**The everyday ethics in sterilization camps in India**

**Introduction**

‘Do not change my name when you write your book,’ says Gunjan, a woman in her thirties who works for Marie Stopes India (MSI), a branch of MSI Reproductive Choices, an international not-for-profit social enterprise which provides sexual and reproductive health services, including contraception and safe abortion in 36 countries and which has been outsourced by the Indian state to conduct sterilization procedures in this rural location. Gunjan mediates the relationships between the clinical team based in the city who travel to rural areas to perform tubal ligations, the state functionaries overseeing various health interventions carried out by the government, and community health workers, government-employed health workers who implement state’s health initiatives in the villages including encouraging women to get sterilised. Gunjan says this while we sit at the registration desk of a weekly sterilization camp held in a local health centre in southern Rajasthan where I have been conducting fieldwork since 2012. A white cloth which has not been washed for months covers an old desk covered in numerous bureaucratic registers. State functionaries are entering various data about women who came to the camp for the tubal ligation procedure and community health workers who accompany them. Throughout the camp, patients are known by numbers which are ascribed to them by the order in which they arrive to the camp from their villages and this number is written with a marker on their inner arm and circled. After registration, Gunjan would often skip the mandatory counselling of patients about the permanency of the procedure: ‘these women will not understand anything anyway and might run away when they hear me,’ she says. One bureaucrat sitting next to Gunjan at the desk agrees: ‘Keep my name too.’ Another also interrupts: ‘Mine too!’ They all nod and laugh, satisfied that their real names might appear in my book.

I went to the field, and particularly to sterilization camps, regularly repeating the assurance that I would change people’s names, localities, and other personal data in the written works that come out of fieldwork to protect my research participants. These assurances meant to help people feel at ease about my presence in their often personal worlds and in settings which may have been ambivalent, if not controversial. Various global and national discourses critique sterilization in India for being a contemporary manifestation of historically coercive population control programme, for not respecting women’s reproductive autonomy, for being part of structural oppression where the entanglement between poverty, caste, and gender lead to limited contraceptive options, for corroded relationships between the state and the poor, and for the lack of quality of care in settings where sterilization services are provided. While sterilization practices in India have been seen as problematic within the global media and by the activists in the country, they are not controversial or taboo in village or camp settings. Professionals who implement sterilization procedures—MSI workers organising the camp, state bureaucrats collecting data, and the clinical team carrying out medical examinations before surgery, tying the tubes, and providing post-operative care—see what they do as ‘good work’, contributing to the wellbeing of local communities. They see it as a form of humanitarianism: relieving the suffering of the poor. They were surprised about my assurances to protect their anonymity by changing their names, a disconnect which often arises between the guidelines prescribed by institutional ethics review boards in researchers’ home institutions and situated ideas about ethical, appropriate, and socially acceptable conduct in the field (Riessman 2005; Staples and Marsland 2023). Gunjan and her colleagues did not need protection; they wanted the world to celebrate their service to India’s villages. While there is a call in anthropology to move away from pseudonyms and to refer to people and places in their real names (Weiss and McGranahan 2021), I did change Gunjan’s name. I did it primarily because the two things that she feels secure, or maybe even proud, about––that what she does is humanitarian work and that the way she does it is excellent—seem and feel ambiguous within other, more hegemonic, discourses. And because, several months into my fieldwork, Gunjan got ‘transferred’ to another MSI office branch after the clinical team realised that she was skipping counselling. In this paper, my argument is twofold. Firstly, I suggest that while different ethical reasonings may co-exist and clash within the camp, professionals working in sterilization camps collectively view their work as ethical despite the controversial nature of sterilization in the country. Secondly, I demonstrate that disgust plays a significant role in the very possibility of such a collective notion of doing ‘good work’ and in shaping the moral imperative surrounding sterilization: disgust felt by professionals towards sterilization patients, rooted in caste and class hierarchies, reinforces professionals’ belief that they are engaged in humanitarian work by providing services to a population perceived as ‘backward.’

Incorporating perspectives of professionals who implement population control programmes is important in understanding how such ambivalent interventions function on the ground. When writing about rural women who come for sterilization, I grapple with what it means to live in conditions of poverty and informality, and with corroded relations with state institutions, and hierarchies of caste, class, and gender which affect all aspects of everyday encounters. When writing about professionals in sterilization camps, the question remains the same: what it means to work in rural areas living in poverty and with patients whose lives are socially distant. In this paper, after I provide some historical and social context of the area, I investigate the everyday ethics primarily in two registers: interactions amongst different professionals involved in the camps and the role of disgust in creating the moral imperative that makes sterilization seem like a humanitarian intervention.

