of communities, especially among groups of female friends and relations, the general outlines of reproductive histories and medical stories—that is, what happened to so-and-so—are commonly known. In my research, I paid particular attention to how women told their own stories with themselves as protagonists navigating difficult and complicated situations.

Why did these women choose to talk to me? By continually visiting their neighborhoods and making notes about their personal health trajectories, women felt that it added to their sense of importance and self-worth. Once a middle-aged woman remarked: “you need to write about our lives and bring it to the attention of people who are not aware of our circumstances, at the least through your writing you can share your knowledge with respect to the poor residents’ everyday struggles.” Another woman residing nearby who was listening to our conversation commented: “the current increase in prices of essential items—that is, vegetables, lentils, cooking oil, flour, milk, and sugar—have affected us; more so, we do not receive these items at a subsidized price.” To this end, both of them affirmed: “do not ask us about health care expenses—the state officials are of the view that the poor do not exist and as a result no monetary aid or assistance is provided to us.”
Many of the conversations I had with people also touched upon difficult situations: conflict with their husbands or mothers-in-law in the familial domain, uncertainties over receiving resettlement plots in case of demolitions, and lack of state subsidies regarding food and health care for the economically marginalized. What did it mean for me to record these accounts, and why did people choose to tell me about these situations? In Noor Nagar, Bengali Muslim residents particularly raised concerns about state violence, referring to how the police arbitrarily picked them up and labeled them as illegal Bangladeshis. They were incarcerated solely on the grounds of suspicion for procuring fake identity documents in order to reside in India.

These recurring themes were usually woven into women's narratives during our conversations about their everyday lives. These accounts helped me understand how women imagine, embody, and strategize state health care schemes and policies. In ethnographic research, it is difficult to detach people's experiences about a specific topic of research inquiry from the complexities of their lives; information does not present itself as discrete and bounded categories.

Reflecting on Positionality

In the initial days of my fieldwork, women were concerned about me. What they perceived as my hanging around in the neighborhoods was my struggle as a researcher to establish rapport and sustain trustworthy relationships. Some of them felt that the most ideal and appropriate task for me was to seek a sarkari naukri, a state or government job, which men in the neighborhoods aspired for. Women remarked that such jobs brought stability, as these were often permanent jobs. Most importantly, once I was employed, my financial career was set and then I could potentially build a family. Having a child was considered a milestone, and women advised me to not delay my plans to have one. Further, they perceived that an office job ensured relative security because I would not have to hang around outdoors making multiple visits to each of the field sites. Women also demonstrated affection and sympathy as they reassured me that I would accomplish my research. They made sincere efforts to introduce me to other families and registered medical practitioners in these neighborhoods.

The residents initially perceived me as a samaj sevika, social worker or an activist, who had visited to impart free education to young children from economically
disadvantaged families. They recalled names of the NGOs that provided educational and vocational training and particularly asked me if I knew any of the social workers associated with these organizations. Some of the residents assumed that I was associated with with *mahila sangathans*, women’s organizations, since members of these organizations provided various kinds of assistance and resources to women. Along with intervening in and resolving domestic disputes, these members also counseled women and arranged shelter for them in cases of domestic abuse and assault. Women also sought their support when their families abandoned them. These organizations imparted sewing and knitting skills to women in order to make them self-reliant. Having worked in a women’s health resource group in Delhi, I was acquainted with these organizations and the various kinds of support they provided. The residents also saw me as someone who conducted surveys and collected data for census purposes.

In the context of threats of evictions, the residents also perceived me to be an employee of the housing and resettlement office who noted the house numbers and the names of inhabitants to help determine their residency status and eligibility to receive resettlement plots in the near future. Though the residents knew that it is difficult on the part of an employee to guarantee the availability of resettlement plots, they were curious to learn about the nature of my work and what brought me to these neighborhoods. The residents had encounters with members of these organizations in the past and thus their assumptions were not baseless.

The above discussion points to how my respondents initially perceived me, an outsider who did not inhabit these neighborhoods. Some of them were exhausted as a result of their work schedules and responded that they did not have time to talk to me. Others were frustrated with members of these organizations who had made promises with respect to improving infrastructural facilities but had never turned up again after their first visits. After my continued visits to these neighborhoods, the residents knew that I could not provide any practical solutions. I was there to write their stories and what they considered important for me to document.

Although at times it was challenging for me as a researcher to develop trust and faith among my respondents, my repeated visits and conversations helped me overcome the unfamiliar surroundings. Women confided in me and revealed the intimate details of
their lives that they considered important to share. As one of my respondents said, “you note down the mundane accounts that we share and also the experiences that are significant to us; perhaps for the purposes of your research all that we say is crucial.” She further remarked: “otherwise why would you leave your middle class comforts and hang around here?” This conversation highlights the positionality of the researcher vis-à-vis the respondent. By bringing up the class differences that existed between us, my respondent acknowledged the power differential in our relationship, an important methodological challenge that I constantly negotiated as a researcher and ethnographer. Though the axes of class, region, and religious differences were discussed in my field sites, my respondents were sympathetic towards me because they witnessed a consistent effort on my part to develop relationships and understand their experiences.

Feminist scholars have discussed how it is difficult to escape the power relations that accompany ethnographic research (Stacey 1988; Abu-Lughod 1993; Visweswaran 1994). Despite these scholars’ emphasis on the reciprocal and collaborative nature of the ethnographic method, that is, the mutual sharing that underlies this method, the respondent has limited control over the authorial interpretations of the researcher. Stacey (1988: 23) underscores this point by arguing: “…the research product is ultimately that of the researcher, however modified or influenced by informants.” Thus, in feminist research, a reflexive analysis attempts to pay attention to the voice and experience of the interlocutor.

I have tried to implement the principles of feminist research in practice despite its limitations. On some occasions, even in the midst of their busy schedules, my respondents were keen to know what I was documenting in my field diary. When I read out my notes, they suggested that I include further details and specificities and remove some parts of the incidents that they had narrated to me. For instance, though the Bengali Muslim residents told me about the intimidation they experienced due to state surveillance, they did not want me to include many details concerning custodial violence when they were incarcerated. They feared these details might bring about more severe forms of intimidation on the part of the police.

Although my discussion of discriminatory evidences and patterns of state exclusion provides context for understanding the reproductive experiences of Muslim women in low-income neighborhoods, this does not presuppose a victimized or a
passive subject. This approach would assume that women’s experiences are self-evident and straightforward. I have attempted to refrain from essentializing women as oppressed subjects or homogenizing and universalizing their experiences in the context of the state’s implementation of population policies. Instead, I have sought to capture reproductive experiences placed within household and family histories and to learn how, why, and when women make decisions to conceive or to delay pregnancy and childbirth.

**Summary of Chapters**

In the following chapters, I aim to understand how women navigate the discriminatory and prejudiced medico-institutional practices that they encounter in state health care institutions. In chapter 2, I focus on the intertwining of basic health care services with family planning measures and the adoption of IUDs, one of the invasive contraceptive technologies. While the health care service providers undermine women’s choices and disregard their pragmatic family building rationales, I illustrate how women counter the prejudiced views of the state authorities by emphasizing their personal agency. They claim that the state authorities are *laparwah*, irresponsible, because they do not take into consideration their social contexts. Contrary to this view, women emphasize that they engage in *samajhdari ki yojana*, wise planning, regarding the number of babies they have, invest in their children’s education and health, and undertake the judicious expenditures that are key components of reproductive health decision making.

Why do anxieties related to contraception persist among women, and what are the pathways they follow to access efficacious and reliable pills? In Chapter 3, I investigate the pill pathways to demonstrate how the anxieties related to contraceptive side effects and failures motivate women to seek support from state dispensaries, private clinics, and pharmaceutical markets. I show how women are cautious about ingesting these pills, because they conceive that their own health and well-being are intrinsically connected to the well-being of their infants and spouses. I argue that these anxieties are a result of the politics of contraceptive provisioning, unequal effects of biomedicine, and social differentiation.

What are the on-the-ground dynamics and complexities associated with women’s acceptance of and resistance to sterilization, a terminal method of birth control? In
chapter 4, I explore the nuances of contraceptive decision making by going beyond the singular narrative of coercion. To this end, I show how women voluntarily adopt, involuntarily submit to, and ambivalently yield to sterilization measures. I also shed light on the campaigns related to sterilization and the motivation of community health volunteers to fulfill targets. I argue how the volunteers exhibit complexities as they simultaneously assert their moral selves and emphasize their client’s well-being despite fulfilling targets.

What kinds of care arrangements do women receive in contexts of obstetric emergencies, mishaps, and risks? In chapter 5, I consider the paradoxical arrangements of care that birthing women have to navigate in medical and familial institutions. In particular, I document how antagonistic and uncompassionate familial relationships, lack of investment in medical consultations, and a culture of preferring sons over daughters are connected to health risks and obstetric accidents. I illustrate the conundrums of birthing to understand why women visit the hospital or stay at home especially in light of institutional concern and mistreatment and familial care and neglect.

How can we understand reproduction as a temporal phenomenon? To investigate this question, in chapter 6, I show how family building and limiting are entwined with the building of neighborhoods, migration histories, and involvement of ‘dais.’ Moving beyond infrastructural constraints, I also explore how neighborly and kin relations, the ambiguous status of migrants, and hierarchies among the ‘dais’ play key roles in family planning. Through accounts from older women, I trace a broader perspective on reproduction and its embeddedness in their social lives. I argue that reordering of reproduction occurs throughout the life course and is not merely a one-time occurrence.
Chapter 2.

Family Planning Narratives from the Margins: Wise Planning versus Accusations

In chapter 1, I summarized the shifts in the population policy discourses in post-independence India. Along with providing a historical genealogy of population policies in India, I discussed how these policies accentuated targeted coercive measures, especially during the emergency period. The reproductive rights and choice approach, initiated by the Indian state in the 1990s, had its origins in the International Conference of Population and Development meeting in Cairo (Qadeer 1998). In this meeting, a host of national and international policy makers, health activists, and feminists deliberated on the ideas around reproductive rights and choices. In turn, the Indian state incorporated the emergent framework into its population policy, which aimed at a policy shift from a targeted approach to a reproductive choice approach.

In this chapter, I investigate the framework of choice in order to understand its contextual realities. In particular, I will ask, why do we need to focus on the narratives of low-income Muslim women around wise planning versus accusations of the state health care providers related to their irresponsible family building and planning choices? The category of choice within a liberal framework connotes freedom, autonomy, and individual rights. This framework foregrounded by the state policies, however, ignores the individual’s location within the intersections of familial responsibilities, gendered relationships, class and religious hierarchies, and state-imposed programs and schemes.

Scholars have argued that the neoliberal Indian state, driven by the dictates of international donors, has couched its population control program within the rhetoric of choice and empowerment since 1990s (Qadeer 1998; Van Hollen 2003a; Rao 2004; Simon-Kumar 2006; Pinto 2008). Despite such claims, scholars like Cecilia Van Hollen (2003a) have shown how the health care sector in Tamil Nadu, India, sets targets in order to control the fertility of women. She illustrates how the postdelivery placement of IUDs in government hospitals is often done without the knowledge of women and their families. The scholars particularly argue that the change in terminology is an
instrumental measure to garner funds from international aid agencies on the part of the Indian state. As Sarah Pinto (2008: 220) contends, the Indian state adhered to the population control agenda of international aid agencies while simultaneously disinvesting in public health services.

The navigation of family-planning programs is contingent upon a host of factors including intrahousehold power dynamics, the social and cultural milieu, and reliable and effective technology of birth control. The liberal emphasis on rights and choices opened up a space for noncoercive decision making in theory. However, women negotiate a coercive and targeted approach on the part of state family-planning bodies on an everyday basis. In this chapter, I particularly attend to what women conceptualize as wise planning in the context of accusations that they are irresponsible when it comes to adopting contraceptive technologies. Through case illustrations, I examine how low-income Muslim women negotiate and evade the prescription of IUDs in Delhi. In their narratives, these women emphasize that invasive contraceptives are the dominant birth control measure enshrined in the population policies. In other words, the insistence on the part of health care providers on adopting invasive contraceptives challenges the policy prescription of noncoercive measures on the ground. I illustrate that the two-child norm is the reigning ideology on the part of the providers despite the liberal emphasis on choices and rights. In this context, I show how women respond to this reigning ideology and navigate different pathways to subvert the state’s fixation on invasive contraceptives to implement a two-child norm.

I have documented low-income Muslim women’s experiential narratives at different temporal moments in their reproductive lives. Along with the ethnographic observations in Noor Nagar and Radha Nagar, I draw on detailed narratives of two women, Reshmi and Salma, in Noor Nagar. I have also drawn on my observation of family-planning programs of the state in two health care settings: a maternity center and a public hospital in south Delhi. I document how state health care providers discount women’s embodied experiences and rationales with regard to making decisions about contraceptives. Most often, providers perceive these women to be irresponsible, ignorant, and ill-informed and label them as such. Hence, it is assumed that the best way to achieve demographic targets is to coerce them to adopt invasive contraceptives. To this end, as the accounts of Reshmi and Salma illustrate, women actively adopt a range of benign and challenging measures. For instance, in order to evade invasive IUDs,
women are compelled to miss scheduled immunization dosages for their infants during their postnatal visits to the maternity centers. During childbirth in hospitals, they are sometimes forced to withhold details about the number of children they have. At other times, they are motivated to submit to contraceptive technologies to benefit from certain programs offered by the state health care facilities.

Making Responsible Citizens: Narratives of Work Arrangements, Immunization Trips, and IUD Use

In this section, I examine the health care providers’ insistence on invasive contraceptives and arguments about personal responsibility. Through ethnographic vignettes, I show how the state’s philosophy is fraught with a lack of contextual understanding with respect to the lived realities of women. I begin with Reshmi. Reshmi, a twenty-six-year-old resident of Noor Nagar, is engaged in domestic work (*kothi ka kaam*) in middle-class households. She has two sons, a three-year-old and a one-year-old infant. Her husband earned approximately 14 USD$ a month by collecting and selling scrap metal once a week.

Reshmi had to work in two households to earn approximately 20 USD$ a month because it was difficult to manage the household with her husband’s meager income. They paid a monthly rent of 14 USD$ for a one-room tenement. Her mother-in-law took care of the children while Reshmi was away at work. Reshmi went off to work at six in the morning and came back by midday. She took a day or two off from work only if she fell extremely sick. And she had to inform her employer prior to taking leave in order not to jeopardize her monthly income. She had to request a friend to work on her behalf if she intended to visit her parents in the village or had to attend to her sick children. Such arrangements were difficult at times, which only confirmed the precarity of her employment.

Women’s narratives often reflect that they had to run numerous errands along with carrying out the household work. In particular, Reshmi’s narrative encapsulates the social realities of running errands and contingencies of work arrangement in poor neighborhoods. Muslim women predominantly worked as domestic maids and Muslim men collected and recycled both metal and paper scrap. Some of the men also found employment as garbage collectors in the middle-class neighborhoods. Their work was
primarily contractual and often low-paid. Apart from collecting and sorting scrap, Muslim men worked as vegetable vendors, cycle rickshaw pullers, electricians, and carpenters. On occasions, elderly Muslim women also engaged in scrap sorting in Noor Nagar. Scrap sorting offered a few advantages compared to other forms of work. It paid better and also provided women an opportunity to attend to their children simultaneously, as the work was mostly in the neighborhood.

Women’s accounts also illustrate the contradiction in scrap-related work. Often, they were disinclined to work as scrap sorters. Reshmi emphasized that most of the younger women did not prefer to sort scrap, as they did not want to be exposed to waste or scrap. Women sorted scrap with their bare hands, often subjecting themselves to minor and grave injuries. For instance, accidents involving glass or metal shards caused severe wounds, which did not heal quickly. The work also involved putting up with the putrid smell of waste and scrap. Women usually noted that the putrid smell lingered even after they thoroughly washed their hands. Dealing with scrap was also seen as socially inferior work in the context of the kind of jobs and opportunities available to residents in this neighborhood. Non-Muslim residents particularly perceived it as dirty work (ganda kaam) and often avoided interactions with Muslim families who worked as scrap sorters. Despite the few advantages associated with scrap sorting, women sought work as domestic maids. This was what Reshmi did.

Finding employment as a domestic worker in a predominantly middle-class Hindu neighborhood is difficult. Reshmi emphasized that the nearby Hindu households preferred to employ non-Muslims, and thus work opportunities was severely limited. Most of the Muslim residents in Noor Nagar explicitly asserted that the Hindu households did not employ them due to their different faith or religious background. Some of them remarked that they were derogatorily referred to as jhuggiwalas, residents of jhuggis or low-income neighborhoods who engaged in theft and burglary. During the course of my fieldwork, the police arbitrarily arrested Muslim residents on mere suspicion of theft without providing any official evidence. In fact, the police often did their rounds in Noor Nagar attempting to prevent disorder and lawlessness. Craig Jeffrey, Patricia Jeffery, and Roger Jeffery (2008: 79) have similarly discussed the prevalence of “intimidation” against poor Muslims by the “Hindu” police force in Uttar Pradesh and Delhi. In this light, low-income Muslim residents found it increasingly difficult to be employed as guards, cab drivers, gardeners, or domestic workers in the middle-class
Hindu households compared to their Hindu compatriots. Reshmi could only manage to find employment as a domestic worker in a Muslim household. Because the Muslim neighborhood was located far away compared to the Hindu neighborhood, she had to walk between eight to ten kilometers each day for her work.

Walking long distances to work in the Muslim neighborhood added to the demands upon the women’s time along with their everyday tasks of taking children to school and picking them up, collecting and storing clean water for household consumption, and buying vegetables and groceries from the market. Despite the additional burden, however, work in Muslim households was considered relatively better as the employers gave a half-day off on Fridays. Women could devote their time to offer prayers (namaz) or pursue other nonreligious tasks. Half-day offs are considered a respite from routinized, monotonous, and continuous work.

Though hierarchical relations existed between the employer and the domestic worker, women regarded Muslim households to be safer as they were trusted and had better opportunities for full-time work. The full-time work arrangement offered better pay and it was preferable to hopping between multiple households to earn a comparable full-time salary. Women engage in trust and confidence building work with their employers over many years prior to their employment as full-time domestic workers. In light of this usual arrangement, Reshmi was pursuing her work with the utmost responsibility and commitment in the hope of being employed full-time. She once commented: “I have to work with utmost dedication to secure full-time work on a long-term basis in a single household” (Mujhe mehnat karni padegi nauki pakk karne ke liye). Women perceived that getting full-time work allowed them to have savings in order to tide over crises in the event, for example, of demolition of their neighborhood.

I met with Reshmi on a wintry evening in November 2011, when she was busy cooking in her one-room house. This was our second meeting. Reshmi’s house was constructed with brick and cement, the walls plastered with white paint, and the roof composed of tin sheet metal. The air in the room smelt of spices as she cooked spinach and potatoes on a kerosene stove. A few steel utensils and small plastic containers filled with spices and lentils were neatly arranged in one corner of the room. Reshmi’s baby was asleep on a wooden bed in another corner of the room. Two aluminum trunks were kept on top of each other with clothes neatly stacked on them besides the wooden bed.
Reshmi’s mother-in-law sat near the baby and folded clothes. Reshmi hurriedly finished cooking and attended to her baby while offering me a wheat bread (roti) and some spinach and potato curry (aloo saag). While she was attending to multiple domestic chores, I reminded her about our earlier conversation regarding her trip to the maternity center that had led to her persistent distress (musibat) and bouts of ill health.

Reshmi told me that she had visited the nearby maternity center after the birth of her second baby for polio drops and vaccines. It was almost three months after the delivery and perhaps her third visit to the center. She had visited the center twice during her second pregnancy to get prenatal injections. At the time of these visits, Reshmi had carried the health card that was provided to her on her very first trip to the center. This health card had her name, number of children, date of visits for prenatal injections, and immunization dates for her children. Reshmi precisely recalled her interactions with the health care providers of the center. As she put it:

“When my turn came, the provider checked my card and exclaimed: ‘You already have two children!’ And she raised her voice and said, ‘Do the tubectomy (nasbandhi),’ even before I could respond. Another provider added immediately: ‘You go ahead and see the doctor for the nasbandhi while we give the vaccine to your baby.’”

Reshmi continued recounting the insults. The providers also rudely remarked “people of my community were responsible for increasing the population of India when I remained silent for a while.” She explicitly noted the blatant remarks: “Your entire Muslim community is responsible for increasing the population of India” (Tum mohmaddan log zimmedar ho desh ki abadi badhane ke liye). And more: the providers insisted that Muslims have to shoulder the responsibility of population control by undergoing nasbandhi. One of them also said that the government has trained doctors to do nasbandhi and there was nothing to worry about. The surgical procedure would be done in a public or state (sarkari) hospital and that she needed only a note from the doctor in the maternity center as a referral to the hospital. To this comment, Reshmi simply nodded and said that she needed some time to consider this. The provider responded: “It is a good thing that the government is providing free vaccination services to you people. At least we can instill some sense in you during these encounters. Otherwise you will just continue having children.”
While Reshmi’s laborious work schedule and precarity defined her decision making with respect to family planning, we see that Reshmi experienced covert forms of coercion to undergo nasbandhi. What happened to Reshmi when she took her child to be vaccinated was a common experience. In fact, the pressure to adopt invasive contraception was manifest even during non-contraceptive-related trips including immunization visits to the local maternity center. The pressure to undergo terminal birth control procedures, the vexatious nature of immunization visits, and the various forms of coercive and noncoercive contraceptive measures illustrate the state’s continuing insistence on a targeted approach to family planning. The imposition of terminal birth control methods also highlights the challenges of accessing health care and family welfare services. In addition, women often remained doubtful about the efficacy and harmlessness of the procedure of nasbandhi.

During our conversations, Reshmi often told me about the fear of nasbandhi and the discomfort of being reprimanded as being irresponsible (laparwah). She had to forego a designated polio vaccination visit due because of this. She felt deeply guilty for missing the vaccination visit, because she was worried about its adverse effects on her child. Fortunately, she could take her child to a free camp for oral polio drops within a few months. However, her child still needed other vaccines.

Reshmi decided to get an intrauterine device, commonly referred to as a copper-t, on her next trip. She perceived that her decision to have the copper-t insertion would considerably lessen the anger of the staff, thereby allowing her to regularly visit the center for vaccinations. In other words, she was willing to pay a reproductive collateral in order to secure vaccination for her children. While women struggled to access the much-required free services, including prenatal injections and vaccinations, they withstood routinized rude behavior on the part of the staff.

Furthermore, Reshmi’s account illustrates the embedded cultural prejudice that Muslims are against sterilization (Tarlo 2003) that heightened the stereotypes against the low-income communities. My interlocutors often reiterated that the state health care providers pressured them to undergo nasbandhi once their religious status was identified. One of the interlocutors expressed: “It did not matter even if we had merely one child. We were often forced to undergo the nasbandhi.” This situation is not new. Mark Nichter (1995: 618) suggests that Muslim people feared that the Indian state
enforced family-planning measures through vaccination programs during the emergency. Commenting on the perceived fear on the part of Muslims in contemporary times, Nichter notes that the “mistrust has reemerged in the 1990s, a time of Hindu-Muslim unrest, vaccination program intensification, and press accounts and critiques of new anti-fertility vaccine trials in India” (ibid.). The association of immunization visits with sterilization measures is not unfounded.

Out of fear of being pressured to undergo sterilization during vaccination visits, people consider private health care service providers. Nichter observed this in the 1990s, and I also saw this in my field sites. However, the inability to pay for private health care services deterred low-income Muslim women in Noor Nagar and Radha Nagar from going to private health care service providers frequently. Women were forced to go to the unregulated and uncertified health care practitioners (commonly referred to as jhola chaap daktars) to cure common ailments. However, they used the services of these practitioners selectively. For instance, women avoided uncertified practitioners for vaccinations, as they considered these a matter of responsibility (zimmedari), which needed the involvement of formal health care practitioners.

In another context, Sarah Pinto (2004: 351) shows that the uncertified health care practitioners are considered both "legitimate and necessary." She further argues that their recognition by the state health care institutions strengthened their legitimacy in rural North India. In Noor Nagar and Radha Nagar, while the presence of uncertified health care practitioners was seen to be necessary for curing various ailments, they lacked the legitimacy in administering vaccinations. Unlike Pinto's observations in a rural setting in Uttar Pradesh, the uncertified health care practitioners in my field sites were subjected to intermittent raids by the police, thereby, further increasing the suspicion of people. During the time of my fieldwork, women avoided the uncertified health care practitioners, fearing health risks associated with vaccinations and other related emergencies. Thus, in Noor Nagar and Radha Nagar, women primarily relied on the national immunization program. They argued that the emphasis on vaccination reflected the amount of concern (parwah) for their children. In saying this, they challenged the labels that the officials ascribed to them. Let me turn to Reshmi’s narrative about IUD use to discuss this point further.
Reshmi considered adopting an IUD to continue with the regular vaccination visits. She had resumed work in two households after her second delivery and did not wish to undergo *nasbandhi*. She had discontinued work for four months during childbirth and had experienced the hardship of living upon a single income. Most importantly, she was compelled to consider some invisible form of contraception, as her husband was opposed to contraception. And Reshmi had to resort to an IUD to avoid the *nasbandhi*. Reflecting on her visit to the maternity center for an IUD, she noted:

“I used copper-t nine months after the birth of my second child. They said the copper-t would work for five years. I was not charged any money for the copper-t, though the health staff charged fifteen rupees for the placement of the copper-t.”

However, Reshmi’s tale of contraception did not end here. The staff had used a cheaper copper-t. She continued, “I did not know about the availability of different kinds of copper-t and the health staff did not inform me about them. The plastic copper-t did not suit me and it had to be removed after two weeks.” Reshmi was constantly in pain and had this needling sensation (*tez se chubti thi*). She told me that the placement of the copper-t had created a wound inside (*andar ghav hogaya tha*). And that she had to stop going for work for a few days. She again went to the maternity center after two weeks for removal of this plastic copper-t. The doctor had removed it and prescribed some medicines for instant relief. She had to spend approximately 2 USD$ for the medicines. The staff at the maternity center asked her to visit again after a month to try a better-quality copper-t.

Obviously, women are not provided extensive information about contraception in the maternity center. There are no prior check-ups or follow-ups in the maternity center with regard to the use of IUDs. On several occasions, women emphasized the casualness and apathy of the health staff while providing contraceptive services. Reshmi stressed that the pain experienced after IUD placement was unbearable, forcing her to discontinue work for a few days. As I pointed out earlier, taking time off was not easy. Apart from being subjected to the rudeness of the employer and the risk of losing pay, women had to compensate by doing extra work. Middle-class house owners often piled up work during absences, and it took several hours to finish such tasks once the women returned to work. Reshmi emphasized that some employers piled up heaps of utensils
that had to be cleaned after women resumed work after breaks. Thus, she considered taking time off only when the matter was urgent.

Despite expressing anger with respect to the carelessness of the staff, Reshmi still considered the option of going back to the staff for an IUD placement as a long-term birth control method. Her precarious existence did not provide her the liberty to seek contraceptive options elsewhere. Further, she had to actively consider long-term contraception as a response to intra-household power dynamics. Her narrative affirms that women are actively involved in contraceptive decision making. They negotiate the landscape of pleasure and pain through various options.

The IUD complications required further visits to the maternity center on the part of Reshmi. The center opened only until midday resulting in queues around closing time. Women waiting in the queue were often asked to come back the next day. It is not uncommon to see women make two to three visits to resolve their complications. Women in these low-income neighborhoods forego work for these visits and at times rush to the center in the middle of work to attend to emergencies. In a nutshell, the everyday work arrangements, domestic responsibilities, intra-household decision-making and power dynamics, the atmosphere in state health care facilities, and complications related to invasive contraceptive methods influence family-planning options on the part of low-income women. The health care service providers seldom address these personal and contextual needs of women, thereby failing to provide appropriate contraceptive advice. Furthermore, women are often compelled to adopt invasive birth control methods to avoid reprimands and intimidation on the part of the health staff and continue with their immunization trips.

**Responsible Citizens vs. Irresponsible State Authorities: Narratives of Wise Planning, State Abandonment, and Neglect**

Women are often chided and labeled as being illiterate, foolish, and uncivil (anpadh, gavar, jahil) by the health care service providers. Various other studies in different contexts show that marginalized populations often experience mistreatment, verbal abuse, and humiliation by health care service providers in institutional health care settings (d’ Oliveira, Diniz, and Schraiber 2002: 1681). On several occasions, women
emphasized that the health care service providers presumed that the poor lacked a sense of responsibility (zimmedari), awareness (samajh) and concern (parwah). Countering these views, however, women perceived themselves as responsible individuals compared to those they regarded as irresponsible state authorities. As opposed to the worldviews of the state health care service providers that low-income Muslim women did not care about the upkeep and future of their children, everyday conversations with women revealed that they were willing to endure laborious work and physical exhaustion in order to secure a better future for their children. In fact, raising children remained the primary concern for women in these low-income neighborhoods.

Women often stated that they were involved in wise planning for their families. For instance, an interlocutor once remarked that the poor planned wisely for their families (hum khud samajhdari se yojana karte hain parivar ke liye). The need to act wisely (samajhdari) was significant due to limited economic resources. She had particularly asserted: “Poor people cannot be careless; we spend according to our income” (garib log gair zimmedar nahin ho sakte; hum payar utna phailate hain jitna chaddar hota hai). “Wise planning” (samajhdari ki yojana) referred not only to family planning but also to planning one’s life and future. Similarly, the decisions regarding immunization of children formed an important component of wise planning. Women showed the utmost eagerness to raise healthy children even during the initial days of conception. Once pregnant, women visited nearby state health care centers to receive prenatal shots for the healthy growth of their fetuses amid their innumerable everyday tasks.

