Documents that matter

Sterilization paperwork in rural India

Eva Lukšaitė
Eva Lukšaitė is a medical anthropologist teaching at the School of Medicine, Keele University. Her research and writing focus on women's everyday encounters with biomedical and state institutions and reproductive chronicity in north India. Her email is e.luksaite@keele.ac.uk.

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1. IIPS & ICF (2017: 112) state that modern methods 'include male and female sterilization, injectables, intrauterine devices (IUDs/PPIUDs), contraceptive pills, implants, female and male condoms, diaphragm, foam/jelly, the standard days method, the lactational amenorrhoea method, and emergency contraception' and exclude 'traditional methods' (rhythm, withdrawal and 'other traditional methods').

Berg, M. & G. Bowker 1997. The multiple bodies of the medical record. *The Sociological Quarterly* 38(3): 513-537.

Branagan, L. 2021. Securing health care within a 'magical' state. *Contemporary South Asia* 29(3): 401-418.

Carswell, G. & G. De Neve 2020. Paperwork, patronage, and citizenship. *JRAI* 26(3): 495-514.

Cohen, L. 2017. Duplicate. *South Asia: Journal of South Asian Studies* 40(2): 301-304.

Cole, J. & D. Durham 2007. Introduction: Age, regeneration, and the intimate politics of globalization. In J. Cole & D. Durham (eds) *Generations and globalization*, 1-28. Indianapolis: Indiana University Press.

What can sterilization paperwork tell us about women's encounters with the state in rural India? I conducted 18 months of ethnographic fieldwork on women's reproductive lives in a predominantly Adivasi (indigenous) region of Rajasthan, India, between 2012 and 2013. Some 43 per cent of rural and 35 per cent of urban married Rajasthani women undergo sterilization (IIPS & ICF 2017), otherwise known as tubal ligation, a permanent surgical procedure during which the uterine tubes are cut, blocked or tied to prevent eggs from reaching the uterus. There is a similar trend in India as a whole. In a context where 48 per cent of married women use a modern contraceptive method,[1] this difficult-to-reverse procedure is the prevalent form of contraception used by 36 per cent of married women. Half undergo the procedure by an average age of 25.7 (IIPS & ICF 2017).

During fieldwork, this operation typically took place in 'sterilization camps', which the government outsourced to Marie Stopes India (MSI) – a subsidiary of Marie Stopes International (since 2020, known as MSI Reproductive Choices). This private, not-for-profit social enterprise provides contraception and safe abortion services worldwide. This article aims to contribute to the ethnographic study of official documents (e.g. Hull 2012; Tarlo 2003) by looking at sterilization paperwork produced by a government facility in rural India as a tool to tell stories about the state and its institutions (Furmage 2016).

Sterilization in context

Unlike early 20th-century Indian economists who understood 'India's poverty as a symptom of colonial misrule', the mid-20th century saw the consolidation of the discourse that overpopulation was a cause of poverty and an obstacle to development, both in India and on a global scale (Hodges 2004: 1159). Instead of addressing the distribution of resources and access to opportunities, the primary attempt to combat increasing poverty relied on limiting population growth. Since India's independence, increasingly coercive population control programmes have been introduced on the recommendation of international funding agencies, such as the World Bank and the Population Council (Connelly 2006).

What started with couples being encouraged to use the rhythm method soon escalated to include the insertion of millions of IUDs (intrauterine devices) via mobile units and the introduction of family planning targets and incentives (Satia & Maru 1986). These changes were undertaken in the face of immense international pressure: for instance, the United States refused to provide food aid unless India introduced stricter population control measures (Connelly 2006). The number of sterilizations, mostly vasectomies, slowly increased during the 1960s and started exceeding IUD insertions.

On 25 June 1975, Prime Minister Indira Gandhi declared a national emergency (known as 'the Emergency'), which lasted until 21 March 1977. Over 21 months, the government suspended elections and civic rights, cleared slums and devoted unprecedented resources to family planning in the name of economic development. Compulsory sterilization became an official part of the poverty reduction programme, and more than eight million people, primarily men, were forcefully sterilized. Access to social welfare schemes, such as housing, water pumps and travel on public transport, alongside keeping jobs and passing exams, were conditional on the presentation of sterilization certificates that were obtained either by getting sterilized or by 'motivating' others to do so (Gwatkin 1979; Tarlo 2003). This historical period has become known as '*nasbandi ka waqt*' ('a time of vasectomies'). It is often passed off as 'a moment of madness' in India's history – a moment orchestrated by people without official posts, over-zealous bureaucrats and pressure from the international community (Tarlo 2003). This narrative spares 'the government' and allows it to continue implementing population control measures (Williams 2014).

