BODY IN TRANSITION: AN ETHNOGRAPHIC STUDY OF HYSTERECTOMIES AMONG WOMEN LABORERS IN RURAL MAHARASHTRA

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Certificate

This is to certify that the thesis entitled 'Body in Transition: An Ethnographic Study of Hysterectomies among Women Laborers in Rural Maharashtra' being submitted by Neymat Chadha to the Department of Humanities and Social Sciences, Indian Institute of Technology Delhi, for the award of Doctor of Philosophy is the record of the bonafide work carried by her under my supervision. In my opinion, the thesis has reached the standards of fulfilling the requirements for submission relating to the degree.

The contents of the thesis have not been submitted in part or full, to any other university or institute for the award of any degree or diploma.

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Abstract

This thesis brings to the fore a series of questions, dilemmas, and poignant realities of the 'local biologies' of female agricultural labourers who have undergone early age hysterectomies in rural Maharashtra. Through an ethnographic exploration of the voices of these women's experiences, this thesis aims to examine how and why the bodies of women from marginalised caste groups are predisposed to disaggregation through hysterectomies. It further explores how these procedures are *presented by* health practitioners and *perceived by* women as signposts of the imaginary 'good life', driven by the hope of increasing the potency of their bodies and those of their families and yet, how these perceived potencies can be fatal and present life-altering risks. I am particularly interested in how the 'disposability' of the uterus after tubal ligation or sterilisation is yielded to fit into the capitalist ethos of 'care' beyond the space of the clinic. I further elucidate how hysterectomies are veiled under the promise of 'cure' and 'treatment' and highlight the processes, fluctuations and compulsions across the life course of women that transform the removal of the uterus as a part of the 'normal' body. In doing so, my thesis brings to the fore three analytical lenses: bioviability, pragmatic investment, and filial operability, to examine how this notion of 'normality' through early hysterectomies, I argue, seeks to secure a stable and liveable present while remaining shadowed by the inevitable risk of prolonged illness and eventual death in the future; a future that is uncertain, improbable, and possible only when the present is secured.

At the core of this thesis is a key question that aims to unravel the linkages between the economy of female labourers' bodies in capitalist agrarian systems and women's medical subordination across the life course which becomes starkly evident through hysterectomies. I

aim to explore the practices that render the bodies of female sugarcane cutters 'bioavailable' and 'operable' which often leads these women to make what I refer to as "pragmatic investments" in the form of early age hysterectomies. This becomes particularly relevant as most female sugarcane cutters in Maharashtra belong to marginalised caste groups, such as Vanjari, Mahar, and Mang. I am especially interested in exploring the intersections of caste, gender, labour practices, and health. It is crucial to not only focus on reproductive chronicity made evident through sterilisation or hysterectomies but also chronicity of the life course, particularly for women from marginalised caste groups, who as evident, are more often subjected to hysterectomies.

Employing an ethnographic approach, I utilised what MSA Rao refers to as a method of double-ended studies to trace the life course of female sugarcane cutters both at the place of origin (home village) followed by the eventual seasonal migratory destination of cane cutters (migratory site). According to Rao, a processual understanding of migration helps trace migration processes at the village of origin and understand why some people migrate and some do not, even though they are similarly situated. Ethnographic fieldwork was conducted between May 2022 and May 2023 in different parts of Maharashtra. My fieldwork focused on three regions: Beed district, Kolhapur and Solapur. Two villages within the drought-prone Marathwada belt of Maharashtra, which I call Ariwadi and Kodewadi, were the primary field sites for my research. The first phase of the ethnographic fieldwork focused solely on the villages. In the second phase, the study encompassed these villages alongside sugar factories, sugarcane farms, private clinics, and hospitals across the state's Western sugarcane belt. Ariwadi is predominantly inhabited by the Vanjari caste group, which has nomadic origins in the State of Rajasthan and is officially recognised as Other Backward Classes (OBC) in Maharashtra. Kodewadi has a mixed population of Mahar and Mang castes. Both villages are home to sugarcane cutters, predominantly. Most families in these two villages, except a few,

migrate for six months annually to work as sugarcane cutters in the booming sugarcane belt of the western part of the state.

Moving beyond the conventional image of the detached observer, my ethnographic research in Ariwadi and Kodewadi sought to privilege a reciprocal exchange of personal narratives, a task that is often complex and fraught with practical challenges. The aim, ultimately, was a "good enough" ethnography that preserves narrative integrity and remains answerable to participants whose lives have been repeatedly rendered bioavailable for labour and intervention. It is through this that I note, we became individuals sharing a common space, our lives intertwined through the threads of conversation. This mutual engagement challenged the notion of anthropological knowledge as passively 'extracted' from unsuspecting informants. Instead, it emerged organically through dialogues and interactions, acknowledging the researcher's and participant's inherent subjectivity. This commitment to reciprocity became particularly poignant when faced with the raw vulnerability of young women's narratives. Hearing stories of infant deaths at factory sites, miscarriages, hysterectomies' long-term impacts, and forced marriages to men five times their age, the pretence of objective neutrality became untenable. How could one remain detached when the research offered no tangible benefit to their lives, merely documenting responses deemed necessary for the academic project while dismissing the unsaid as irrelevant? This compelled me to reconsider how research participants perceive the ethnographic process and what they hope to gain from it– wherein women's voices transcend the sterile realm of academic analysis, just as their hopes for a better life, once shared with media personnel, transcended empty promises.

This thesis positions itself within new inquiries into the emerging biosocial dimensions of the commodification of bodies and bioethics. Its aim is to contribute to a new generation of anthropological research that explores the socio-cultural, political, and economic dimensions of emerging biotechnologies and bioethics. While extensive literature in the anthropology of

the body has focused on the links between the capitalist economy and women's reproduction, the impact of biotechnological and surgical interventions on women's bodies in the labour process has been largely overlooked. This thesis aims to bridge the gap between medical anthropology, which centres on clinical aspects, and the anthropology of work, which focuses on farms and factories. I further extend the analysis to the often-overlooked intersection of rural poverty and market forces, particularly where the removal of the uterus has become a precondition for the survival of rural women. By exploring the violent entanglement between social reproduction and productive labour, I aim to bring the everyday realities of rural women in Beed to a broader audience, both within and beyond social anthropology.