Wise planning also involved handling day-to-day household expenses, contributing to monthly savings, and ensuring formal education and health care for family members. On several occasions women said that they invested in Life Insurance Corporation for the future of their children. Often, they compared their lives to those of their own children. Another resident once stated: “Our lives have become worthless, but we want to make sure that our children’s lives are not worthless” (Apni zindagi to bekar hogayi ab apne bachon ki zindagi kyon bekar karenge). Grinding poverty and the lack of opportunities to escape it made women perceive that they led worthless lives. Their accounts often reflected their personal agency in educating their children, saving for their children’s future, and economizing on spending. Such everyday practices remained crucial in order to mitigate the impoverishment of their children. The investment in
personal agency and autonomous planning has also to be located within women’s awareness of demanding work arrangements, extremely low wages, intra-household inequities, and the lack of state resources.

Furthermore, women spoke about the state in ambivalent terms. While they approved of the state’s immunization programs and actively sought contraceptive methods, they also narrated about the state’s apathy regarding their abysmal living conditions. They often argued that the living conditions and the lack of amenities predisposed the poor to illnesses and mortality. Sherine Hamdy (2008) has suggested the framework of political etiology to understand illnesses and mortality as a consequence of state irresponsibility; women’s narratives resonate with this framework. My interlocutors often emphasized state irresponsibility (laparwahi) and unequal distribution of state resources to understand their predicament. In other words, they turned the notion of irresponsibility upside down. One of the residents commented: “See, the long water pipeline, which passes through our neighborhood, carries clean water to the richer neighborhoods. But, our neighborhood does not have a potable water facility.”

Similarly, the residents drew attention to the lack of toilet facilities in the absence of sewage and drainage system. The few toilets that were constructed by a nongovernmental organization had become dysfunctional within a few years. Women argued that the absence of clean drinking water and sanitation facilities further demonstrated state irresponsibility. They often showed me heaps of litter and waste in the neighborhood to illustrate the laparwahi of the state. In fact, the settlement was built precariously adjacent to a huge drain carrying waste from the middle-class neighborhoods. The residents had managed to build one-room tenements beside this drain. Women reiterated that impoverishment and state apathy predisposed the poor to illnesses.

In the absence of basic amenities and other structural difficulties, women had to instill a combined sense of responsibility, awareness, and concern in order to care for the health and well-being of their families. They fashioned their responsible selves by emphasizing the need to boil and filter water and provide nutritious food for their families even with meager resources. They remained attuned to medical knowledge circulated through media and graffiti. For instance, they routinely collected oral rehydration salt packets from health centers to administer during bouts of diarrhea. My research findings
echo the sentiments of Charles L. Briggs and Clara Mantini-Briggs (2003: xvi), who argue that “medical profiling” perpetuates the stereotypes commonly associated with the poor. They contrast “sanitary citizens” with “unsanitary subjects” in their discussion of stereotypes and profiling, saying that “some people are credited with understanding modern medical concepts and behaving in ways that make them less susceptible to disease. Others get branded as unsanitary subjects; they are deemed to be incapable of helping themselves or taking advantage of medical services—and even presented as threats to the health of the body politic” (ibid.).

Women vehemently and explicitly countered the cultural stereotypes and discourses promoted by the state institutions. Their insistence on good sanitation, safe drinking water, and the dietary needs of their families countered the state discourses that portrayed them as irresponsible. Instead of solely focusing on terminal procedures, they provided a holistic perspective about family planning and reproductive choices. It was clear that their decisions to adopt or refrain from forms of contraception at different moments in their reproductive lives are tied to critical issues of employment, work, and basic survival.

**Making Evasive Subjects: Narratives of Hospital Birthing and Evasions**

In the above section, I discussed the negotiation of *nasbandhi* and IUDs during immunization trips to the maternity center. In this section, I elaborate upon this negotiation in the context of a public hospital through the narrative of Salma. Salma, aged thirty-three, is the mother of three children. She worked in three households as a domestic maid. Salma’s family of five members survived on 65 USD$ per month. I once met Salma in the afternoon of February 2012; she had returned from work early to collect monthly rations from the nearby store (the poor have to rely on substandard grains available through fair price shops or rations shops). We sat on the terrace and talked while she winnowed waste from the wheat grain she had collected from the government fair price shop. Her two-year-old daughter sat beside us and played with my pen.

Salma hurried to remove the waste before her other two children returned from school. She complained about the indifference on the part of the state authorities: “The
politicians are interested only in getting our votes, they do not care about the poor people’s everyday troubles or difficulties.” Furthermore, she argued, the poor experience a range of state prejudices. In particular, Salma narrated her experiences in a public hospital during the birth of her younger daughter:

One of the doctors said: “It is mentioned in Quran that you will have to bear ten children.” The doctor also told me: “You are not inclined to undergo *nasbandhi* now, but you will take all sorts of pills in order to avert pregnancy. And then you will come to us. Remember we will not help you then.” (*Tum log toh nasbandhi nahin karwate, phir bacha rokne ke liye idhar udhar ki goliyan khate ho aur hamare paas ate ho. Tab hum log kuch nahin karenge, ye yaad rakhna*).

Salma insisted that Muslim women are often blamed for their supposed careless reproductive practices and their reluctance to adopt birth control measures. She was insistent: the health care service providers seldom care to know whether they have used contraceptives or not. Neither did they explain the advantages and disadvantages and the effects of the contraceptives on their bodies. Salma noted that the recurring cultural stereotypes about Muslims foreclosed the possibilities of reliable medical advice and good care during instances of unplanned pregnancies. Instead, economic constraints, contraceptive failures, and inaccessibility to better health care services forced women to rely on over-the-counter drugs to terminate unplanned pregnancies. The health care service providers promoted *nasbandhi* as the only reliable family-planning measure rather than recognizing the state’s inability to provide effective and reliable methods of birth control.

Salma’s views resonate with Iris Lopez’s (1998) analysis of fertility control among poor Puerto Ricans in New York. Lopez (1998: 253) argues that the health care service providers often recommend “mechanical and surgical forms of fertility control to the poor” by presuming that the poor lacked initiatives. It is often assumed that unplanned pregnancies resulted from nonadherence to family-planning measures. The assumption belies the poor women’s strategies of family planning and the possibility of contraceptive failure. Thus, cultural stereotypes and prejudices disregard specific reasons for the resistance against the invasive procedure. In turn, the poor often resort to evasion in order to resist invasive procedures and receive institutional support during childbirth.
For instance, Salma knew she had to evade answering questions about her previous pregnancy details in order to receive institutional birthing support during her third delivery. Although she had a son and a daughter prior to her third delivery, she told the hospital staff that it was her second delivery instead of third to receive support; she gave birth to a daughter and hid information about her other daughter. It is common knowledge in the neighborhood that the public hospitals usually did not provide birthing support beyond the second childbirth. Salma noted that the health care service providers showed overenthusiasm to admit pregnant women if they received prior approval for nasbandhi. She was asked to undergo the procedure after the birth of her third child, and her refusal invited scolding and shouting from the health care service providers. The providers insisted that they were promoting an ideal family setting of a son and a daughter.

Salma noted that the safe delivery of her third child made her ignore the reprimands. She felt that the public hospitals and facilities compared favorably to home birthing in dealing with pregnancy-related risks and complications. Apart from the medical care and support, it is easier to obtain birth certificates for the infants during institutional birthing. Birth certificates are needed for a variety of reasons. Women could obtain birth certificates, which are required for school admission of their children, for free at public hospitals. Otherwise, they had to take on additional expenditures and delays if they had to collect the paperwork from midwives and uncertified health care practitioners to obtain these certificates.

Moreover, women made use of the monetary incentives during institutional birthing, although they always spent additional money from their pockets to meet all the costs in the public hospitals. One of my interlocutors remarked once: “We spent approximately 50 USD$ during childbirth in public hospitals. The expenses equal our entire month’s earnings. The health care service providers often ask us to buy medicines, gloves, injections, and various other items. Further, the providers refer us to nearby pathological laboratories to undergo requisite health tests, ultrasounds, and x-rays.” Nevertheless, women emphasized that the public hospitals were preferable since the expenses were relatively lesser than the private health institutions. Their meager earnings kept them from going to private health care practitioners and hospitals.
It is obvious that women had to resort to institutional birthing despite reprimands. Thus, evading details of other births remains a primary strategy for negotiating such a scenario. Resisting invasive contraceptives upon admission to the state hospitals during birthing remains the primary priority on the part of women. In this regard, women conceal their religious identity to begin with: they hide their names and identities and provide incorrect information about past pregnancies. Women are provided with official slips at local maternity centers that have details about their identity and pregnancy. The health staff at the local maternity center update these details during immunization visits. This is the reason why Salma had to directly go to the hospital for her third delivery without taking the reference from the local maternity center. Fortunately, she could be admitted to the hospital just prior to the delivery. It could be the case that the hospital staff was compelled to admit her given the urgency of the situation.

On several occasions, women noted that it was difficult to even receive prenatal and regular tests without official slips from the local maternity centers. One had to maintain good relations with the staff at the maternity centers to receive official slips for hospital admission. Sometimes, the staff would not provide official slips if women did not adhere to particular contraceptive methods. This opened up a space of enormous negotiations and relationship building. However, women resisted invasive procedures for what they considered to be practical and beneficial reasons. Salma mentioned to me that she did not undergo nasbandhi for her own benefit. Her husband was scared of the procedure. As she said: “He was scared about any untoward incident during the procedure. He himself did not undergo the operation or vasectomy (nasbandhi) due to fear. My husband did not trust the state health care service providers. As he pointed out: “Going for a family-planning operation at the government health center is like inviting your own death.”

On another occasion, she narrated the following: “I was aware of the family-planning methods. It is not a big deal to be aware of the methods.” We are bombarded with contraceptive advertisements on television and told about the methods at the maternity center, although we are only provided with mere information. Neither the television advertisements nor the instructions by the health staff address the particular experiences of the contraceptive users. Salma was repeatedly told to get an IUD placement in the maternity center. This is the reason why women carry out extensive discussions with other women regarding family-planning methods in the settlement. It is
better to draw on people’s experiences before adopting or avoiding a family-planning method.

Women remain indecisive about the method of contraception. Nonetheless, they explore and adopt different methods of contraception despite contraceptive failures at times. On occasion, fear of dislodgement of IUDs forced them to consider nasbandhi. Further, decisions about contraception are also imbricated within intra-household dynamics. On the one hand, women negotiate with unconcerned family members, and on the other they listen to well-meaning partners and family members. Often husbands, mothers, and mothers-in-law influenced women’s decisions. Sometimes the family members and relatives invoked religious arguments to support particular sorts of contraceptives in opposition to nasbandhi. One of the community health volunteers commented once, “Most often, women adopt nonterminal methods of family planning. But they also undergo nasbandhi when their husbands agree to the procedure.”

Further, the women’s accounts led me to believe that the incidences of high infant morbidity and mortality also remained primary reasons for not undergoing nasbandhi. The community health volunteers often noted that women found it difficult to adopt irreversible methods of contraception.

The negotiations, evasions, and intra-household dynamics become salient with respect to the use of copper-t in the neighborhoods. One of my interlocutors stated, “The maternity center promotes copper-t as the predominant spacing method in our locality. The health providers supply free oral pills and condoms in a nonchalant way. In reality, the focus is on copper-t and the nasbandhi.” The health staff often argued that the use of copper-t leads to a “tension-free” (pareshaniyon se mukti) life. Ironically, the health staff believed that men would not be willing to use contraception despite the free condoms given away during prenatal and immunization visits. The health care service providers did not consider oral contraceptives as effective methods of contraception as they required everyday planning and remembering. In other words, the intrauterine device is promoted as an inevitable appendage of women’s bodies.

Furthermore, the state health care service providers project intra-uterine devices as devices of freedom and autonomy. Along with limiting family size, the intra-uterine device is also promoted as a safeguard against patriarchy. It is ironic that IUDs are
associated with a tension-free life, autonomy, and freedom when in reality they reflect the medical patriarchal framework where men are conveniently regarded as careless, thereby bestowing the entire responsibility of contraception on women. In other words, the health staff reinscribes patriarchal thinking by absolving men of any responsibility for family planning. In fact, the notion of freedom and autonomy associated by the use of copper-t is misplaced and illusory. Women are primarily assigned the task of family planning. As one of the community health volunteers declared: “It is mostly women who are informed about the family-planning measures. And approximately ninety-nine percent of those who undergo the nasbandhi are women.” Harini Narayan has also argued that most of the women receive directives about contraception during their initial visits to maternity centers and dispensaries in Delhi (2011: 44). Thus, they are often compelled to choose between an IUD placement and the nasbandhi.

Such health care practices denied women the options of safer contraceptions and non-invasive procedures that were available to middle-class women in private health institutions. As one of my interlocutors remarked, “The state resorts to deception (tarkeeb). It does not care for the desires and wishes of the poor.” In this context, women have to carefully negotiate or evade particular modes of contraception despite their desire to adopt reliable spacing methods. Given the difficulties, including excessive bleeding, intense pain, and discomfort that can result from IUD placement evasion of particular methods of contraception is strongly linked to pain and complications. The dislodgement of the IUD is a commonplace experience especially in the scenario of women’s laborious work schedules. The inability of the staff to place the devices appropriately or the loosening of the thread that kept the IUD in place resulted in severe pain and uneasiness. As my field accounts suggest, women experience intense pain during urination and intercourse if the IUD is dislodged.

The above experiences create an atmosphere of fear regarding the dislodgement of IUDs in the neighborhoods. During my visits, I often heard from my research interlocutors that the dislodged copper-t traveled to the upper part of the body. As an interlocutor remarked once: “Sometimes the copper-t gets stuck near the liver or the chest. This happens when it gets dislodged from the uterus” (Copper-t kabhi kabhar kaleja aur chatti mein atak jati hai. Aisa hota hai jab copper-t bachadani se chhut jata hai). Further, there is also an atmosphere of anxiety concerning the difficulties of IUD removal. The IUD could only be removed in the same health institution where it was
inserted; other health institutions, fearing mishaps and possible consequences, refused to take responsibility for removing them. This is the reason why women had to preserve the official slips testifying to IUD use.

**Conclusion**

This chapter illustrates the difficulties, negotiations, and evasions of coercive birth control measures promoted by the state health institutions. In particular, the narratives of Reshmi and Salma illustrate how low-income Muslim women encounter and negotiate invasive contraception during immunization visits and institutional deliveries. The narratives draw attention to the everyday social realities of low-income Muslim women in Delhi. As I discussed, women engage in wise planning in order to sustain their lives. In fact, the everyday planning of expenses and negotiation regarding basic amenities overlap with careful decisions concerning family building. Economic impoverishment and everyday realities concerning work schedules and intra-household power relations necessitate this wise planning. Furthermore, Muslim women encounter state apathy, cultural prejudice, and reprimands during contraceptive decision making and family planning. Their narratives counter the notion that the poor are irresponsible and incapable of family planning.
Chapter 3.

The Life of Oral Pills: From Prescribed to Non-Prescribed Contraceptive Anxieties

I have discussed low-income Muslim women’s negotiations surrounding family planning in state health institutions during immunization trips and institutional deliveries in chapter 2. I also illustrated the cultural prejudices, reprimands, and apathy that these women faced in the state health institutions. Apart from coercing them to adopt irreversible methods of contraception, the health care service providers also prescribed invasive methods of contraception. The providers did not promote contraceptive pills with the same enthusiasm they showed for irreversible or invasive procedures of contraception in maternity centers and dispensaries. Nonetheless, contraceptive pills are routinely distributed to women during immunization and other health-related trips. And women often use contraceptive pills to escape the invasive procedures of birth control.

In this chapter, I trace the life of contraceptive pills through the narratives and experiences of low-income Muslim women in two neighbourhoods in Delhi. Through case illustrations, I explore the context that motivates women to consider, access, and use contraceptive pills for birth control. In particular, I elaborate on the pathways that women take by highlighting their trajectories of continuing or discontinuing oral contraceptive pills. These pathways illuminate women’s negotiation of the use of oral contraceptives within a patriarchal context where their bodies remain sites for national concerns of development and fertility limitation. The narratives highlight how vexatious issues of choice, autonomy, and individual freedom have to be situated within the larger context of social differentiation, unequal effects of biomedicine, nutritional and health concerns, and state policies. The case illustrations shed light on how contraceptive anxieties emerge in everyday decision making with regard to using contraception. These anxieties are worth exploring, as access to effective and reliable contraceptives becomes a challenge for women in low-income neighbourhoods.

This is a critical question especially since India is one of the prominent countries in the Global South that initiated family planning programs during the pre-Independence era, further heralding a range of contraceptive technologies. Because class hierarchies
and elite decision making at the policy level subordinate the interests of the marginalized, it is important to show how low-income Muslim women conceive of the state’s promise to provide safe and reliable contraceptive options.

In contemporary times, women are left to rely on their own judgement after being given hormonal contraceptive pills, but they are not given appropriate counseling in the maternity centers and dispensaries. At times, women stick to these prescribed pills since they are freely distributed and are an alternative to invasive IUDs or sterilization as a birth control measure. However, anxieties accumulate as complaints surface and resurface with regard to the substandard contraception provided in these state-run health centers. In fact, a thorough understanding of women’s contraceptive practices makes it evident why certain prescribed hormonal pills are considered bekar (useless or of no value) or substandard.

Apart from the possibility of contraceptive failure, women become anxious when they try to access reliable contraceptives. In this respect, I argue that contraceptive anxieties are an outcome of social relations, gendered responsibilities, interpersonal family dynamics, and lack of resources. Contraceptive anxieties are not merely limited to the physiology of the body and personal predilections or choices; rather, they are made up of the social experiences embedded within the everyday lives of women. The availability of a variety of oral contraceptives reflects gradations or hierarchies with respect to the quality of oral contraception. And access to oral contraception is strongly tied up with social differentiation and the politics of provisioning by the state.

Although there has been significant scientific advancement with regard to the quality and effectiveness of oral hormonal contraception, such efforts seldom target the male body. In other words, as various scholars have argued, there is selective targeting of female bodies and disproportionate emphasis on promoting female contraception on the part of the health institutions and policy makers (Asdar Ali 2002; Greenhalgh 1994; Hartmann 1995; Van Hollen 1998). The manufacturing, testing, advertising, and marketing of female contraception far outnumber male contraception. Women of marginalized socioeconomic classes particularly bear the brunt of fertility regulation. Further, testing the efficacy of contraceptive drugs is often conducted on women in poorer countries prior to their use in rich countries (Hartmann 1995; Bandarage 1997). For instance, the hormonal birth control pills were tested on poor women in Puerto Rico,
India, and Pakistan before being marketed as safe drugs. As Towghi remarks, “communities in India and Pakistan, as in Puerto Rico, thus became unmarked laboratories” and women in particular became “experimental subjects” (2014: 116).

As I discussed in chapter 2, the policy makers’ promotion of the rhetoric of choice is unrealistic in everyday social context. The concept of real choice necessitates a gender analysis of reproductive technologies (Mallik 2003: 120). Moreover, a gender analysis of technology needs to be supplemented with a gender analysis of everyday life. This in turn can provide for a holistic perspective on social and personal trajectories of choices and constraints with respect to contraception. A gender analysis of everyday life can generate insights into the nuances of everyday life (Das 1994; Dossa 2013). An analysis of everyday life and routinized mundane practices will unravel the multiple layers of meanings as well as power arrangements foisted upon the lives of women. Veena Das has argued that “individual biographies” are constituted through both traditional and modern institutions and their intersections (1994: 53). She notes that the frameworks of tradition and modernity shape institutions, arguing that individuals are shaped within families, which uphold both traditional social prescriptions of caste and class as well as the modern health and education programs of the state. In fact, the “double articulation” of tradition and modernity constantly reshapes conflicting masculine and feminine identities within families (1994: 53-57). For instance, challenges to prescribed gendered codes have been accompanied with instances of violence on the part of men within a context of masculinity crisis related to joblessness and capability (1994: 60).

Similarly, Parin Dossa (2013) documents the everyday suffering of Afghan women in the context of the ongoing war in Afghanistan. Drawing on women’s memories, she uncovers the socially invisible suffering that is absent from official narratives: women often carry the burden of coping with the deaths and injuries of family members, destruction of houses, frequent displacement to evade attacks, and economic hardships resulting from loss of work in war contexts. In particular, she illustrates how the availability of meager resources affects nourishment, sustenance, and building of kin relationships in the absence of get-togethers over meals. Within the context of everyday food preparation, Dossa argues that the focus on women’s memories illuminates the vulnerabilities and suffering in everyday lives as well as the collective suffering endured by families and communities in war-torn Afghanistan. Drawing on their work, I attempt to
uncover the unacknowledged suffering that women embody in familial spaces and to show how gendered selves are enacted within a multitude of intersecting institutions.

India has experienced a transition from prescribed to non-prescribed over-the-counter contraceptive pills. This can be explained by intersecting roles of a multitude of institutions including state, market, and private health care institutions. In exploring this, I analyze the ideologies and practices of the state healthcare service providers and policy makers and the gendered relations that suffuse contraceptive usage within families.

Prescribed Contraceptive Pills and the Contraception-Nutrition Complex

Naushi, whom I met in Noor Nagar, asserted that women are handed Mala-d birth control pills for free at the local maternity centre irrespective of the reason for their visits:

No one ever needs to ask for Mala-d. Each one of us has received it during immunization visits, post-natal visits, and also during pre-natal visits. Sometimes the healthcare service providers even provide Mala-d pills to women who have received IUDs during earlier visits. The irony is that the providers slip Mala-d pills into our hands when we are visiting the centre for cough or fever. We may have to make two or three visits to receive cough or fever medicines. At times we are asked to carry bottles or containers to receive the requisite dosage of cough syrup or fever medicine. However, the birth control pills are always in stock and dispensed on each visit. We desire ‘behatar’ (better) contraception than the ‘bekar’ (worthless) pills provided in the state health institutions. The providers are also aware that we buy pills from elsewhere in order to avoid Mala-d pills. But they still impose the free pills on us. It is not wise to deny free pills, as that would annoy the healthcare service providers. And could also result in the imposition of IUD placement or coercion to undergo ‘operation.’

Naushi expresses mistrust associated with Mala-d birth control pills. For women like her, contraceptive anxieties are inevitable due to the unavailability of behatar (better) contraception at state health centres. Mistrust of the free pills pushes women towards alternative pathways of contraception, and they frequently discontinue using the free pills. Contraceptive failure and major side effects are the primary reasons for their discontinuance of Mala-d pills. As Naushi once argued, “Isn’t it surprising that the pills prescribed by health experts are ineffective? This is the reason why we try various pills from medicine stores rather than using a single state prescribed pill.”
Naushi asserted that Mala-d birth control pills are promoted over Nirodh—the state-supplied condom. It can be argued that the fertility of women remains the primary concern of the state health institutions despite the provision of both female and male contraceptives under family planning programs. Men rarely accompany women during pre-natal or post-natal visits, thereby successfully avoiding any direct state targeting of their bodies. In contrast, women remain the locus of reproductive surveillance and control. Further, the poor quality of Nirodh condoms often keeps men from using them in spite of the fact that the state subsidizes and promotes them. Women often remarked that men bought better-quality condoms that were marketed as more appealing and pleasure inducing.

My field observations reaffirm Mazzarella’s arguments regarding the developmentalist promotion of state-supplied condoms as opposed to the promotion of the Kama Sutra brand of condoms available in the market (2003). As Mazarella notes, the Kama Sutra’s advertising was altered from an emphasis on birth control to an emphasis on sexual pleasure. In fact, as Mazarella notes, one magazine referred to the Nirodh condom as “rhinoceros hide” (ibid: 65). I often heard from my interlocutors that Nirodh condoms ripped during sexual intimacy; in fact, women cautioned that parts of ripped condoms get lodged in their private parts. The state health institutions also promoted condom use to prevent the transmission of sexually transmitted diseases. However, the healthcare service providers often turned people away due to the substandard quality of contraception.

Naushi had been consuming Mala-d pills for almost a year. As she noted during our conversation: “I take Mala-d daily. If I forget to take the pill, I have to take two pills the subsequent day according to the guidelines on Mala-d related contraception. This causes heavy bleeding. I have also heard that the pills are hot and they may damage my liver if I continue to take them for long.” As she put it, “goliyan bahut garam hai aur zyada din khane se mera kaleja phat jayega” (the pills produce a lot of heat and taking these for a long time will rupture my liver). Naushi’s husband visited his village for a week and Naushi stopped taking Mala-d during this period of sexual inactivity. As a result, she suffered from blood loss, bouts of shivers, and weakness. She was compelled to continue taking the pills even while her husband was away from home rather than endure severe bleeding and feverish chills.
The healthcare service providers advised women to consume nutritious food 
(*poshteek khana*) to lessen the side effects of pills. The providers especially advised 
taking the pills along with milk or juice. Women noted that it was difficult to have two 
proper meals everyday amid their laborious work schedules. Often, women merely ate 
flat wheat bread (*roti*) and sweetened milk tea (*chai*) in the morning before they left for 
work, thereby failing to consume a proper meal till late afternoon or early evening 
because their employers seldom provided lunch to their domestic maids. Further, 
women were more concerned with their children’s nutritional needs than theirs in the 
context of increasing costs of essential food items and their meager financial resources. 
In other words, the policy experts do not take into account the material realities of low-
income residents and their struggles for daily nourishment. Women bear the 
responsibility for managing their scarce financial resources and purchasing nutritious 
food for their children and partners. As Naushi remarked, if we could afford nutritious 
diets on a daily basis, we could as well afford the best contraceptives. While reflecting 
on the advice of the indispensability of nutritious food, Naushi chuckled and remarked: 
“The ability to remember and take mala-d pills routinely at the end of the day when one 
is fatigued and tired deserves self-appreciation, and in these circumstances there is an 
added burden of preparing juice or warming milk, if at all available.”

As Claire Snell-Rood (2015) argues, women affirm their moral authority by 
providing food and nourishment to family members amid scarce resources in urban low-
income neighbourhoods instead of fulfilling their own personal nutritional requirements. 
In addition, she emphasizes that marital conflicts often lead to loss of appetite. Because 
women bear the brunt of unequal arrangements of caregiving and feeding in these 
households, understanding the life of oral pills necessitates an understanding of the 
nutrition-contraception complex. The life of oral contraception and resultant 
contraceptive anxieties can be understood only within the larger context of nutrition, 
family and caregiving responsibilities, and gendered targeting on the part of the state. 
Thus, women both embody and negotiate moral and gendered burdens with respect to 
oral contraception. The lack of suitable state-subsidized contraceptives compelled 
women to turn to over-the-counter contraceptive pills available in the market. As Naushi 
argued, “there is a lack of necessary health counseling and advice concerning both 
prescribed and non-prescribed pills. However, non-prescribed pills are preferred as there
is at least a range of pills to choose from.” At the very least, women could choose the pill that worked best for them individually rather than sticking to state-imposed Mala-d pills.

**Non-Prescribed Contraceptive Pills: This, That, or the Other One**

Saira (Noor Nagar): “I have three daughters. I did not use any contraception until the birth of my two daughters. I used Mala-d pills after six or seven months of the birth of my second daughter. I did not consider copper-t as an option, though I was repeatedly asked to use it during my visits to the maternity centre. The possibility of displacement of copper-t was my worst fear. I also heard about infections, body cramps, and excessive bleeding due to the use of copper-t. I could temporarily avoid copper-t, as I was not menstruating after childbirth for a few months. However, Mala-d pills were provided on each visit irrespective of the onset of menstruation. The healthcare service providers insisted that I regularly consume Mala-d. In turn, I always gently responded to the staff that I would use the pills once I start having menstruation. I used the pills once menstruation resumed. However, I conceived despite regular intake of Mala-d pills. The third pregnancy occurred while I was on Mala-d pills. I had used these pills for almost eight or nine months.”

The above narrative underscores Saira's experience of contraceptive failure resulting from the use of state-prescribed contraceptive pills. Saira was upset that her pregnancy occurred even while using Mala-d pills for almost eight to nine months. She became aware of the pregnancy almost three months after conception. She was not much concerned about missed menstruation for three months, as she had experienced irregular menstruation on earlier occasions as well. Saira was keen to terminate the pregnancy, but her husband’s fear of abortion-related complications deterred her. Saira also shared similar experiences of conception despite the use of Mala-d pills on the part of other women in the neighborhood. Saira argued with the healthcare officials about the ineffectiveness of Mala-d pills at the maternity centre after confirmation of her pregnancy, though the healthcare service providers were not convinced. Instead, they claimed that she resisted starting to take the pills at the right time and that her pregnancy reflected her carelessness.

Saira was not keen to use contraception immediately after childbirth, as she thought it could harm her uterus and affect her breast milk. As women in Noor Nagar collectively note: “The uterus (bachadani) remains open after childbirth and the intake of the Mala-d pills at this stage could damage the uterus. The uterus is very vulnerable at
this stage and susceptible to infection. Once the uterus is infected there are increased chances to experience complications while conceiving again. The birth control pills also dry our breast milk." This is the reason why women resist using Mala-d pills after childbirth almost for a year. Further, women argued that breastfeeding delayed menstruation after childbirth, which in turn delayed conception. As Saira argues: "The delay of menstruation was a huge relief as I could temporarily avoid the use of contraceptives. I did not have to bother too much about what to choose and when to start contraception again. More importantly, I could avoid the numerous side-effects of contraception." Thus, Saira could prolong breastfeeding as a substitute to inferior quality contraceptives.

I often came across women prolonging breastfeeding in order to delay or prevent pregnancies. Women emphasized to me that the practice posed no health risks compared to the use of inferior contraceptives. Moreover, menstrual discontinuation while breastfeeding is considered a respite. Women often noted that menstrual discontinuation relieved them from body aches, migraines, weaknesses, and other discomforts associated with menstruation while engaging with laborious work schedules. Women often rely on breastfeeding and circumvent birth control measures almost for a year after childbirth.