**Family planning as humanitarianism in India: a historical perspective**

Throughout history, population control in India has been framed as different forms of humanitarianism (Barnett 2011). In colonial India, British officers have been concerned with economic calamities affecting India and blamed these on Indian conjugality: imperial humanitarianism involved a civilising mission to change Indian marriage practices and kinship patterns to ‘liberate’ Indian women and achieve economic gains. During the struggle for independence, poverty has been seen as a consequence of colonial misrule but that discourse quickly shifted in independent India and neohumanitarianism emerged: overpopulation has been established as a primary cause of poverty and a barrier to development (Hodges 2004). India introduced family planning as an official national programme in 1952 and became the first country to do so. Independent India and its nationalist leaders accepted that reproductive practices had economic costs and, under a huge pressure from the international community which was worried about India’s ‘population bomb’ and ‘population emergency’, spent decades implementing population control measures as a way to eradicate poverty. Sreenivas (2021) demonstrates that India’s women’s movement has been integral to these efforts and argued for contraception as vital for women’s and children’s health, especially in the early years after India’s independence. She describes an elitist agenda where middle-class feminist activists promoted birth control to impoverished women in cities and villages as a form of social service. Following recommendations from international funding organizations like the World Bank and the Population Council, increasingly coercive population control measures were introduced in order to bring ‘development’ and ‘modernisation’ to the country (Connelly 2006). While the programme started with measures such as the rhythm method, it soon escalated to the mass insertion of IUDs, introduction of targets and incentives for government institutions and employees (Satia and Maru 1986). Stricter population control measures were demanded by international actors, and the US, for instance, provided food aid only and when India introduced more measures (Connelly 2006). Yet the eagerness for population control did not come exclusively from outside of India: Indian feminist activists, academic institutions, and health care professionals participated in the promotion of this agenda in different ways throughout the decades (Olszynko-Gryn 2014; Sreenivas 2021).

During a National Emergency declared by Prime Minister Indira Gandhi in the 1970ies, the government halted elections and restricted civil rights, removed slums, and dedicated unparalleled funds for family planning framed as a development strategy. Involuntary sterilization formed an essential component of the anti-poverty initiative. During less than two years, over eight million people, predominantly poor men, had forced vasectomies. Ever since the Emergency, vasectomies have been associated with coercion and loss of masculinity. In the 1980s, tubal ligation became––and continues to be (IIPS and ICF 2021)––the most common method of contraception in India.

In the 1990s, we see the emergence of liberal humanitarianism: the reproductive rights frameworks reconceptualise population control into an ‘unmet need’ for contraception and aim to serve women who have been denied access to contraception. The Indian government consistently denies a population control narrative and emphasises the role of choice and voluntarism in family planning initiatives. But even within this liberal humanitarianism framework, reducing fertility serves as a solution to poverty (Qadeer 1998). In 2012, the Gates Foundation and other international actors launched FP2020––and later FP2030––and pledged to expand contraceptive use globally by 120 million users across the most disadvantaged regions: liberal humanitarianism and its desire to help poor women across the world continues and India has actively embraced the initiative. Even though India’s total fertility rate dropped from 6 births per woman in 1951 to replacement fertility of 2 in 2020 (Ministry of Health and Family Welfare 2022), fertility decline has not reduced the country’s focus on family planning. While the rhetorics, methods promoted, and approaches used in population control policies throughout the different decades in India were indeed very different, the Indian state remained strongly troubled by high fertility and preoccupied with reducing its population growth as a key political priority. Despite several ‘paradigm shifts’ in the approach—the key ones being the National Population Policy (NPP) 2000 and the turn to reproductive health and rights––and despite of which political alliance is in power, population question in India remains conceptualised as a problem that needs tackling (Rao 2018).

**Methods and fieldsite**

This article is based on ethnographic fieldwork I carried out in Udaipur district in Rajasthan from March 2012 to August 2013. During fieldwork, I resided in a village in Jhadol sub-district full-time for 18 months and engaged in its everyday life. I have conducted two subsequent short follow-up visits in 2015 and 2016 and continue engaging with the field on other research topics. While fieldwork focussed on the place of sterilization within reproductive and state lifeworlds, I paid attention to many other aspects of rural everyday life. Fieldwork included participant observation in at least 38 sterilization camps held weekly during the ‘sterilization season’ (Fiks 2023) in two towns in the subdistrict, regular visits to rural healthcare facilities, and occasional visits to government offices. In the sterilization camps, I was given permission to observe most bureaucratic and medical processes except surgery. Bureaucratic and medical personnel gave me explicit permission to observe various interactions in the camp. I left spaces where I felt my presence was inappropriate and positioned myself in conscious ways in different spaces so as not to impose. In the camps, I interacted primarily with community health workers, local state officials, the MSI staff––nurses, doctors, organisational supervisors, and occasional visitors from MSI offices in Jaipur and Delhi––and patients, but also occasionally with patients’ kin and staff at the community health centre where camps were held. In the village, I spent time with residents going about their daily routines and discussed their everyday lives, families, and reproductive histories in spaces ranging from the domesticity of people’s homes to public spaces of the market and various institutions: local state offices, private and public healthcare providers, NGO spaces, and other village settings.