After the Emergency, the historical trauma that enveloped vasectomies, alongside the development of laparoscopic tubal ligation techniques, meant that the focus of population control shifted from men to women. Tubal ligation has been the most prevalent method of contraception since the 1980s. Even within the reproductive rights frameworks that proliferated in the 1990s, reducing fertility continued to be seen as a solution to poverty (Qadeer 1998). During my fieldwork, almost half of rural married women in Rajasthan underwent tubal ligation, most of them in camps (IIPS & ICF 2017). Soon after fieldwork, 15 women died after undergoing the procedure in a camp in Chhattisgarh, and the Supreme Court ordered the government to shut down sterilization camps within three years. Despite this judgement, journalists report that sterilization camps continue to function throughout India (Ghosh 2021).

Sterilization certificates

After undergoing the sterilization procedure, women receive a sterilization certificate. Women would often wrap these government-issued documents in plastic bags

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Fig. 1. *CMHO and MSI staff fill in paperwork at the registration desk.*

Connelly, M. 2006. Population control in India. *Population and Development Review* 32(4): 629-667.
Corbridge, S. et al. 2005. *Seeing the state: Governance and governmentality in India*. Cambridge: Cambridge University Press.
Das, V. 2004. The signature of the state: The paradox of illegibility. In V. Das & D. Poole (eds) *Anthropology in the margins of the state*, 225-252. Oxford: Oxford University Press.
Furmage, S. 2016. A critical archaeology of documents: Analyzing plans, maps, and bureaucratic artifacts with Federico Pérez. *Fieldsights*, 26 May.
Ghosh, A. 2021. Male sterilizations simpler, but the more complicated female procedure is what India opts for. *ThePrint*, 7 September.
Gupta, A. 2012. *Red tape: Bureaucracy, structural violence and poverty in India*. Durham: Duke University Press.
— 2013. Messy bureaucracies. *HAU: Journal of Ethnographic Theory* 3(3): 435-440.
Gwatkin, D. 1979. Political will and family planning: The implications of India's Emergency experience. *Population and Development Review* 5(1): 29-59.
Hodges, S. 2004. Governmentality, population and reproductive family in modern India. *Economic and Political Weekly* 39(11): 1157-1163.
Hull, M. 2012. *Government of paper: The materiality of bureaucracy in urban Pakistan*. London: University of California Press.
IIPS & ICF 2017. *National Family Health Survey (NFHS-4), 2015-16: India*. Mumbai: IIPS.
Karmakar, R. 2019. Over 19 lakh excluded from Assam's final NRC. *The Hindu*, 31 August.
Lukšaitė, E. 2016. The intimate state: Female sterilisation, reproductive agency and operable bodies in rural North India. PhD Thesis, Brunel University London.
Mathur, N. 2012. Transparent-making documents and the crisis of implementation: A rural employment law and development bureaucracy in India. *Political and Legal Anthropology Review* 35(2): 167-185.
Messick, B. 1993. *The calligraphic state*. Berkeley: University of California Press.
Qadeer, I. 1998. Reproductive health: A public health perspective. *Economic and Political Weekly* 33(41): 2675-2684.
Satia, J.K. & R.M. Maru 1986. Incentives and disincentives in the Indian family welfare program. *Studies in Family Planning* 17(3): 136-145.

and hide them inside metal chests deep inside their houses, away from children, dust, goats and other potential sources of damage. These metal chests hold other precious possessions such as documents produced by various agencies: ration cards and land records issued by government officials, certificates of participation in NGO (non-government organization) activities, bank account documents and vehicle loan contracts.