Women told me taking affected their breast milk and thus harmed their infants. In the context of low income and the lack of unaffordable, nutritious food, breast milk remains a major source of nutrition for infants. Breastfeeding is also perceived as an immunity builder in the context of widespread pediatric problems. Saira noted to me once that children in her neighborhood are much more prone to illnesses. As a result, women are extra-attentive to their newborns. They often raised questions about the lack both of counseling and of harmless contraceptive methods. In contrast, the healthcare service providers turned hostile when their advices and suggestions were disregarded. The healthcare service providers did not trust women’s tales of contraceptive failure; rather, they considered the women to be noncompliant and irresponsible. Often, the healthcare service providers argued that women often miscalculated the simple regimen of birth control pills. In other words, the providers were primarily guided by the predominant ideology of women’s inability to make decisions regarding the use of oral contraception. Biomedical failure was translated, as in Saira’s case, into the moral failure of being irresponsible and careless.
Widespread perception of deleterious effects and ineffectiveness of state-prescribed pills compel women to make frequent trips to private pharmacy stores. Saira once listed the range of low-cost non-prescribed over-the-counter contraceptive pills: Ek Roz, Pearl, and Saheli. She considered using one of these pills after the failure of the prescribed Mala-d pills. She sought advice and suggestions from female friends and kin members in selecting an effective low-cost oral pill. My field observations confirm that women in Noor Nagar and Radha Nagar used at least two or three different varieties of low-cost non-prescribed over-the-counter contraceptive pills to ensure efficacy and to avoid side effects. However, they remained disillusioned with the range of low-cost pills available in the market because they did not reduce the anticipated side effects. The pills available in the market also caused dizziness, nausea, and weight issues. I often heard women complain about weight gain or weight loss while on birth control pills.

Though women considered over-the-counter birth control pills better than Mala-d pills with regard to contraceptive success, they did not perceive any difference between the two with respect to side effects. As a result, my interlocutors consistently worried about the long-term health effects of the pills available in the market. Their contraceptive anxieties increase especially because they are not able to afford what they perceive to be superior-quality pills in the market. Nevertheless, they are urged to endure the side effects in order to avoid conception. At times, they also have to adopt alternatives when their preferred pill is unavailable in the market. Thus, women choose from a limited range of reproductive technologies based on their ability to cope, their health and well-being, and affordability.

Drawing on research on women’s negotiation of donor-driven family planning programs in Egypt, Asdar Ali has argued that international health experts attempt to create autonomous, capable, and responsible subjects who can make rational decisions regarding family planning (2002: 371). Challenging this abstract notion of autonomy, he calls for attention to “women’s own notions of self and constructions of the body” (2002: 372). As my cases illustrate, their contraceptive anxieties reflect how women construct and conceive their own selves and bodies by connecting their health with the health and well being of their infants and partners. In other words, they challenge liberal assertions of individualism and autonomy. In contrast to linear narratives of coercion and autonomy, their perspectives provide insights into how contraceptive practices are the outcome of social relations, as use of oral contraceptives is contingent on infants’ and mothers’
health and well-being, sexual intimacy with partners, financial stress, and laborious work conditions. The above narratives underscore women’s active role in planning families even while navigating their limited contraceptive options. Moreover, the experiences of my interlocutors reflect the state’s coercive approaches in promoting terminal methods of contraception rather than appropriate non-terminal methods. This scenario creates what Unnithan-Kumar (1999) calls a reproductive burden.

Dreze and Murthi (2001) argue that strengthening welfare services, including health and education services, stabilizes population growth. In this respect they have called for appropriate non-terminal methods of contraception along with proper counseling regarding birth control measures (2001: 34). Because healthcare service providers fail to provide adequate counseling and show lukewarm interest in promoting safe contraceptive measures, women are forced to adopt inferior and invasive methods of contraception until a tipping point is reached (Hoggart and Newton 2013). Here tipping point refers to their inability to withstand the side effects of inferior oral contraceptives and invasive procedures. This constitutes embodied knowledge, and this repertoire of knowledge provides deeper understanding of the dynamics of larger systems of power and how women navigate these spaces.

**Non-Prescribed Contraceptive Pills: Reverting and Adapting to These Pills**

Shabnam (Radha Nagar): “Actually I first started taking pills after the birth of my second child. I did not use contraception as a spacing method between two deliveries. Rather, I had decided along with my spouse to have two children before adopting birth control methods. I must also tell you that I did not use contraception for the first two years after the delivery of my second child. I was breast-feeding for two years and hence did not menstruate. I have been using oral contraceptives for the past fifteen years intermittently since the birth of my second child. I used over-the-counter pills approximately for ten years and then an intra-uterine device for a few years. Then I reverted back to pills again. I purchased the birth control pills from the nearby pharmacy store. I was constantly apprehensive of failure of oral contraceptives. My work schedule and financial constraints did not allow me to seek consistent consultations in private health clinics. The local maternity centers did not provide me with any knowledge about contraceptive options. I reminded myself to adopt a better contraceptive almost everyday in the initial years. After a few years, I stopped worrying about contraceptive failures, as I wanted to have a third child. My son [first child] became ill. He had skin sores and
people around the neighbourhood mentioned that he was under an evil spell.”

Shabnam had to work in order to sustain the family, as her husband’s income was inconsistent. She made some money by preparing and selling tea in her house in the initial years of their marriage. Shabnam was relieved that she was able to earn even during late pregnancy and could resume her work of selling tea within a few days of the birth of her eldest child. She had chosen to sell tea rather than work as a domestic maid because she did not have any child care support—both her maternal and paternal family members lived in a village in Uttar Pradesh. Shabnam saved some money, bought a tiny piece of land adjacent to her house, and constructed a makeshift grocery shop, which she stocked with essential household items such as milk, salt, sugar, oil, soap, and a few varieties of pulses, matchsticks, biscuits, and toffees.

Shabnam recounted that she planned to conceive a second child, as she started having steadier earnings from the grocery shop compared to her tea-selling business. However, the grocery shop was destroyed in a fire. Although she was upset by the loss of the shop, she was relieved that her family was safe—their one-room tenement was not engulfed in the fire. Shabnam did not have any way to make a living for a few months after the fire, and she had to resort to the savings that she had accumulated. She realized that it was worth spending the majority of her savings to build a concrete house that could save the lives of her husband and children. Subsequently, she rented another makeshift room in the low-income neighbourhood in order to sell vegetables. Shabnam’s earnings plummeted but she was at least relieved that she could feed and educate her children. Shabnam noted that she could earn approximately three thousand rupees from selling vegetables in the neighbourhood.

Shabnam remarked that she was using over-the-counter pills while selling vegetables for a living. She took these low-cost pills regularly in order to avoid another pregnancy during her ten years of financial hardship. She was constantly anxious about side effects. She gained excessive weight and also experienced nausea and loss of appetite while using these pills. Shabnam could not escape the side effects even after experimenting with three different brands of pills; as I noted earlier, women continue to experiment with inexpensive over-the-counter pills rather than searching for a superior-quality pill due to economic constraints.
Shabnam reconsidered conceiving another child, as she was worried about the health and life of her eldest child, who suffered from frequent nosebleeds, skin sores, and fevers. Shabnam was convinced by the suggestions of her family and kin members that her son’s ailment was the result of an evil eye or a spell, which could be cured by the birth of another son. Shabnam’s relatives wished her to beget another son; however, the gender of the third child was not of much concern to her. Shabnam tried allopathic, homeopathic, and herbal medicines to alleviate the ailments of her son. She even resorted to offering prayers in religious shrines and tying amulets on her son’s arms. However, the health of her child did not improve, and she planned another pregnancy and conceived her second son. As she notes, her relatives regarded the birth of another son an auspicious event because the health of her older son started improving. However, as Shabnam argues, she was more concerned about the health and well-being of all her children irrespective of their genders.

Shabnam did not rely on the low-cost over-the-counter pills after the birth of her third child. She opted for an intra-uterine device in order to avoid further pregnancies. Shabnam got the placement of the IUD in a private health clinic because she considered its support and resources to be superior. The private clinic had better contraceptive options, availability of extensive counseling, and follow-up care, and she thought that she could avoid the health complications resulting from careless invasive procedures encountered in the state health institutions. She spent approximately two thousand rupees for the IUD and five hundred rupees for the consultation fee in the clinic. Shabnam used two IUDs in a span of six years, replacing the old IUD after three years in the same clinic. Because Shabnam noted that using the superior-quality IUD did not necessitate recurrent visits for check-ups or follow-up care, it can be argued that her decision to use an IUD was contingent on the nature and conditions of her work. She could opt for an IUD because she was working independently as a small businesswoman. It would have been difficult to take this contraceptive route if she worked as a domestic maid.

At the time of my field research, Shabnam had reverted to using low-cost over-the-counter oral contraceptives. She had removed the IUD and had been taking these pills for the past five years. The periodic replacement of the IUD and the associated prohibitive consultation fees created financial difficulties for her. During my field research, she noted that her sharir (body) had adapted to the pills well. She had been
using these pills for over a decade at the time of my field research. She went on to give me the details of an intricate routine concerning her usage of the pills. Shabnam remarked that she did not have to take pills on an everyday basis for the past three years. Rather, she improvised by using the monthly dosage of twenty-eight pills over the course of two months. Shabnam took these pills after menstruation for ten days continuously and then a pill once every two days or every three or four days. She had found this routine to be successful in preventing conception. In fact, she planned on using such a regimen until she reached menopause. In other words, she used the pills in an instinctive manner and understood the physiology of her body without prescribed medical logic.

Shabnam’s use of IUDs at a private clinic and her subsequent resumption of over-the-counter pills reinforce the failure of the state in providing reliable contraceptive options to the poor. Women noted frequently that they could access superior-quality, reliable, and safe oral contraceptives in private clinics instead of experimenting with a range of over-the-counter oral contraceptives or suffering from the inferior pills available the state health institutions. The case illustrations reflect the central role of private pharmacies and health clinics in relieving contraceptive anxieties to an extent. However, women often faced difficulties buying pills from the market because of their grinding poverty. Pamela Feldman-Savelsberg’s (1999) ethnographic study among Cameroonian women illustrates how the issues of fertility and infertility are embedded within the context of family conflicts, ownership of economic resources, and status among kith and kin. She argues that issues of fertility and infertility are social and gendered matters and not merely biological or physiological matters, which is confirmed by my research.

Prescribed Contraceptive Pills, Contraceptive Failure, and Non-Prescribed Abortion Drugs

Mehmuda (Radha Nagar): “You tell me, would the state healthcare service providers ever hand over expired Mala-d contraceptive pills to economically better off women? But, they provided me Mala-d pills that had expired two years ago. I was unaware of the expiry and used them for three months. Not surprisingly, I conceived while using the pills and became aware of the pregnancy two months after conception. I was growing anxious about the missed menstrual cycle. Further tests confirmed that I was pregnant. I had to terminate the pregnancy, as I was not prepared for another child. I experienced health complications while terminating the pregnancy. I had also experienced extreme
dizziness and unbearable burning sensation while using the expired Mala-d pills. I was consistently worried about these symptoms. Women using the pills had told me about the side effects including dizziness, nausea, body aches, bloating, and loss of weight. I am extremely worried even now as I do not know what long-term damage it could have done to my body. I do not know how to read English and am thereby unable to check the expiry or manufacturing dates of medicines. I trust the healthcare service providers and assume that they would verify the expiry dates before handing us the pills.”

Mehmuda was extremely upset that she conceived despite routinely taking the prescribed pills. She had started using the pills immediately merely a week after the birth of her first child, a daughter. Because she thought that it was a responsible act, unlike other women in the neighbourhood, she did not consider delaying the use of pills. Mehmuda was annoyed when she conceived despite her responsible behaviour; she felt helpless and vulnerable. Ironically, her health worsened because she complied with the contraceptive advice of the state providers. Because it was futile to discuss the failure of the expired pills with the state healthcare service providers, Mehmuda sought immediate assistance in terminating her pregnancy. This case shows how Mehmuda turns the perception about poor women upside down. Indeed, the carelessness and irresponsibility of the state providers rendered the Mehmuda’s wise planning efforts ineffective. It must also be noted that though the state seldom offers the most appropriate contraceptives, it is impractical to expect women to totally avoid the state given their financial constraints. Women in the poor neighbourhoods must deal not only with inferior contraceptives but also with expired pills at the state health institutions, which exacerbates their anxieties.

Mehmuda initially wished to terminate her pregnancy at a private clinic. However, the prohibitive cost, two to four thousand rupees, kept her from considering this route, and she decided to terminate her pregnancy at a state health institution. Mehmuda noted that she would have spent almost one thousand rupees at the state health institution, though the services are supposed to be free. She did not have anyone to accompany her to the distant state health institution. Further, she worked as a domestic help and could not take a day or two off. When Mehmuda was almost five or six weeks pregnant, she decided not to delay the termination of her pregnancy and consulted an untrained healthcare practitioner in the neighbourhood. The practitioner provided abortion drugs for five hundred rupees. She was initially reluctant to seek the assistance of an untrained practitioner, fearing health complications. However, her acquaintances assured her that
the practitioner had successfully terminated pregnancies in the neighbourhood. Mehmuda was also motivated to consult the practitioner because she was not keen on having a surgical procedure of abortion. Thus, women turn to the informal reproductive market due to many factors. The high costs of private healthcare clinics, lack of family and kin support, and the challenges of working as a domestic help shape women’s oral contraceptive pathways.

Unfortunately, the intervention of the untrained practitioner created more troubles for Mehmuda. She experienced health complications after taking abortion pills. The pills caused heavy bleeding for almost ten days. Mehmuda’s anxiety worsened as the bleeding continued for more than a week. As she remarked, “the bleeding was accompanied with lumps of blood at times.” The practitioner suggested other pills for terminating the pregnancy when the suggested pills failed, but Mehmuda was reluctant to experiment with other varieties at this juncture. She also experienced extreme weakness, dizziness, severe exhaustion, and loss of appetite. Mehmuda noted that she was not even able to walk to the house of her employers. She had to take leave as her health deteriorated.

Despite the relief of taking a break from work, she was worried about losing a certain amount of her pay from her meager earnings. She was also anxious about losing her job. As Mehmuda commented: “The employer may ask you to leave permanently if you seek leave for a week.” At this point, she eagerly sought assistance from a trained healthcare practitioner in order to prevent the continuous bleeding. She visited a private health clinic adjacent to the neighbourhood. Her acquaintances in the neighbourhood trusted this specific female gynecologist. My other interlocutors in Radha Nagar had also suggested that they trusted the advice and treatment of this gynecologist. Mehmuda also noted that the gynecologist could be reached through a phone call after in-person consultations.

Mehmuda had to spend approximately fifteen hundred rupees in order to pay for a consultation, an ultrasound in a private diagnostic centre, another set of abortion pills, and vitamins for restoring her well-being. She noted that the gynecologist prescribed her an ‘Unwanted-Kit’ for terminating the pregnancy made up of one mifepristone and four
misoprostol pills.\textsuperscript{12} Mehmuda made one follow-up visit to confirm the abortion and prevent complications. She was prescribed Ovral-L oral contraceptives during the follow-up visit; at the time of my fieldwork she had been using these contraceptives for the past five or six years. Mehmuda spent around a hundred rupees to buy these contraceptives from the chemist stores each month. Despite being expensive, these contraceptives considerably lessened her anxieties.

Mehmuda’s negotiation of the informal and formal reproductive market was better than her encounters with the state institutions. The gynecologist was annoyed that she had sought support from an untrained practitioner. Nevertheless, Mehmuda noted that the doctor did not reprimand her; instead, the gynecologist was empathetic and understood the abysmal state of affairs at the state health institutions. Her perception reflects the contradictory nature of negotiation with contraceptive pathways. While the low-income women wish to access state healthcare, they often turn away due to the inferior quality of services and hostility at the state institutions. Again, they may not be able to afford the pills available in the private market, but they are compelled to visit them in the case of emergencies. Further, the recourse to abortion is not an easy option. While the medical termination of pregnancy has been legal in India since 1972, married and unmarried women still encounter challenges while terminating pregnancies in the health clinics.\textsuperscript{13} For instance, the above news report suggests that women have less difficulty terminating pregnancies if they cite contraceptive failure. Mehmuda was perhaps able to terminate her pregnancy because she provided evidence of contraceptive failure. However, women may face another layer of complication in terminating their pregnancies that causes them to resort to oral pills with their dangers of complications. It is telling that Mehmuda looked into the expiry issue of oral pills – an illustration of how reproductive issues affect the welfare of their families.

\textsuperscript{12} Unwanted-Kit comprises of one mifepristone tablet to be taken orally, and four misoprostol tablets to be administered vaginally. The tablets can be administered up to nine weeks of pregnancy. Unwanted-Kit is marketed by Mankind Pharma Limited, New Delhi. The packaging leaflet mentions that “mifepristone exhibits anti-progestational activity, that is, by inhibiting the activity of progesterone, mifepristone results in termination of pregnancy. And misoprostol interacts with prostaglandin receptors, and causes the cervix to soften and the uterus to contract, ultimately resulting in the expulsion of the uterine contents.”

In this respect, women challenged the commonplace view of the community health volunteers that they easily relied on over-the-counter oral pills for terminating pregnancies. On the contrary, women asserted that it was extremely difficult to buy abortion pills without a prescription. Rather, they sought support from the private healthcare practitioners in these circumstances. And, if they were not able to afford the prohibitive consultation fees, they were compelled to access oral pills from the untrained healthcare practitioners in the neighbourhood.

Community health volunteers routinely insisted on accompanying low-income women to medical termination of pregnancy (MTP) clinics. Usually they accompanied women to Marie Stopes clinics in Delhi, which are also referred to as MTP clinics. The Marie Stopes clinics provide a wide range of reproductive services including abortions. However, women are not keen to visit these clinics because these clinics engage in activities beyond dilation and curettage. In other words, women avoided the MTP clinics because they feared that they would be forcibly sterilized during the course of an abortion. Ironically, then, the free abortion services provided to below-poverty line families are not much used due to fear and a lack of trust. As I will discuss in chapter 4, Marie Stopes clinics in alliance with other charitable dispensaries and nongovernmental health organizations undertake campaigns to promote sterilizations.

Scholars have argued how aggressive promotion of over-the-counter drugs by pharmaceutical agencies adversely affects women in developing countries. According to Towghi, though misoprostol is promoted in “resource poor” countries as a “humanitarian measure” to prevent post-partum bleeding while birthing at home, the “routine” use of misoprostol has deleterious effects. Drawing on ethnographic research in rural Balochistan, Towghi argues that the “routine” administration of misoprostol to women without ascertaining the need for it on the part of both trained and untrained practitioners has led to higher mortality of women in the recent decade. Towghi suggests that the promotion of misoprostol in developing countries advances experimentation and testing of off-label drugs primarily on women’s bodies (2014: 123). This is alarming given the widespread use of misoprostol in the low-income areas in Delhi. Misoprostol is also administered to induce labour which, especially in resource-poor settings, enhances health risks and complications rather than providing a therapeutic alternative.
As I have shown, although state healthcare service providers often perceive low-income women as careless, forgetful, and non-compliant, the women in my study challenged these stereotypes by being quick to choose the best possible contraceptive in their attempts at wise planning of their families. While the community health volunteers suggested that the poor relied on over-the-counter emergency contraceptives, women in Noor Nagar and Radha Nagar seldom spoke about using the emergency pills. These emergency pills primarily delay ovulation and could work optimally if taken within seventy-two hours of having unprotected sexual intercourse. It contains the progestin hormone. Most women did not invest in buying these pills, which differ from the emergency pills used to induce abortions. Instead, they adopted a range of contraceptives and also urged their spouses to use condoms. It should also be pointed out that they are well aware of the adverse side effects of these emergency pills and rarely adopt them as a method of contraception. Further, it is difficult for them to access the state health services while experiencing such adverse symptoms, as women are likely to experience hostility and censure.

Drawing on her research about contraceptive use among high-income women, Sheoran (2014) argues that these women perceive themselves as modern, responsible, and sexually liberated by highlighting the adoption of emergency contraceptives in India. As a corollary, she suggests, these women distance themselves from what they consider to be the irresponsible reproductive practices of low-income women without any knowledge of the everyday struggles associated with contraceptive decision making by the latter. Sheoran rightly argues that a “privileged contraceptive reality” exists alongside “contraceptive ghettos” in India. She claims that economically privileged women are aware of the emergency contraceptives and could easily access these contraceptives in contrast to women belonging to the marginalized strata.

However, Sheoran implies that women belonging to “contraceptive ghettos” are neither aware of the novel contraceptive technologies nor have the monetary resources to access them. On the contrary, I found that low-income women are aware of the range of novel technologies through various channels of information. Women receive

information about these contraceptive technologies through television advertisements, billboards and graffiti. They also get updated information from family and kin members, employers, and chemists at pharmacy stores. Women of Noor Nagar and Radha Nagar suggest that they experience constraints other than financial constraints when they try to access emergency contraceptives. And as I have shown in this chapter, they make family planning decisions based on contingent contexts. Stacy Pigg (1996) has suggested that villagers in Nepal do not remain incarcerated within their place; rather, they engage with the flows of modern commodities, medicines, and technologies and varying social relations in “cosmopolitan” and “modern” ways. For instance, Pigg notes that the decisions of village people correspond with the healthcare practices of people in the cities with respect to specific healthcare treatment. People in the villages sought traditional healers as well as modern practitioners of medicine depending on the circumstances and the magnitude of their suffering. Similarly, it can be argued that women in Noor Nagar and Radha Nagar made contraceptive decisions based on contingent conditions.

In fact, the low-income residents of Noor Nagar and Radha Nagar relied on the subsidized state healthcare services despite inadequate provisioning of medicines, equipment, and personnel (Jeffery and Jeffery 2008; Amrith 2007; and Qadeer 2001). Women’s narratives about contraceptive pathways illustrate how proactive measures in family building fail as a result of the substandard contraceptives in the state healthcare institutions, which forces them to seek support from private chemists and private healthcare practitioners. Thus women navigate the complexity of accessing contraceptive services from the public, private, and informal reproductive market in their neighbourhoods. In this light, my observations are in line with Das’s (2003) findings in showing how the poor navigate both public and private healthcare services.

**Conclusion**

The chapter illustrates the everyday experiences of using and making decisions about using oral contraceptives among low-income Muslim women. The case illustrations shed light on women’s experiences with respect to prescribed and non-prescribed oral contraceptives. I have shown the inequities underlying contraceptive usage and also discussed the varying reasons undergirding contraceptive acceptance or non-acceptance. In so doing, I have analyzed the challenges, constraints, and
inequalities that women encounter on an everyday basis while accessing effective contraceptives. I have also shown how the reproductive health and family planning programs are unable to provide basic contraceptive counseling and services, which highlights the state’s incompetence in providing contraceptives despite its sustained emphasis on birth control. Ironically, women continue to rely on affordable and prescribed contraceptives available in the state health institutions and limit the use of the range of non-prescribed contraceptives available in the market. In other words, they assert the paradox of choice in engaging with a range of institutions within the context of deficient state services.
Chapter 4.

Voluntary, Involuntary, and Ambivalent Reproductive Entanglements: Perspectives on Sterilization Cases

In chapter 3, I discussed low-income Muslim women’s contraceptive anxieties in order to highlight the politics of contraceptive provisioning within state health institutions and the differential access to reproductive drugs and technologies. In examining the social life of the use of oral contraceptives, I underscore how they are embedded in the everyday lives of women. The contraceptive pathways that these women take also highlight the complexities of continuing and discontinuing contraceptive use.

With the above backdrop, I explore women’s experiential decision making with regard to sterilization in this chapter. The decision to undergo sterilization is an inevitable upshot of contraceptive anxieties within the context of the lack of adequate non-invasive procedures and options. I explore the complexities around sterilizations by underscoring the voluntary, involuntary, and ambivalent nature of decision-making. Scholars have examined the coercive nature of sterilization and the targeting of women’s bodies that is enshrined within the population policies of the Indian state (Qadeer 1998; Ram 2001; Van Hollen 2003a; and Rao 2004). In this chapter, I attempt to understand sterilization dynamics on the ground by exploring both the coercive and the non-coercive aspects of sterilization. I focus on women’s experiential decision making in voluntarily adopting, involuntarily submitting to, and ambivalently yielding to sterilization.

Women’s decision making is enmeshed with the incentives and the disincentives offered by both domestic and transnational health care institutions. The institutions periodically set up camps and campaigns to fulfill sterilization targets, and my interlocutors have in-depth knowledge of the entanglements of community health volunteers (basti sevikas) of these institutions in the population control programs. In this respect, the chapter also sheds light on the dilemmas of community health volunteers. It can be argued that the volunteers undertake three different types of work with respect to population control and sterilization policies: persuade their clients to undergo sterilization, cultivate their own moral selves, and emphasize the well-being of their clients. I draw on the analytical lens of governance of reproduction as proposed by
Margaret Lock and Vinh-Kim Nguyen (2010: 114) to understand how biomedical

technologies are used in controlling, regulating, and manipulating populations across the
globe. They show how the biomedical/bio-contraceptive technologies developed in
Western countries target people in non-Western countries once population is considered
to be a problem. In other words, the reigning assumption is the presence of
“standardized human bodies,” thereby sidelining the existence of the “contingent body”
(ibid.).

Building Bodily Immunity: A Case of Voluntary Sterilization

I begin the discussion about the complexity of sterilization by drawing on
Kulsum’s narrative, which suggests that undergoing sterilization can be voluntary in
specific circumstances. In particular, her narrative illustrates how factors like building
bodily immunity, the restoration of bodily energy and strength, and the healthy growth of
children motivate decisions to undergo sterilization.

I met Kulsum one early evening during the summer of 2011 in Radha Nagar
when one of the community health volunteers took me to her house. Kulsum had
undergone sterilization voluntarily a few years ago. She fed bottled milk to her two-year-
old daughter as her four-year old daughter played outside the house. Kulsum’s husband
was sitting outside on a low plastic stool sorting scrap into separate heaps. Kulsum
greeted me with a smile and mentioned that I had visited her at the most appropriate
time. She had returned from work a little while ago and had some free time to chat.
Kulsum had just finished her first week of work as a domestic maid at her new
employer’s house, which was possible due to the reference and support of her sister-in-
law. Kulsum was relieved by the prospect of relatively steady monthly earnings, and she
also showed gratitude to her sister-in-law, who had worked as a domestic maid for
several years.

Kulsum left for work early in the morning and returned home around three o’clock
in the afternoon. Her husband looked anxious about the responsibility of caring for and
feeding the children on an everyday basis. He remarked that it was difficult to attend to
the children while she was away at work. Fortunately, their elder daughter was about to
join the nearby municipal school, thereby relieving her husband of childcare
responsibilities during Kulsum’s work hours. Kulsum noted that her husband was lucky
because he did not have to engage in physical labour for ten to twelve hours each day like other men in the neighborhood. Her husband usually left home after having his lunch to collect plastic scrap from the nearby middle-class neighborhoods. He came back home by five or six o’clock in the evening. Kulsum argued that her work as a domestic maid was physically more strenuous than that of her husband: on an average, she had to complete her cleaning work in three different houses in a day. Moreover, she had to cook and care for her children and husband apart.

Kulsum’s parents and her husband were not pleased that she worked as a domestic maid. However, her husband’s paltry monthly income of 50 USD$ was insufficient to cover the cost of food, household commodities, medicines, and baby products including oil and diapers. Besides these everyday expenditures, they had to save for the children’s education and expenses during festivities. Further, Kulsum’s husband frequently faced financial difficulties because the scrap dealers did not pay him regularly. It was difficult to run the household in the city under such circumstances. However, as Kulsum noted, the generosity and kindness of her parents helped tide them over difficulties. Her parents had given them the two-room concrete house in Radha Nagar before they moved back to their village in Uttar Pradesh. This had come as a big relief as they did not have to pay the exorbitant house rent in the city.

Kulsum’s parents owned a piece of agricultural land in the village and had decided to move back to the village along with her younger siblings four years ago. Kulsum narrated in great detail how her father had saved money to construct the concrete house while he worked as a car driver for a private company. Apart from providing for a house, he also had supported her during financially difficult times. Kulsum and her husband had moved into the house after seven months of marriage. She recounted that it was difficult to live in the tiny house of her in-laws especially after she was diagnosed with tuberculosis. Apart from her ill health, she recounted domestic quarrels with her mother-in-law. She argued that her mother-in-law did not treat her well and even looked for a second wife for her husband. She went on to note that she did not even have enough to eat at her in-laws’ place.

In contrast, Kulsum received a great amount of affection, care, and support from her parents and siblings. Also very supportive, her husband accompanied her to collect the medicines provided in the state health care clinics each week. Kulsum’s husband
resided with his parents initially but visited her every day with milk, protein powders, fruits, and juices. There were frequent altercations between her husband and mother-in-law when her husband defied her mother-in-law. Eventually, her husband decided to move into her parents’ house. Kulsum narrated how the care and affection of her parents during this trying time helped restore her health. She rarely interacted with her mother-in-law at the time of my conversation, though her husband continued to make occasional visits to ensure the well-being of his aging mother.

Kulsum recovered from tuberculosis within fourteen to fifteen months of treatment. She planned to get pregnant six months after her recovery. However, she worried that she had relapsed because she experienced excessive weakness and fatigue during her first pregnancy. She visited the public health care providers regularly up to four or five months into her pregnancy. Her anxieties regarding the effect on the fetus were eliminated after an ultrasound confirmed that the fetus was healthy.

Her parents had moved back to the village even before her first pregnancy after she had recovered from tuberculosis. Kulsum had used the option of delivering in the village due to her parental support. As noted earlier, she did not receive any support from her mother-in-law. Kulsum had undergone mandatory health check-ups and received the required prenatal injections in the nearby private health care dispensary before moving back to her village. In fact, she had decided to deliver both her daughters in the village with the support of parents and the assistance of a ‘dai,’ who had received basic training in the community health center in their village district to birth babies. Kulsum remarked that she did not experience any health complications while birthing and the ‘dai’ was an expert in assisting during childbirth. Moreover, Kulsum considered home birthing to be a safer option as most of her neighbors and relatives had successfully used it. Home birthing was also cheaper compared to institutional birthing, and Kulsum could avoid the unfamiliar setting of the health care institution by resorting to this route. Her views resonated with those of my other interlocutors concerning institutional birthing. My interlocutors often remarked that the expenses incurred, the unavailability of female obstetricians, and the fear of family planning or caesarean ‘operations’ kept them from seeking institutional health care support during childbirth.