सार

यह शोध प्रबंध ग्रामीण महाराष्ट्र में उन महिला कृषि मज़दूरों की 'स्थानीय जैविकताओं' से जुड़े प्रश्नों, दुविधाओं और मार्मिक वास्तविकताओं को सामने लाता है, जिन्होंने कम उम्र में गर्भाशय-उच्छेदन (हिस्टरेक्टॉमी) करवाया है। इन महिलाओं के अनुभवों की आवाज़ों का नृवंशविज्ञानात्मक चित्रण करते हुए, यह शोध प्रबंध यह जांचने का प्रयास करता है कि हाशिए पर स्थित जाति समूहों की महिलाओं के शरीर क्यों और कैसे हिस्टरेक्टॉमी के माध्यम से विखंडन के लिए प्रवृत्त होते हैं। यह आगे यह भी खोजता है कि स्वास्थ्यकर्मियों द्वारा इन प्रक्रियाओं को कैसे प्रस्तुत किया जाता है और महिलाएं इन्हें 'अच्छे जीवन' के काल्पनिक संकेतक के रूप में कैसे देखती हैं—एक ऐसा जीवन जो उनके और उनके परिवारों के शरीर की क्षमता बढ़ाने की आशा से प्रेरित है, जबकि ये कल्पित क्षमताएं घातक हो सकती हैं और जीवन-परिवर्तनकारी जोखिम प्रस्तुत कर सकती हैं। मैं विशेष रूप से इस बात में रुचि रखता हूँ कि नसबंदी (ट्यूबल लिगेशन) के बाद गर्भाशय की 'निष्प्रयोज्यता' को कैसे पूंजीवादी 'देखभाल' के सिद्धांत में फिट किया जाता है, जो क्लिनिक की सीमाओं से परे है। मैं यह भी स्पष्ट करता हूँ कि हिस्टरेक्टॉमी को 'इलाज' और 'उपचार' के वादे के तहत कैसे छिपाया जाता है और यह दिखाता हूँ कि महिलाओं के जीवन-क्रम में कौन-सी प्रक्रियाएँ, उतार-चढ़ाव और मजबूरियाँ गर्भाशय को हटाने को 'सामान्य' शरीर का हिस्सा बना देती हैं। ऐसा करते हुए, मेरा शोध प्रबंध तीन विश्लेषणात्मक दृष्टिकोण प्रस्तुत करता है: जैव-जीवनीयता, व्यावहारिक निवेश, और पारिवारिक संचालनशीलता, ताकि यह समझा जा सके कि यह 'सामान्यता' की धारणा वर्तमान को स्थिर और रहने योग्य बनाने का प्रयास करती है, जबकि यह भविष्य में लंबी बीमारी और अंततः मृत्यु के जोखिम की छाया में रहती है—एक ऐसा भविष्य जो अनिश्चित, असंभव और केवल वर्तमान के सावधानीपूर्वक संरक्षण के माध्यम से प्राप्त किया जा सकता है।

इस शोध प्रबंध के केंद्र में एक प्रमुख प्रश्न है जो राज्य-आयोजित पूंजीवादी कृषि प्रणालियों में महिला मज़दूरों के शरीर की अर्थव्यवस्था और उनके जीवन-क्रम में चिकित्सा अधीनता के बीच संबंधों को उजागर करने का प्रयास करता है, जो हिस्टरेक्टॉमी के माध्यम से स्पष्ट हो जाता है। मैं उन प्रथाओं का पता लगाना चाहता हूँ जो महिला गन्ना मज़दूरों के शरीर को 'जैव-उपलब्ध' और 'संचालनशील' बनाती हैं, जो अक्सर इन महिलाओं को कम उम्र में हिस्टरेक्टॉमी जैसे "व्यावहारिक निवेश" करने के लिए प्रेरित करती हैं। यह विशेष रूप से प्रासंगिक है क्योंकि महाराष्ट्र में अधिकांश महिला गन्ना मज़दूर वंजारी, महार और मंग जैसी हाशिए पर स्थित जातियों से आती हैं। मैं जाति, लिंग, श्रम प्रथाओं और स्वास्थ्य के अंतर्संबंधों का पता लगाने में विशेष रुचि रखता हूँ। यह न केवल नसबंदी या हिस्टरेक्टॉमी के माध्यम से प्रकट होने वाली प्रजनन संबंधी दीर्घकालिकता पर ध्यान केंद्रित करना महत्वपूर्ण है, बल्कि महिलाओं के पूरे जीवन-क्रम में दीर्घकालिक समस्याओं पर भी विचार करना आवश्यक है, विशेष रूप से उन महिलाओं के लिए जो हाशिए पर स्थित जाति समूहों से आती हैं और जिन्हें अधिकतर हिस्टरेक्टॉमी का सामना करना पड़ता है।

नृवंशविज्ञानात्मक दृष्टिकोण अपनाते हुए, मैंने एम.एस.ए. राव द्वारा संदर्भित डबल-एंडेड अध्ययन की विधि का उपयोग किया ताकि महिला गन्ना मज़दूरों के जीवन-क्रम को उनके मूल स्थान (गाँव) से लेकर गन्ना मज़दूरों के मौसमी प्रवासी गंतव्य (प्रवासी स्थल) तक खोजा जा सके। राव के अनुसार, प्रवासन की प्रक्रियात्मक समझ गाँव में प्रवासन प्रक्रियाओं का पता लगाने और यह समझने में मदद करती है कि कुछ लोग क्यों प्रवास करते हैं और कुछ क्यों नहीं, जबकि वे समान परिस्थितियों में होते हैं। नृवंशविज्ञानात्मक क्षेत्रकार्य मई 2022 से मई 2023 के बीच महाराष्ट्र के विभिन्न हिस्सों में किया गया। मेरा क्षेत्रकार्य तीन क्षेत्रों पर केंद्रित था: बीड़ जिला, कोल्हापुर और सोलापुर। महाराष्ट्र के सूखा-प्रवण मराठवाड़ा क्षेत्र की दो गाँवें, जिन्हें मैं अरिवाड़ी और कोडेवाड़ी कहता हूँ, मेरे शोध के प्राथमिक क्षेत्र स्थल थे। नृवंशविज्ञानात्मक क्षेत्रकार्य का पहला चरण केवल गाँवों पर केंद्रित था। दूसरे चरण में, अध्ययन में इन गाँवों के साथ-साथ चीनी कारखानों, गन्ना खेतों, निजी क्लीनिकों और राज्य के पश्चिमी