Hull (2012) demonstrates that even the humblest bureaucratic artefacts can have huge effects. Written documents are not simply records of activities but are constitutive of social and political action (Gupta 2012). Such documents are essential for accessing benefits and making claims on the state (Branagan 2021; Carswell & De Neve 2020; Street 2012). Sterilization certificates are required in some states to access specific benefit schemes, such as financial incentives for 'parents of only daughters', which often require parents to be sterilized to be eligible – for instance, the *Bhagyalakshmi* scheme in Karnataka or *Ladli Lakshmi Yojana* in Madhya Pradesh (Sekher 2010). While there was a similar scheme operating in Rajasthan at the time of fieldwork, most households did not qualify because they had at least one son. The sterilization certificate provided no tangible benefits to women in my field site at that time.

Nevertheless, women hold on to them and keep them safe as if they consider them a precious possession. Even if currently bureaucratically futile, sterilization certificates remain long-term investments in proof necessary for engaging with the state in these rural areas (Corbridge et al. 2005). My rural interlocutors know the consequences of the document's materiality – or, indeed, its absence.

India's family planning efforts continue to be haunted by the Emergency, when sterilization certificates could be exchanged for '(b)asic amenities such as land, jobs, electricity, water and paving' (Tarlo 2003:11). No surprise, then, that even today, women should keep their sterilization certificates safely, not knowing if they may need them one day – a currently futile document may one day be needed to prove something in the unpredictable world of the state. Given their experiences, marginalized rural and urban poor cannot afford to expect the state to be predictable or reliable. The state is only predictable in its unpredictability, in that the realm of bureaucracy is often routine yet unpredictable (Hull 2012).

The state constantly demands documents as proof of all kinds and for new reasons (Srivastava 2012). For instance, the call to update the National Register of Citizens (NRC) in Assam demanded its residents produce paper proof that they or their ancestors arrived in India before 1971. An inability to provide such papers excluded almost two million people from the final list published in August 2019 (Karmakar 2019), with the dire consequence that these people were labelled 'illegal immigrants'. In the face of calls to extend NRC to other states (*The Hindu* 2018), it is not surprising that people would hold on to all kinds of documents as potential safeguards against unpredictable possibilities – you may need them one day to prove something.

Not many women in my field site can read these documents themselves, but most acknowledge their authority. The sterilization certificate is invested with the power of the written word (Messick 1993). It establishes sterilization as a bureaucratic fact that not only 'evidences' the lived truth of the sterilized body but can supersede it (Hull 2012). A sterilization certificate may not trigger processes in the present. Still, when placed with other 'paper truths' (Tarlo 2003) in plastic bags and hidden inside metal chests, it produces the state as a concrete, material, and, for most, illegible unit. It was entirely reasonable for poor, marginalized women to expect to need to provide 'paper truths' from their metal chests to further engage with this material state one day.

Paperwork in a sterilization camp

The sterilization certificate that women receive after their operation is also the product of several relationships (Luksaite 2016). It is only one of the material bureaucratic artefacts produced during the encounter between women, local state functionaries, MSI staff and biomedical personnel in a sterilization camp.

The registration process at the sterilization camp is an elaborate encounter with Indian bureaucracy. The MSI and the Chief Medical and Health Officer's (CMHO) staff wait at the registration desk in front of the community health centre (CHC) to accompany the women along with their community health workers – mainly auxiliary nurse midwives (ANMs) – to the camp. Even though official family planning targets were abandoned in 1996, many local government functionaries are expected 'to motivate' women towards tubal ligation, with ANMs bearing the highest expectations. ANMs are known as 'motivators'; the women they accompany are 'cases'.

MSI and CMHO staff register the cases and their motivators on MSI and CMHO registers. They fill out female sterilization case cards, perform pregnancy tests and wait for the MSI's surgical team to arrive from Udaipur. In a CMHO meeting hall, whose corners are covered with piles of forms, leaflets, reports and newsletters from ongoing and discontinued government schemes, they occasionally counsel women on the procedure, its effects and post-operative care. The team fill out the case card with the women's demographic data: the motivator's name, the woman's and her husband's name, village, caste, religion, education, the woman's age, number of sons and daughters and the age of the youngest child. They leave most spaces for more detailed and intimate information blank. The camp staff fill in the registers, but the motivators or camp staff fill in the case card. Motivators work in their villages long term and claim to know about the women they bring in as cases, though rarely consult the women themselves.