Through narrative evidence, I inferred that Kulsum’s circumstances compelled her to seek terminal contraception a few months after the birth of her second child.
Although she had recovered from tuberculosis, her immunity had considerably deteriorated due to the TB medication. She experienced excessive weakness, fatigue, body aches, and joint pains even after the birth of her second child. Kulsum had lost a considerable amount of weight during her pregnancies, and she perceived that weight loss, body aches, and fatigue contributed to her low immunity, which in turn affected her capacity to produce breast milk. She had to rely on nutritional supplements for her children rather than breastfeed them. Kulsum avoided contraceptives to protect herself from further harm. Her relatives and neighbors had experienced side effects from oral contraceptives and intra-uterine devices and had advised her against using them. She adopted periodic abstinence and persuaded her husband to use condoms. However, Kulsum was constantly apprehensive, as she had heard stories of women conceiving despite their partners’ usage of condoms. Further, abstinence and the use of condoms affected her sexual intimacy.

Kulsum was aware that any further pregnancy would not only worsen her health and bodily immunity but also create further difficulties for her parents and partner. Rather than relying on non-terminal fertility methods, Kulsum voluntarily opted for the family planning operation. She perceived that eradicating the possibility of conception would not only improve her health but also lessen the financial and childcare burden on her and her parents and siblings. She also thought that undergoing the operation would help restore her energy and build her bodily immunity. Kulsum emphasized that her strength, energy, and immunity were important as she had to look after her two children. Because she was aware of the prevalent complications and failures associated with the family planning operation in the state health care institutions, she sought health care support at Marie Stopes—the transnational not-for-profit organization that offers reproductive health care services—rather than undergoing the operation free of cost in the state health care institution. She spent almost 20 USD$ for the operation at Marie Stopes.

Kulsum visited the Marie Stopes clinic along with a community health volunteer. The private health care dispensary in Radha Nagar, which has an alliance with Marie Stopes, employs the health volunteers. She remarked that it was reassuring to undergo the operation at the clinic because the health volunteer was familiar with its personnel and could ensure appropriate care and attention during the procedure. It should be noted that the health volunteers usually reside in the same neighborhoods. Thus there is mutual trust between women and the volunteers at times. The volunteers are also
concerned about safeguarding the health of the women who mostly are their neighbors or relatives. However, in the context of abysmal health care services, residents also mistrust the volunteers or at least are ambivalent about them. For instance, some of my interlocutors often noted that the community health volunteers promoted sterilization measures because they received gifts and monetary incentives for doing so. My interlocutors did not adhere to the advice of the volunteers blindly; rather their embodied experience surrounding their health, well-being, family dynamics, and sexual intimacy influenced their decision-making.

In Kulsum’s case, her primary reason for undergoing sterilization was to prevent further pregnancies and restore bodily strength and energy in order to resist infections. The practice of restoring bodily strength and energy through fertility limitation measures resonates with the adoption of long-acting contraceptives in order to prevent worsening health conditions among Gambian women researched by Bledsoe and others. Bledsoe, Banja, and Hill (1998) argue that Gambian women use the injectable contraceptive Depo Provera as a “re recuperative” measure to heal their bodies in the event of reproductive complications and obstetric trauma. They also argue that these long-term contraceptives are used to avoid reproductive mishaps including miscarriages and stillbirths rather than merely to limit fertility or space pregnancies. The authors challenge the “dominant” or “Western” assumption that contraceptives are merely used to limit fertility or space pregnancies by highlighting the specific “intents” of contraceptive use in different contexts (1998: 17). In other words, the embodied experience of women influences the adoption of both terminal and non-terminal contraceptive methods.

Kulsum suggests that the restoration of bodily energy and recuperation from reproductive complications is central to the well-being of the family. Thus, adoption of terminal methods of contraception is also tied up with a sense of well-being, care and sustenance of families, and future birthing of healthy babies. In fact, the contingent embodied experiences of women shape the decision-making process around terminal and non-terminal contraception. Kulsum’s decision to undergo sterilization in order to maintain her bodily health and well-being is enmeshed within the realm of social relations (see also Scheper-Hughes and Lock 1987). Her narrative sheds light on how factors like caring and sustaining the family are entangled with the concerns of strengthening bodily immunity by avoiding further pregnancies. Having analyzed a case of voluntary adoption of sterilization, I turn to a discussion of involuntary sterilization.
Sterilization and Obstetric Complications: A Case of Involuntary Sterilization

I have argued in chapter 2 that women encounter covert and overt pressure to undergo sterilization even when their visits to the health care institutions did not concern seeking contraceptive advice. Often, the providers aggressively promote and impose irreversible and invasive fertility limitation methods. The providers also work under the assumption that Muslim women are resistant to contraception. As shown in chapter 1, this prejudiced assumption is guided by the Hindu right propaganda that Muslims would outnumber the Hindu population as a result of their non-adherence to fertility limitation methods (Jeffery and Jeffery 2005; Jeffery and Jeffery 2002). The providers are preoccupied with “numericized achievements” in their call to expedite cases of sterilizations (Greenhalgh 2005b: 354). In this light, Muslim women devise a range of methods, thereby successfully resisting at times and submitting at other.

In most cases, women’s submission to the irreversible fertility limitation measures is involuntary, primarily undertaken to secure appropriate treatment during childbirth. Women also receive immunization and vaccination services and other non-obstetric services without being reprimanded if they voluntarily submit to sterilization. Women are pressured to provide signatures without even learning about the contents of consent forms before undergoing sterilization. They are made to sign the consent forms when they are either in delivery wards or waiting areas experiencing labour pains. Furthermore, they are not provided adequate time to consult their husbands or other family members before signing the forms. In other words, the providers work under an assumption that women are careless with regard to family building decisions and unable to make informed decisions, therefore, it falls to them to take measures to push more women toward sterilization.

Shahida (Shabnam’s niece) had to submit to sterilization in order to receive treatment for obstetric fistula developed during the home birthing of her first child. I have discussed Shabnam’s experience with regard to contraceptive pills in chapter 3. She is the aunt of Shahida, and a resident of Radha Nagar. Shahida lived with the fistula for almost six years after the birth of her first child. At the time of my fieldwork, she had made up her mind to get the sterilization in order to receive free treatment for her condition. She was actively looking for a reproductive bargain to undergo sterilization.
only after she was treated for fistula. Shahida could not save enough and was unable to pay for the cost of treatment in private clinics for six years. As she told me, “My husband is wayward and irresponsible and worked intermittently. It is not possible for me to expect him to pay for the treatment.” Because Shahida relied on her natal and in-law families to meet her everyday basic needs, she was not keen on asking for money to undergo the treatment. Further, the home birth of her second child in 2009 had worsened her fistula condition. Her family members had not sought immediate health care treatment because they assumed that the injury would heal in a few days. The ‘dai’ had merely suggested home remedies. Shahida suffered from acute discomfort and incontinence due to tears and other injuries. The state health care providers assured her that they would treat the fistula only after she agreed to undergo sterilization. In other words, they used a medical emergency to fulfill their sterilization targets.

Shahida had to endure her suffering because of her extreme poverty. And she submitted to sterilization in order to receive immediate treatment. Shabnam, her aunt, had considered borrowing money and had resolved to support her during this emergency. However, they were both discouraged since the cost of treatment was almost 130 USD$ at a private clinic and arranging to borrow such an amount of money required time and connections. Because Shahida was not willing to borrow money, given the usurious interest rates, sterilization became a way to alleviate her obstetric complications. As the narrative suggests, the Indian state advances neo-Malthusian population policies, with a focus on population stabilization (Rao 1994). Maternal, child, and general health is linked with sterilization and the poor have to pass through a range of motivations in order to receive even basic health care services. Having discussed a case of involuntary sterilization, I discuss a case of ambivalent motivation for undergoing sterilization in the next section.

**Persuasion and Guilt: A Case of Ambivalent Sterilization**

I reproduce a narrative from Leela-ji (one of the community health volunteers) to illustrate a case of ambivalent motivation for undergoing sterilization. While Kulsum was certain about undergoing sterilization, one of Leela-ji’s clients was quite uncertain about it. Women often desire to escape the cycle of contraceptive failure commonly associated with the contraceptives provided by the state health care institutions. However, they do not adopt sterilization as a preferred option. The client of Leela-ji expressed ambivalence
due to apprehensions associated with the complications involved in the invasive procedures. However, Leela-ji persisted for almost two years to persuade her client to undergo sterilization. It is a common practice for the health volunteers to persuade women to undergo sterilization after the birth of two children in Radha Nagar. Often women assented to undergo sterilization after an extended period of persuasion, while some remained unconvinced about the procedure. The client of Leela-ji received assurance about the risk-free procedure and quick recovery after the sterilization. However, she remained reluctant to adopt the terminal fertility limitation method. Leela-ji remarked that even after emphasizing about the suitability of the relatively painless procedure (laparoscopic incision), hygienic conditions, and the credibility of the transnationally recognized Marie Stopes clinic, her client could not make a concrete decision with respect to sterilization.

Her client still desired to adopt a long-acting contraceptive rather than undergoing sterilization after the birth of her second child. Her client started using injectable contraceptives administered in the private health care dispensary of Radha Nagar merely a few months of the delivery of her second child. Leela-ji noted that she had informed her about the side effects of the injectable contraceptive, including the possibility of the cessation of menstruation. Leela-ji continued to stress sterilization in order to convince her client about the absence of long-term side effects. However, Leela-ji’s client continued to use injectable contraceptives for almost two years and intended to carry on for another two or three years. Then her client started having irregular menstruation cycles and began to show keenness about transitioning to another method of contraception. The client was ambivalent about immediately undergoing sterilization. However, Leela-ji had consistently persuaded her to undergo sterilization during her volunteer outreach services in Radha Nagar. Leela-ji emphasized that Marie Stopes offered free sterilization services once in three years. In addition to offering subsidized sterilization services to low-income clients in the clinic, Marie Stopes practitioners also conducted sterilizations free of cost in the camps occasionally set up in the clinics. Leela-ji argued that her client could save approximately 20 USD$ by undergoing sterilization at Marie Stopes. Leela-ji emphasized the benevolence of the personnel of Marie Stopes in providing contraceptive services to the low-income residents free of cost. As some of my interlocutors noted, Leela-ji, in reality, was actually obscuring the state’s targeted population control measures. My interlocutors emphasized
that the volunteers used the argument of free services in order to motivate women to undergo sterilization.

Finally, the client of Leela-ji agreed and underwent sterilization during the winter a few years ago. Leela-ji noted that her job was to persuade, and persuasion is an important task. Marie Stopes pays the health volunteers 3 USD$ for each sterilization case. It should be noted that the health volunteers are required to provide at least five sterilization cases per month during the winter season. My interlocutors noted that the family planning campaign reached its peak between November and February each year. At times camps are aggressively organized during the winter months to fulfill sterilization targets. Thus, her client had eased a bit of pressure by contributing to Leela-ji’s target that particular winter. Leela-ji noted that the health volunteers and authorities at Marie Stopes also experienced some pressure to expedite sterilization cases during specific times of the year, because targets had to be met and records had to be passed on to the senior officials and aid agencies. The record keeping and “documentary practices” (Coutinho, Bisht, and Raje 2000: 656) demonstrated the efficiency of the volunteers in achieving sterilization targets. Lester Coutinho, Suman Bisht, and Gauri Raje (2000: 659) note that frontline health workers in Uttar Pradesh and Gujarat, who were evaluated as “capable” were especially provided targets to meet immunization and family planning goals.

Leela-ji had emphasized the safe and hygienic practices at the Marie Stopes clinic. However, her client suffered post-sterilization complications. Leela-ji expressed guilt in narrating this to me. She took personal responsibility; because her persuasion had convinced her client to undergo sterilization, she associated the complications and suffering of her client with her persuasion. Further, such cases of complications and post-sterilization suffering made the task of the health volunteers in persuading clients to undergo sterilization even more difficult. The circulation of news concerning the incidents of harm, injuries, and risks experienced in the health care institutions undermined the efforts of motivation on the part of the volunteers. Such news discouraged women from undergoing sterilization despite the assurance of good-quality care at the clinics. In particular, women stopped reposing faith in Leela-ji after her client experienced the medical mishap.
Leela-ji’s client experienced severe bleeding during the sterilization procedure. The health care personnel had not stitched the laparoscopic incision on the abdomen of her client properly at the Marie Stopes clinic. They had stuffed a ball of cotton onto the incision. Leela-ji learnt of such negligence after the client had returned home and had suffered severe bleeding while resting. Leela-ji had to immediately rush to the client’s house, as soon as she was informed about the bleeding. Her client and the client’s husband were in a state of panic. Leela-ji remarked to me that she was scared after seeing her client’s sari and bedspread drenched in blood. She argued that the stitches and adhesive medical tape on the incision were missing. She immediately arranged for a taxi to accompany her client and the client’s husband to the Marie Stopes clinic. Leela-ji noted that her client was non-confrontational and calm while the health care providers attended to her, thereby showing utmost patience.

Even though the client and her family did not blame Leela-ji, she was unable to absolve herself of the guilt. Leela-ji felt morally responsible and was extremely embarrassed because of this incident. The years of what she thought was community service were scrutinized and even discredited due to the inattentiveness of the health care providers. Leela-ji noted that she had convinced three women to undergo the operation at the time of the incident. However, the women balked after hearing about the complications. The potential clients were obviously scared about the procedure and questioned their safety in a well-reputed transnational health care institution. The volunteers struggled to generate trust in women after this incident. Leela-ji refused to motivate women to undergo sterilization for almost two years because she was annoyed with the providers at Marie Stopes and, perhaps, as a penance. She argued that only she took this adverse and distinctive decision; none of the other volunteers took such decisions in the neighborhood.

In fact, the health volunteers submit to the dictates and requirements of the authorities for the promise of renewal of their jobs and meager salaries. I am not arguing that this is a case of ambivalence on the part of the client merely because the operation went wrong. The client was ambivalent from the beginning, and it was unfortunate that it went completely wrong for her. The client’s negotiation of the medical personnel after undergoing trauma should also not indicate utter passivity. Her strategic calmness despite the anger and pain she experienced has to be located within the unequal power relations in the medical setting. The client understood that deference rather than
confrontation could secure the attention of the health care providers. Her marginalized economic status required her to maintain her equanimity. Although the providers were responsible for her suffering, the client may have perceived that complaining and protesting would delay receiving urgent medical assistance and support. Thus her strategic deference might have helped her to claim legitimate medical attention even though she was powerless. The clients could initiate legal action against providers at Marie Stopes in case they experienced negligence, as noted by volunteers. But in reality the clients refrained from initiating such measures even when they possessed sterilization certificates that in turn provided proof of undergoing the operation at the designated institution. The client of Leela-ji did not pursue any legal action.

Leela-ji considered herself to be an empathetic and conscientious volunteer and distanced herself from the other volunteers. The client’s composure even while experiencing pain moved her deeply and made her feel accountable. Leela-ji experienced financial difficulties in refraining from providing clients to Marie Stopes. However, she had to withdraw temporarily at least to restore her moral uprightness. She was keen to demonstrate her compassionate side to the women in the neighborhood rather than being perceived as a greedy (lalchi) volunteer. Leela-ji even abstained from collecting the gifts such as steel bowls, tumblers, and torchlights from Marie Stopes that are provided to volunteers yearly. Leela-ji was also demanding accountability to the Marie Stopes authorities through such acts. She thought her acts would force the authorities to ensure the well-being of the clients in the future. Leela-ji noted that this marginal protest was a conscientious act that lessened her guilt. While her client had been ambivalent from the beginning, I realized that Leela-ji began investing in her own work ambivalently after the incident. In other words, she was not convinced about sterilization as a method of contraception and remained ambivalent about resuming the task of motivating clients, suggesting the ambivalence experienced by the client and the volunteer, the motivated and the motivator.

Another issue is the presence of subtle coercion and incentives as transnational and domestic health care institutions aggressively set up camps and meet sterilization targets. However, the volunteers do not completely abdicate their moral responsibility to the community while serving for minimal pecuniary gains. Betsy Hartmann and Mohan Rao (2015: 10) argue that there is a “neo-Malthusian resurgence” in the activities of transnational donor organizations that have set contraceptive targets in contemporary
India. They assert that the attempt to widen the “basket of contraceptive choices” for women in the Global South conceals the “target oriented” measures and the “harmful” effects of contraceptives (ibid.). In this respect, the “word ‘target’ has now been euphemistically replaced by ‘Expected Levels of Achievement (ELA)” (Sama Resource Group for Women and Health, Jan Swasthya Abhiyan, National Alliance for Maternal Health and Human Rights 2014: 35). In fact, the health activists emphasize that the Indian state has conducted an average of 4.5 million surgeries each year since mid 1980s (ibid.). Sterilization as a method of terminal contraception is aggressively pursued in contemporary times. However, it hardly invites attention in popular media today.

The above narrative also reflects the complexities surrounding the involvement of the community health volunteers in persuading clients to undergo sterilization. The health volunteers receive money and gifts while providing cases to Marie Stopes. Leela-ji noted that the money was not a major concern for her. In fact, the community health volunteers downplay this aspect as a result of the guilt involved in pressuring women to undergo sterilization. Although the volunteers primarily work for the health care authorities of the private dispensary of Radha Nagar, they usually accompany clients to the private dispensary one week after they undergo sterilization at Marie Stopes. The volunteers have the responsibility of accompanying their clients to remove stitches. They prefer the neighborhood dispensary to the distant Marie Stopes because they save considerable amount of money incurred on transportation. Marie Stopes enjoys a good reputation for being a relatively safe and hygienic institution. However, most of the staff in the private dispensary has connections with Marie Stopes in certain ways, thus indirectly increasing its reputation. The volunteers receive money from Marie Stopes for each case of sterilization and a monthly salary from the private dispensary—in other words, they work in tandem both with Marie Stopes and with the private dispensary in their neighborhood. They gain the reputation of being labeled ‘capable’ volunteers only if they attend to their clients till they have recovered after sterilization. At the time of my fieldwork, the private dispensary, which operated on the principles of a charitable trust, received funds from the transnational aid agencies. However, it experienced cutbacks from transnational aid agencies and was forced to lay off ten community health volunteers. As a result, the four remaining volunteers had hastened their sterilization drive in order to demonstrate their capability in motivating clients in Radha Nagar. These instances highlight the coercive population control practices of transnational aid.
agencies, especially their attempts to promote camps and campaigns through an incentives approach suffused with neo-Malthusian concerns.

Matthew Connelly (2003; 2006) has shown that the transnational donor organizations have advanced population control measures since independence in India. Connelly (2006: 630) notes that the United States provided “food aid” by coercing the Indian state to accept intra-uterine devices as the primary contraceptive method when India experienced food crises in the 1950s and 60s. The coercive campaigns had successfully targeted approximately 29 million women to adopt IUDs (ibid.). According to Connelly (2006: 649-650), the organizations promoted IUDs because oral contraceptives were “expensive” and “too dependent on women’s motivation.” Similarly, Susan Greenhalgh (2005b: 359) in the context of China shows how the population control program is used as a strategy to “catch up” with the “modern” and “global” West. It must be emphasized that the population control policies target peasants, marginalized classes and castes, and specific religious communities. As Mary E. John and Janaki Nair (1998: 20) argue, the Indian population control policies target the Muslims and those of lower castes because they are perceived to be “polygamous” and “licentious.” The above studies highlight the consistency in thinking and policy making on the part of both transnational and domestic health institutions in targeting women in low-income neighborhoods.

I discuss the complexities of tasks undertaken by the community health volunteers in the following section. On one hand, the health volunteers overtly or covertly coerce women to undergo sterilization. On the other, they also show care and concern while securing appropriate and good-quality facilities for these women. At times, the health volunteers are guilt-ridden as a result of their coercive activities, but they emphasize that their outreach services enabled women to become “rational” and “ideal citizens” who made responsible contraceptive choices (Chatterjee and Riley 2001; Ram 2001). Scholars have shown how women are encouraged to fashion themselves as “rational” and “ideal citizens,” by adhering to a small family norm in order to uphold the goals of Indian progress and modernity (ibid.). The health volunteers also assert their contribution in spreading awareness about safe contraceptives, maternal and infant morbidity, and mortality in low-income neighborhoods. In this context, the health volunteers assert their moral selves by emphasizing their clients’ well-being.
Moral Selves and Clients’ Well-being: Perspectives of Community Health Volunteers

Women undergo sterilization for free in the camps organized by Marie Stopes. However, women who are not in appropriate health conditions for undergoing the procedure are advised to consult the physicians at the clinics by the volunteers. Clients who experienced irregular menstruation, high blood pressure, or other ailments are advised to visit Marie Stopes during regular hours. These clients are required to undergo specific health tests prior to the sterilization procedure; these ‘motivated’ clients are required to pay the full cost of the procedure. The clients possessing a below poverty line ration card are eligible to secure monetary concessions. The below the poverty line clients are required to pay 8 USD$ for the procedure, whereas the above the poverty line clients pay 20 USD$. However, it is difficult to receive a below the poverty line card. Most low-income families are denied this document because they are unable to provide proof of their income. In addition, low-income families survive on multiple contract jobs, which are primarily short-term. Substantiating records of work documentation and income is not feasible since low-income families are mostly employed in the informal sector as casual laborers, electricians, vendors, scrap sorters, scrap collectors, and domestic workers.

As Sanjeev Routray (2014a, 2014b) shows, the poor experience a range of struggles in order to possess these critical documents. Further, the mere possession of a below the poverty line card did not ensure health subsidies at the clinics. Rather, it required additional validation on the part of the local councilor. Routray’s (2014b: 80-126) study of the types of intermediaries highlights how they adopt different techniques and tactics by making use of different kinds of capital in Delhi. The health volunteers constitute a specific kind of intermediary in negotiating among the local councilor, the staff at the Marie Stopes clinic, and the clients. Often, the volunteers receive certificates of validation from the councilors in establishing proof of residence in the neighborhood in addition to the below the poverty line documents. These documents and certificates make the clients eligible to receive subsidized medical care at the clinics. Thus, the volunteers assert their moral responsibility in securing official letters and documents so that their clients can access subsidized contraceptive services at Marie Stopes. However, as Routray (2014b) shows, this raises critical questions about alliances and solidarities on the one hand and exclusion, exploitation, and dependency on the other.
Apart from fashioning their moral selves, the volunteers also articulated their investment in the well-being of their clients. They consistently scrutinized the inadequacies of the state health care institutions. Unlike the complexities associated with getting free sterilization services in the Marie Stopes clinic, getting free sterilization services at state institutions was relatively straightforward. As Somvati-ji, one of the volunteers, told me, clients possessing below the poverty line cards not only get free sterilization services but also receive monetary incentives at the state institutions. However, during the course of my field research, I realized that women received smaller monetary incentives than promised in hoardings, graffiti, and advertisements. For instance, the specified monetary incentive was 10 USD$ and 13 USD$ for female and male clients respectively, but I was often told that the clients received around 6 USD$ after undergoing sterilization. At times, the volunteers reconfirm the inadequacy of available funds or demand the promised money for their clients.

Often, the health volunteers deterred their clients from visiting state health care institutions due to what they perceived as a myriad of problems. For instance, they informed the clients about the absence of health check-ups before and after the sterilization, a longer duration of stay following the procedure, and unhygienic conditions. Although female sterilization involved tying the fallopian tubes, the surgical procedure considerably differed in the state health care institutions compared to Marie Stopes. The health care providers in the state institutions primarily conducted mini-lap tubal ligation, also known as mini-laparotomy. This procedure is usually conducted on women immediately after childbirth while the epidural is still effective. Though a small incision is done on the abdomen, there is an increased risk of infection as the fallopian tubes are pulled out and then replaced after the completion of the procedure. In this case, an infection could occur if the incision or the operated fallopian tubes did not heal properly. Apart from the possibility of infection, I heard that some women had become pregnant even after undergoing the sterilization procedure in the state health care institutions. Such incidents occurred when the surgical procedures were conducted on women without a thorough monitoring of their overall health condition. Moreover, women complained about heavy menstrual bleeding and severe cramps, which they had not anticipated after the procedure. Unfortunately, they had to carry on with routine activities without any follow-up care, remedies, or counseling in the state institutions. In contrast, the health care providers at Marie Stopes relied on a minimally invasive laparoscopic
procedure to seal off the fallopian tubes. The tubes were not pulled out; instead, sophisticated technology like the fiber-optic device was inserted into an incision to block the passageway of the tubes. Unlike the clients in the state health institutions who had to stay for at least two days, Marie Stopes ensured quick recovery and healing and discharge of clients within a few hours of the procedure.

Although I have discussed a case of negligence and post-sterilization complications at Marie Stopes, I argue that the community health volunteers ensured adherence to a particular regimen of procedures before and after the operation. Clients are advised not to eat or drink on the day of the operation. The volunteers ensured that the staff at Marie Stopes conducted blood tests and measured blood pressure before the sterilization. Such care and attention were missing at the state institutions. The health volunteers articulated their moral correctness and concern for the well-being of their clients despite the fact that they coerced or otherwise persuaded women to undergo sterilization. The volunteers not only accompanied the clients to the Marie Stopes clinic but also paid for travel and food such as fruits, drinks, and glucose biscuits after the procedure. In this respect, the volunteers constantly rearticulated their concern and lack of mere self-interest.

The volunteers also asserted their moral selves in fulfilling their responsibilities diligently. They meticulously documented instances of pregnancies, adoption of contraceptive methods, methods of spacing, vaccination during pregnancies, and immunization of infants. Although they received money for carrying out these duties and remained under the surveillance of their supervisors, they emphasized their moral responsibility of ensuring their clients’ well-being. The volunteers were also responsible for providing oral polio dosages to infants, oral rehydration salts, chlorine tablets, and medication for worms and diarrhea. They routinely informed women about the routes of transmission of jaundice, malaria, epilepsy, worms, and sexually transmitted diseases and suggested preventive measures. The volunteers identify the symptoms of various ailments and advise immediate medical intervention to protect the fetus and the expectant mother.

This is not to suggest that families refrain from self-care. As noted in chapter 2, women meticulously boil and purify and at times chlorinate water as a prevention against water-borne ailments. The lack of potable water in the neighborhood rendered its
residents vulnerable to ailments including diarrhea, gastroenteritis, jaundice, and typhoid. At times, women made their own oral rehydration salts and also resorted to home-based nutritional supplements in the case of diarrhea by serving watery lentils (daal ka pani), light tea (halki chai), lemonade (shikanji), and tender coconut water (nariyal pani). Women learn about home-based cures from elders, graffiti, hoardings, and educational advertisements by Delhi Nagar Nigam and the Ministry of Health and Family Welfare. At the time of my field research, the situation concerning the availability of water had improved. Women received piped water in the neighborhood and did not have to walk a long distance to collect it. Nonetheless, the volunteers actively engaged with women in suggesting home care remedies, preventive tactics, and family building strategies. Because the volunteers came from the same neighborhood, they were aware of the social world and the hardships faced by the women. In this way they could assert that the ideology of community service was central to their work, rather than the meager payment.

Though the transnational health institutions recruited the community health volunteers primarily to fulfill sterilization targets, the ambivalent position of the volunteers reveals how they desisted from performing the tasks and responsibilities that were part of their training repertoire. For instance, as illustrated, one of the health volunteers temporarily withdrew from participating in providing sterilization cases, foregrounding the attention to the social contexts of women in the neighborhood. The lack of social distance between the volunteers and their clients might have brought about such initiatives. In discussing health-related training programs in Nepal, Stacy Pigg (1997: 283) argues that development projects that seek to modernize rural villagers operate through “universalizing categories” and “standardized procedures.” To illustrate this point, she analyzes the complexities surrounding who could qualify as a traditional birth attendant in Nepal. The planners assumed a fixed set of practices with regard to childbirth; however, on-the-ground realities revealed the different levels of expertise and assistance that women, especially relatives, provided during childbirth (Pigg 1997: 271-272). These women did not fit into the universal categories of what constituted a traditional birth attendant with limited roles and practices (ibid.).

In another case of the planners’ intention to carry out “culturally appropriate development,” traditional medical practitioners who in the local context are identified as shamans are trained to “instruct” villagers to use modern medicines for illnesses (Pigg
Instead of relying on rituals to alleviate illnesses, the shamans are trained to diagnose symptoms, provide biomedical remedies, and persuade the villagers to turn to modern medicines. Pigg critiques this initiative on the part of development planners because they impose biomedical knowledge and assume that the shamans possess the authority to convince the villagers to visit health care institutions. She emphasizes that the planners' misperception about local cultural contexts poses an impediment to the realization of their development agendas (ibid.). Thus, the planners encountered different outcomes in implementing these projects: some of the traditional medical practitioners aligned with the official vision while others questioned or challenged it.

In this light, I argue that at times the community health volunteers were cynical about the knowledge imparted by the trainers or the health care service providers. They believed that the service providers or training officials prioritized sterilization in order to fulfill state-designated targets and thus gain promotion or a raise in salary. Rather than following such pathways, the volunteers felt accountable to their neighbors and relatives in the context of reproductive injustice.

**Conclusion**

Drawing on the above narratives, I illustrate the embodied experience of decision making in assenting, resisting, or submitting to sterilization on the part of low-income Muslim women. The notion of decision making is complex, and these women underscore the fact that deciding to undergo sterilization is the result of a chain of circumstances. The narratives shed light on the ways that contraceptive practices may have either liberating or restraining effects within a patriarchal context. Contraception to build the immunity of the body and restore energy is a positive aspect of decision making, whereas persuasive and coercive motivations raise questions about the experience of restraint. What is perhaps required is a “responsible policy of fertility” that primarily focuses on the issue of “gender equity” (Sen 2001a: 474), “freedom and justice” (Sen 2001b: 174), and the embodied experiences of low-income women.