गन्ना बेल्ट के अस्पतालों को शामिल किया गया। अरिवाड़ी मुख्य रूप से वंजारी जाति समूह द्वारा आबाद है, जिसकी उत्पत्ति राजस्थान में घुमंतू रही है और महाराष्ट्र में इसे आधिकारिक रूप से अन्य पिछड़ा वर्ग (ओबीसी) के रूप में मान्यता प्राप्त है। कोडेवाड़ी में महार और मंग जातियों की मिश्रित आबादी है। दोनों गाँव मुख्य रूप से गन्ना मज़दूरों के घर हैं। इन दो गाँवों में अधिकांश परिवार, कुछ को छोड़कर, राज्य के पश्चिमी हिस्से के उभरते गन्ना बेल्ट में गन्ना मज़दूर के रूप में काम करने के लिए हर साल छह महीने के लिए प्रवास करते हैं।

अलग-थलग पर्यवेक्षक की पारंपरिक छवि से आगे बढ़ते हुए, अरिवाड़ी और कोडेवाड़ी में मेरा नृवंशविज्ञानात्मक शोध व्यक्तिगत कथाओं के पारस्परिक आदान-प्रदान को प्राथमिकता देने का प्रयास करता है, जो अक्सर जटिल और व्यावहारिक चुनौतियों से भरा होता है। अंततः उद्देश्य एक "पर्याप्त अच्छा" नृवंशविज्ञान था जो कथात्मक अखंडता को संरक्षित करता है और उन प्रतिभागियों के प्रति उत्तरदायी रहता है जिनके जीवन को बार-बार श्रम और हस्तक्षेप के लिए जैव-उपलब्ध बना दिया गया है। हम ऐसे व्यक्ति बन गए जो एक साझा स्थान साझा कर रहे थे, हमारे जीवन बातचीत के धागों के माध्यम से आपस में जुड़े हुए थे। यह पारस्परिक जुड़ाव मानवशास्त्रीय ज्ञान की उस धारणा को चुनौती देता है जिसे अनजान सूचनादाताओं से निष्क्रिय रूप से 'निकाला' जाता है। इसके बजाय, यह संवादों और अंतःक्रियाओं के माध्यम से स्वाभाविक रूप से उभरा, शोधकर्ता और प्रतिभागी की अंतर्निहित व्यक्तिपरकता को स्वीकार करते हुए। यह पारस्परिकता के प्रति प्रतिबद्धता विशेष रूप से तब मार्मिक हो गई जब युवा महिलाओं की कथाओं की कच्ची संवेदनशीलता का सामना करना पड़ा। कारखाना स्थलों पर शिशु मृत्यु की कहानियाँ, गर्भपात, हिस्टरेक्टॉमी के दीर्घकालिक प्रभाव और पाँच गुना बड़े पुरुषों से जबरन विवाह सुनते हुए, वस्तुनिष्ठ तटस्थता का दिखावा असहनीय हो गया। जब शोध उनके जीवन में कोई ठोस लाभ नहीं देता, केवल शैक्षणिक परियोजना के लिए आवश्यक माने गए उत्तरों को दर्ज करता है और अनकहे को अप्रासंगिक मानता है, तो कोई कैसे अलग रह सकता है? यह मुझे यह पुनर्विचार करने के लिए मजबूर करता है कि शोध प्रतिभागी नृवंशविज्ञानात्मक प्रक्रिया को कैसे देखते

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Introduction

I met Vijaymala[1] *for the first time when she was coming from the fields with her husband, sitting on a bullock car at her home village I call Ariwadi. As she saw me walk past, she called out, "Madam, come home tomorrow. I will make gud vali chai (tea made from jaggery) for you". The next day, as we sipped tea, sitting in her house made of tin sheets, Vijaymala abruptly got up, went to the corner of the room and began searching through an old, rusted steel trunk. Frustrated, she came to me with a pishvi*[2] *(bag) full of papers and sat beside me. Since she could not read, she handed me every paper she could find, including a brochure of a standing fan, a pamphlet endorsing IVF treatment from a private hospital, and documents of her husband's motorcycle, among others. Yet, there were no reports of her hysterectomy or any other medical procedure she had undergone. Repeatedly trying to reach her lower back to ease the pain, she added,*

> *"Tai, we leave our homes for six months yearly. Even if I had some reports, they might have been misplaced during travel. But I know when I asked the doctor for the report for my pishvi* (uterus)*, he said why do you need it now? I have removed it successfully."*

Vijaymala, now in her early 30s, has cut sugarcane since she was seven years old–earlier accompanying her parents and now as a part of the koyta with her husband. Married at the age of 12, a month after her first padi (menstrual cycle), Vijaymala had her first pregnancy within months of marriage. With tears in her eyes, holding on to the corner of her saree, she recalls,

> *"I must be in the fifth month of my pregnancy. I had come back from cutting cane around 10 PM at night. I walked to the kopi to pick a stack of wood for fuel. As I bent to pick*

[1] Pseudonym

[2] *Pishvi* refers to both a uterus and bag in the local Marathi dialect.

them up, I felt this unbearable pain in my abdomen, and as I looked down, my legs were already full of blood."