Women asked to sign the papers tend to giggle, showing their thumbs to indicate they want to use their thumbprint instead. Suraj (MSI supervisor of the camp and liaison between the CMHO's office, clinical team and the motivators) directed to the ANM when her case, holding an infant, indicated her thumb: 'Take the baby from her – she needs to sign'. The ANM repeated this to the woman accompanying her: '*bacca le*' ('take the child'); an order where '*le*', more than a request, signifies subordination. The camp staff open an ink box, take a woman's thumb, and press it first in purple ink and then on paper, turning pages of the case card and various registers which require numerous signatures throughout.

Women's signatures and thumbprints are essential for creating legitimate paperwork that can produce effects. Similar to how transparency in implementing the National Rural Employment Guarantee Act (NREGA) is constructed 'through the production, transaction, circulation, and exhibition of certain key documents' (Mathur 2012: 167), women's signatures are integral to the family planning programme itself. The production of paperwork 'became proof of the "legality" of the operations' (Das 2004: 240) conducted during the Emergency. Today, women's signatures stand as 'evidence' of 'choice' against the shadow of the Emergency and more contemporary concerns over the quality of care and incidents of botched procedures (Sharma 2014). To produce solid 'evidence' of 'choice', the staff press women's thumbs hard into ink and even harder onto paper and often complain that a poor-quality ink makes their job harder. The case card covered with solid purple thumb imprints

राजस्थान सरकार

चिकित्सा, स्वास्थ्य एवं परिवार कल्याण विभाग

NATIONAL RURAL HEALTH MISSION

नसबंदी प्रमाण-पत्र

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

पुत्र/पत्नी श्री ..... पता.....

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

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

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

क्रमांक .....

दिनांक .....

हस्ताक्षर चिकित्सा अधिकारी

केन्द्र/कैम्प .....

जिला .....

(मोहर)

हस्ताक्षर/अंगूठा निशानी
नसबन्दी कराने वाले का

"छोटा परिवार, सुखी व स्वस्थ परिवार"

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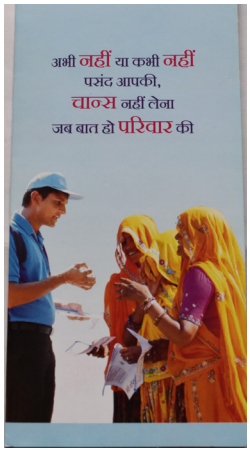

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From left to right, above to below:

Fig. 2. *A blank sterilization certificate.*

Fig. 3. *An MSI slogan at the back of the sterilization certificate: 'abhi nahi ya kabhi nahi, pasand aapki. chaans nahi lena, jab baat ho parivaar ki' (not now or never, it is your choice; don't leave it to chance when your family is concerned).*

Fig. 4. *An MSI booklet with the slogan, see Fig. 3 for transliteration and translation.*

Fig. 5. *MSI posters placed on the CHC wall in the morning of the camp.*

Fig. 6. *Repainting opening times on the CHC wall where sterilization camps are held once a week, Jhadol, Rajasthan.*

supersedes any enquiry into the conditions that situate these 'choices'.

In the same way that the state and its rules are illegible to its citizens and functionaries, the social worlds of citizens are also illegible to the state's gaze. The registration process at the camp illustrates how people's lifeworlds are translated and simplified, enabling modern institutions to 'see like a state' (Scott 1998). Suraj is filling in a form about Kanku, an Adivasi woman standing across a desk from him. After learning the number of her children, he asks, 'Your three children: how big are they?'; Kanku replies, 'Two are big, and one is small'. Trying to determine the age of the older two children, Suraj asks: 'Are you planning the marriages for the two?' Kanku laughs and says, 'No, no, they are not that big'. Suraj gets slightly impatient and asks: 'So what age are they? Are they six or four? And how small is the small one?' Kanku's motivator intervenes: 'One is four, one is two, and one is six months old'.

The disjuncture between the language of official paperwork and the language used in the village becomes apparent in this ethnographic moment. While the state bureaucracy needs to count the age of people through the numeric system of years, age and birthdays are not particularly relevant to the people in the village and, therefore, are rarely written down or celebrated. Suraj is aware that people rarely know their own or their children's chronological ages, so his question about arranging the children's marriages aims to establish if they are in their teens, which would be enough to satisfy the state's need for numeric data.