My work also reveals the complexity of the work by the community health volunteers. The narratives of the recruiter and the recruited highlight the complexities of their persuasion strategies and negotiations with a range of actors in these neighborhoods. In this respect, Matthew Connelly’s (2003: 129) argument is worth
noting: “…works limited to the history of science and elite decision making will not reveal the consequences, intended or not, of ideas and policies in the population field, because their impact depended on how they were received and acted upon by program workers and participants.” I have tried to show how population policies are encountered and negotiated on the ground, especially through the policy of sterilization.

My focus on “embodied” decision making as a framework of analysis is an attempt to counter the way that contraceptive decisions tend to be treated in the mainstream demographic and family planning literature, specifically in the quantitative analysis through categories such as “acceptors” and “resistors” or “unmet need.”
Chapter 5.

Conundrums of Birthing: Homes, Hospitals, and Reproductive Emergencies

In earlier chapters I have focused on the gendered politics of family building and planning experiences through the window of contraception. I have shown how contraceptive technologies are actively and ambiguously sought after as well as how they are rejected and imposed in the state maternity centers and dispensaries. For instance, I have shown how access to institutional health care services is contingent upon contraceptive use among low-income Muslim women. I now turn to the process of birthing within women’s family planning and family building experiences. Reproductive narratives reveal how birthing experiences are embedded in the familial, social, material, and institutional milieus affecting women. These narratives often focus on the contradictory arrangements of care experienced by low-income Muslim women during pregnancy and childbirth in homes and hospitals, in situations such as reproductive emergencies, health risks, and obstetric accidents that impel women to navigate homes and hospitals. Women’s stories reveal how social and marital relations determine care within families. They also show the conundrums that women face in seeking support in hospitals.

The first narrative focuses on the paradoxes of institutional care as service providers bypass or suspend the strict rules regarding clients’ registration in the state hospitals while admitting women with severe obstetric complications who have no prior medical record with them during the course of pregnancy. Despite the hostile encounters, state hospitals become important sites for those seeking medical care and treatment in critical circumstances. To illustrate this point, I draw on a specific narrative that sheds light on how worsening health conditions compounded by a fear of risk to the mother and the baby during home birth compel families to seek institutional care.

The second narrative attempts to show the dilemma of women needing to continue to avail themselves of medical assistance after childbirth, especially in the context of post-delivery mishaps in the state hospitals. This particular narrative also illuminates the tactics or strategies of coping and withstanding the inattentiveness of
service providers when women seek remedies for post-partum injuries. It underscores the complex and contested characterizations of biomedical care that both provides treatment and subjects clients to physical and psychological harm (Ong 1995). I examine how the state hospitals are seen both as spaces of assurance (bharosa) and mistrust (avishvas), as women negotiate obstetric services in these sites.

The third narrative brings to center stage marital and social relations because they significantly determine the level of attention and care that women receive during the prenatal, childbirth, and postnatal phases and even beyond such physiological events. Through a specific case, I turn my attention to the familial site where injudicious decisions of partners or mothers-in-law at times precipitate conditions for obstetric complications. I show how families are reluctant to take on financial responsibilities that could prevent risks and avert the need for emergency medical treatment. My analysis foregrounds how familial negligence, antagonistic interpersonal relationships, and marital discord affect the health and well-being of women. Although families can be sites of antagonism, the convivial relations and personalized care they provide are also fundamental to health and well-being. Familial arrangements thus shed light on situations of neglect (beeparwahi) and care (dekh-rekh).

The everyday experiences and negotiations of Muslim women within these institutional and familial sites are the focal points of this chapter. In this respect, I examine their negotiations with the health care service providers, spouses, and marital family members. I draw on the analytical frameworks of structural violence (Farmer 1999, 2004) and social suffering (Kleinman 2010) to understand the susceptibility to reproductive emergencies, risks, and uncertainties during pregnancy, childbirth, and post-partum phases. Drawing on the works of these scholars, I emphasize the socioeconomic and sociopolitical conditions that play a major role in shaping the reproductive trajectories of women. Anti-Muslim sentiments and Islamophobia among the formal and informal health care service providers are quite rampant. It is a standard prejudice that Muslims are resistant to contraception. Such sentiments exacerbate the social and medical vulnerabilities and worsen the health conditions of women. The reproductive biographies discussed below will underscore the effects of these hegemonic discourses and inequal inter-community power arrangements.
I argue that reproductive emergencies or obstetric complications are biosocial (Farmer 1999; Berry 2010) and entrenched as a result of state and familial structures of discrimination, inadequate infrastructure, material and emotional neglect, and social exclusion. I also examine how health care inequities increased due to the advancement of a neo-liberal model – where the Indian state has drastically reduced investment in health care over the past decades. In fact, the reproductive health services offered by the state are dismal, and women have to invent ways to adapt to such transformations.

Further, drawing on various studies, I examine the gendered dynamics in the household and how the neo-liberal policies marginalize women within the domestic sphere. Economic instability and the lack of job opportunities have affected the distribution of resources in the household. This has resulted in minimal or negligible investment for women in the fields of education, health care, and nutrition. Thus, this chapter broadly focuses on institutional concern and discrimination as well as familial neglect and care as they are manifested in the successes and uncertainties of birthing in homes and hospitals. In the next sections, the reproductive biographies of Sheeba, Nasreen, and Asma foreground how obstetric emergencies and mishaps can occur in both familial as well as institutional sites.

Paradoxes of Institutional Care, Reproductive Emergencies, and Home Birthing

Sheeba's elder son is six years old, but her memory of his birth has not faded with the passage of time. Twenty-six-year-old Sheeba remembers the infuriated hospital staff who initially denied her admission and treatment. Sheeba had suffered complications while birthing at home and was rushed to the state-run hospital. The angry staff repeatedly scolded her mother-in-law and husband when they saw her in blood-soaked clothes. Sheeba notes that the staff screamed: “You seek institutional care only when you suffer emergencies while birthing in home” (Jab aap ka delivery case ghar mein bigad jata hai tab aap log haspatal aate hain). The hospital staff was apprehensive about the health of the fetus due to Sheeba’s excessive blood loss. In such a scenario, the staff was not keen to shoulder the responsibility of treatment due to escalated possibilities of risks.
As Sheeba recounts, she waited, almost fainting, near the entrance of the hospital while her family members conversed with the staff. She reclined against a wall, as she was unable to sit upright. Sheeba recalled that she drifted in and out of consciousness due to extreme pain and discomfort. She had bled for at least two hours by now. Sheeba noted that they made a trip to the hospital around six o’clock in the morning, and it had taken them nearly an hour to reach the hospital; they lived in Zaidpur, a low-income settlement on the outskirts of Delhi at that time. Even finding an auto-rickshaw was difficult early in the morning. Further, the negotiations with the staff in order to persuade them to admit her had taken more than an hour. Fortunately, after repeated pleas by her family members, the staff yielded and she was given medical attention around eight in the morning.

Sheeba’s marital family members could not afford institutional care. Both the state-funded dispensary and the hospital were located far away, and the family had to incur substantial expenses even for a single visit. Sheeba had confirmed her pregnancy in a state-funded dispensary. The dispensary staff had also conducted blood tests to rule out HIV infection during this visit. However, she could not step out of the house for any further routine prenatal consultation due to the costs of travel, and she would have needed her mother-in-law’s support to navigate the unfamiliar city. In any case, she had been scared to venture out on her own since moving into Delhi after her marriage. It would have cost 2 USD$ for two people per visit for the fare of two buses and a shared auto-rickshaw. Sheeba thus was entirely reliant on the decisions of her mother-in-law and husband regarding any prenatal consultation at the dispensary.

Sheeba reminisced about the initial days of her marriage teary-eyed. She lamented their severe financial hardships prior to settling in Noor Nagar. It was even difficult to arrange two full meals a day, she said. Her husband apprenticed as a repair mechanic in an electrical store. He earned 20 USD$ per month during their marriage in 2006. Sheeba’s parents were hopeful that their son-in-law would have a steady income with a raise within a few months. That is why they had agreed to the marriage. After marriage, Sheeba lived in a rented one-room house along with her husband and mother-in-law. They paid a monthly rent of 5 USD$. The rent was low compared to Noor Nagar, as Zaidpur was located in the outskirts and sparsely populated without many infrastructural facilities. They lived without electricity, water, or toilets for up to two years. The harsh weather made it even more difficult to survive. In the summers, the intense
heat made Sheeba enervated and dehydrated most of the time. She recalls that the worst part had to do with the daily task of cooking under such conditions. Sheeba remarked that her mother-in-law helped her with the daily household chores. She was lucky that she had time to rest during the pregnancy.

The lack of drainage and sewage facilities attracted a lot of mosquitoes. Sheeba notes that people residing in Zaidpur were often afflicted with mosquito-borne diseases such as malaria, dengue, and chikungunya. It was difficult to sleep properly in the mosquito-infested settlement during the summer and monsoon season. She recalled, “we longed for the winter but the onset of it was not a respite either.” She possessed few blankets and bed sheets, which were insufficient to keep them warm during the winters. Sheeba and her husband had to endure the biting cold as they slept on a worn-out single mattress on the cement floor. Her mother-in-law occupied the lone charpoy in the house. The absence of electricity exacerbated the wintry conditions. Sheeba’s family relied on a cooking stove for extra warmth because they could not afford an electric heater to warm up the room. Sheeba recalled that the room remained cold and uncomfortable even after the stove was lit for a long period of time. Moreover, they had to stop using the stove when the consumption of kerosene oil was beyond their financial capacity.

Sheeba spoke of these details to contextualize how material inequalities affected her health conditions during her first pregnancy. She wanted me to know that she desired an institutional delivery, but circumstances made it impossible. Her mother-in-law had counseled her to have a home birthing. Her mother-in-law had reached out to a ‘dai’ who resided in the neighborhood after hearing about her from the neighbors. Although the neighbors had not personally sought the ‘dai’s’ support, they had heard about her expertise in handling complicated cases of childbirth in homes. Sheeba’s mother-in-law had eventually trusted the ‘dai’ and asked her to regularly visit them. The ‘dai’ used to visit once in three months in order to gauge the position of the fetus. Sheeba noted that the ‘dai’ used to place her right palm on her belly in order to confirm the normal position of the fetus. She conveyed to me how much confidence her mother-in-law had developed in her ‘dai’ during such visits.

Sheeba remarked that the ‘dai’ insisted that with home birthing she could avoid the enormous costs involved in institutional delivery and subsequent indebtedness. But
Sheeba told me that she was not reassured by the ‘dai’s’ exhortations in favour of home birthing. She did not have any firsthand evidence about the suitability and expertise of the ‘dai,’ and the oral stories about the expertise of the ‘dai’ were not enough to convince her. None of her family members was interested in confirming the ‘dai’s’ stories of handling complicated cases. Sheeba opined that her family took a huge risk in trusting the ‘dai,’ as they had just recently moved into the neighborhood. Though she was eager to verify the ‘dai’s’ expertise, she was unable to take any steps due to her restricted physical mobility in the early years of marriage. She acquiesced to home birthing despite her fears and anxieties.

Sheeba’s anxieties were not misplaced. Unfortunately, she experienced a reproductive emergency while birthing at home. Sheeba notes that she had to endure the birthing contractions for about three hours before the ‘dai’ could arrive. She had informed her mother-in-law as soon as the contractions had started around two o’ clock in the night. Her mother-in-law had immediately gone to fetch the ‘dai.’ The ‘dai’ had assured her mother-in-law that she would follow her back to their place but she did not arrive in the night. Sheeba was extremely worried all this while. She did not know what to do if the ‘dai’ did not turn up at all. Her contractions intensified and lengthened for over three hours. Sheeba’s family members debated whether they should seek institutional care while she lay on the floor writhing in pain.

Fortunately, the ‘dai’ turned up early in the morning at five. She began by gently massaging Sheeba’s belly with mustard oil in order to soothe her pain. Then she administered two dard ki sui—contraction-enhancing injections—that she had brought with her. The ‘dai’ had forced her fingers inside the vaginal opening after injecting the drugs. Sheeba recalled that instead of having patience (sabr) for the baby to emerge, the ‘dai’ had almost reached her uterus (bachadani). She recounts, “I felt as if the sharp fingernails had pierced into my uterus” (Jaise ki nakhun bachadani mein chubh gaya hai).

Sheeba experienced a sensation of warm gushing between her legs after the ‘dai’s’ fingernails dug into the innermost area. Shocked to see a mixture of water and blood trickle down her legs, Sheeba and her mother-in-law panicked. The ‘dai’ was frightened too. She whispered that “The amniotic sac holding the baby had burst” (Pet mein paani ka thaila phat gaya hai). But she was still hopeful about an uncomplicated
birthing even after the fluid had come out. All of them eagerly waited until about forty-five minutes past five; however, there was no sign of the baby. Her mother-in-law rushed out of the house to hire an auto-rickshaw at six in the morning in order to reach the state-run hospital. Sheeba sat in the middle and her husband and mother-in-law held on to her from both the sides. She continued to bleed on her way to the hospital. By the time Sheeba reached the hospital, her condition was dire, yet she was not automatically admitted into the hospital. More invested in lecturing poor Muslims on the proper way to behave than in speedily attending to the emergency at hand, the staff showed no understanding whatsoever of the problems of money and transport that put a planned hospital birth out of reach for this struggling family.

Sheeba recounted in detail how they stalled. The staff sought documentation of prior visits and medical history. When her family members could not provide any record of routine medical consultations during the pregnancy, the service providers became even angrier. Had they had even a small bit of evidence, Sheeba notes, their anger might have been assuaged and then she could have been treated. Finally, a doctor who had refused to admit her retracted his decision after urgent appeals by the family members. The doctor, she said, did not want to be held accountable for any risks with regard to the survival of the mother and the baby. Once in the hospital ward, she was given an intravenous glucose drip. Then two contraction-enhancing drugs were injected into the drip. Sheeba had a normal delivery within half an hour, and she was relieved to learn that the baby boy was absolutely fine.

In telling me this, Sheeba indicated that she regarded the hospital as a space of what she and others term assurance (bharosa). After a worry-filled pregnancy, a terrifying birth complication, and humiliation and disregard on the part of the hospital staff, Sheeba’s story ends with her matter-of-fact recounting of the ways the service providers of the state hospital contributed to her bharosa as they ensured the safe delivery of her baby. She only needed a few stiches due to minor perineal tears. The doctors also administered a tetanus injection and prescribed medicines to suppress any infections. They cautioned Sheeba against relying on a ‘dai’ in the case of future pregnancies.

Fortunately, the doctors said that her uterus had not ruptured; rather, the ‘dai’s’ forcible insertion of hands and sharp fingernails had caused cuts and abrasions. Sheeba
in recounting this incident emphasized that perhaps the ‘dai’ was in haste because she had used contraction-enhancing injections in quick succession. The doctors considered this practice harmful and repeated that the injections needed to be timed precisely in order to avoid complications. Sheeba recognized the irony that her marital family had initially avoided the hospital due to financial hardships but had ended up spending almost 265 USD$ to ensure a safe institutional delivery.

Sheeba’s experience highlights how impoverishment itself can often lead to reproductive emergencies when families are unable to afford the expenses incurred during institutional deliveries. Many residents of Noor Nagar pointed out to me that most people plan for a home birth and expect to manage complications on their own. Sheeba’s experience may be a testament to harsh financial constraint; however, it is a story that also suggests an insouciant attitude on the part of her family members. Sheeba was distraught that her husband and mother-in-law had not properly verified the ‘dai’s’ expertise before seeking her assistance. She had been worried all along. Sheeba held her family members partly responsible for the fact that she almost suffered a hemorrhage during the birth of her first child. She was relieved that she did not lose her baby during the ordeal and that septic infections could be avoided due to the intervention of the service providers. Her story cast the ‘dai’s’ imprudent interventions during childbirth as the cause of a reproductive emergency. Yet like most women, Sheeba and her family needed the ‘dai’s’ assistance because no other option was realistic.

Sheeba delivered her second baby after a gap of nearly three years with the support of a trustworthy ‘dai.’ By this time the family had moved to Noor Nagar. Sheeba claimed that it was easier settling in this particular neighborhood as they had acquaintances and extended kin, and thus it was not difficult to approach a reliable ‘dai’ in Noor Nagar. Because kin members and neighbors vouched for the ‘dai’s’ perceptiveness and skillfulness, Sheeba placed her hope on a ‘dai’ again despite her painful first experience. Low-income Muslim communities often heard stories of difficulties like Sheeba’s at hospitals. Their poverty is something people themselves recognize as a barrier to going to hospitals.

Women’s understandings about the dard ki sui and how it is viewed as a cure-all remedy in solving childbirth complications sheds light on the confidence that women repose in this technology, especially in the context of material hardships. Women
perceived that they could take things into their own hands and manage any eventuality with the dard ki sui, which in a way dissuaded them from visiting the hospital. As Sheeba mentioned: “Once the mouth of the uterus opens up after the administering of contraction-enhancing injections then there is no danger” (Agar dard ki sui se bachadani ka muhn khul gaya toh phir mushkil khatam). But there was also ambivalence about using this technology. Many residents in the low-income neighborhoods of Noor Nagar and Radha Nagar viewed the timely administration of the contraction-enhancing injection as one of the crucial tasks during childbirth. The ‘dais’ who successfully administer these technologies are considered to be knowledgeable in this context. Sheeba notes that two pain injections were administered in an interval of ten minutes during her second childbirth. Her second baby boy was delivered within thirty minutes after the injections caused severe contractions. Women noted that at times the ‘dais’ demonstrate patience in waiting for delivery without the support of any drugs.

Women shared with me a folk theory of why the ‘dais’ did not always have recourse to the dard ki sui. If women could deliver without these drugs, then the ‘dais’ did not see any necessity of administering it. But it required utmost patience on the part of the ‘dais’ and endurance on the part of the birthing women. However, this was not the case usually with the health care providers. Women were suspicious because whenever they had an institutional delivery they ended up receiving these drugs without any thorough medical assessment or consultation. They had to trust the decision of the health care providers because questioning them merely elicited ire. In this context, women perceived that the providers’ administration of these drugs during the delivery of their first child made their bodies dependent on it in the case of subsequent deliveries. Thus they urged the ‘dais’ to inject them with these drugs during subsequent childbirths. As Sheeba once commented: “Once we are injected with the pain-augmenting drugs, the body gets accustomed to it” (Ek baar dard ki sui lag ti hai toh phir sharir ko aadat padjati hai).

Consequently, women insisted to me that it was becoming increasingly difficult to experience natural or spontaneous bodily contractions during childbirth. Cecilia Van Hollen (2003b: 58) claims that women in Tamil Nadu perceive the labour-inducing drugs positively, as enduring intense pain in the course of birthing validates their experience as mothers who possess “power” or strength. Van Hollen (2003b: 63-64) also makes an important observation that these drugs are administered in the state hospitals to conduct
deliveries in a short amount of time due to the lack of beds and other facilities. On the contrary, women in Noor Nagar and Radha Nagar perceived that the use of such modern technologies further weakened their fragile bodies. They also argued that cases of emergencies due to inappropriately timed contraction-enhancing drugs were widespread.

Researchers would endorse this view. Patricia Jeffery, Abhijit Das, Jasodhara Dasgupta, and Roger Jeffery (2007: 174-176) argue that the inappropriate administration of oxytocin injections during deliveries in homes often resulted in complications such as fetal suffocation and uterine rupture in rural Uttar Pradesh. Inaccurate dosage and the routine intra-muscular usage (rather than the intravenous administration) of oxytocin create physiological problems (2007: 172-173). These problems are then compounded when there are no surgical provisions to conduct cesareans in the case of an obstetric emergency and no technologies such as fetal stethoscopes in resource-deprived settings (ibid.). In this context, Sheeba’s case corroborates how the usage of dard ki sui during home birthing without proper monitoring could result in complications.

In another context, Fouzieyha Towghi (2012) sheds light on how the induction of labour during childbirth on the part of lady health visitors causes abnormal uterine bleeding and hysterectomies among women of nomadic communities in rural Baluchistan, Pakistan. She argues that such incidents point to a “failure of biomedicalization” when Balochi women suffer harm and injuries despite seeking medical care (2012: 230). According to Towghi, women turned to folk medicines and healing powers of indigenous practitioners to recover from complications at times (ibid.). She emphasizes that women are referred to city hospitals where the doctors suggest surgical removal of uterus as a “logistical” solution to treat abnormalities in most cases (2012: 240). Towghi claims that the doctors conduct hysterectomies due to the difficulty that women have in maintaining treatment regimens, following up on care, and affording medical services within the options of non-surgical treatment (ibid.). Further, she discusses how Balochi women sought the assistance of indigenous health care practitioners for reproductive complications historically, but the unavailability of herbs due to severe droughts affected the practices of these healers, and gradually women turned to formal health care practitioners and medical institutions. Towghi highlights the paradox of medical institutions as they subject women to further health complications.
Kirti Iyengar and Sharad D. Iyengar (2009) highlight the importance of early monitoring of obstetric emergencies prior to referring clients to the tertiary hospitals. They discuss the role of trained nurse-midwives in providing “first-aid” care to women suffering from post-partum hemorrhage in rural Rajasthan (2009: 9). They argue that the appropriate administration of oxytocin and intravenous fluids helped nurse-midwives stem blood loss and improve the health condition of women. Sheeba’s reproductive case history shows the absence of first-aid care in the local maternity centers or dispensaries, thereby compelling birthing women to seek emergency care in the tertiary hospitals. This emphasizes the need for the state to invest in holistic health care rather than merely focus on birth control and sterilization (Jejeebhoy 1999; Sundari Ravindran and Mishra 2001).

In Sheeba’s own telling, the state hospital became a site of assurance (bharosa) for her, allowing her to survive an obstetric emergency. My other interlocutors in Noor Nagar and Radha Nagar did not uniformly share this viewpoint. At times they were critical of the service providers for their disrespect towards low-income clients. Further, they usually blamed these providers when they experienced mishaps or post-delivery complications at the hospitals. In the next section, Nasreen foregrounds her experiences in the same state-run hospital and also illustrates how she perceives this institutional site both as a space of assurance (bharosa) and mistrust (avishvas).

Dilemmas of Care-seeking, Reproductive Risks, and Mishaps

Twenty-two-year-old Nasreen Begum is a resident of Radha Nagar. Her husband earned almost 130 USD$ a month in 2012. Thus, unlike Sheeba, she did not live in absolute penury. I met Nasreen on a muggy afternoon in July. She was washing clothes when I arrived at her house. She had asked me to visit her in the afternoons, as she was relatively free during this time. Nasreen could prolong our conversations in early afternoons because she would have completed her chores by this time. She had fed and put her one-year-old daughter to sleep when I arrived at her house. Nasreen had married without the approval of both her and her husband’s families. As she mentioned to me, “We have been married for four years but our family members have not wholeheartedly approved the marriage yet.” Nasreen had hoped that the birth of a child
would significantly decrease the hostility on the part of both their families. But the hostility had still not abated in these years.

Nasreen had fallen in love and married in her community; however, her parents did not approve the wedding because her husband is not economically well off. Her parents had arranged her wedding to the son of a family friend who belonged to her village in Uttar Pradesh in a relatively affluent family as soon as they came to know about her relationship. Upon learning about her parents’ plans, she eloped. Her parents were embarrassed and severed ties with her following this incident. She had approached her parents for blessings after the wedding, but they did not relent. Moreover, her parents were angry because they thought that Nasreen had jeopardized the marriage prospects of her three younger sisters. Nasreen was worried too. She had hoped for good matches and a comfortable conjugal life for her sisters. Nasreen felt guilty and did not want to take the blame for ruining the happiness of her family. She yearned for their warmth and affection, and she was upset that her parents did not even accept their granddaughter.

Nasreen lived in a one-room rented house with her husband after their marriage. They rented a house in Radha Nagar where both of their families resided. They often met their family members in the neighborhood and also got updates about them through friends. Nasreen learnt about her sisters’ upcoming wedding and about the gifts that her parents purchased for her sisters. She mentioned to me that her parents had bought various wedding gifts including furniture, jewelry, clothes, utensils, microwaves, water filters, and motorbikes. She had also learnt about the planning of the wedding feast for the guests. Her parents made this substantial expenditure to ensure a comfortable life for their newly wed daughters. Nasreen emphasized that her parents would have spent for her marriage too. The recent news of the marriage of her siblings, however, made her hopeful of a normal relationship with her family. She was optimistic and expected an invitation to the wedding.

Nasreen remarked that her parents had saved almost 5000 USD$ for the marriage of their daughters. Her father owned a small tailoring shop in the neighborhood and her mother worked at home. With a single household income, her parents had managed to set aside a significant amount of money for the weddings. Nasreen told me about the frugal and modest habits of her parents that had allowed them to accumulate
the savings. However, as she noted, her father had to spend some amount of this savings when he suffered a leg injury in a minor accident while operating his sewing machine. The treatment in the hospital had depleted the savings of her family. Nasreen was a bit concerned that her parents might have incurred debts in borrowing money from friends and relatives for the wedding.

Nasreen had offered financial help when her father met with an accident. However, her father had not accepted the support. Nevertheless, she was buoyant about the possibility that her parents would accept her back into the family after the marriage of her sisters. Nasreen expressed guilt for not being able to help her family in times of crisis. Her parents had been supportive when she found a job in a confectionery, where she worked for two years before her marriage. She earned 50 USD$ per month and gave a substantial amount of her salary to her parents, a major support for them. However, her parents stopped accepting money from her once her relationship deteriorated after her elopement and marriage. Nasreen continued to work after her marriage and defied pressure from her in-laws to quit her job. Thus, her relationship with her in-laws was also strained. However, she had to quit her job during her pregnancy. Her employers wanted her to return after the birth of her child; however, the lack of family support in childcare made it difficult for her.

These circumstances made Nasreen and her husband independent and self-reliant. The income of her husband had gradually increased after their marriage. Nasreen argued that her earning was crucial in the initial years because her husband did not earn much. Her earnings rescued them from destitution. Her financial independence had also given her the courage to marry despite resistance from their families. Nasreen’s husband had found a job in a private electrical company as a repair mechanic and earned 80 USD$ per month. He also made extra money in a second shift by driving an auto-rickshaw. Nasreen was worried about the health of her husband, who worked very hard for almost fourteen hours every day. Apart from his eight-hour shift in the private company, he managed to drive the auto-rickshaw for six more hours. Nasreen mentioned that her husband drove the auto-rickshaw from six to nine in the morning and then between eight to eleven in the night. As she commented, her husband wanted to ensure a better life for their daughter. He deposited money in the bank each month for their child. Moreover, her husband had to repay the loans he had borrowed from his friends to buy an auto-rickshaw. He worked really hard to meet these goals.
The relative economic security influenced Nasreen’s decision to have an institutional delivery. She had undergone routine monitoring like periodic ultrasounds, blood tests, weight checks, and vaccinations during her pregnancy in a private obstetric clinic. She had spent almost 65 USD$ in the private clinic. Nasreen was keen to continue the consultations and to deliver her baby in this clinic. She and her husband had developed trust in the doctor during their visits. A normal delivery in this private clinic would have cost them about 900 USD$. Nasreen remarked that her husband was even planning to arrange the finances for this. Unfortunately, Nasreen met with an accident in the advanced stage of her pregnancy. It was difficult for her husband to effectively plan a course of action. And she was hurriedly admitted to the state hospital following the accident.

Nasreen recounted, “I experienced sudden pain in the eighth month of my pregnancy when I lifted a heavy metal bucket filled with water” (Mujhe aathvi mahine mein achanak dard huya jab maine wazan wali paani ki balti uthai). The bucket contained eighteen to twenty litres of water. It was a routine task for Nasreen to store water since there was no direct water supply in her home. Usually, she filled and carried several plastic jerry cans as well as large containers from a municipal water tap about three hundred meters from home. Her husband and neighbors helped her with storing water during the pregnancy at times. But on the fateful day of her accident she did not have any help. Nasreen single-handedly had carried the heavy metal bucket and had to stop after taking a few steps. She had experienced excruciating pain within a few minutes. The neighbors informed her husband about her condition and she was rushed to the state hospital immediately.

The service providers had conducted blood tests along with an ultrasound. It was not difficult to get admitted into the state hospital because Nasreen had proof of routine medical consultations in the private clinic. She was advised to stay in the hospital for a few days to rule out any health risks. She was kept under medical observation to address any eventual complications. The service providers wanted to ensure that she could continue with a full-term pregnancy and deliver the baby as scheduled. Nasreen argued that she had to stay in the hospital for a longer period, as she did not receive the ultrasound report immediately. Because the hospital did not have diagnostic ultrasound facilities, she consulted a private diagnostic center. After a delay of four days, Nasreen was relieved that the report did not indicate any fetal abnormalities. The couple had to
pay only for the ultrasound. The state health care service was cheaper compared to that of the private clinic. Thus, they perceived the state health care institution as a site of assurance (bharosa) in this context.

Nevertheless, Nasreen also emphasized the conundrum of using the state health care services despite medical supervision and the minimal expenses. She noted that it was difficult to stay in the hospital. The stench from the toilet made the simple tasks of eating, sleeping, and relieving oneself difficult. Commenting on the insalubrious environment, Nasreen recounted, “I felt nauseous all the while” (Mujhe har waqt ulti lagti thi). She did not heed the advice of the providers to stay longer for monitoring after receiving the ultrasound report. The couple was not very keen to have the delivery in the state hospital. They had planned to have it in the private clinic. They had decided to consult their obstetrician with the ultrasound report in the private clinic.

Once she was back at home, Nasreen started experiencing pain. She had to return to the hospital when the pain was unbearable the following day. They were convinced that the service providers would provide prompt services as they were acquainted about her case. Nasreen had to be admitted to the labor room, and she had a normal delivery by the evening. However, she recalled her agony about the hostile behavior of the staff at the hospital. The staff had shouted at her and even hit her when she screamed in pain during the childbirth. She was startled, because they had attended to her patiently during her prior visit. Nasreen claimed that the apathy, abuse, and hostility on the part of the service providers had caused a post-delivery mishap. The inattentiveness of the providers had resulted in perineal tears during the delivery. Further, she also encountered problems with the medical sutures. The doctor had assured her that she would recover and would heal soon at her home. She was told that she did not have to visit the hospital to remove the sutures, as they were dissolvable.