Vijaymala, who weighed not more than 40 kg then, was rushed to the nearby private clinic by her husband and father-in-law on a motorcycle. This was the case of her first miscarriage a few months before she turned 13. Within the next two days, Vijaymala was back to cutting cane. Two months after her miscarriage, Vijaymala had her second conception. With little to no time to rest, she recalls working 18 hours a day, most days, until the day before her delivery. During her third trimester, just two weeks before her delivery, Vijaymala experienced severe swelling all over her body. Her husband called her parents and asked them to admit her to a private hospital as they could not secure a bed in a government hospital, and her husband refused to pay for a private hospital. Doctors speculated that she developed severe food poisoning from eating stale and rotten food at the factory site.

After being admitted for a week, the doctors informed her family that she should be admitted till she does not go into labour. However, with mounting bills from the hospital, Vijaymala forced her parents to get her discharged. The next day after her discharge, she was back to cutting cane. Within a week, she had delivered a baby through a caesarean. With a gap of one year between each pregnancy, by the age of 19, Vijaymala, now a mother of four, had experienced another miscarriage and a sex-based abortion. Soon after her last delivery, she underwent tubal ligation in a government hospital. A few months after the procedure, while carrying a bucket of water from a borewell, Vijaymala experienced acute stomach pain again.

In days that followed, she recalls, "The blood just did not stop. I had never experienced padi(menstruation)like this. I kept changing a cloth every 2 hours.". With no hospital or clinic at a 21 km stretch from Ariwadi, she and her husband hired a jeep for INR 2000 and consulted a private doctor. The doctor performed sonography and informed Vijaymala that her 'uterus

had gone bad'. She was also informed about an appendix–which, according to the doctor, required her to undergo surgery to remove both her appendix and her uterus, or she would not be able to survive for more than a week to ten days. The next day, she underwent both surgeries– a pan hysterectomy (removal of the uterus and both ovaries) and removal of her appendix which cost her INR 35,000.

Within a week of the two surgeries, it was time to migrate to the cane fields and like every other hospital encounter in the past, she was back to cutting cane soon after.

> *"Tai, where do you think the money for my pishvi came from? We had to take an additional advance (uchal) from the mukadam (local cane contractor). Now, we have to pay it off. If I do not cut cane, we will be in debt. What will happen to my children? Who will feed them? Who would have worked in the field with that bleeding every day? One does not have time to wait for medicines to work."*

To manage the everyday pain, she has tied a small bag made of a handkerchief on her saree– filled with un-prescribed painkillers, which she continues to consume for a decade every time she suffers a bout of unbearable pain and at the same time, cautious of the medicines getting finished and fearing renting paying INR 2000 to travel to the nearby chemist to buy more tablets. Now, Vijaymala, who weighs 77 kgs, has developed three kidney stones, two in her kidney, measuring 3mm and 7mm and one in her urinary tract, measuring 4mm, for which the doctor has recommended surgery. Alongside, she has diabetes, hepatomegaly (enlarged liver) with grade 2 fatty liver and high blood sugar levels, surpassing 290.

Vijaymala' s narrative above, like the many voices of women in this thesis, brings to the fore a series of questions, dilemmas, and poignant realities of the 'local biologies' of female agricultural labourers who have undergone early age hysterectomies[3] in rural Maharashtra

[3] Early age hysterectomies refers to the removal of the uterus before 45 years of age (Desai et al., 2019, 2024).

(Lock, 2006). Through an ethnographic portrayal of the voices of these women's experiences, this thesis aims to examine how and why the bodies of women, from marginalised caste groups are predisposed to disaggregation[4] through hysterectomies. It further explores how these procedures are *presented* by health practitioners and *perceived* by women as signposts of the imaginary 'good life', driven by the hope of increasing the potency of their bodies and those of their families and yet, how these perceived potencies can be fatal and present life-altering risks. I am particularly interested in how the 'disposability' of the uterus after tubal ligation (referred to sterilisation thereafter) is yielded to fit into the capitalist ethos of 'care' beyond the space of the clinic. I further elucidate how hysterectomies are veiled under the promise of 'cure' and 'treatment' and highlight the processes, fluctuations and compulsions across the life course of women that transform the removal of the uterus as a part of the 'normal' body. In doing so, my thesis brings to the fore three analytical lenses: bioviability, pragmatic investment, and filial operability, to examine how this notion of "normality", I argue, seeks to secure a stable and liveable present while remaining shadowed by the ongoing risk of prolonged illness and eventual death in the future; a future imagined as uncertain, improbable, and attainable only through the careful preservation of the present.

Globally, the incidence per 100,000 women varies widely across countries, with Denmark reporting a rate of 173/100,000 women, Germany with 295/100,000 women, and the United States of America (USA) with 510/100,000 women having undergone hysterectomies (Desai et al., 2019; Merrill, 2008). Similarly, China reported an estimated 3.3% prevalence of hysterectomies among women aged 25-69 years, with a mean age of 44 years (Hassan et al., 2024; Liu et al., 2017; Madueke-Laveaux et al., 2021). In India, nearly 10% of women undergo a hysterectomy by the age of 50, with the median age for the procedure being 37 years,

approximately a decade earlier than the average age of natural menopause, which is 48 years (Desai et al., 2019). In India, over two thirds of early age hysterectomies are performed in private healthcare facilities. While among women aged 30-39 and 15-29, 71.3 and 65.7% of hysterectomies respectively are performed in private facilities, for women between 40-49, this prevalence rises is 66.6% (Desai et al., 2019). However only 34.3% of women aged 15-29 underwent hysterectomies in public facilities.

Studies conducted in India show that the self-reported reasons for hysterectomy among women vary by age but reveal consistent patterns (Desai, 2016; Desai et al., 2019). According to Desai et al. (2016, 2019), the most common reason for undergoing the procedure is excessive menstrual bleeding or pain, reported by 51.2% of women aged 15-29, 54.8% of women aged 30-39, and 56% of women aged 40-49. The second most frequent reason is the presence of fibroids or cysts, with prevalence increasing with age (14.2% in the 15-29 age group, 17.9% in the 30-39 age group, and 20.7% in the 40-49 age group). Uterine disorders, such as rupture, account for 13.3% of cases in the youngest group, increasing to 14.9% among those aged 30-39 before slightly declining to 13.4% in the oldest group. The incidence of cancer as a reason for hysterectomy decreases slightly with age, with reports of 6.2% in the 15-29 age group, 5.9% in the 30-39 age group, and 5.3% in the 40-49 age group. Uterine prolapse is noted by 7.9% of women aged 15-29, peaking at 8.9% in the 30-39 age group and then declining to 7.3% for women aged 40-49. Severe postpartum haemorrhage is a less common indication, decreasing from 5.0% in the youngest group to 3.2% in the oldest(Desai et al., 2019).