The primary tool for data recording was fieldnotes. I took detailed notes daily, though differently in each setting. In the village, I often took short notes during the day as events and conversations unfolded and later expanded on them. In sterilization camps and other institutional settings, I took most notes as the events unfolded due to my primary role as an observer. I often took short notes during conversations with staff at the camps and expanded on them either later in the camp or after reaching home that evening. I audio-recorded some conversational interviews with key interlocutors, including camp staff, as well as some counselling sessions, with the participants’ consent. These recordings were later transcribed. Most interactions between patients and camp staff occurred in a mixture of Hindi and the local dialect, Mewari. I conducted most conversations and conversational interviews with camp staff and patients in Hindi. I wrote most fieldnotes in a mixture of English, Hindi, and occasional Mewari and Lithuanian. Conversations that appear in the fieldnotes are often written in Hindi or Mewari because they were written down during or shortly after they occurred. Most notes recollecting the day’s events and reflections are written in English. I maintained separate journals for different sites: one for sterilization camps, one for the maternity ward, and one for life in the village. I analysed fieldnotes and transcripts using thematic analysis. Repeated re-reading of the fieldnotes helped to identify key themes. This organic approach to theme development helped me interpret key aspects of the data and identify patterns across different types of data (Clarke and Braun 2016).

As a white woman conducting fieldwork in rural India while affiliated with a UK university, my positionality inevitably shaped the research process. My institutional affiliation conferred a degree of privilege and access to certain spaces, including healthcare and bureaucratic institutions, which may not have been accessible in the same way to locals. My otherness elicited different responses: curiosity in some settings, which facilitated unique opportunities for connection, and suspicion in others, particularly where my educational undertaking and lone working conflicted with gendered expectations. The initial period of fieldwork was intentionally designed to last 18 months to overcome language barriers, assumptions that my interlocutors had about me and I about them, and to build meaningful long-term relationships with both a rural community I lived in and with professionals I met during camps. Throughout the fieldwork and writing process, I have strived to remain critically aware of how my positionality intersects with broader structures of privilege, inequality, and representation and an awareness of my role within these power dynamics.

In rural southern Rajasthan, life remains precarious for most, barring a few prosperous and socially connected, mostly dominant-caste households. The area is predominantly populated by Adivasis, indigenous population groups which have been systematically oppressed in economic and social life. Adivasi communities continue carrying the label of being ‘wild’ and ‘backward’––notions that precede India’s colonial history but which have been employed in particularly violent ways by colonial officials (Guha 1999; Skaria 1997)––in state discourses and in everyday conversations in mixed-caste villages in the area where fieldwork took place. Most families are small landowners, depend on land and livestock holdings, and are considered to live Below Poverty Line. Poverty is a form of political subjectivity: people make claims to the state—for subsidised food, free healthcare, financial assistance for building houses––on the basis of being poor. Rural population here is a quintessential object of what Fassin (2011) calls humanitarian reason: the disadvantaged and dominated who elicit affect and normative action; attention to their suffering, a politics of compassion, and moral sentiments in the most general sense legitimise a distinct ‘mode of governing’ of their lives.

Marriage and motherhood are central to women’s lifeworlds in Rajasthan. The pressure to get pregnant within a year of marriage is strong; son preference is widespread. Thus, by the time most women get sterilized, they already have at least two children, often more, and almost always at least one son. Many rural women see sterilization as a form of care—ambivalent though it is—and a means to cope with their chronic reproductive suffering (Fiks 2024, Lukšaitė 2022). Rural women describe their bodies through local idioms of weakness and as being chronically ill. They experience reproduction as a form of chronic illness without an underlying biomedical pathology. This suffering, which I term ‘reproductive chronicity,’ arises from persistent and fluctuating ill health linked to adverse and ordinary reproductive events, such as pregnancies, abortions, and child loss, but also care demands, reproductive labour, and unreliable support structures within the home, and precarious socio-economic conditions. The chronic-ness and long-lasting suffering of the reproductive woman’s body is closely linked with the ill health of communities and institutions. Just like any other chronic illness, reproductive chronicity cannot be ‘cured’ and must be managed through care. Women navigate a healthcare system fraught with inadequate infrastructure and entrenched social hierarchies, seeking practical care solutions that fit their daily lives. Reproductive chronicity is helpful in understanding how women engage with sterilization (Fiks 2024). By sharing very little, if any, social information about patients and community health workers in this article, I seek to re-create the false homogeneity of these two groups of rural women which is created in the clinical settings I describe.

**The sterilization camp**

According to the latest National Family Health Survey (NFHS–5), 38 per cent of married women aged 15–49 in India have been sterilised. Tubal ligation is the most prevalent method of contraception, followed by condoms (10 per cent) and contraceptive pill (5 per cent). Half of the women who undergo sterilization have it before they turn twenty-six (IIPS and ICF 2021). Most sterilised women have at least two living children, often more. At the time of fieldwork, one-third of sterilization procedures in rural Rajasthan were conducted in camps (IIPS and ICF 2017, 63). Camps are a common setup in India, serving as temporary facilities for delivering services organized by the government, NGOs, or private companies. These camps typically offer specialized services, such as eye camps for vision check-ups, immunization camps for vaccinating children, and pension camps to assist with government pension paperwork. In rural areas, sterilization camps are organized to provide clinical teams and equipment for performing tubal ligation procedures.