However, the sutures came out within a few hours of her delivery. As she recounted, “The sutures came out when I urinated” (Saare taanke khul gaye jab maine pisaav kiya). The providers resutured the perineal tears, but the experience was extremely painful. Nasreen had to stay in the hospital till the pain and inflammation subsided. She was on painkillers to alleviate her discomfort. However, she had to share the bed with another patient at the hospital. Nasreen had to lie on her side in order to allow enough space for the other patient. Because she could not lie on her back.
properly, she experienced further pain. The bed did not have a mattress; only a thin rubber sheet and bed sheets covered it. The hard surface of the bed and her uncomfortable position further worsened her post-delivery complications. Even sitting on the bed was very painful. She had a bit of comfort only when her husband bought a soft cushion to sit on for her.

Nasreen also worried when her newborn fell off from the bed. She did not even realize that she had stretched during her sleep and pushed the baby to the ground. Luckily for her, the newborn was not hurt because it was wrapped in a blanket and the bed was not too high. Nasreen had thought about shifting to the floor of the hospital ward, but the lack of mattresses and blankets could have resulted in further discomfort during the winter if she had used the floor for sleeping along with her baby. She had to stay awake and remain extra cautious in order to not commit her inadvertent mistake again. Thus, as she noted, it was difficult in the given context to recuperate after the childbirth.

Nasreen had initially showed hesitation to share her bed with another woman who had also delivered, but the staff had sternly replied that she did not have a choice. One of the staff had made an offensive remark: “None of this is your personal possession, owned by your father, that you ultimately have the prerogative to choose where to rest and recover” (Yahan kuch bhi tumhara baap ka nahin hai joh tumhara marzi chalega). In this context of the scarcity of beds, Nasreen was left with no other option than to rest in a crouching posture so she could fit into the bed. She spent the days in the hospital with discomfort in the hope for a quick recovery after the service providers had resutured the perineal area. The couple knew that home was the ideal place for postnatal recovery in comparison to the hospital, but in the absence of affinal and natal kin support leaving the hospital was not a sensible decision. Nasreen added that apprehensions related to the childbirth had compelled them to stay at the hospital despite the indignation. She was of the view that clients who could pay extra money to the staff were not asked to sleep in already occupied beds. In Nasreen’s words: “If you are able to pay money then the staff will ensure that you are cared for while you are in the hospital” (Paisa agar do toh staff tumhare aage peeche lag jayenge).

Moreover, she pointed out that even a basic comfort such as warm water was denied to her. At times, clients needed warm water to drink, warm some infant formula,
wipe off the milk from their infant’s face and neck, or sponge themselves in the cold winters. Although the container that kept liquids warm for a longer period of time was placed in the post-natal recovery ward, it was usually empty. Repeated requests for warm water, blankets, and bed sheets were ignored and any further exhortations led to rude remarks on the part of the staff. As Nasreen mentioned: “The hospital staff shout at the women and shut them off with the remark that are you eminent dignitaries like the Prime Minister or Chief Minister who require special treatment” (*Staff log hamare upar hukam chalte hain aur bolte hain kya aap log VIP ho, Prime Minister ya Chief Minister ho, ki aap ko special treatment chahiye*). This remark is usually followed by a general comment that if you require constant attention and care, then perhaps you could have been admitted to a private hospital instead of a public hospital.

Nasreen further complained that the staff were inconsiderate as they refused to let her husband stay for a longer time in the evenings to care for their newborn. Though there was a specific time schedule for visitors in the post-natal recovery ward, it became difficult to stick to the schedule in certain cases. For instance, Nasreen took a longer time to recover due to the perineal tears and needed the support of her husband during her hospital stay. It was difficult to hold the newborn due to the pain, and space constraints made tasks increasingly onerous. Holding the newborn and helping Nasreen nurse were critical in the event of postnatal complications. But the staff did not allow her husband to stay after the visiting hours, instead asking for anywhere between 2 USD$ to 4 USD$ every day to extend his stay. Nasreen noted that the staff also objected to a male family member staying overnight in the hospital. Sticking to these rules in Nasreen’s case was complicated especially because she was not on good terms with her affinal or natal family members. In this context, it was a challenge to explain the circumstances to the staff, who rarely demonstrated empathy. The male relatives of the clients had no other option than paying extra if they could successfully convince the staff to agree to the overnight arrangement.

Nasreen’s pain and indignation convinced her not to pursue the option of an institutional delivery at the state hospital in the case of a second pregnancy. However, as the narratives show, there is always uncertainty when it concerns the health of the mother and the baby from conception until the postpartum phase at the least. Thus, it is difficult for women and their families to make any conclusive decisions related to childbirth based on incidents of indignation, inconvenience, and distress experienced in
the state hospitals. There are many instances where residents of both Noor Nagar and Radha Nagar reconsidered seeking treatment at the state hospital in spite of past inconveniences. For instance, one of the residents of Radha Nagar told me how after she had suffered a miscarriage during her first pregnancy, she desperately wanted frequent follow-ups in the hospital, and the family could afford the expenses only at the state hospital.

Unable to continue to share a bed in the postpartum ward, Nasreen left the hospital after a day, angering the staff and the doctors. They had insisted that her husband sign a handwritten letter saying that the family would not hold them responsible in case of any postpartum complications. Her husband readily signed the letter because he felt that she would recover sooner at home with proper rest. Rather than expediting or facilitating the issue of a birth certificate, the irate staff refused to provide it.

Nasreen’s experiences of institutional delivery resonated with the unpleasant incidences that other women shared with me. For instance, women emphatically complained that they had to sit on the floor of the state hospital wards to nurse their newborns to avoid being suffocated on shared beds. Another resident of Noor Nagar had experiences similar to those of Nasreen when an institutional delivery was critical to save the life of both the mother and the infant. The resident eulogized the doctors at the state hospital because they had treated her after she was refused admission to many private hospitals. After falling from bed in the third trimester of her pregnancy, she had started to bleed profusely and also experienced pains in her lower abdomen. It is contestable whether she had reached the full term of pregnancy, as she and her family members debated whether it was her eighth or ninth month of pregnancy.

Nevertheless, she was immediately taken to a nearby private hospital, but seeing her condition the staff thought that the fetus might not have survived and thus they did not want to shoulder any liability in case of further complications—they did not want to risk the reputation of the hospital because the element of danger was so high in this particular case. They suggested the family seek treatment in a state/public hospital; however, in the hope of receiving exceptional attention, the family visited a couple of private hospitals before ultimately resorting to the state hospital. Often, the refusals for admission to a private hospital centered on upholding the distinctive popularity that the hospital had achieved over the years, and preserving this popularity was critical to attract
clients. Even the staff at the state hospital had initially denied her admission but had finally yielded. They had immediately stemmed the bleeding and suggested an ultrasound at the diagnostic center within the hospital precincts. Although a cesarean was recommended after learning about the fetus position, senior doctors advised against it, and after a few hours a normal delivery was conducted. Both the mother and the newborn were well and eventually discharged after three days.

In recounting such incidents, women wavered between receiving critical treatment and experiencing a pattern of mistreatment in the state hospitals. Nonetheless, women resorted going to the hospitals for treatment during obstetric emergencies and accidents. In short, the social exclusion experienced by low-income women determines how they navigate care options in the medical settings during childbirth, and this has implications for their health outcomes (Spangler 2011). As Gita Sen, Aditi Iyer and Asha George (2007: 688) assert, marginalized women navigate a “continuum of care” in the health care institutions that treat medical emergencies. They highlight the indifference and prejudice of the service providers when these discount women’s experiences of pain. Drawing on research in rural Karnataka, they show how the providers diagnose women’s labour pain as “lower back pain” or “false labour pain” (2007: 689). The insensitivity of health care providers toward low-income clients has been extensively documented. Their Muslim religious identity further marginalizes clients seeking assistance in the state health care institutions.

Through these narratives, I also intend to draw attention to the subaltern voices to understand the power hierarchies in the medical domain and the kinds of care that was received, denied, or delayed (Gutschow 2016). Research has shown that in most cases of maternal mortality, the deaths have occurred in the institutions; this negates the common assumption that the deaths occurred due to lack of skilled assistance (ibid.). The World Health Organization has recommended maternal death reviews especially to account for the reasons why women die from preventable and treatable conditions during childbirth, and some of the reviews suggest that doctors routinely blame the staff placed lower in the medical hierarchy for errors that they cannot be held accountable for and also deny treatment to women, fearing birthing complications and deaths (ibid.). Further, similar to Carla Makhlouf Obermeyer’s (2000: 191) observations, despite the awareness of risks related to birthing, women usually resort to medical care depending
on the specific “circumstances of their labour and the services that are accessible to them.”

Moving beyond institutional care, familial and social relations can also be the cause of anxiety and even outright neglect or abuse. I next draw on the reproductive biography of Asma Begum and her specific case of retained placenta and ectopic pregnancy. Familial neglect and marital conflict can also exacerbate medical and reproductive emergencies. With this case, I show how women’s relationship with family members including spouses and in-laws significantly shapes their health conditions during pregnancy and childbirth. I argue that women’s health and well-being are embedded in contradictory arrangements of care in the homes.

Familial Negligence, Marital Discord, and Health Risks

I first met Asma Begum at Sheeba Begum’s home when I frequently visited Noor Nagar. On a hot summer day in June 2012, Sheeba and I were engaged in a conversation regarding her reproductive history. Suddenly someone knocked the door in a restless and vigorous manner. Sheeba rushed to unlock the door, mentioning that her children have come back for lunch—it was scorching hot outside and the children must be hungry and dehydrated. However, Sheeba was surprised to see her friend Asma with her four-year-old daughter at the door. It was an unexpected visit because Asma usually worked until late in the evening. Asma worked as a cook in two houses in the nearby middle-class neighborhood. Usually she left her daughter in the nearby municipal school on her way to work, and her aunt attended to her daughter after the school was over. After letting her in, Sheeba gently asked Asma if she had gone to work. Asma responded agitatedly that she had had a fight with her estranged husband, and he had hit her. She showed us the bruises on her arms and back. One of her eyes was swollen and blood-shot, and she had a cut on her lower lip. She was furious and hurled abuse at her estranged husband and in-laws.

I did not intervene while Sheeba and Asma were conversing. I prepared to leave and conveyed to Sheeba that I would meet her at a later date. However, Sheeba and Asma both insisted that I stay on for a while to have tea with them. Sheeba got up to make tea amid her attempts to console Asma and listen to her troubles. I felt assured that Asma was comfortable in my presence though we had met for the first time. She
turned to me to say that her friends had already told her about my work in the neighborhood. She told me that I should talk to her to learn about decision making around issues of family building and reproduction. She invited me over to her place, as she did not want to go to work that particular day. Asma wanted to tell me in detail about her experiences of marital discord and reproductive complications. I joined her at her house after we finished having a cup of tea at Sheeba’s place.

As we walked together, Asma sorrowfully noted that she had encountered adversities and hardships since her childhood. Now, she was making plans to improve her own as well as her daughter’s situation by undertaking transnational migration. She did not want her daughter to experience any kind of distress, and she had made plans to work as a cook in the Middle East. She worked sincerely at two different houses in the hope of getting support and referrals from the current employers. She told me that her employers’ relatives lived in Saudi Arabia and also needed help in domestic work. Asma was also independently trying to negotiate with transnational labor agents in order to find work abroad. In this respect, she explored the option of securing a passport first. She planned to leave her daughter with her aunt when she worked in Saudi Arabia for a few years. Once she had saved enough money to afford basic comforts, she could return to her daughter.

When we arrived at her house, Asma collected the papers to show me. She also sought my help in filling out her passport application. She noted that people in her neighborhood had found work in Saudi Arabia. She was hopeful and resolute in her decision to travel abroad for work due to the ongoing conflict with her husband. Apart from the emotional hurt, she also experienced severe material deprivation after her husband deserted her for another woman almost two years ago. Her daughter was barely two years old at that time. Both of them struggled to have sufficient food after her husband deserted her. The situation improved only when she had found work as a cook in a nearby neighborhood.

While I filled out her passport application form, Asma told me about the emotional and financial difficulties she had endured in her twenty-two years of life. Her aunt and uncle had brought her to Delhi when she was very young. She could not even recall any vivid memories of her childhood because she left her village at the age of five. Her parents could not afford to take care of six children living in a village in Cooch Behar.
district of West Bengal. Her father was a landless casual laborer and also took on any odd job that was available. None of her siblings was admitted to a school due to monetary problems. Her parents had hoped that she would have a relatively better life in Delhi. Her paternal aunt was lonely after marrying off her only daughter in the village, and she was keen to raise Asma in Delhi. Asma noted that they had lived in two other low-income neighborhoods before settling down in Noor Nagar. They were evicted from the earlier two neighborhoods at two different points of time. However they could not receive resettlement plots upon eviction because they did not have eligibility documents. She mentioned that the earlier neighborhoods were familiar as most of the people had come from Cooch Behar. In fact, Noor Nagar was also under the threat of demolition during my fieldwork, as I discussed in the methodology section.

Asma noted that her aunt and uncle lived in a rented accommodation in Noor Nagar; they could not afford to buy a plot after living in the city for so long. Both of them had found work as house cleaners in the adjacent middle-class neighborhood. Usually Asma joined them, helped them with errands as they worked. It was also convenient for them to keep a eye on her while she played in the premises of the employer’s house. Asma could not enroll in school due to the work schedule of her aunt and uncle. They did not trust their neighbors to care for her in their absence. Their fragile community-building efforts had been disrupted due to eviction drives in the past, and they were relative strangers to many in Noor Nagar. As she grew up, Asma started working along with her aunt and uncle. When she was ten, she was offered the job of a full-time live-in domestic worker. She was paid around 5 USD$ each month along with food and clothes at her employer’s place. Thus, she was financially independent at a very young age despite earning dismal wages. She worked for eight years until her wedding was arranged.

Her uncle and aunt arranged her marriage and financially contributed to the wedding in the neighborhood. Asma also used her savings in her marriage. Her husband was a scrap sorter and earned about 50 USD$ per month at the time of their marriage. Asma was eager to continue with her domestic work to supplement her husband’s paltry earnings. However, her husband and in-laws would not allow her to work at someone else’s place. Asma recalled bitterly that she was turned into a domestic worker at her own house but this time without any opportunity for compensation. She tirelessly carried out all the domestic chores while her in-laws rested the whole day. Even her unmarried
sister-in-law did not help her with the domestic chores. Further, Asma complained that her family members always found fault with her and did not acknowledge the hard work she put in. They even gossiped about her in the neighborhood, saying that she was not efficient enough to run a household. Often she was mocked and scolded by her sister-in-law and mother-in-law.

Asma felt isolated and uncared for since her husband did not intervene on her behalf or support her. She was upset that her marital family members did not seek her opinion or inform her about any important household matters. She recalled that her husband and in-laws did not tell her about their plans to build a house in the suburbs of Delhi. Asma did not complain to her aunt and uncle about the familial conflicts, as she did not want to bother them. It was difficult to reach out to her parents in the village because she had not been in regular communication with them all these years; she received updates about her parents only once or twice a year when her aunt spoke to them.

Asma was positive that her relationships with her marital family would gradually improve in the initial years of her marriage. However, the minor conflicts or skirmishes worsened with each passing year of her marriage. She expected that her pregnancy would placate her husband and in-laws. However, the familial neglect and marital discord resulted in complications and health risks during her pregnancy, and she would not have survived without the support of her aunt and uncle during her pregnancy. In fact, only her aunt and uncle had sought medical help and provided for the expenses while she recuperated after childbirth in the hospital.

Asma had conceived within five months of her marriage. She had planned for a child after two years of marriage but had to concede to the wish of her husband. She had heard that very young women were more likely to have obstetric complications. She was barely seventeen years when she conceived for the first time. Once pregnant, she wanted to seek routine medical consultations, vaccinations, and diagnostic tests in the health care institutions. But her husband and in-laws remained unconcerned about her anxieties regarding her pregnancy. They merely reiterated that they could not afford such services. Further, her mother-in-law thought that she could consult her aunt, who used to be a ‘dai’ back in their village. In this respect, her mother-in-law planned to have her aunt deliver the baby at home to save on medical expenses. However, her aunt had
almost stopped assisting in childbirth since she had left the village. Asma was taken
aback because her aunt had helped in birthing only five or six babies since she came to
the city twenty years ago. Asma noted that her aunt had been compelled to assist those
few deliveries of women from her village because they experienced severe monetary
constraints in the initial years of settling down in Delhi. Her aunt did not like to work as a
‘dai’ because of the associated risks and stress. Asma felt herself caught between the
views of her aunt and mother-in-law.

In fact, Asma’s aunt was worried about the pregnancy and volunteered to spend
her little savings on the medical consultations. She prepared Asma’s favorite foods and
regularly massaged her body when she was tired and exhausted. But she was not in a
financial position to pay for the institutional delivery. Nonetheless, she assured Asma
that she could pay for the expenses of a registered medical practitioner to assist with the
delivery. Her aunt knew the registered medical practitioner, who provided allopathic
medicines and injections to people in the neighborhood. Her aunt also emphasized that
there was no reason to panic because the registered medical practitioner, who was
referred to as daktar sahib, lived in the neighborhood and could be contacted at any
hour.

When Asma’s birthing pains started, her aunt rushed to her immediately. She
was prepared. She had carried a new razor blade, thread, and mustard oil along with
her. She attended and gently massaged Asma’s stomach when she experienced
sporadic pains. Her aunt was at her side until 3:00 am the following night. She also
periodically prepared warm milk and tea for Asma. Once Asma experienced severe
elongated birthing pain, her aunt called for the neighborhood registered medical
practitioner, who administered the oxytocin injection after arriving at Asma’s place. Asma
delivered her baby within fifteen minutes of being injected with the drug.

But five days after the birth, she fell ill, though the baby did not suffer any harm.
As Asma recounted, “I had a high fever after the childbirth along with frequent cold
shivers and body chills” (Mujhe bacha hone ke baad bahut bukhaar tha aur mera sharir
thand se kanp ta tha). Even blankets, she said, could not keep her warm. Her head
throbbed and felt heavy; so she could not even stand up properly. Asma recalled that
she was extremely weak after the childbirth. She had dozed off and did not quite
remember how her aunt attended to her after the delivery. But she and her baby were
cleaned up when she woke up. Her aunt had prepared rice and vegetables for her to eat. She also helped her breastfeed the baby. Her aunt reassured that the fever and chills would go away within a few days. She got medicines from the registered medical practitioner when the fever continued for a longer time, but they did not help either. Asma could not properly nurse and care for the baby given her health, although she was relieved to have her aunt take care of the baby.

Asma lightly bled in the first few days, but after a week the bleeding was severe. She felt miserable, and the bleeding did not stop, so she was admitted to a hospital. Her aunt was by her side all this while. At the hospital, she underwent tests to rule out malaria and tuberculosis due to her persistent high fever. The service providers suspected she was suffering from delivery-related hemorrhage and prescribed medicines. The test results were negative, so she was advised to undergo an ultrasound. From the ultrasound report, she learned that her placenta had not completely expelled during childbirth, and she had to undergo a dilation and curettage procedure to remove the remains. After surgery under anesthesia, she was given saline and blood transfusions to help her recuperate faster. She was advised to seek immediate follow-up care in the case of any abnormal bleeding. She was also advised to delay any second pregnancy.

Asma’s aunt herself spent approximately 400 USD$ of her own money for the medical expenses. She took the blame on herself for this emergency. Her aunt was committed to the well-being of Asma and her child. The service providers had scolded them for not coming to the hospital for the delivery. Although Asma did not reveal the details, fearing the denial of health care services, the service providers could figure out that she had had the assistance of an untrained practitioner. Despite the incomplete removal of the placenta, Asma did not blame her aunt; instead, she remained grateful for her efforts especially in the context of serious negligence on the part of her marital family.

Asma returned to the hospital three months after the surgical procedure to ensure complete recovery. The prescribed medicines had helped restore her health and normalize her menstruation cycle. She was also advised to delay any second pregnancy for at least five years. However, Asma told me she was not able to adhere to this medical advice—she was under tremendous pressure to bear a son after the birth of a
daughter. The birth of a daughter had strained her relations with her husband, who desperately wanted a son, and she started planning for another baby barely six months after the first delivery as a way to secure her marriage. She had anticipated conceiving soon, as she had with her first pregnancy, but three years passed before she conceived. Her relationship with her husband deteriorated. To make matters worse, her in-laws provoked her husband continuously by alleging that she surreptitiously used birth control. Her husband suspected that she had undergone sterilization during the first pregnancy in the hospital. Asma was depressed due to the frequent fights with her marital family. Furthermore, she was shattered to learn that her husband had a relationship with a woman in the neighborhood.

Initially, she ignored the tales about her husband’s infidelity as merely neighborhood gossip. But soon her worried aunt reconfirmed the affair with further details. The aunt took her to various shrines of Muslim saints (dargahs) to pray for her well-being. Asma chose not to confront her husband because she was hopeful of a peaceful relationship soon after she conceived again. Luckily for her, she was pregnant again after three years. Her husband was elated and attended to Asma. However, she immediately started developing complications. She had to consult a doctor in a nearby private clinic soon after she experienced slight pain in the second month of her pregnancy. Her husband had accompanied her to the clinic and also paid for the expenses. She was worried that she would be reprimanded at the state hospital, because she had not abided by the doctors’ advice to delay her second pregnancy. This led her to forego the cheaper option of visiting the state hospital.

The doctor at the private clinic did a pelvic exam, comforting her about the smooth progress of her pregnancy. However, Asma experienced sharp and stinging pain in the pelvic area shortly and was compelled to return to the clinic. The doctor conducted an ultrasound, confirming an ectopic pregnancy. Immediately, the doctor had to conduct an emergency surgery in order to avoid the rupturing of the embryo in the fallopian tube. The doctor reassured her husband that Asma could conceive even after one tube was removed. However, Asma recalled that the removal of the tube made her husband angry and bitter. Her husband was not convinced about the likelihood of any future conception. Within a few months, her husband deserted her and moved in with the other woman. Her in-laws did not even intervene to persuade her husband to return.
Commenting on the malicious intentions of her husband and in-laws, Asma considered them to be heartless and inconsiderate. Asma had to find her own accommodation in the neighborhood. Her husband never saw their daughter, despite living in the neighborhood, nor did he contribute financially towards her upbringing. His income had increased when he became the owner of a scrap godown; he earned 130 USD$ per month by this time. Asma’s resentment increased when she learned that her husband was building a new house for his current partner while she was penniless and depended on her aunt for the basic necessities. At times, she did not have the financial wherewithal to buy food for herself and her daughter. She rented a place as soon as she found work as a cook, especially to avoid depending on her aunt during her old age, although she actively sought her aunt’s support for babysitting. Asma wholeheartedly strived to support herself and her daughter; she coped with broken-heartedness by working and regularly visiting the dargahs. Despite these efforts, she found it difficult to remain calm, especially when she encountered her husband and his partner in the neighborhood.

Asma’s husband’s partner was a widow living with her son and daughter. As soon as Asma heard about the birth of their child, she confronted them especially to ascertain her husband’s reaction to this girl. Wanting revenge for her pain and misery, she cursed the couple, declaring that they would never bear a son and that her husband would remain discontented and unhappy. These curses so infuriated her husband that he chased and hit her. Asma responded by mockingly advising her husband to treat his stepson as his own. Asma emphasized that she had become apathetic towards her estranged husband. However, she had gone to their residence in a fit of rage and frustration. She waited for the day when the couple would leave the neighborhood, she said, so that she could focus on her work without being reminded of her troubled past. Moreover, she was trying to find work abroad in order to afford a comfortable life for her daughter.

Asma’s narrative illustrates how uncompassionate family relationships, marital discord, and a culture of preferring sons shape the birthing experiences. Her marital family members did not show any concern for her despite all her household responsibilities. She did not get any assistance with household chores even when she was pregnant; her unpaid domestic responsibilities were devalued and invisibilized. Apart from the physical exhaustion, Asma also experienced psychological distress due
to the indifference and negligence of her husband and in-laws, and lack of medical consultations during the pre-natal and post-natal phases resulted in the reproductive emergencies. Further, her husband’s preference for a son pressured her to conceive soon after the first pregnancy despite the advice of the doctors to delay another pregnancy. In a significant way, this led to health risks and lesser chances of conception in the future.

Asma’s case sheds light on how women’s access to material resources in the families is gendered and thereby contributes to health risks (Sen 1987; Shah 1989; Choudhary and Parthasarathy 2007; Kundu 2010). Asma had to comply with the decisions of her husband and in-laws and submit to the hierarchies in her marital home. The lack of support from her marital family members and their denial of monetary expenditures during the childbirth resulted in birthing complications. Further, Asma perceived that the remuneration she would have earned through paid domestic work could have been used during the institutional delivery, thereby minimizing the risks.

Bina Agarwal (1997) has argued how the birth of a son enhances women’s position in the family because they are entitled to claim property through their son. It also ensures financial security during old age. Scholars have emphasized that the state’s policy of small families and the culture of son preference in families have debilitating consequences for women (John, Kaur, Paliwala, and Raju 2009). The practice of aborting daughters is an outcome of such coercive state policies and patriarchal arrangements in the families (ibid.). Although Asma did not abort the pregnancy, her inability to bear a son soon after marriage affected her marital relationship. Her narrative illuminates how the birth of a daughter led to a series of abuse.

The above narratives show that the familial and medical domains overlap in complex arrangements of care and indifference. Obstetric emergencies are common, driving women to state hospitals for treatment. Women depend on state-run institutions in spite of the hostility and prejudices of the service providers. It is important to note that despite their valid complaints about deficient medical infrastructure, women also acknowledge the empathetic side of the providers. Sheeba, Nasreen, and Asma were at pains to tell me that their own survival and that of their newborn babies were due to the supervision and support of the service providers in the state hospitals.
Apart from the financial constraints, the narratives also reveal how interpersonal relationships with the affinal family have an effect on receiving care at the time of pregnancy, childbirth, and beyond. For instance, in Sheeba’s case, the challenges of inhabiting a new neighborhood and post-marital patriarchal restrictions in physical mobility were compounded when her affinal family did not show any interest in seeking a reliable ‘dai’ or investing in medical consultations during her pregnancy. Nasreen’s case sheds light on how the extended kin network is crucial in the case of any problems. Although the conjugal bonds were strong in her case, the tensions underlying both the natal and affinal relations had affected her because she had no one to attend to her during postnatal complications or help her with childcare. And Asma’s narrative shows how the deep-seated animosity and antagonism that at times characterize affinal relationships can lead to psychological distress and physiological harm in the long term. In addition to suffering reproductive emergencies and health risks, Asma felt angry and humiliated when her husband deserted her for another woman for not bearing a son. Despite living in the same neighborhood, Asma’s husband never made any efforts to meet their daughter or share any expenses related to her upbringing. Their relationship reflected a suspension of affective ties, and with the passage of time their interactions became bitter. Asma’s feelings of resentment persisted though she tried to forgive her husband for his deception. She could not reach a state of closure despite visiting dargahs and keeping herself busy with work and childcare.

These narratives provide a window onto familial, intimate, and affective relationships and elucidate how the emotional and physiological well-being of women is connected to the care they receive within their personal and private domain. In so doing, I want to ask, What is a family, and how are care and sustenance conceptualized and practiced in this intimate domain? Scholars in the South Asian context have argued that families can simultaneously be sites of affective care, material entitlements, cooperation and conflict, and gendered oppression (Sen 1987; Ganesh and Risseeuw 1993; Karlekar 1998; Kannabiran 2006). But the “family” figures in a certain way in state visions of reproductive health, and the pictorial representation of an “ideal family” – of a young married couple with two children, a boy and a girl – displaying a cheerful demeanor projects a superficial notion of the family without capturing the actual social realities. Similarly, the way that family dynamics are understood in medical care is simplified because looking at the experiences of women really shows the complexities in familial
relationships. Further, gendered inequalities in low-income families are exacerbated due to the cutback of state medical subsidies and the lack of work opportunities with guaranteed minimum wages (Ganesh and Risseeuw 1993; Lingam 2006).

Drawing on women’s everyday experiences, I illustrate that what is considered to be a biological phenomenon, procreation, is an inherently social process because the social fabric of family and kin significantly influences fertility decisions (Carsten 2004). Thus the crucial argument that “close kin ties are intrinsic to the social constitution of persons” (Carsten 2004: 83) is relevant to contextualizing women’s relational selves. Rather than a focus on the “natural order of things,” a significant departure in the anthropological discipline has led to documenting the experiences, emotions, meanings, and messier realities of kinship relations (Schneider 1997; Carsten 2004).

Conclusion

By paying attention to reproductive biographies, I have been able to document the challenges of home birthing and the circumstantial imperatives that cause women to seek urgent obstetric treatment. The stories women shared with me revealed how tensions and antagonisms within families adversely affect women. Often, the gendered family arrangements themselves can be said to cause reproductive emergencies and obstetric accidents. Home and hospital birthing situations make evident how familial negligence, marital discord, and interpersonal relationships affect women’s pregnancies and births. Women’s accounts also underscore their resilience and strategies of survival in the familial contexts.

Having discussed how giving birth occurs within the matrix of social and material circumstance, I next turn to questions of history. How have the parameters of reproductive experiences shifted over the years? The narratives of older women provide insight into family planning and building.
Chapter 6.

Privation, Precaution, and Deliberation: Narratives of Older Women

On a wintry afternoon in January 2012, I visited Mohammad Abdul—an informal health care practitioner referred to as daktar sahib—in his makeshift room built of wooden planks in Noor Nagar. Mohammad Abdul had a roster of patients across the age spectrum. He listened to their symptoms, prescribed or handed over medicines, and then beckoned to the waiting patients one at a time. I sat at one end of the room’s long wooden bench but had to shift to a rickety wooden stool to make space for others. The room was partitioned, and the door of the wooden partition opened into a cabin that accommodated a wooden bed used as a substitute for an examining table. The patients lay on the bed during the diagnosis and administration of injections. The room was scantily furnished; apart from the wooden bench, there was a chair and a table that Abdul daktar used for writing prescriptions. Two rusty iron shelves in one corner held tattered books on fundamentals in allopathic medicine and herbal drugs to treat various ailments along with packets of disposable syringes, sterilized cotton, and antiseptic.