For over a decade, activism and advocacy regarding hysterectomies have been ongoing in various states, including Rajasthan and other high-prevalence areas (Chaudhuri, 2013; Prayas, 2013). In 2023, India launched the National Guidelines on Preventing Unnecessary Hysterectomy, aimed at improving the quality of gynaecological care (*Dr. Narendra Gupta v. Union of India and Others; Writ Petition (Civil) No 131 of 2013*, 2023; Ministry of Health &

Family Welfare, 2023). These guidelines include the monitoring of hysterectomy rates at national, state, and district levels, especially for women under 40; standardised treatment protocols for prevalent gynaecological issues like abnormal uterine bleeding and fibroids to avoid unnecessary procedures; and recommendations for better outreach and primary healthcare to address women's gynaecological needs. However, in 2019, Beed, a drought-prone district in the Marathwada region of Maharashtra, gained media attention (Chatterjee, 2019; Express News Service, 2019; Shelar, 2019). While Maharashtra is not among the top five states in India for hysterectomy prevalence, a series of reports revealed a shocking increase in the number of hysterectomies among female sugarcane cutters in Beed. A study commissioned by the Maharashtra State Commission for Women in 2018 found that 36% of female sugarcane labourers in the state had undergone hysterectomy procedures (Chadha, 2020; Express News Service, 2019). A 2019 study indicated that over 13,000 sugarcane cutters had undergone early age hysterectomies with 8.6% of female sugarcane cutters across eight districts in Maharashtra, including Beed, having undergone hysterectomies, four times higher than the state average of 2.6%, according to the National Family and Health Survey-4 (Mulye, 2019). This alarming trend prompted the National Commission for Women to issue a notice to the Maharashtra state government, leading to the formation of a committee to monitor the high rate of hysterectomies among female sugarcane cutters in the district.

While Maharashtra as a state is not unique regarding early-age hysterectomies in India, district-level data shows a worrying pattern. Based on the National Family and Health Survey 2015-16(NFHS-4) data, early hysterectomy rates are troubling compared to districts with little to no seasonal migration connected to sugarcane farming (see Figure 1.1 and Figure 1.2). For example, districts like Jalna, Latur, and Beed, where sugarcane cutters migrate annually, the hysterectomy rates are evidently higher, for instance, 9.86% in Beed and 10.17% in Latur among women aged 40-49. Similarly, districts such as Kolhapur, Solapur, and Sangli, where

sugarcane cutters migrate to annually, also show high hysterectomy rates, as high as 19.63% in Kolhapur and 13.43% in Sangli for women aged 40–49. Similarly, for women between 15-49, Kolhapur and Sangli report 6.93% and 5.58% hysterectomy rates respectively. The correlation between women involved in agricultural labour, seasonal migration and early-age hysterectomies highlighted by these trends emphasises the need for an ethnographic exploration of both biological and non-biological factors contributing to these procedures.

Figure 1.1
Prevelance of hysterectomy (15-49) in Maharashtra(NFHS-4)

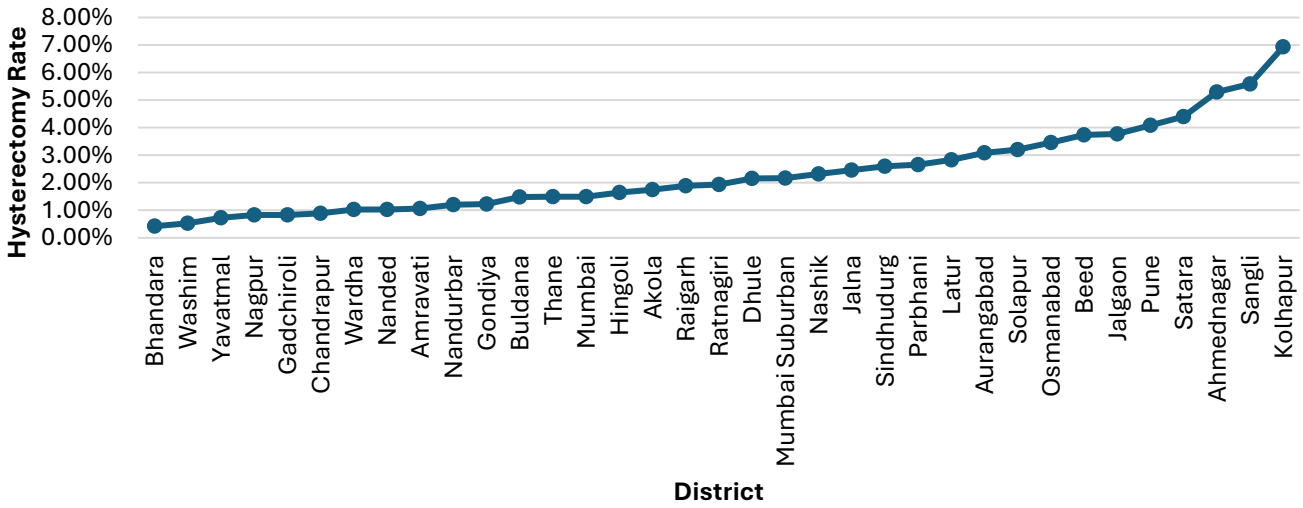
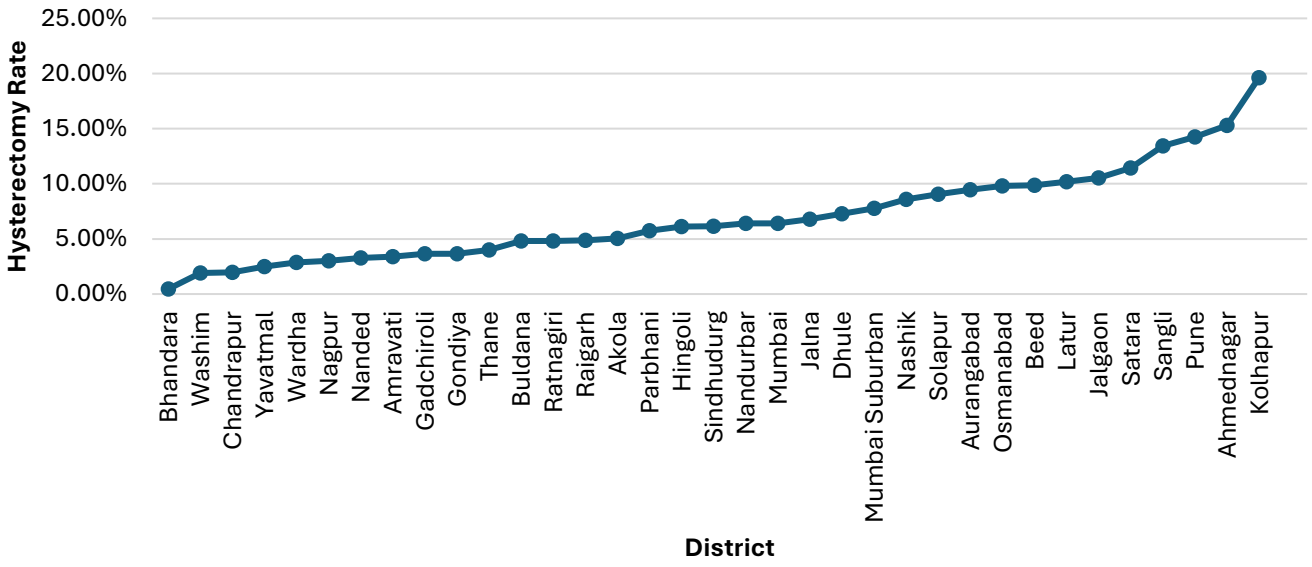