In 2014, fifteen women died after undergoing tubal ligation in a sterilization camp in Chhattisgarh in central India. On this occasion, one surgeon performed tubal ligations on 83 women in one and a half hours, traces of rat poison were found in antibiotics distributed to patients, and autopsies found signs of sepsis. The Supreme Court of India ruling highlighted that 363 women lost their lives between 2010 and 2013 during or after sterilization camp surgeries. It directed the government to phase out this service delivery method within three years (‘Devika Biswas v. Union of India’ 2016). The judgment recommended replacing the camps with an alternative service delivery approach, ensuring that women provide informed consent and that clinical standards outlined in government guidelines are strictly followed to maintain quality care. Journalists report that sterilization camps continue to operate in much the same way across India, despite the Supreme Court’s ruling (Agrawal 2017; Dash 2021; Ghosh 2021; Verma 2022).

Sterilization camps that I have observed during fieldwork and that I describe in this article are not like the camps that make it into global north media and into the Supreme Court narrative, where a single surgeon, often with the single blade, operates on a hundred rural women in a few hours. The camps organised by MSI are very different settings. MSI is a subsidiary of MSI Reproductive Choices, a UK-based international NGO which provides sexual and reproductive health services, including contraception and safe abortion, in 36 countries. In 2020, Marie Stopes International was rebranded as MSI Reproductive Choices in order to distance itself from its founder Marie Stopes who was a prominent family planning advocate but whose advocacy was grounded in strongly eugenic views. The organisation today is strongly aligned with the reproductive rights discourses and advocates reproductive choice. In sterilization camps organised by MSI, a full clinical team consisting of two nurses, two clinicians—one gynaecologist/surgeon and an anaesthesiologist—and two clinical assistants travel to rural locations bringing their own clinical equipment to perform laparoscopic tubal ligations. They bring anaesthetic agents and equipment, medications for post-operative care and possible emergencies, disinfectants, dressing materials, laparoscopes, material to block uterine tubes, carbon dioxide cylinders, insufflators, personal protective equipment, and other necessary inventory. They set up in a local health centre and closely follow the standards for tubal ligation procedures set out in the government guidelines (Ministry of Health and Family Welfare 2008) and crack down on those employees who occasionally skip a prescribed step. Prior to surgery, the clinical team examines patients to ensure they are healthy: they take a full medical history, measure blood pressure, carry out blood and urine tests, respiratory examination, and a gynaecological examination. Patients can get rejected for sterilization because of low haemoglobin and glucose levels, high blood pressure, a positive pregnancy test, a recent abortion, a history of surgeries in the abdominal area, tuberculosis, or epilepsy.

Rural women come for the procedure out of their volition but accompanied by a motivator, most often a community health worker, who has worked to ‘motivate’ them for the procedure. Community health workers––auxiliary nurse midwives (ANMs), accredited social health activists (ASHAs), and Anganwadi (pre-school centre) workers––are an all-female workforce employed by the Indian state to provide maternal and reproductive health services, including family planning, to rural communities. Motivation is an ambiguous practice in these settings: community health workers can be patronising and pushy because they have unofficial yearly targets but they also care for their patients in ways that are often valued by local women (Fiks 2024; Zabiliūtė 2021) as we will now see with patient number 13.

**Conflict as ethics work**

Dr Tiwari, a gynaecologist and surgeon, rejects a patient number 13 due to a recent abortion after a conversation with her as part of the gynaecological consultation (Fiks 2024). The patient, an Adivasi woman in her late twenties/early thirties and a mother of three––two girls and one boy––has not conceived for four years since her smallest child was born. She is disappointed to be rejected for the procedure, leaves the room, and comes back with her mother-in-law advocating on her behalf. A community health worker who accompanied them also comes into the room to explain to the doctor that there was some misunderstanding due to language differences and the patient has not had an abortion. Neither the mother-in-law nor the community health worker convince the doctor to change her mind. It is quite the opposite. Both figures have been demonised in scholarship as having a lot of power over young women: community health workers for putting pressure on women to use contraception so as to implement India’s family planning policies and mothers-in-law for exercising power over young daughters-in-law’s reproductive decisions. The MSI doctor works within a reproductive rights framework––MSI Reproductive Choices is a London-based international NGO providing contraception and abortion services and associated with reproductive health and rights agenda across the world––and rejects these two powerful agents as potentially having their own interests in mind more than that of a patient. As prescribed by guidelines, she advises the patient to return to the sterilization camp the following month, after her next menstrual period. Patients are often keen to get their tubes tied on the day that they arrive at the camp: they have made care and labour arrangements at home, have made the journey from their villages to the town where the camps are held, and are mentally prepared for the procedure. Rejection and delay cause frustration.