As I sat in his clinic, Abdul daktar routinely handed over bottles of Cheston cold syrups to the mothers of children who had visited him for curing coughs, fevers, and nasal congestion. A few of his patients visited him for the second time when the prescribed drugs did not cure their ailment. In turn, Abdul daktar prescribed Amoxicillin, antibiotic oral drops, and stronger doses of pediatric drugs to cure a severe cold. He also advised the mothers to visit the hospitals if the infection did not subside to avert a possible threat of bronchitis or pneumonia. Apart from flu, patients also visited for stomach ailments. Abdul daktar used the standard Pepto-Bismol syrup along with the oral rehydration salt packets for these ailments.

The conversations between the daktar and the mothers centered on diarrhea, disobedient children who ate street food in the neighborhood, and the dogged efforts of mothers to feed healthful food to their children. Mothers opined that they were unable to constantly monitor children due to their absence when at work in middle-class neighborhoods. Many women felt helpless when their children drank contaminated water.
from the supply pipe. Furthermore, women complained to the daktar that the sewage from the overflowing drains seeped into the piped water supply; they clearly linked the infections with the dismal infrastructure in the neighborhood (Haider 2000; Das and Das 2007; Snell-Rood 2015b). During my field research, women expressed their helplessness and embarrassment regarding the lack of sewage and garbage disposal facilities. They also remarked about the scrap and the garbage storing work that contributed to ill health in the neighborhood; however, they emphasized that scrap sorting work was a major source of earning for most of the residents in the neighborhood. Although women strived to raise healthy children, deficient infrastructure and public health facilities affected their wise planning (samajhdari ki yojana).

Older women maintained that the situation had improved over the years, but the situation was challenging when they initially arrived as migrants in the city. They recalled the lives lost in case of preventable illnesses such as diarrhea, pneumonia, and jaundice. Often, children died due to drowning in open drains or the neighborhood’s frequent fires. Given this backdrop, in this chapter I examine how family building and planning are historically connected to the establishment of urban neighborhoods and challenges of migration-related experiences. Moving beyond infrastructural facilities and public health provisioning, I also explore how neighborly and kin relations and the ambiguous status of migrants play a key role in family planning.

Through the accounts of older women, I trace a broader perspective on reproduction and its embeddedness in their social lives. Drawing on extended conversations with older women and their families, in the first section I illuminate what I call the reordering of reproduction in contexts of privation. I show how reproductive arrangements are thoroughly embedded in contexts of infrastructural facilities and kin relations. In so doing, I underscore the wise planning that women enact in seeking treatment from doctors and religious healers to cure illnesses of infants and prevent risks during subsequent pregnancies. Further, I foreground how the death of sons and the survival of daughters engendered taunts of kin and deception of neighbors that precipitated mental distress. I argue that family building and limiting are imbricated in material necessities as well as social ties in fledgling urban neighborhoods. Through the reordering of reproduction, women shed light on how reproduction can be conceptualized as relational (Greenhalgh 1995) and temporal phenomena (Bledsoe 1995; Carter 1995) that have to be considered throughout the course of their lives.
In the second section, I examine how the ambiguous citizenship status and surveillance of migrants (Ramachandran 2003; Srivastava 2012; Mehta 2018) pose difficulties for women seeking assistance and care during childbirth. For instance, reluctance on the part of trained ‘dais’ to provide support led to complications that necessitated intergenerational planning of families. I show how a case of uterine prolapse affected exercising of precaution and counseling children about wise planning.

In the following section, I discuss the case of Yasmeen Begum to underscore the reordering of reproduction in the context of privation, especially the adversities encountered due to dismal infrastructure in the low-income neighborhood apart from the dynamics of kin relations.

Reordering Reproduction: The Context of Privation

Yasmeen Begum, in her early fifties, lived with her husband and two daughters in a rented accommodation in Radha Nagar. She had grown up in this neighborhood and had continued living here after her marriage. Her mother and siblings had settled here with the help of distant relatives upon migrating from a village in eastern Uttar Pradesh. The family was forced to fend for itself since her father’s demise. Yasmeen’s husband was employed as a driver and had lived in Delhi for almost forty years after migrating from Bihar. He told me that he had traveled with his young friends to the capital city in search of employment and had luckily managed to find work as a daily wage laborer in construction sites initially. His mother still lived in his hometown in Bihar.

Somvati, a community health volunteer in Radha Nagar, had introduced me to Yasmeen, who was apparently her neighbor. On a weekend when Somvati did not go on her usual rounds to visit pregnant women and hand over vitamin and iron supplements, she was relaxing on the verandah of her house showing her new anklets to Yasmeen, who looked enthusiastic about buying these trinkets for her two teenaged daughters. After their conversation had ended and Yasmeen left, Somvati revealed the tragic details about her neighbor. That day I learned that both Yasmeen and Somvati had encountered similar events in the past: the deaths of their children. Somvati had lost her one-year-old daughter, and Yasmeen had witnessed the death of six of her children. Somvati told me that her infant daughter had passed away after suffering from an acute bout of diarrhea, but she did not know what illnesses had led to the death of Yasmeen’s
children, although she was certain that they had died during infancy and that only two of her daughters had survived.

Somvati emphatically told me that after losing her daughter to an illness that could have been prevented, she had made up her mind to become a community health volunteer (basti sevika) and advise families about how to prevent or treat the ailments that commonly afflicted infants in her neighborhood. She perceived that her work was a small effort towards reducing infant morbidity and mortality, as these ailments had far more adverse health consequences among their people. Her resolution, as I understood it, had stemmed from her own personal experience of helplessness when she was unable to save her daughter’s life.

Undoubtedly, Somvati espoused an obligation towards the community, a commitment to promote modest health interventions that could enhance the quality of life. As she put it: “Just a chlorine tablet or simple restorative solutions could have saved my child.” I argue that her involvement in the volunteering service was a redemptive effort to preempt ailments afflicting newborns in the neighborhood. In the absence of comprehensive state health care interventions, Somvati reposed hope in a charitable trust in Radha Nagar that carried out regular health campaigns to stem the prevalence of infectious diseases. While Somvati promoted health awareness and demonstrated a socially confident self, she represented Yasmeen as an inhibited and withdrawn person who was deeply affected by the unexpected death of her children. In Somvati’s opinion, Yasmeen hardly ventured out and chatted only occasionally while seated near the window of her home in the evenings. However, my interactions with Yasmeen over a period of a year revealed a different persona. The persona of a withdrawn self, I understood, obscured Yasmeen’s resilience in overcoming the deaths of her children, the reordering of reproductive arrangements, and the fostering of neighborly and kin relations in the context of privation.

Yasmeen, her husband, and their two teenaged daughters were affable and sociable and welcomed me into their home. In early 2012, the family had experienced a crisis with regard to marriage and property matters. Yasmeen’s eldest daughter, Rukhsana, had entered into a romantic relationship with Ahmed, her neighbor’s son. Despite initial reservations, Yasmeen’s family had agreed to their relationship and had even invested in Ahmed’s leather manufacturing business. In order to support their
daughter, they sold one of their houses in the neighborhood to raise 650 USD$ for the business venture. Furthermore, the family cooked meals, bought gifts on festive occasions, and provided emotional support to Ahmed routinely. They had agreed to delay the wedding until Ahmed settled down in his business and Rukhsana turned eighteen.

Ahmed, however, had betrayed them after a year of courtship when he married a different woman and moved to Kanpur, a city in Uttar Pradesh. Though the family had made attempts at reconciliation, they soon realized that this arrangement was not feasible because Ahmed already had a child from his recent marriage. This situation disrupted neighborly relations because the family felt disappointed, deceived, and manipulated. They had agreed to the marriage after Ahmed threatened to kill himself if he could not marry their daughter. Ahmed’s mother also spent hours convincing the family to agree to the relationship. When I spoke to Rukhsana, she recalled her relationship in ambiguous terms. She spoke about Ahmed’s initial obsession, about how he often stalked her when she ran errands. She told me that her parents had worried about her safety and had hastily approved the proposal in the context of incidents of revenge by spurned lovers that were regularly featured in newspapers and on television. After agreeing to the relationship, Yasmeen had allowed the young couple to meet even though this went against strict societal codes.

In light of the breakdown of the relationship, Yasmeen was worried about the stigma, dishonor, and shame directed at her family. She knew that finding a new match for Rukhsana would be almost impossible in this neighborhood. After this incident, she had become extremely protective of her daughters. As she contended, her sole intention now was to find honest in-laws rather than dwell on the duplicitous relations. Yasmeen was convinced that Ahmed and his parents had deceived them to gain control of their assets. After duping them, Ahmed had retreated from the marriage and pursued other plans. Rukhsana too noted that Ahmed had tricked them by concocting tales of love, romance, and obsession. Moreover, Yasmeen felt hurt that the neighbors had manipulated her maternal sentiments because she had treated Ahmed like her son. She remarked that they had taken advantage of her especially in the context of the death of her sons.
Apart from tenuous neighborly relations, the family also experienced conflicts with their kin. Yasmeen’s younger brother-in-law and his wife, who lived in the neighborhood, claimed a share of their house. The brother-in-law had recently settled in the city and was having trouble making ends meet. Unable to pay his rent, he morally pressured them to support him. He insisted on staying in their two-room house, and he had plans to build an additional floor and live there permanently with his wife and two sons. Yasmeen worried that her brother-in-law would eventually claim ownership of their house in order to disentitle her daughters. To avoid these imminent possibilities, she and her husband had even considered selling their house. They deliberated about possible property disputes or malice involving their own children in the future, especially after they were dead. Although their house had significant market value, they felt compelled to sell it.

Despite these conflicts, Yasmeen and her husband offered monetary support to her younger brother-in-law and also provided financial support to her mother-in-law in the village. They spent 25 USD$ each month although Yasmeen’s husband, a contractual bus driver, had only a modest income. The family maintained these kin ties even while experiencing financial hardships, property disputes, and matrimonial problems. Age-related ailments and medical treatments constantly bothered them as well. The failing eyesight of her husband concerned them, since he required good eyesight to continue his job of a driver. Further, Yasmeen experienced bouts of epilepsy, which required her to visit the hospital regularly. Her medications added to the family expenses. As a result, the daughters decided to tutor children to help support their parents.

Yasmeen emphasized that her neighbors and kin exacerbated her difficulties rather than being a source of support. She did not have supportive natal kin as well. She was still angry at her brothers because they had lived off her earnings while she slogged in a garment factory. In recounting her life before marriage, Yasmeen noted that her brothers had not taken any initiative to arrange her wedding. She thought they were interested more in her earnings than in her future well-being. Though her brothers lived in the same neighborhood, she had decided to withdraw from maintaining relations with them since the death of her mother. In this light, she did not rely on her natal kin for support in arranging the weddings of her daughters or settling the ongoing property
disputes. Yasmeen’s natal family was far from comforting and not a place of “refuge” to turn to while experiencing adversities or crisis in marital life (cf. Grover 2003).

During my visits, Yasmeen’s daughters took care of her and ensured that she took her medications on time. When the epileptic seizures occurred, the younger daughter missed school to attend to Yasmeen. Both the daughters helped her with the household chores and grocery shopping and also accompanied her to hospitals for regular consultations. Yasmeen noted that the seizures affected her well-being by sapping her physical energy and vigor and dulling her mental agility. She complained of frequent headaches, watery eyes, and trembling hands and legs. She could no longer enjoy her favorite pastimes like embroidering or watching television serials. She felt drowsy the entire day due to the side effects of medicines.

Yasmeen asserted that it would have been difficult to endure the illnesses and frailties of old age without the support of her daughters. She considered herself fortunate that both her daughters had thrived after she lost four daughters and two sons in the first decade of marriage. The deaths of her children had affected her relations with her husband, kin, and neighbors because she experienced severe mental distress during this time. Although she was keen to delay recurrent pregnancies after the death of each infant, she feared that her decisions could fracture her intimacy with her husband. She also felt pressured to conceive when kin and neighbors taunted her about her supposed ill-fate and doomed future to remain childless in every day conversations. Yasmeen also suspected that her younger brother-in-law and his wife wished her to remain childless so that they could lay claim to her property.

In our conversations, Yasmeen emphasized the lack of proper housing and basic facilities in the neighborhood, which she perceived had led to the deaths of her children. To preempt afflictions in the very early stages, she had always resorted to home remedies such as massaging her children with warm oil in the case of flu-like symptoms or relying on herbal concoctions like gripe water (janam gutti) for digestive disorders. Yasmeen had also consulted elderly ‘dais’ in the neighborhood to cure her children of frequent bouts of dysentery. As I had often observed, the ‘dais’ whispered religious verses into the ears of the children and also bestowed prayers on food, especially on tender coconut (dab) and yogurt (dahi), which most of the children consumed to cure them of sudden attacks of dysentery. In addition to such alternative therapies, she had
sought allopathic treatment to hasten the recovery of her children. In most instances, the pediatricians at the state hospital had diagnosed chronic dehydration and undernourishment. The pediatricians usually administered glucose drips and closely observed the children for a few days in the hospital, as Yasmeen recounted. The children were not discharged from the state hospital until they had completely recovered. But, Yasmeen tearfully noted, misfortune befell her family because her children were often afflicted with severe dysentery and thus had to undergo similar treatment regimens in the hospital instead of convalescing after receiving home therapy and medical care.

During our conversations, Yasmeen represented herself as a conscientious mother, countering the pediatricians’ opinion that she did not adhere to the recommended kinds of food and medication. She emphatically stated that she fed healthy diets such as boiled and mashed vegetables to her children apart from the prescribed medicines. Despite the privations of her early years of urban migration, she had made persistent efforts to care for her children. To her dismay, however, none of these efforts saved her children, and each death left her deeply devastated and distressed. Unable to bear such grief, Yasmeen gradually revealed to me that she had surreptitiously taken contraceptive pills, which she thought would serve two of her motives: she wanted to delay further pregnancies, and she hoped that extending the time between pregnancies would lead to the birth of healthy babies. I inferred from our conversations that she did not have the heart to witness the tragic deaths of her children each passing year, and thus the pills provided temporary relief from descending into despair and gave her time to work through her grief and sorrow.

In these intervening years, Yasmeen told me that she had also approached religious healers for succor when modern medicines did not help. She had believed that these healers could help allay her fears and subdue the unpleasant thoughts that led her to link her misfortunes to the sinister motives of her kin and neighbors. At times she considered them unscrupulous, which made them capable of using devious tactics like black magic or charms that could harm her family. In order to protect herself from further harm, Yasmeen had turned to the healers. Pointing to the amulet (taweez) tied to a thick black string around her neck, she revealed that it had protected both her daughters until now. Since the time she had conceived them, Yasmeen had worn this amulet and had never once removed it, although a few years ago she began to wear it as a necklace instead of around her belly. She considered the amulet her lucky charm and grew
sentimentally attached to it because her daughters had not suffered from any severe illnesses during their growing-up years.

Yasmeen told me that she had received this charm from a popular healer at a dargah in her natal village who was apparently a relative of her late father. Many healers knew her father because he worked as a priest in the dargah. Unfortunately, Yasmeen could not ask her father for support since he had died within a few years of her birth. This unexpected death led to monetary problems, as her father was the sole earner in the family. In this context of precarity, Yasmeen’s mother had decided to migrate along with her children to make a living in the urban city of Delhi. Despite hard times in the initial days, her mother had managed to travel to the village every year and thus maintained the familial and kin relationships. Because of these relations that her mother had built over many years, Yasmeen could receive both emotional sustenance and spiritual or religious guidance. She had developed more intimate relations with some of the relatives in her natal village especially after the death of her mother.

Given the robust health of her two daughters, Yasmeen was convinced of the power of the amulet, and she believed the divination of the healers that her children had suffered due to the evil eye and black magic cast on them by jealous kin and neighbors. And the only protection offered by the healers from this voodoo or black magic (masan ki bimari) was the modest amulet. Apart from the remedies of the healers, Yasmeen also emphasized that her attempts at reordering reproduction through contraceptive pills was an important step in the larger scheme of things. Such timely reproductive practices might have helped avert further deaths of her infants.

Despite her privations, Yasmeen had persisted with medical treatment along with relying on home remedies to heal the colds, fevers, colic, digestive disorders, dysentery, and teething problems of children – ailments that constituted “part of the normal flow of life” (Das and Das 2007: 69). In addition to their susceptibility to illnesses due to the poor infrastructure of the neighborhood (Scepher-Hughes 1992; Haider 2000; Das and Das 2007; Das and Hammer 2007; Snell-Rood 2015b), Yasmeen also believed that black magic played a vital role. To prevent further harm, she sought cures from the religious healers to stave off the ominous forces affecting her children (Unnithan-Kumar 2003; Das and Das 2007). She relied on a network of relatives and healers to protect her daughters (Das and Das 2007). Further, her cautious adoption of contraception had
helped delay the birth of her daughters, which enabled her to provide them with the utmost attention and care.

Although Yasmeen’s daughters supported their aging parents (cf. Lamb 2000), the absence of a son evoked pity on the part of her kin and neighbors. During my time in the neighborhood, I learned that many neighbors and close acquaintances considered the elderly couple to be pitiable or helpless (bechara) and without support (sahara) because of an incomplete family (Unnithan-Kumar 2003; Thapan 2009; Singh 2016). Yasmeen considered that such neighborly and kin relations engendered worries rather than providing emotional sustenance. In the light of such entrenched gendered ideologies, Yasmeen was worried about her daughters and doubted their ability to protect their assets. The urgency of finding dependable sons-in-law and relatives to fall back on (Leonardo 1987; Lamb 2000; Snell-Rood 2015b) dominated our conversations. Further, the family perceived that jealousy affected their relations with neighbors and kins (Lamb 2000; Snell-Rood 2015b), which became burdensome and exacting without providing any reciprocal benefits (Snell-Rood 2015b). However, at times, the couple still maintained ties with their families to fashion themselves as considerate rather than self-seeking individuals. As the accounts reveal, the kindred ties did not completely dissolve during adversities faced by the families.

In recent years, Yasmeen had started taking medications every day to control or suppress her epileptic seizures. I had seen her take the Eptoin pills for preventing the sudden seizures during my visits to her house. I often had long conversations with Yasmeen when her husband and daughters were out on errands. This ailment, according to Yasmeen, was triggered both by aging and by the social and emotional experiences of her life (Weaver, Barrett, and Nichter 2016; Weaver 2016). Enduring the prolonged grief and anguish caused by the deaths of her infants had been a major incident that set in motion her mental distress. Furthermore, the tenuous relations with her affinal and natal families as well as betrayal and deception on the part of her neighbors had had adverse effects on her health. In the context of the narrative evidence, I came to the conclusion that Yasmeen’s mental distress could be associated with degenerative conditions, psychosocial experiences, harsh material realities, and the social dynamics inherent in neighborly and kin relationships (Das and Das 2007; Weaver, Barrett, and Nichter 2016; Weaver 2016). Her case illustrates how women navigate the complexities of relationships as they both benefit and suffer from them.
Moreover, the narrative shows how reproductive complications can be perceived as “social and spiritual threats that require personalistic treatment and interventions” (Chapman 2006). In this light, as Rachel R. Chapman (2006) argues, women do not rely solely on clinical treatment; they also seek the services of informal care providers who can identify and treat the maternal health risks and vulnerabilities emanating from witchcraft and sorcery. Further, Yasmeen’s efforts to seek a “diverse therapeutic regimen” reaffirm Ravindra S. Khare’s (1996: 840) argument that one’s health and illness depend on “personal choices and actions, as well as religious merit and demerit and moral cosmic forces.” In this context, Khare suggests that a host of factors such as “prayers, patient’s discipline, and God’s will” undergird what constitutes “practiced medicine” in India (ibid.). This practiced medicine foregrounds the cultural reasoning and ethos that “human life span, suffering, and misfortune are beyond human control,” which influences the ways that caring and healing are seen as “moral and non-competitive activities” (ibid.).

This narrative also reinforces the argument that improved infrastructural provisioning or “public goods” can play an important role in checking communicable diseases in low-income neighborhoods (Das and Hammer 2007). However, the state of public health facilities, as I have discussed, for example, clean drinking water and sewage disposal, is still worse in the low-income neighborhoods of Delhi. In this context, Jishnu Das and Jeffrey Hammer (2007) have suggested that such constraints led to high infant mortality in these neighborhoods. Drawing on data from the National Family Health Survey (NFHS 1999), they underscore the fact that 70 of 1,000 infants die in the poorer neighborhoods, while these statistics are insignificant among the rich (2007: w339). They point to the fact that it is not the availability of health care but the quality of care and the competence of medical care providers that have an effect on the health of low-income residents. Ironically, though the low-income residents seek medical care more often than rich residents do, this does not lead to better health because the providers in the low-income neighborhoods are not competent, and there is an increased probability of misdiagnosis of illnesses and ineffective treatment (ibid.). For instance, at times, even the providers in government hospitals with bachelor of medicine and bachelor of surgery credentials prescribed “harmful” treatments such as antibiotics and anticholinergics for diarrhea (2007: w344).
This particular account also sheds light on how reordering of reproduction is intrinsically connected with various aspects of decision making like seeking medical and alternative therapies to treat infants, delaying recurrent pregnancies through contraception, and warding off harm by adhering to the expertise of religious healers. Yasmeen’s story underscores how wise planning with respect to reproduction is a composite whole embedded in infrastructural facilities, neighborly and kin relations, and psychosocial experiences. This story also reflects how Yasmeen achieved medical, emotional, and moral well-being through her wise planning.

In the following section, I examine how the ambiguous citizenship status and surveillance of migrants (Ramachandran 2003; Srivastava 2012; Mehta 2018) pose difficulties for women seeking assistance and care during childbirth. For instance, reluctance on the part of trained ‘dais’ to provide support often led to complications that necessitated intergenerational planning of families. In particular, I show how a case of uterine prolapse led to precaution, deliberation, and counseling children about wise planning.

**Exercising Precaution and Deliberation: Intergenerational Family Planning**

Fifty-eight-year-old Tazmeera, a Bengali Muslim, lived with her husband and five children in Noor Nagar. The couple supported their family because none of their children was employed. Tazmeera sold candies, cookies, snacks, and savories from the verandah of her two-room house while her husband sold plastic toys on the sidewalk of a busy street adjacent to the neighborhood. Her married daughter also lived with them because she needed help with her newborn baby. Tazmeera had borne the costs of the institutional delivery of her grandchild because her son-in-law, a rickshaw puller, struggled financially. During my visits, Tazmeera was preoccupied with procuring a birth certificate for her grandchild and a voter identity card for her daughter, as these documents provided proof of their residency status in the city, which in turn entitled them to various welfare benefits (Routray 2014a). She needed a birth certificate to enroll her grandchild in school. Because she did not wish her grandchild to miss the admission deadline due to incomplete paperwork, she worked to receive the documents without any errors to avoid multiple visits to the office to rectify mistakes (Routray 2014b).
Although none of her children had received a formal education, Tazmeera had resolved to educate her granddaughter by having recourse to a state policy. The Ladli (in Hindi, this word connotes an endearing form of address for a girl child) scheme, a state policy to educate girls belonging to low-income families, was launched in 2008. It covered the costs through high school of educating at least two girls from each low-income family. This policy aimed to curtail discrimination and minimize the school dropout rate of girls from underprivileged families. Apart from addressing the gendered exclusions in educational institutions, the policy was introduced with the aim of countering the skewed sex ratios in north India. There was a strong preference for son in this region that had led to selective abortions of girl child. Through these social initiatives the state attempted to improve the gender imbalance.

Tazmeera, however, asserted that she also dealt with deep-seated anxiety and fear that her family members could not avail themselves of state benefits even after they successfully procured the state-issued identity documents. During our conversations, she mentioned that she had witnessed cases of both seizure and destruction of identity documents, such as voter IDs and ration cards, of the Bengali Muslim residents in Noor Nagar. On one hand, the low-income families experienced difficulties in obtaining these documents (Routray 2014b). On the other, Muslim families especially faced enormous surveillance in authenticating their documents as citizens of the Indian nation-state. Despite the possession of state-issued IDs, for example, the voter ID and the ration card, I observed that often the police and state officials suspected that Bengali Muslims were "illegal" Bangladeshi immigrants (also see Ramachandran 2003). Further, the police accused them of misrepresenting social, demographic, and migration-related facts and routinely seized their proofs of identity. Most of the Bengali Muslim residents in Noor Nagar, however, countered the official narrative of illegality and claimed that they had migrated from the Cooch Behar district in West Bengal, a state in east India. In this atmosphere of suspicion and hostility, it is not difficult to imagine that the routine seizure of identity documents threatened the Bengali Muslim residents’ right to welfare entitlements such as subsidized monthly rations and resettlement plots upon demolition of their present-day houses.

Apart from encountering state surveillance, the Bengali Muslim residents were also subjected to animosity in the neighborhood and beyond. On many occasions I felt that the non-Muslim residents with whom I interacted while visiting the informal care
providers or the community health volunteers lacked friendly or cordial relations with the Bengali Muslims in their neighborhood. They too suspected them as to be illegal Bangladeshis who had somehow crossed the border through agents and procured fake documents to secure welfare benefits. Often, the issue of mistrust was projected onto the bodies of the Bengali Muslims: their atypical ways of wearing a saree, chewing betel leaf, cooking, and speaking.

Such discourses against the Bengali Muslims had increased their vulnerability while eking out a living in a low-income neighborhood of Delhi. In particular, the Bengali Muslim residents complained about the every day harassment at the hands of the police. Tazmeera and other residents told me how the police arbitrarily questioned women as they returned from work in the evenings. Usually, such questioning took place on the last day of the month, when the women carried their salary for their domestic services in middle-class neighborhoods. Even though they furnished proof of their citizenship, these documents did not convince the police, as the cotton saree-clad women chewing betel leaf had become a fixed racial representation of a Bangladeshi Muslim, an alien who could not be permitted to partake of the rights and entitlements granted to citizens of the sovereign Indian state.

In these circumstances, as the Bengali Muslim residents noted, the police did not detain women who offered them their salary, which amounted to almost 50 to 60 USD$; those who resisted were taken into custody and released upon depositing a surety amount. At the time of my fieldwork, I had seen four different cops making daily trips during the mornings, afternoons, and evenings in Noor Nagar. One of the cops told me that most of the so-called Bangladeshis knew how to procure fake documents and thus their task was to detain them and make arrangements to take them across the Indo-Bangladesh border. In fact, during my conversations with Tazmeera’s family, her husband did not completely reject this claim, though he discounted such a generalized perception. He revealed that at least five out of ten people who had Indian nationality had migrated from the riverine villages adjoining the Indo-Bangladesh border in the northeastern states.

The police, according to him, did not fulfill their duties of ascertaining the facts; instead they dealt brutally with the Bengali Muslims. These strategies of the police had created a situation of despair; at times, residents with authentic identity documents who
had been detained lost hope that any genuine appeals and requests would be taken seriously. It was difficult to cope with accusations, interrogations, and detentions concerning their citizenship status, and such measures also influenced the social relations in the neighborhood. The non-Muslim residents’ suspicion turned to conviction when the police detained the Bengali Muslims. Furthermore, it became extremely difficult to be employed without the possession of identity documents.

As I understood, the police presence in the neighborhood had caused relationships between the Bengali Muslim and the non-Muslim residents to deteriorate. The Bengali Muslim residents emphasized that their non-Muslim neighbors provided false information to the police under duress in order to protect themselves from intimidation and violence. Tazmeera once noted that some neighbors even settled personal feuds by siding with the police. Most of the Bengali Muslim residents in Noor Nagar confirmed that the neighborhood dynamics were inimical to their interests, and some of them claimed that their non-Muslim neighbors had informed against them after receiving money from the police. I was often told that these informers received money ranging between 50 to 100 USD$ for providing specific house numbers and the names of “illegal” Bangladeshis who resided in Noor Nagar. Such tactics led to frequent searches of Bengali Muslims at any hour of the day.

For instance, several times I witnessed the beat cop questioning the members of the suspected families about why they still had not left for work, or where did they work at present, or arbitrarily asking them to furnish their identity documents. Bengali Muslim men involved in scrap collection were also accused of theft (also see Kornberg 2019) when the police found them using electronic gadgets like air coolers, stereos, or video recorders. In fact, Tazmeera and her neighbor lamented that their sons had been in police custody without committing any wrongdoing. The police had detained them and released them on a surety amount of 50 USD$. Without any evidence, the young men were arbitrarily picked up and detained even though they claimed that the electronic gadgets were discarded; at times they were sold at a nominal price to the scrap collectors when outdated. The adjoining middle- and upper-middle class residents, as the Bengali Muslim residents claimed, usually preferred to dump these old gadgets once they had acquired the latest models.
To reassert this point, sometimes the Bengali Muslim residents showed me the old and rusty gadgets, which demonstrated their skill in repairing the items and putting them to use. While claiming innocence, Tazmeera’s family members also pointed to the fact that when theft or burglary was reported in the middle- or upper-middle class neighborhoods, the police arbitrarily detained the Bengali Muslim residents on grounds of suspicion. It was convenient for the police to act this way, as I perceived, because they could justify their capability to apprehend the so-called offenders, receive money through sureties, and thus close the case.

At times, in order to negotiate the release of their family members, the Bengali Muslims had to provide a lump sum of anywhere between 50 to 130 USD$. Barely able to make ends meet, they had no other option than to borrow this amount. They always had to be prepared for such eventualities because they kept recurring. Most of the Bengali Muslim families knew that the special branch policemen conducted such search operations. In this light, Tazmeera’s husband revealed that families who were unable to pay the surety amount underwent dire consequences. These families did not see their parents, siblings, spouses, or children for several years because the special branch police made arrangements to take them to the Indo-Bangladesh border and force them to enter Bangladesh. I heard accounts of families who still hoped for the return of their near and dear ones. As I understood, the residents left across the border contacted their family members and relatives in Noor Nagar, asking them to send them money so that they could travel back to India. In some cases, the families had absolutely no contact and thus no clue about the whereabouts of the deported members.