However, what is a 'big' child for Suraj is not the same for Kanku. In the eyes of the woman, 'big children' are four and two years old, whereas Suraj assumes they would be teenagers. This disjuncture is explained by how the different intersections of class, caste and rural/urban distinctions influence the understanding of childhood, children's independence, the necessity for supervision and the political economy of childbearing. Age is 'implicated in divisions of labour within and beyond households' (Cole & Durham 2007: 14), with the children's age – big or small – being defined by the care work required to attend to them by Kanku.

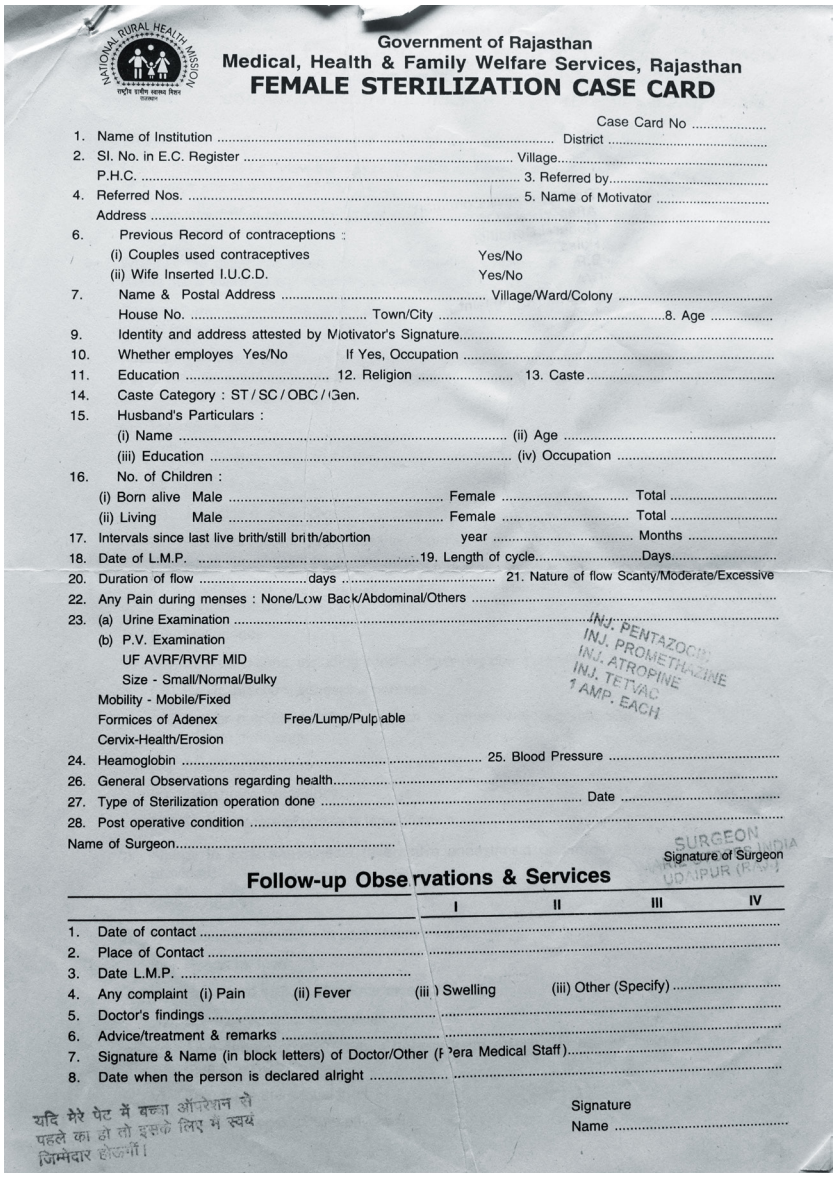
The motivator bridges the gap between state language and Kanku's, a disjuncture that often occurs in people's encounters with institutions, including the camp. Motivators sometimes translate the official jargon and categories for women and provide answers based on their knowledge about the women and their families. They shape and adjust facts to fit what the state wants to hear in order to proceed with the procedure. Kanku's 'unruly empirical world is brought into conformity with a prefabricated system of categories' (Gupta 2013: 436). The case card is replete with 'facts' that obscure their production at the interface between paperwork, women, camp staff and motivators. Kanku's case card noted her children's numeric age, hiding the process through which they established this guestimate.