The government official overseeing health affairs in the area, the Chief Medical and Health Officer Dr Sharma, gets involved. After he is also unable to change Dr Tiwari’s decision, he advises the rejected patient to get the procedure done in Udaipur, the nearest city. This suggestion undermines Dr Tiwari’s supposition that Dr Sharma’s involvement in the matter is simply meant to increase the numbers of sterilization operations performed at the camp. Satya Hospital––a private facility on the outskirts of Udaipur––is a common option after women get rejected in the camp. MSI clinicians say that this private hospital has lower standards of care because they conduct procedures on women with pre-existing health conditions. Community health workers, however, value that this facility promises convenience and provides what they see as hassle-free services (Fiks 2024). Convenience is something that both patients and community health workers value and seek in their daily lives (Oka 2021). The laparoscopic surgery itself is often framed as a convenient option (Fiks 2023) albeit also criticized as an instrument of a target-driven population control programme (Olszynko-Gryn 2014). The MSI nurse says: ‘At Satya, they do not do haemoglobin or urine tests, give only one injection of anaesthesia and make patients leave 15–30 min after the operation.’ MSI staff say that such practices in private healthcare settings compromise women’s health. Motivators claim that they take patients to Satya Hospital out of their ethical duties to the women. One motivator says: ‘Patients prefer going there. Some women believe that operations in the camps are performed by medical students and doctors in training.’ A distrust of free government-offered healthcare services is expressed relatively often in my fieldsite. Some people think that free generic medicine scheme distributes expired medications or that free healthcare advice in rural health centres is ineffective; many do prefer attending private practitioners who have harnessed more public trust than formal qualifications.

The camp staff are not preoccupied with dramatic ethical questions (Zizzo, Bell, and Racine 2016) and do not oppose sterilization: it is seen fundamentally as a service to rural women. However, the camp staff present varied justifications for why exactly sterilization is an ethical option for rural women. Some staff believe in the superior quality of care offered by the MSI clinical team, contrasting it sharply with the services available at private hospitals or government-run sterilization camps. Others view it as means to bring ‘development’ to this Adivasi region, labelled as ‘backward,’ through a particular modernity framework involving bodily interventions (Cohen 2005). While some advocate for Adivasi women’s reproductive autonomy, others trust the bureaucratic instrumentality outlined in government documents and follow the logic of the state. Professionals view their work as ethical because sterilization is seen as aligned with moral principles of inherently benefiting rural women. Dr Trivedi in the ethnographic vignette above prioritizes adhering to biomedical care practices, asserting that safeguarding women’s health is her main concern. Dr Sharma claims to facilitate the woman’s decision to cease childbearing promptly, respecting her reproductive autonomy. Meanwhile, the motivator emphasizes the importance of convenience for both the patient and herself. Women’s health, reproductive autonomy, and convenience emerge as some of the most powerful arguments for sterilization in these settings and effectively obscure broader powerful forces at play: population control policies that target women who have been historically, socially, and politically constructed as ‘backward’ and lacking awareness.

Despite a strong demand from the patient and those advocating on her behalf, Dr Trivedi refuses to perform the tubal ligation procedure in this instance and wants her to return for the procedure next month. Dr Trivedi questioned everyone else’s ethical basis and her biomedical reasoning outcompeted the justifications provided by the state, motivators, patients, and their kin. Staff reflected on ethics when they questioned each other’s motivation: biomedical personnel question state bureaucrats’ focus on unofficial targets; state functionaries question private hospital staff’s preoccupation with lower eligibility criteria and faster process on the one hand and MSI staff’s pre-occupation with a zealous following of biomedical guidelines; motivators question biomedical personnel’s commitment to women’s wellbeing as, from their perspective, excessive biomedical tests and checks contradicts patients’ ideas of convenience. Ethical considerations emerged in a conflict between differently institutionally positioned agents involved in the delivery of the population control programme.

The camp is organised by professionals working within different frameworks, institutional logics, and with different social statuses, all of which situate their actions and perspectives. State functionaries enjoy the comfort of a desirable government posting, often come from dominant-caste and economically privileged circumstances, and work for an apparatus––the Indian state––which has been enveloped by widespread distrust in rural areas (Jeffery and Jeffery 2010) but which is also one of the biggest spenders on social welfare programmes redistributing benefits to the country’s poorest families. The community health workers also work for the Indian state but their educational requirements and salaries are lower, they reside in or near villages in which they work attempting to become part of rural communities but who have historically been predominantly associated with family planning (Jeffery, Jeffery, and Lyon 1989; Jesani 1990). MSI employees work for a branch of an international organisation advocating for reproductive rights and justice but are most often dominant-caste people who either retired from government jobs (the clinicians) or who failed at finding government employment. Doctors are from privileged caste and class backgrounds, have high social status but low public trust, and historically do not like practicing in rural areas (Kumbhar 2022). My ethnographic data shows that all of them find each other’s positionality suspicious and potentially problematic. However, while all professionals have their individual moral reasonings––some grounded in Brahminical Hinduism, some in Catholicism, some in the government’s discourse of helping the underprivileged, some in medical and reproductive ethics––the notion that they are doing ‘good work’ is collective.