Figure 1.2
Prevelance of hysterectomy (40-49) in Maharashtra(NFHS 4)



The provocative nature of the womb has been central to contemporary social thought, and its significance continues in Indian reproductive history and politics (Neyer & Bernardi, 2025; Prasad, 2008; Sreenivas, 2021). Most existing sociological and anthropological research on the uterus or womb has focused on surrogacy and motherhood (Hodges & Rao, 2016; Majumdar, 2018b, 2018a; Rudrappa, 2015; Vora, 2009, 2015).Studies on women's health have predominantly centred on reproductive issues such as sterilisation, menstruation, menopause, childbirth, and fertility or infertility (Chaparro-Buitrago, 2022; Fiks, 2023; Hollen, 2003; Lock & Kaufert, 2001; Luksaite, 2016; Luksaite, 2022; Melby et al., 2005; Pinto, 2008; Ram, 2013; Syamala & Sivakami, 2005; Tarlo, 2000).

However, there is little work on both, the implications of the absence of the uterus and its relationship to the overall health of women throughout their lives In this thesis, I argue that the uterus should not be perceived or studied as a self-evident object of analysis; rather, it requires examination of how perceptions surrounding it evolve at different life stages, influenced by various stakeholders, including families, healthcare providers, and the women themselves. This

calls for a life-course approach that considers early life factors, events such as early marriage and the interplay of social, biological, cultural, familial, and economic elements affecting attitudes toward hysterectomies and life afterwards, including the prevalence of non-communicable diseases (NCDs), as part of the investigation (Gupta, 1995; Kuh & Hardy, 2002; G. Mishra et al., 2023; G. D. Mishra et al., 2010; G. D. Mishra & Sarah E, 2013).

Kuth and Ben (1997) define Life Course Epidemiology as an exploration of the long-term biological and psychosocial processes that link health and disease risks to physical or social exposures at various life stages, including gestation, childhood, adolescence, and early adulthood across generations (Kuh & Ben-Shlomo, 2004). This framework suggests that a range of biological, behavioural, and psychosocial mechanisms connect adult health outcomes and disease prevalence to early-life events and exposures (G. D. Mishra et al., 2010). Research indicates that the incidence of hysterectomy (G. Mishra et al., 2023; G. D. Mishra & Sarah E, 2013) is influenced by socioeconomic factors such as Body Mass Index (BMI), socioeconomic status (SES), and weight gain during adulthood, reflecting the impact of life course trajectories. The sociological perspective on the life course emphasises the social pathways individuals navigate, which are deeply embedded within social institutions (Alwin, 2016). This perspective is particularly central to this thesis, as it examines how hysterectomies are influenced by life stages preceding the procedure and how those events shape the life course after surgery. I aim to explore how women's bodies experience varying degrees of biomedical intervention and neglect, which may include early marriage and pregnancies, sex-selective abortions, labour-induced miscarriages, forced caesarean sections, sterilisations, botched procedures, unnecessary surgeries for gynaecological conditions, and eventual hysterectomies, along with post-hysterectomy complications, that shape women's local biologies (Lock & Kaufert, 1998; Nguyen & Peschard, 2003).

At the core of this thesis is a key question that aims to unravel the linkages between the economy of female labourers' bodies in state-organised capitalist agrarian systems and their medical subordination across the life course which becomes starkly evident through hysterectomies. I aim to explore the practices that render the bodies of female sugarcane cutters 'bioavailable' and 'operable' which often leads these women to make, what I refer to as, "pragmatic investments" in the form of early age hysterectomies (Cohen, 2003, 2007; Desai, 2016; Lock & Kaufert, 1998). This becomes particularly relevant as most female sugarcane cutters in Maharashtra belong to marginalised caste groups, such as Vanjari, Mahar, and Mang (Deshpande, 2010). I am especially interested in exploring the intersections of caste, gender, labour practices, and health. It is crucial to not only focus on reproductive chronicity made evident through sterilisation or hysterectomies but also to consider chronic issues throughout women's life courses, particularly for those from marginalised caste groups, who are more often subjected to hysterectomies.