Living in the absence of an intimate family member was difficult on the part of the Bengali Muslims and on some occasions they feared the worst, especially when connections could not be reestablished for a long time. As my interlocutors reaffirmed, there were instances of shootings carried out near the border by the armed policemen of the Border Security Force on the account of “Bangladeshis” trespassing on Indian territory. As Tazmeera’s husband put it: “Border Security Force guards often shot at ‘suspected’ Bangladeshis whom they perceived as thieves especially trafficking narcotic drugs across the Indian border” (BSF guard goli chala dete the aur bolte the ki ye Bangladeshhi chori chakari karte hain aur ganja bej te hain). Because of such unprovoked fatal shootings of people trying to earn their daily bread, the Bengali Muslim residents
were fearful when a family member was deported and left to cross the border on foot. With the passage of time, doubts resurfaced about the survival of the family member.

In this context, the Bengali Muslim residents avoided infuriating the police. But cases of unlawful confinement occurred during my visits to Noor Nagar. Often, the policemen barged into the homes of suspected illegal immigrants in the middle of the night. As another Bengali Muslim resident opined, the policemen usually detained around fifty people in the city on grounds of suspicion every month, and the families had to actively negotiate with the police for the release of the detained members. This could cost the families an entire month’s salary. Given these common conditions, the Bengali Muslims are often required to furnish additional certification such as birth certificates, passports, or property deeds of landholdings in their native place in order to establish their Indian citizenship (Ramachandran 2003: 640-641). Procuring birth certificates is now fundamental to the security of their children, which was not a usual practice a decade ago. Most of these residents, however, do not possess passports because they rarely undertake transnational travel. Furthermore, the lack of landholding also keeps them from producing any land deed when required. The reason for migration/immigration is intrinsically connected to their marginal social existence in the villages, especially without any land entitlements to support their families.

The constant surveillance associated with their ambivalent citizenship status and the threat of incarceration and forcible deportation reflect how the communal Hindutva forces embolden the police (Ramachandran 2003: 641), thus consequently leading to persecution and the othering of religious minorities (Mehta 2018: 67). Moreover, in 2019 – as I was writing this dissertation – the Citizenship Act of 1955 was amended, which granted citizenship rights to persecuted minorities that constitute mainly non-Muslims: Hindus, Christians, Sikhs, Jains, Parsis, and Buddhists from Pakistan, Bangladesh, and Afghanistan (ibid.). The Bharatiya Janata Party’s religious and communal bias is foregrounded because Ahmadiyyas, Muslims, and Rohingyas from Pakistan, Bangladesh, and Myanmar respectively cannot lay claim to the similar entitlements and rights granted to the above religious communities (ibid.). Muslims now especially fear that the ruling government’s plans to implement the National Register of Citizens nationwide could strip them of their citizenship if they are unable to provide the required
paperwork (Chhabra 2020). The anxieties surrounding proof of Indian citizenship have increased, because migrant families who could not provide proof documents are excluded from the national register in the northeastern state of Assam and held in detention centres and deported to Bangladesh primarily on the grounds of their “illegal” citizenship status."

The Bengali Muslims, derogatorily called “Miyas” in Assam, are conceived to be a threat and a burden on the state’s scarce resources and are very likely to be deported when unable to provide a range of documents demonstrating their Indian citizenship. The Bengali Hindus in similar circumstances, however, who trace their origins to Bangladesh did not encounter such outright xenophobic sentiments. There are contestations and complexities surrounding what constitutes a subordinate versus a superior ethnic, racial, and religious identity in the northeastern states in India, particularly in Assam, concerning the immigration of marginalized Muslims and Hindus from Bangladesh over centuries. Because massacres of suspected illegal Bangladeshis have taken place in Assam in earlier decades, the national register already implemented in this state was conceived as a tool to clear any doubts regarding citizenship claims. But this process of authentication has created further doubts due to spelling errors and missing middle names or surnames in voter IDs, and lack of documents tracing paternal lineage or marriage has led to many Bengali Muslim and non-Muslim migrants who have lived in Assam for generations to be declared “foreigners” or “doubtful” voters. Many news reports claim that people employed in state government jobs for several years have also been declared “doubtful” voters, which could impede their political participation.


Both Bengali Hindus and Muslims in Assam are asked to provide government-issued documents that could prove that they had been residing in the state prior to March 24, 1971,\footnote{This particular date and year has been decided by the Assam Students Union in agreement with the state and central governments.} in order to be registered in the national list that validates their Indian citizenship. This process, however, has led to a situation of panic since members belonging to a single family do not always find their names listed in the register. Commonly, when spouses, parents, or children are excluded from the register, appeals are made to the Foreigners Tribunal especially set up to investigate such matters. In most cases, the economically and socially marginalized migrants/immigrants relied on the administrative officials or literate members in their community to fill in their voter, ration, and education forms. Consequently, such exercises had led to numerous errors related to their names and ages. In one case\footnote{Siddiqui, Zeba (2018). “In India’s Citizenship Test, A Spelling Error Can Ruin a Family.” Caravan Daily, 22 August. https://caravandaily.com/in-indias-citizenship-test-a-spelling-error-can-ruin-a-family/ accessed on 4 January 2020.} a middle-aged woman called “Sajida Bibi” was excluded from the list because her documents did not show any consistency related to her name. On the contrary, the officials had raised concerns since there were three different versions of her name: Sabahan Bibi, Sahajadi Begum, and Sajida Begum. The news report mentions that she had filed an affidavit explaining that the first two versions of her name had been misspelled and wrongly inscribed in the citizenship registry (first undertaken in 1951 in the aftermath of the partition of India in 1947) and school certificate. And she was addressed as Sajida Begum but had changed her name to Sajida Bibi after her marriage. Even after she explained in detail about the reason for such inconsistencies, the tribunal officials had not considered her affidavit because they saw this as a “self declaration” that had no “evidentiary value.”

This kind of stratified citizenship\footnote{De, Rohit and Surabhi Ranganathan (2019). “We are Witnessing a Rediscovery of India’s Republic.” The New York Times, 27 December. https://www.nytimes.com/2019/12/27/opinion/india-constitution-protests.html accessed on 4 January 2020.} suggests xenophobic and Islamophobic attitudes that have led to further intimidation and mistreatment of the suspected Muslim immigrants from Bangladesh. In this light, I believe that my interlocutors, especially the Bengali Muslims in Noor Nagar, had experienced discrimination and stigma in their native villages and in this context of everyday challenges had migrated to Delhi.
Although they strove to sustain themselves and their families while doing odd jobs, the detentions and deportations ruined their employment opportunities in the city. Even the state-issued IDs did not provide them any security. Nevertheless, as with Tazmeera, the suspected illegal Bangladeshi Muslim families knew that procuring such IDs was crucial to avail various “privileges” (Srivastava 2012). It was also critical for these immigrant families to build and maintain “personal relationships” and “friendships” despite hostile relations in the low-income neighborhoods in order to be considered as “one of us” rather considered “foreigners” (Srivastava 2012: 91-92). In fact, Srivastava argues, it became vital for these “suspected” families to maintain neighborly relations because certain residents of these neighborhoods who claimed authority through their political and bureaucratic connections conducted the “verification” of IDs (ibid.).

The frequent detentions, seizure of documents, raids, and social isolation further exacerbated the vulnerabilities of women in Noor Nagar. In particular, they encountered challenges in receiving birthing assistance from skilled ‘dais’ in the neighborhood. The skilled ‘dais’ who primarily belong to the non-Muslim communities, refused to attend to the Bengali Muslims, citing linguistic, religious, and sociocultural differences. In addition to the language barrier, these ‘dais’ noted significant variance in diets and customs during pregnancy and after childbirth. The folk knowledge, beliefs, and birthing practices, as the ‘dais’ insisted, conflicted with the knowledge and practices of the Bengali Muslims.

For example, the skilled ‘dais’ showed disapproval regarding certain practices such as drinking black tea or chewing betel leaf to induce contractions closer to the time of delivery. On the contrary, the ‘dais’ suggested consumption of milk tea or dry fruits ground with clarified butter (mewa masala) to intensify labour pains and to nourish and replenish birthing bodies. The Bengali Muslims, however, provided freshly cooked rice along with roasted garlic and sesame seeds to women during the post-partum recovery phase. Another practice that the skilled ‘dais’ deprecated was a folk knowledge among the Bengali Muslims that putting the birthing women’s hair in their mouth could help expel a retained placenta. One of the Bengali Muslim woman residents once told me that the puking sensations enabled the body to force the placenta out.

In this context of disparate practices related to birthing and post-partum recovery, it was difficult for the Bengali Muslims to seek the services of the skilled ‘dais’ in Noor
Nagar. In fact, Tazmeera recalled that birthing assistance in her village was better compared to the services in the low-income urban neighborhoods of Delhi. The village ‘dais,’ according to Tazmeera, had assisted in birthing three of her children without any complications. But she had experienced severe problems during the course of her pregnancy in this city. Tazmeera told me that she was bedridden in the third trimester of her pregnancy, which compelled her family to admit her in a public hospital since none of the skilled ‘dais’ would attend to her. In the hospital, she had given birth to healthy twins and was relieved after the delivery because she had absolutely no clue that she was carrying twins. Tazmeera, however, considered herself unfortunate when she again conceived a few years later. She had not visited any hospital, dispensary, or maternity center, because she believed that the pregnancy progressed smoothly. Closer to the time of delivery, she sought the support of a ‘dai’ in her own community.

Tazmeera narrated how she had felt miserable for a long time after delivering a stillborn infant. Her postpartum recovery had taken years because she had also suffered uterine complications during childbirth. Although she lamented her loss, she did not blame the ‘dai’ for the tragic occurrence. Rather, she emphasized that the ‘dai’ just could not ascertain what could have caused these problems. Without any assistance from the skilled ‘dais’ in the neighborhood, her ‘dai’ had used her knowledge and skills as efficiently as possible. Tazmeera noted that she had continued to rely on this ‘dai’ especially in the context of uterine complications. The ‘dai’ had regularly massaged her pelvic area for many months to ease the pain and soreness of a prolapsed uterus. At the least, such support had helped her tremendously to carry out her daily chores of looking after the children and cooking for the family.

Onerous schedules of housework, according to Tazmeera, had gradually worsened her health, which posed significant difficulties in sitting, walking, and relieving herself. Protrusion of the uterus also caused heavy bleeding at times along with an unusual amount of white discharge. She added that she had lost a considerable amount of weight during this time and could walk only when she bend her hip forward. At this point, because the massages did not seem to provide much relief and comfort, Tazmeera and her husband had consulted an obstetrician in a private clinic, who initially prescribed medicines to ease her pain. But Tazmeera said that the medicines did not aid in healing; they merely relieved her discomfort. During a follow-up visit, the obstetrician
had recommended that Tazmeera undergo a hysterectomy, and she told me that she had agreed to this procedure so that she could completely recover her health.

Tazmeera’s health had also affected the couple’s sexual intimacy. Although they had to spend 75 USD$ for the surgery, they had no regrets about their decision. Tazmeera affirmed that she had recuperated after the surgery though she had irregular spotting every month. Such traumatic birthing experiences, I inferred, had made her resolute with regard to providing extensive care and counseling to her daughter about family planning. Furthermore, Tazmeera had taken precautions that her daughter had frequent consultations with the obstetrician up to the delivery and even beyond. She had assured her that she would care for her during the pregnancy and after childbirth. During my visits, her daughter and son-in-law were proactively considering whether to use long-term contraceptive technologies.

In this light, I argue that wise planning (samajhdari ki yojana) also involves the ethical obligation of parents to raise children and safeguard their future. The “stigma” associated with “illegal” immigrant identities contributed to “low social bonding” in the neighborhoods, which in turn compounded the health problems of the residents (Wutich, Ruth, Brewis, and Boone 2014: 556). Low-income Bengali Muslim residents particularly lacked social resources necessary during familial crises and health emergencies. Through the above narrative, I show how families care for their children and grandchildren, wanting to provide them with safe and secure lives in the context of surveillance, precarity, and uncertainty (Cornwall 2007). Drawing on their personal experiences, women strived to reorder and reshape their own and their children’s reproductive decision making. Their responsible efforts significantly shaped intergenerational planning of families. As we see, Tazmeera’s debilitating health due to a prolapsed uterus (Smith-Oka 2014: 112-113) influenced her daughter’s decision to use contraception.

The role of family members, especially mothers, is critical in shouldering the responsibility for their married daughters. For instance, Tazmeera’s neighbor, a middle-aged woman, still worked as a domestic worker to support the aspirations of her daughter. Despite severe arthritic pain in the winters, she continued to work in order to meet the household expenses since her daughter and grandchild had started living with her. During a conversation, she spoke about how her son and daughter-in-law had
expressed displeasure because they had to share their scarce resources with the married sibling and her child. Hence, she had felt compelled to work so that she could contribute towards the overall expenditures. Indeed, her financial support had lessened the frequent conflicts and placated her son. She explained that she had to take on the responsibility for her daughter and grandchild because her son-in-law had recently secured work in the trash collection and recycling sector in Kerala. Because this kind of stable income was not easily available for the Bengali Muslim residents in Delhi, she had advised her daughter to save the remittance money and buy a small plot on the outskirts of Delhi. Her daughter could save the amount due to her commitment and concern for their betterment.

I inferred that police surveillance had a significant effect on the upbringing of young children, particularly in Noor Nagar. Parents were concerned that the arbitrary detentions and deportations and extended absences disrupted their familial arrangements. Apart from deficiencies in material resources, the children had to navigate the emotional shock and trauma associated with such blatant police intimidation. Some of the families had become cynical of their life trajectories and articulated their apprehensiveness about their adolescent children being imprisoned on suspicion of theft. Such incidents made it extremely difficult for children to continue with their education or work. Families also remarked that the stigma of imprisonment made their children deeply distrustful of the state’s legal machinery and led them to cope with shame and embarrassment through social isolation, drugs, or alcohol.

Through the familial accounts, I learned that the Bengali Muslims sometimes felt compelled to send their children to their grandparents or affinal relatives so they could be raised in a less hostile environment. Some of them were obviously anxious about this arrangement and concerned about the well-being of their children in distant locations. And this deprived the families of partaking in the joys of parenthood even during times of hardships. Only families who still had relatives settled in their native villages, however, could adopt such strategies. Those who had sustained relations over the years were able to repose faith in their decisions.
Conclusion

This chapter sheds light on the difficulties families encountered while building and sustaining lives in low-income neighborhoods. The struggles of migration and the stigma of belonging to minority religious communities have affected families psychosocially and transformed the kin relations and family-planning decisions of women. Through the narratives, this chapter especially documents women’s resilience, precaution, and deliberation in contexts of privation.
Conclusion

Endless stereotypes that essentialize Muslims as being opposed to family planning have led to their constant vilification and have fueled ongoing controversies about what is considered to be the alarming fertility rate of the low-income Muslim population. By exploring the interlinkages among community, gender, and fertility in India, in my dissertation I ask whether this generalization constitutes a valid understanding of the Muslim community and whether distinctly differentiating the Muslim community in such a reductive fashion can be justified. If high fertility rates exist in the Muslim community, can they be explained only with reference to their religious practices? Or do we need to consider other factors that shape the contours of fertility outcomes of a population? I argue that this emphasis on high fertility rates as a threat to the demographic balance of the nation-state has obscured the realities of the lived and gendered lives of Muslim women. As a consequence, there is inadequate analysis of how the socioeconomic positioning of Muslim women interacts with the agenda of the state.

As I reveal throughout the thesis, an overarching focus on religious identity has inevitably displaced other structural determinants, including class, caste, region, and gender, from an analysis of fertility and reproductive practices. On a broader level, if we move away from maternal health and reproductive behavior aspects and engage with how Muslim women’s bodies have been a site of contentious debate and state intervention historically and in the contemporary period, we will see a similar pattern of anxiety on the part of the majoritarian Indian state that is concerned with saving Muslim women from Muslim men and the larger Muslim community (see Pathak and Rajan 1989: 566-567). This anxiety specifically emanates from the stereotype that Muslim women do not possess agency to articulate or negotiate their concerns with their spouses or family members or seek justice from the courts to subvert conservative laws that bring to light issues of social and gender justice (see Pathak and Rajan 1989; and Agnes 2018).

For instance, Flavia Agnes (1994) has raised concerns about how legal rulings of Indian courts that undermine the Shariat or Muslim personal laws at times can potentially be regressive rather than progressive. Flavia Agnes (1994) gives the example of a particular couple in Uttar Pradesh, which claimed divorce according to Shariat law, and
how it affected their stakes in joint property ownership. The government claimed the property of this couple according to the prevailing Land Ceiling Act as it conceived that the property owned was in excess of the permitted ownership. However, Khatoon Nisa and her husband approached the court and appealed that they were already divorced according to the triple talaq ruling based on religious personal laws, and they did not own the joint property together. In other words, though they had joint ownership claims on paper, the divorce entitled them to separately claim parts of the property as individual owners. Thus, the property of the woman escaped the Land Ceiling Act specifications, as she did not own any excess property that could be seized by the government. However, this particular task of proving legal claims to the land on the part of Khatoon Nisa became extremely difficult because the court did not consider her divorce or separation as valid, and thus did not perceive her as a separate entity having her own claims to land possession (ibid.).

There were also other complexities that shaped the court’s decision of refusing to consider their divorce as valid. For instance, though the couple had divorced, the separated wife still lived in the matrimonial home of her husband. As a consequence, the court did not consider the depositions of family members and the documentary evidence of talaqnama as sufficient to prove the divorce of the couple (ibid.). Subsequently, the divorced woman, Khatoon Nisa, lost her property that was acquired by the state through the Land Ceiling Act. As we see here, the court’s entire focus on the conservative customary law of triple talaq amongst Muslims neglected addressing the significant question of loss of property rights of a divorced Muslim woman. In other words, while this liberal court ruling attempted to redress gendered injustice of arbitrary divorce, it ironically disenfranchised the woman of her property (ibid.).

Similarly, the case of Shahbano raises critical questions about maintenance rights upon divorce through the Shariat law of triple talaq. Shahbano had approached the court to claim a higher maintenance amount following her divorce, as the maintenance granted to her in the Shariat law was inadequate. She also appealed to avail maintenance support for a longer period than the specified period of three months following her divorce. The Supreme Court favorably ruled that Shahbano’s husband pay her a higher maintenance amount (Pathak and Rajan 1989). However, this secular judgment had wider ramifications because it undermined the importance of Muslim Personal Laws. The personal or religious customary laws usually adjudicated in intimate
matters of marriage, divorce, maintenance, property inheritance, or child custody among Muslims (Pathak and Rajan 1989: 561-562). Though the secular groups within the Muslim community in India endorsed and welcomed what they considered a ‘progressive’ pronouncement, the Muslim conservative groups criticized this ruling (ibid.). They saw this secular law of the state as infringing on their religious decrees and laws. According to Zakia Pathak and Rajeswari Sunder Rajan (1989: 561), the conservative Muslims decried the ‘homogenizing influence’ of the state and secular laws that threatened to destroy the distinct identity of Muslims in India. As a result, the Muslim Personal Law Board after losing the battle in the Supreme Court took the battle to Parliament (ibid.). In the context of acrimonious debates and stark divisions in the Muslim community across India, Shahbano was compelled to ultimately decline the secular judgment related to her maintenance while proclaiming her Muslim religious identity (Pathak and Rajan 1989: 565). Given such polarizations, the Indian state is now considering having a Uniform Civil Code that will be applicable to all religious communities, but this could undermine the ‘religious freedom’ of minorities (Pathak and Rajan 1989: 567). At present, there are contentious debates in Indian courts and legislative assemblies to consider whether instituting a Uniform Civil Code that will be universally applicable to all religious communities as opposed to religious personal laws will bring forth equitable gender just laws. Most often, the majoritarian Hindu religious community articulates the question of Muslim women through a protectionist discourse. Rather than promoting this discourse of victimhood of Muslim women, I show how their lives are enmeshed in familial and kinship relations, neighborhood and migration histories, and their interactions with the state authorities. In particular, I demonstrate how they navigate and negotiate social relations and power hierarchies in these domains.

This dissertation locates the practices of low-income Muslim women in their social settings. My research aimed to document the ensuing experiences of fertility and health of women in conjunction with their embeddedness in these overlapping and predominant structures. In analyzing my ethnographic findings, I have particularly highlighted issues of family and household dynamics, marital practices, and migration histories in examining the everyday experiences of women—the agential dynamics within these structures have been the focus of my descriptions in my attempt to add to the burgeoning discourse on the regulation and management of fertility in the Indian populace.
I have examined how women’s bodies have been reconfigured within the purview of developmental initiatives, family planning policies, and neoliberal market principles. As I argued, the statist agenda has been furthered through family planning programs that encourage various invasive and irreversible surgical procedures targeting low-income women, especially Muslim women. There is a tendency to see matters of reproduction and family planning only through the lens of “health” and through the tools of public health planning. I believe, however, that the domain of reproductive health needs to be seen first and foremost as an arena where statist agendas are enacted (Jolly and Ram 2001).

A longer historical analysis sheds light on different statist agendas in different eras. For example, the Nehruvian state agenda, during the first two decades after Indian independence, emphasized limiting family size in the service of the development of the Indian nation-state (Anandhi 1998). The Emergency and post-Emergency statist era in the 1970s and 1980s implemented a eugenicist reproductive agenda, whereby the state targeted poor people, especially poor Muslim people. A vertical program through educational initiatives during the Nehruvian era gave way to coercive policies of sterilization and various forms of incentivization.

Since the 1990s, the state has addressed population policies through the rhetoric of empowerment and the exercise of reproductive choices and freedom. This era has emphasized neoliberal market rationalities that have foregrounded the provisioning of reproductive technological choices through national and international non-governmental organizations. As my ethnographic analysis shows, the neoliberal rationality has initiated various coercive and selective policies of reproductive intervention in the name of empowerment. In addition, the emergence of this neoliberal rationality has converged with the rise of the Hindu right and Hindutva ideology – the politics of religious nationalism based on anti-Muslim sentiments that has systematically aimed to make India a Hindu nation-state. As a consequence, the politics of Hindutva has aimed to restrict the fertility rate of Muslims, particularly marginalized Muslim populations.

In this light, my focus has been on how marginalized Muslim women in Delhi identify, receive, interpret, and understand the ideology of choice, rights, agency, and autonomy that state policies impose on their lives. Through ethnographic evidence, this dissertation makes the case that multiple contingent factors influence decisions around
family building and planning. Rather than focusing on the aggregated and generalized reproductive data and behaviours that constitute uncritical demographic evidence in reproductive health policy research and in the stereotypes of the health providers, I focus on familial lives and contemporary realities in two neighborhoods in Delhi. My dissertation contests long-standing preconceived notions that marginalized Muslim women are ignorant or irrational – ideologies that promote coercive strategies on the part of the health service providers. Instead, I demonstrate how low-income Muslim women actively pursue contraceptive decisions.

The ethnographic evidence I have presented reveals the mismatch between what is currently going on and what the policy people think is happening. Each chapter illustrates how women perceive themselves as wise planners and how they pursue wise planning in situations where they encounter coercive strategies, substandard contraceptives, familial pressures, and state surveillances. By enacting their responsible and wise selves, women critique the hierarchies that they are subjected to on an everyday basis. Nevertheless, this enactment of selves is deeply ambivalent and contradictory, which also reflects the effects of ideologies, structural determinations, and social settings of the marginalized.

Although Muslim women in low-income neighbourhoods consider the subsidized state health care services a respite, they also highlight some of their discriminatory aspects. Women provide a commentary on how state irresponsibility exacerbates further impoverishment and suffering. Moreover, women counter the official argument of state authorities that the poor are irresponsible by providing concrete examples of how they have to be exceedingly responsible, particularly given the fact that their neighborhoods have almost no infrastructure and thereby embody the state’s neglect on an everyday basis. These case illustrations also reaffirm the argument that acceptance of contraceptives is embedded in the lives of women and, thus, that the use of invasive or non-invasive contraceptives is essentially connected to state provisioning, affordable private pharmaceutical products, work arrangements, and intimate familial and kin power dynamics.

In contrast to the state’s claim that low-income Muslim women are irresponsible, these women claim that the state is irresponsible. Women have to conduct wise planning regarding the number of babies they have, the ways they invest in their children’s
education and health, and the judicious expenditures they undertake to achieve their goals. Other than these key components of family building, women must safeguard their children’s future in an atmosphere of frequent police surveillance. I argue that the strategies they adopt portray them as neoliberal selves who make proactive decisions about their own and their families’ health and well-being in the current neoliberal reality in India, where the state has deliberately failed to provide welfare measures and protect the interests of marginalized communities. This idiom of wise planning has emerged from the discourses shaped by the confluence of neoliberalism and the legacy of the Indian family planning programs.
References


## Appendix. Demographic Profile

<table>
<thead>
<tr>
<th>Name and Origin of Residence</th>
<th>Age</th>
<th>Caste</th>
<th>Occupation and Income</th>
<th>Family History</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reshmi had migrated from Cooch Behar district in West Bengal.</td>
<td>26 years</td>
<td>Telis Caste</td>
<td>She was employed as a domestic worker. And her husband worked as a scrap seller. They both earned 34 USD$ per month.</td>
<td>She lived with her in-laws family, husband, and two children in Noor Nagar.</td>
</tr>
<tr>
<td>Salma was born in Delhi. Her parents had migrated from Bihar.</td>
<td>33 years</td>
<td>She was not certain about her caste.</td>
<td>She was employed as a domestic worker. Her husband worked as a scrap-sorter. They survived on a total income of approximately 70 USD$ per month.</td>
<td>She lived with her husband and three children in Noor Nagar.</td>
</tr>
<tr>
<td>Naushi had migrated from Cooch Behar district in West Bengal.</td>
<td>28 years</td>
<td>Telis Caste occupation: Oil pressers</td>
<td>She did not work. Her husband worked as a garbage collector. He earned approximately 60 USD$ per month.</td>
<td>She lived with her husband and three children in Noor Nagar.</td>
</tr>
<tr>
<td>Saira was born in Noor Nagar. Her parents had migrated from Bihar.</td>
<td>30 years</td>
<td>Ansari Caste occupation: Julaha/Weaver</td>
<td>She did not work. Her husband worked as a scrap sorter seller. He earned almost 80 USD$ per month.</td>
<td>She lived with her husband and three children in Noor Nagar.</td>
</tr>
<tr>
<td>Shabnam was born in Radha Nagar. Her parents had migrated from Uttar Pradesh.</td>
<td>27 years</td>
<td>She was not certain about her caste.</td>
<td>She sold tea and earned around 50 USD$ per month.</td>
<td>She lived with her husband and two children in Radha Nagar.</td>
</tr>
<tr>
<td>Mehmuda was born in Radha Nagar. Her parents had migrated from Uttar Pradesh.</td>
<td>25 years</td>
<td>Ansari Caste occupation: Julaha/Weaver</td>
<td>She was employed as a domestic maid and earned 50 USD$ per month.</td>
<td>She lived with her husband and two children in Radha Nagar.</td>
</tr>
<tr>
<td>Kulsum was born in Radha Nagar. Her parents had migrated from Uttar Pradesh.</td>
<td>22 years</td>
<td>Ansari Caste occupation: Julaha/Weaver</td>
<td>The couple earned around 80 USD$ per month.</td>
<td>She lived with her husband and two children in Radha Nagar.</td>
</tr>
<tr>
<td>Shahida now lived in Noor Nagar.</td>
<td>23 years</td>
<td>She was not certain about her caste.</td>
<td>Her husband did not have a stable income.</td>
<td>She often lived with her parents in Noor Nagar.</td>
</tr>
<tr>
<td>Name and Origin of Residence</td>
<td>Age</td>
<td>Caste</td>
<td>Occupation and Income</td>
<td>Family History</td>
</tr>
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<tr>
<td>Sheeba had migrated from Uttar Pradesh.</td>
<td>26 years</td>
<td>Ansari</td>
<td>She did not work. Her husband apprenticed as a mechanic in an electrical store. He earned 25 USD$ per month.</td>
<td>She lived with her mother-in-law, husband, and two children in Noor Nagar.</td>
</tr>
<tr>
<td>Nasreen and her parents had migrated from Uttar Pradesh.</td>
<td>22 years</td>
<td>Ansari</td>
<td>She did not work. Her husband worked as a repair mechanic in an electrical company and also drove his own auto-rickshaw. Her husband earned approximately 120 USD$ per month.</td>
<td>She lived with her husband and a child in Radha Nagar. It was a love marriage.</td>
</tr>
<tr>
<td>Asma had migrated from Cooch Behar district in West Bengal.</td>
<td>20 years</td>
<td>Telis</td>
<td>She worked as a cook and earned approximately 40 USD$ per month.</td>
<td>She lived with her daughter in Noor Nagar. Her husband had separated from her. She had suffered a miscarriage as a result of reproductive complications during her second pregnancy.</td>
</tr>
<tr>
<td>Yasmeen Begum had migrated from Uttar Pradesh.</td>
<td>53 years</td>
<td>Qureshi</td>
<td>She did not earn any income. Her husband worked as a driver. His monthly income was around 80 USD$. He had migrated from Bihar.</td>
<td>She lived with her husband and two daughters in Radha Nagar. She had suffered the loss of six of her children during their infancy years.</td>
</tr>
<tr>
<td>Tazmeera had migrated from Cooch Behar district in West Bengal.</td>
<td>58 years</td>
<td>Pathan</td>
<td>She sold snacks and savouries from her house in Noor Nagar. Her husband sold plastic toys. The couple earned a total of approximately 70 USD$ per month.</td>
<td>She resided in Noor Nagar with her husband and five children. She had lost one child at the time of birthing.</td>
</tr>
</tbody>
</table>