Another patient enters the examination room for the vaginal exam. The government surgeon is replacing the MSI surgeon Dr Tiwari who is on vacation. She is changing her gloves in-between examinations: she keeps one pair of gloves on all the time and changes the second pair of gloves. In the meantime, the motivator accompanying the patient tells her to lie down on the examination table: ‘Take off your underwear and put your legs like during a delivery.’ A little brown bird flies in from the corridor, does a few loops and leaves through the window––rural healthcare settings have rules and boundaries that are more flexible and permeable than healthcare contexts in the global north. The gynaecologist performs the vaginal exam and asks for a repeat pregnancy test. The patient’s uterus is enlarged, and she suspects it could be a pregnancy. The motivator explains that this patient was diagnosed with an STI in a camp two weeks ago and was given one injection ten days ago. The gynaecologist says that she needs another injection 21 days after the first one and then they should bring her for tubal ligation. The motivator says: ‘Who will bring her each time? She is ok now.’ The doctor replies: ‘No no, if there is infection in the blood, we cannot do the procedure.’ The motivator tries to convince her once again: ‘It will be ok, madam, just do it.’ The patient is officially rejected, and both the motivator and the patient leave the camp unhappy and complaining. Before they leave, the doctor suggests inserting an IUD instead of sterilization, but the motivator says the patient does not want it. After they leave, Gunjan and state functionaries discuss the situation and agree that most likely the motivator does not want to ‘lose’ the sterilization case as part of her unofficial target for the year. Once again, the rationale of differently positioned agents is questioned as part of the everyday ethics work: in such a way Gunjan and state functionaries establish community health workers as motivated by the ‘wrong’ rationale, such as demands of their jobs, while constructing themselves, by contrast, as motivated by the ‘correct’ reasons: women’s wellbeing. In a field enveloped in ambivalence and filled with heterogeneous actors, it is conflict—not collective and shared practices—that allows the everyday ethics work to be carried out. The confirmation that what the camp staff are doing is ‘good work’ emerges only through conflict when the motives of other professionals or healthcare delivery mechanisms are questioned. The collective notion of doing ‘good work’ despite diverse moral frameworks––medical ethics, the moral positioning of the Indian state, Brahminical Hinduism, or Catholic morality––is rooted in something that can transcend these diverse approaches: the view that providing sterilization to India’s poor is a form of humanitarianism.

**Disgust and the moral imperative**

The government doctor gestures with her head and arm towards the examination table on one side of the room after another patient hesitantly enters. ‘Lift the clothes,’ she says to the woman on the table. ‘Get down,’ she directs the woman a minute later, when the pelvic exam is done. These are the only words she says to most women during this clinical encounter unless there is an issue. ‘Is this number twelve?’ she says looking at the illegible characters on the woman’s inner arm, handwritten with a black marker in a hurry at the registration desk. The patient shrugs her shoulders, but her motivator affirms. After each examination, the doctor removes the top pair of plastic gloves, throws them into a rubbish bin and puts another pair of fresh gloves on: one pair would not be able to protect her from the pollution of rural women’s vaginas.

Quite often discussions on health and ethics are set within healthcare landscapes in the global north characterised by comparative resource abundance and the ‘political economy of hope’—an imaginative and affective universe where biomedical technologies and clinical expertise are generally trusted and wrapped in hope for resolution of illness, restoration of health, and kindness as a quality of relationship between patients and healers (Good 2007); a system where society sees clinicians, in line with their self-image, as fundamentally good (Brodwin 2014). Clinicians’ ethical thinking in conditions where power inequality is built into care has been discussed by scholars, for instance, in relation to psychiatrists’ power over people with psychiatric distress (Brodwin 2014). Power inequality is posed as a problem in and of itself in healthcare systems in the global north, something to come to terms with. But in rural India, power inequality in healthcare contexts is so normalised that it is rarely seen as out of place; it is a fact of everyday life in the clinic. For rural patients, paternalistic doctor-patient relationship laced with occasional disregard or ridicule was simply something doctors did; it was something that rural patients had to persevere in the moment but could disregard after exiting the clinical setting beyond which doctor’s authority rarely reached. For clinicians in India, ‘(b)eing authoritative was perceived as equivalent to being ethical in acting in the best interest of the patient’ and was rationalised ‘as necessary to maintain order in the overburdened system’ (Subramani 2018, 139). Moral imperatives sustain politically configured forms of oppression as part of the doctor-patient relationship (e.g. Ticktin 2011; Fassin 2011). It raises questions about what everyday ethics in healthcare looks like in a moral universe where violence—not hope—is built into care. Disrespectful behaviour is integral to the government’s healthcare settings and ranges from the everyday micro-inequities (Subramani 2018) to obstetric violence (Chattopadhyay, Mishra, and Jacob 2017), especially when poor patients are concerned. It is also a healthcare system, where clinicians are fundamentally powerful, not fundamentally good. There is plenty of hope too––particularly in the power that clinicians in India hold, in technologies they master, in the knowledge held by big doctors in big hospitals—but the hope is for cure, relief, solution, not for kindness. Rural women, however, have a nuanced understanding and experience of how violence is built into care and how to navigate it successfully (Fiks 2024).

Disgust is integral to clinical interactions between patients and clinicians in rural India: the gynaecologist was not the only clinician protecting herself by double-gloving. In the rural maternity ward, a clay water pot is placed for patients and their relatives. There is a separate one––inside the office––for clinicians. Often, patients’ relatives do not want to drink from the public clay pot either, because, in their view, it is meant for women who have just given birth and childbirth is considered to be one of the most ritually polluting experiences. So they ask for alternative water but clinicians refuse to share water from their pot. While they reject the ideas about childbirth pollution as ‘backward’ and something rural illiterate people believe, they do insist on not sharing water with villagers on the basis of hygiene. The hygiene rhetoric, initially employed by colonial authorities when establishing hospitals, eliminating the work of traditional midwives, or conceptualising big scale health interventions, has continued today and became another form that caste pollution takes in contemporary settings (Lüthi 2022). I have seen nurses and doctors making disgusted faces when encountering post-partum women and making sure not to hide it from patients or myself. Jullien (2017) describes many encounters where nurses and doctors in maternity care contexts expressed disgust in relation to a poor patient’s weight, pubic hair, and tattoos and calls it socio-moral disgust: the form of disgust upper-class and often dominant-caste healthcare staff experience when in contact with illiterate, underprivileged, and oppressed-caste patients.