My focus on hysterectomies in a rural-agrarian setting contributes towards shifting the anthropology of the body and biomedicine towards new directions and investigates the unequal distribution of rural poverty and its implications on local gender constructions. With an ethnographic focus on the biosocial strategies that seek to regulate the bodies of rural women, my research traces the intersection between operability, biopolitical regulation and poverty, and the transformation of various actors—clinicians, bureaucrats, factory owners and *mukadams* into biomedical brokers.

Agrarian ethnographies of the sugarcane industry of Western India, are over three decades old (D. Attwood, 1992; D. M. Attwood & Baviskar, 1987; Baviskar, 1969, 1976; Breman, 1978a, 2007). Even within the existing anthropological work, the growth of commercial sugarcane production in Western India and its implications on local gender constructions have remained outside the ambits of ethnographic analysis. My research aims to contribute to filling this gap

by providing a renewed ethnographic lens to trace the socio-economic and political changes in the sugarcane economy of Western India that have pushed rural women to the margins of an already precarious rural periphery through routinised usage of biomedical procedures. I do this by posing a critical inquiry: Which women's bodies are perceived as having the capacity to be commodified, not by virtue of the presence of the uterus but through its absence?

This thesis positions itself within new inquiries into the emerging biosocial dimensions of the commodification of bodies and bioethics (Cohen, 2003; V. Das, 1999; V. Das & Kleinman, 2000; Kleinman, 2020; Scheper-Hughes, 2000). Its aim is to contribute to a new generation of anthropological research that explores the socio-cultural, political, and economic dimensions of emerging biotechnologies and bioethics (Kahn, 2000; Lock & Kaufert, 2001; Majumdar, 2018a, 2018b; Martin, 1989, 2001; Nguyen & Peschard, 2003; Oudshoorn, 2003; Petryna, 2013; Rapp, 2004). While extensive literature in the anthropology of the body has focused on the links between the capitalist economy and women's reproduction (Cross, 2012; Mies, 1980; Naidu & Ossome, 2016), the impact of biotechnological and surgical interventions on women's bodies in the labour process has been largely overlooked.

This thesis aims to bridge the gap between medical anthropology, which centres on clinical aspects, and the anthropology of work, which focuses on farms and factories. It seeks to understand how certain bodies, communities, and populations are positioned as 'bioavailable' and 'operable' within market economies. I draw upon anthropological studies related to the organ transplant market (Cohen, 2003, 2007; V. Das & Kleinman, 2000; Lock, 2001a; Satz, 2010; Scheper-Hughes, 2000; Sharp, 2000), where the selling of organs serves as a means to exchange life (organ) for life (debt). I further extend this to the often-overlooked intersection of rural poverty and market forces, particularly where the removal of the uterus has become a precondition for the survival of rural women. By exploring the violent entanglement between

social reproduction and productive labour, I aim to bring the everyday realities of rural women in Beed to a broader audience, both within and beyond social anthropology.

Building on an attempt to bridge medical anthropology and the anthropology of work, this thesis examines how the intersecting economies of sugarcane labour and biomedicine shape women's lives and subsequently their bodies in rural Maharashtra. The two spheres: one structured by caste-based labour exploitation and the other by medical practice of both state-incentivised sterilisation and private-sector centred hysterectomies entangled with negligence, profit, and biopolitical control, I argue make women's bodies simultaneously indispensable for sustaining household and wage labour and expendable within capitalist and biomedical regimes that profit from their debilitation. Moving beyond framings that restrict women to a strict binary of either being passive victims or independent agents, I aim to develop analytic that traces the structural constraints that steer these procedures while laying bare how women endure and at the same time resist decision-making within these complexities.

Thus, I ask, how is the medical practice of hysterectomy, with the bodies of female sugarcane cutters as its point of focus, employed to facilitate labour processes in rural India?

1. How, through the confluence of rural poverty and agrarian distress, are certain bodies, communities and populations—particularly female labourers from oppressed castes are positioned as having the potential of being 'bioavailable' and 'operable' within agrarian economies, thus transforming hysterectomies into 'pragmatic investment'? With an ethnographic focus on the biosocial strategies that seek to regulate the bodies of rural women, how can one trace the intersection between operability, biopolitical regulation and poverty?
2. As opposed to viewing women as passive victims, how does the case of hysterectomies among rural labourers through a life course approach present complex narratives of

bodily suffering and everyday tactics through which women rework and reconstitute their agency by negotiating between socio-economic structures and medical control beyond the clinic?

3. How does the biomedical framing of the menopausal body, which compares the female body to 'a factory-producing substance' and renders it 'functionless' after the cessation of menstruation, contrast with the agency of rural female labourers who, through the decision to undergo hysterectomies, materialise the 'post-menstrual' futility of the uterus by transforming the 'reproductive body' into the 'productive body'?

In answering these questions, I aim to unpack the imbricated nature of coercion and agency, and introduce three interrelated conceptual lenses: of bioviability, pragmatic investment, and filial operability. Expanding the notion of bioavailability, I introduce bioviability to reveal the fragile threshold of bodily functionality required to sustain life and labour under conditions of structural bodily and economic debilitation, which is explored in Chapter 3. Linked to this, pragmatic investment facilitates the repositioning of hysterectomies as a structurally constrained yet deliberate choice made by women aimed at securing the continuity of wages and familial caregiving amidst cyclical social, economic, and health precarity, as expanded upon in Chapter 4. Filial operability attends to the intergenerational transmission and normalisation of hysterectomy within kin networks, embedding surgical intervention in familial strategies of survival, as discussed in Chapter 5.