Similarly, a woman's age is always an approximation by the camp staff, motivators and the women themselves, providing five-year intervals of possibility based on the women's appearance and reproductive history: '*tees–petees hogi*' ('she will be 30-35'). This renders any official statistics regarding 25.7 being the median age of women getting the procedure (IIPS & ICF 2017) an

Scott, J. 1998. *Seeing like a state*. New Haven: Yale University Press.

Sekher, T.V. 2010. *Special financial incentive schemes for the girl child in India: A review of select schemes*. UNFPA Working Papers.

Sharma, D. 2014. India's sterilization scandal. *The Lancet* 384(9961): 68-69.



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

Case Card No .....

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

INJ. PENTAZOCINE
INJ. PROMETHAZINE
INJ. ATROPINE
INJ. TETVAC
1 AMP. EACH

SURGEON
UDAIPUR (RAJ.)

Follow-up Observations & Services

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

यदि मेरे पेट में बच्चा ऑपरेशन से पहले का हो तो इसके लिए मैं स्वयं जिम्मेदार होऊंगी।

Signature
Name .....

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BBC

PUBLIC DOMAIN

PUBLIC DOMAIN

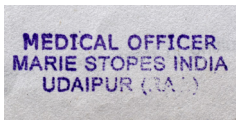

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Fig. 7. *A blank female sterilization case card.*
Fig. 8. *India's family planning is haunted by a dark history of sterilisations, BBC Asia, a screenshot of a Twitter post.*
Fig. 9. *Marie Stopes in her laboratory, 1904.*
Fig. 10. *Birth control clinic in caravan, with nurse. Wellcome Collection.*
Fig. 11. *An ink stamp of Medical Officer, MSI, imprinted on the case card.*

arbitrary, even magical number. Magic numbers based on magical signatures on magical paperwork: the unforeseen potentialities of sterilization certificates feed the state's magic, with illegibility, uncertainty and arbitrariness being their key features (Cohen 2017; Das 2004; Gupta 2012).

The case card serves several functions within the camp. It is not only a tool of the state, enabling its functionaries to produce tables and data sets, present them in monthly meetings and keep their copies in archives afterwards. From the registration desk to the operating room, the case card circulates to, in the end, serve as a secure medical record. No trust is placed in the women themselves to handle this document. Instead, their motivators carry the case card as they accompany their cases through different medical examinations.

After each examination – blood and urine tests, medical history, blood pressure measurement and a consultation with a gynaecologist – biomedical personnel inscribe their findings at the top of the card, thus enabling cases to proceed smoothly to the next stage. The case card – or a collaboratively constructed patient file – facilitates the connections between multiple bureaucratic and medical encounters (Berg & Bowker 1997). Carefully checked and double-checked at every meeting, the case card allows doctors to act, leading up to the final step –opening the doors to the operating room for the laparoscopic tubal ligation to be performed.

Conclusion

Sterilization paperwork encapsulates some of the ambiguities that bureaucratic artefacts contain. Rural women, bureaucrats and clinical staff know that documents have serious effects. The case cards enable women to get their tubes tied, the registers demonstrate that women get sterilized voluntarily and the sterilization certificates may provide access to state benefits. They also know that these documents have serious effects *despite* being filled with arbitrary information, futility and potentiality. The magical modes of the state manifest through its documentary practices and are further maintained by the way women engage with bureaucratic artefacts in their homes. While continuously producing the state as a concrete and material object, bureaucratic modes of engagement between rural women, health workers, bureaucrats and paperwork demonstrate the routine unpredictability and arbitrariness at the heart of state bureaucracy. These aspects of illegibility maintain the aura of authority in a world where documents have the potential to supersede reality (Hull 2012), especially in a programme haunted by a history of coercion. ●

Srivastava, S. 2012. Duplicity, intimacy, community: An ethnography of ID cards, permits and other fake documents in Delhi. *Thesis Eleven* 113(1): 78-93.

Street, A. 2012. Seen by the state: Bureaucracy, visibility and governmentality in a Papua New Guinean hospital. *The Australian Journal of Anthropology* 23(1): 1-21.

Tarlo, E. 2003. *Unsettling memories: Narratives of the Emergency in Delhi*. Berkeley: University of California Press.

The Hindu 2018. Extend NRC to all states and seal border: Sonowal. 11 September.

Williams, R. 2014. Storming the citadels of poverty: Family planning under the Emergency in India, 1975-1977. *The Journal of Asian Studies* 73(2): 471-492.