Hodson and Costello (2007) have demonstrated that such disgust ‘is not accounted for by fear of infection, but rather is mediated by ideological orientations and dehumanizing group representations.’ Double-gloving is reportedly common in some healthcare contexts in India but the recommendations for infection prevention do not justify such use even when taking into consideration the reportedly poor quality of gloves. Double-gloving was a common practice in India at the height of the HIV/AIDS epidemic (a. khanna, personal communication, January 23, 2025) and might still be prevalent in HIV care in some parts of the country (Fernandez et al. 2022). But in the literature, it is discussed alongside other stigmatizing practices, such as using gloves during all interactions with HIV patients regardless of if physical contact occurs or burning bedding upon discharge (Nyblade et al. 2009). Double-gloving during a gynaecological examination, too, is accounted for by social fear and ideological orientations towards women marked by rurality and their oppressed-caste status rather than a fear of infection.

Not every healthcare professional related to their patients via disgust. The gynaecologist double-gloving is a government doctor temporarily replacing the MSI doctor, Dr Tiwari, due to the interconnection between state and non-state healthcare provision. Both Dr Tiwari and MSI anaesthesiologist put clear efforts in accepting the cultural ‘otherness’ of Adivasi women and treated them better than what I have witnessed from government doctors and in state healthcare contexts. But this did not extend to other MSI personnel: nurses and healthcare assistants avoided touching patients’ urine cups while performing urine tests, touched patient garments only if absolutely necessary and carefully with two fingers only, and made disgusted faces when observing various aspects of patients’ bodies and behaviour.

Disgust is ‘a physical experience […], a mode of rejection that can engage the entire body’; and it is anchored in the body in culturally specific ways (Durham 2011, 134). Disgust marks social boundaries (Douglas 2003; Lawler 2005) and is often directed by the powerful against the oppressed. In India, disgust is central in the maintenance of the caste system (Hasan, Huq, and Nussbaum 2018; Kapoor 2018; 2022; Lee 2021). Disgust functions as a modality of exclusion and solidifies ‘the affective life of hierarchy’ (Lee 2021, 311). While medical professionals in the global north settings feel shameful about and consequently suppress disgust (Vollaire 2011), disgust in India is exaggerated in front of colleagues and visitors. It does not simply maintain social boundaries but also legitimises the work that clinicians do––whether conducting hospital deliveries in rural health centres or sterilization procedures––and the tools they employ. Precisely because rural women elicit disgust from their healthcare providers, clinicians feel like the interventions they implement are undoubtedly ‘good work’, a form of social work towards the marginalised populations.

Kumbhar (2022) argues that public distrust in physicians in India lies in the dominance of individuals from dominant caste and class backgrounds in the medical profession. Thus, caste fundamentally shapes the way doctors see and connect with their patients and vice versa. For the majority of India’s poor, ‘doctors as a professional community [a]re at best alien and distant, and at worst disrespectful and “callous” ’ (Kumbhar 2022, 112). The social work that clinicians see themselves as doing does not invite reflections on their role in caste oppression, but, instead, makes them feel good about ‘helping the poor.’ Disgust, then, is an integral part of the new moral economy of suffering that Fassin proposes: a way of not only relating to suffering but also a mode of governing it (Fassin 2011). Disgust is the basis of the moral imperative that fuels the population control intervention being framed as a form of humanitarianism.

But none of this undermines the fact that this is also a form of care work: not the good, positive, idealised version of care but the care that comes through in detailed ethnographic studies showing that all care is ambivalent, that care and disregard are so closely intertwined to be inseparable (Biehl 2012; Fiks 2024; Garcia 2015; Stevenson 2014; Ticktin 2011). Fassin (2011) demonstrates that politics of inequality is a key part of all humanitarian endeavour too: there would not be humanitarian interventions if there were no distinction between the victims of suffering and those who relieve that suffering. Disgust, then, too, is an integral part of care and humanitarianism: sometimes hidden, sometimes denied, sometimes emphasised.

**Situated ethics**

After the anaesthetics take effect, healthcare assistants set up the OR, and doctors finish their tea, Dr Trivedi calls that they are ready. The first case is taken into the operating theatre; the second case is brought to wait in the corridor. A few minutes later, Dr Trivedi shouts again: ‘Bring another one.’ I squat in the corridor with women squatting in line for their turn. A woman squatting next to me is visibly and expectedly under the effects of partial anaesthesia. Gunjan approaches her and asks for her signature on one of the forms, where her signature has been missed during the registration process. The patient extends her hand and Gunjan presses her thumb into a purple ink pad and then into the blank space on the form. Copious amounts of paperwork are an integral part of the sterilization process as this is how ambivalent interventions establish evidence of ‘choice’ made by individual patients and, thus, the legitimacy of the whole programme. However, the process of obtaining women’s signatures is not important in attributing meaning to the signature: the signature does not become any more or less meaningful or any less capable of producing effects if it was obtained by someone guiding the partially conscious woman’s hand. Rural women know that paperwork has ‘serious effects *despite* being filled with arbitrary information’ or through non-uniform processes (Lukšaitė 2022, 12). The situated nature of ethics highlighted through the everyday ethics approach allows us to see such practices as not in some way ‘failing’ to live up to ‘good practice’ standards originating in the global north institutions which have the luxury of time and resources to be put in place and consistently followed. The elaborate process of creating legitimate paperwork is not part of the everyday ethics work: Gunjan sees it as a bureaucratic requirement but not as a process which contributes to making sterilization any more or less ethical on the ground.

A few minutes later, Gunjan pushes a patient out of the OR in a narrow mobile chair and squishes half of the patient’s breast back into the saree blouse. She looks around to see if others have registered her action and catches my eye. She smiles. This act of care, precisely because it was witnessed by someone else, produces Gunjan as a moral agent and makes her feel secure in the goodness of what she does and how she does it. It is neither reflexive nor embodied: it is performative. What it means to be a moral person in the world, for Gunjan, involves being seen as caring for the rural women. Bureaucratic procedures used to obtain informed consent or counselling are not seen as part of this care. If we consider everyday ethics to include ‘persistent everyday work with the different kinds of things we find important,’ (Pols 2024) then what Gunjan wants to be seen as doing—and what she skips—reflects what she considers important. Ethical decision-making is a shifting situated process rather than a premeditated individual act; such decisions are made within local constraints rather than following universal principles (Kaufman 1997), something that ‘common morality’ principlism may disagree on (Beauchamp and Childress 2009; Evans 2012). And if ethical principles are not universal but relational, then local social relations are key to understanding local ethical principles. When relationships between patients and professionals—bureaucrats, clinicians, and MSI staff—are structured around social inequalities of caste, rurality, and gender, care and violence entangle to produce effects that contribute to reproductive chronicity: care offers temporary relief but deepens chronicity in the long-term. In situations characterised by fundamental ambivalence—whether that is population control programme, doctor-patient relationship, or provision of healthcare in resource-limited settings more generally—ethics work takes local forms and does not comply with universal principles but universal principles can be pragmatically employed both by patients and professionals in achieving what they want: be it pragmatic and convenient access to contraception for patients or feel-good humanitarianism for professionals.

**Conclusion**

In this article, I interrogated the ethical-moral dimensions surrounding sterilization within the local biomedical and bureaucratic personnel perspectives and processes taking place in settings where sterilization procedures are carried out. Different forms that ethics work takes in this ambivalent context informs contemporary discussions on the everyday ethics. While the field of bioethics often focusses on rather dramatic questions, there is a call to refocus on the everyday ethics, an approach that offers relevance to wide range of everyday clinical and academic settings (Zizzo, Bell, and Racine 2016). Sterilization has been seen as a dramatic practice in the global media, particularly after the death of women in Chhattisgarh, but it is not controversial, taboo, or dramatic either in village or camp settings. And, thus, camp staff are not preoccupied with the dramatic questions about the ethics of sterilization. However, their everyday clinical work is filled with various other ethical considerations. Conflict in regard to which and whose ethical basis is the correct one is an important element of the day in the field performing sterilization procedures. However, even though all professionals have their individual moral reasonings, the notion that they are doing ‘good work’ and that there is a moral imperative to do this work is collective. The moral imperative that fuels the view that providing sterilization to India’s poor is a form of humanitarianism is grounded in disgust that healthcare workers feel towards their patients. Disgust as a social relationship between rural oppressed-caste patients and city-based often dominant-caste doctors resonates with how the Indian state itself engages with its rural populations. ‘As a practice regularly carried out by state functionaries across healthcare and other sites, [disgust] enacts––and solidifies––the state that is disgusted with its citizens’ (Fiks 2024, 134). As a state relation I have observed across various sites and institutions where state functionaries encountered rural citizens, disgust becomes one of ‘actualities of social subordination’ (Abrams 1988, 63) and is yet another form state violence can take in the everyday encounters. As a modality of exclusion closely linked to caste, the prevalence of disgust in state contexts demonstrates how the everyday state itself is integral to the maintenance of caste order in rural India.

While this article is ethnographically grounded in a very specific ethnographic context, a specific moment in time, and focuses on a particular procedure, the arguments I make may resonate with other contexts in development and global health arenas where the narrative of helping the poor legitimises interventions but often solidifies the economic and social privileges of those implementing the programmes rather than the ones benefiting from interventions. Pornography of poverty––the sensationalised portrayal of poverty in media and humanitarian fundraising contexts which exploits the suffering of the vulnerable for emotional appeal, attention, and profit––substantiates the moral imperatives to act. The shocking images of starving children or dilapidated houses aim to elicit pity, guilt, and compassion, sentiments which can foreground a moral imperative (Rorty 1998) which can materialise through donations to fundraising campaigns. Disgust is an integral affect that, together with pity, elicits normative action in these arenas too.

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