Situating Hysterectomies Amidst Gendered Labour, Migration, and Biomedical Rationalities

According to the National Family and Health Survey (NFHS 4), in India, women from rural areas especially those belonging to the Other Backward Classes (OBC) or the Scheduled Castes/Scheduled Tribes (SC/ST) are significantly more likely to undergo hysterectomies (S. K. Singh et al., 2024). Specifically, 3.6% of OBC women and 2.7% of SC/ST women employed

as agricultural labourers experience this procedure at higher rates compared to women in other sectors. Notably, studies indicate that hysterectomies are more common among women engaged in any form of wage-related work (A. Singh & Govil, 2021). While only 5% of urban women face this risk, the percentage rises to 7% among women in rural areas. Moreover, the likelihood of hysterectomy increases for women who marry or begin cohabitation at a younger age, particularly those under 15 years. In contrast, women who start cohabitation after the age of 20 have a 55% lower chance of undergoing the procedure compared to those whose cohabitation begins before 15 (Shekhar et al., 2019). While these statistics provide a national overview, there is a significant lack of qualitative or ethnographic research into the seemingly non-biological factors contributing to hysterectomies at the regional level.

In Beed, media reports (Chatterjee, 2019; Express News Service, 2019; Jadhav, 2019; Mulye, 2019; Shelar, 2019) presented varying perspectives on the reasons behind these surgeries. Some suggested that *mukadams* (jobbers and foremen) were reluctant to hire menstruating female sugarcane cutters, believing that menstruation and pregnancy affected women's physical capabilities. Others indicated that some women choose to undergo hysterectomies to avoid the inconveniences associated with menstruation after completing their menstrual cycles. Initial reports may have oversimplified the situation by linking the *mukadams*' hiring preferences to a perception that natural processes hindered daily labour. Additionally, some reports sensationalised the issue, with headlines like "Half of the women in this village in Beed do not have wombs." These articles speculated about a possible connection between *mukadams* and private health practitioners, suggesting that financial incentives might lead doctors to misdiagnose women and pressure them into unnecessary hysterectomies (Kalia, 2023). The current non-anonymised media coverage in Beed portrays hysterectomies as a recent and novel surgical intervention, primarily focusing on the experiences of women who have undergone this procedure in the past four to five years. Moreover, these reports predominantly highlight

the stories of women from villages near the central district while neglecting numerous remote areas where high rates of hysterectomies have also been seen. The ethical issues surrounding these procedures, and the complex experiences of the women involved are also underrepresented.

For example, my fieldwork indicated that the role of *mukadams*, local cane contractors is unclear. According to the women who have undergone the procedure, these contractors are not explicitly mandating hysterectomies, contrary to what the media narrative suggests. Further, the ramifications of publishing non-anonymised stories are significant; leading to harassment of women by local leaders. The role of activists calls for further scrutiny, as many women view them as intermediaries for both national and international media. Despite extensive media coverage, there is a noticeable lack of meaningful interventions or adequate healthcare facilities, particularly inadequate gynaecological setups. Additionally, the linear portrayal of hysterectomies in the media tends to isolate these procedures from the context of previous medical encounters and fails to address critical factors such as child marriage and sex-selective abortions. Thus, I note that this is essential to frame these narratives within the broader context of hysterectomy practices in India, considering the familial, economic, and social factors that influence the decision to undergo the procedure. The experiences of women following hysterectomy extend far beyond a couple of years, in fact, spanning decades, which has not been the focus of media narratives that are only interested in immediate outcomes of the surgery. This is particularly critical for the implications of these procedures in leading to non-communicable diseases (NCDs) and surgical menopause, among others. I argue that accepting these procedures, in many cases in four consecutive generations of women, can be viewed as a form of biopolitical control, disguised as ‘choice’ while functioning as, what I term, a ‘pragmatic investment’ for women.

Following the media reports on hysterectomies in Beed, the state government mandated that all private surgeons submit monthly reports of all hysterectomies conducted to civil surgeons. Nevertheless, hysterectomies remain prevalent, particularly in mostly unregulated private health sectors across the state. Notably, despite being India's second most populous state, Maharashtra is one of three Indian states (along with Uttar Pradesh and Karnataka) facing significant disparities between private and public health systems (Jaffrelot & Jumle, 2020). In Maharashtra, three-fourths of all patients seek treatment in private hospitals, with 73.7% of all hospitalisations excluding childbirth, occurring in private healthcare facilities (Shaikh, 2020). The growth of the private health sector in the state began in the 1970s; however, until the 1990s, there was little information regarding the number of registered hospitals in the state (Hunter et al., 2022). It is important to mention that Maharashtra has yet to implement the Clinical Establishment Act (CEA). The official draft of the CEA emphasises the need to register and regulate clinical establishments and protect patient rights to enhance both public and private healthcare facilities. A sizeable portion of the private health sector in Maharashtra, like that in several other states, is primarily run by practitioners trained in Ayurveda and homeopathy. Additionally, many alternative medicine practitioners are employed in the allopathic sector to address gaps in the shortage of medical personnel and provide cost-effective staffing.

Yearly, due to prolonged drought, an unprecedented rise in crop failure, debt accumulation and the lack of employment opportunities, lakhs of labourers migrate from Beed to the sugar belt regions of Western Maharashtra to work as sugarcane cutters during the harvesting season from October to March, at times extending till May. Migration from Beed to the Sugar Belt is not a recent phenomenon. This migration can be traced back to the 1972-73 droughts that gravely hit Maharashtra in three districts, Ahmednagar, Solapur and Beed, making Marathwada one of the worst affected regions (Asawa, 2016; Kendre, 2011). This marked the advent of a large movement of toilers, who were pushed to look for alternative employment opportunities despite

having their cultivable land, due to a lack of irrigation facilities and erratic weather conditions. With climate change worsening with each passing year and dwindling land quality, women traditionally involved in agriculture have lost their livelihoods (Subramanian, 2024). Families from the Mahar and Mang caste groups, who were historically engaged in *begari*, a form of unpaid or forced labour, shifted to daily wage manual work during the non-migratory season. Like Vanjari communities, they later turned to cane cutting, which became one of the few viable livelihood options available to them. Since the 1950s, the cooperative sugar factories of Maharashtra have been described as constituting a critical part of the regional domination of the upper caste Maratha elites with close links to powerful state and national politicians (D. Attwood, 1992; D. M. Attwood & Baviskar, 1987; Baviskar, 1969, 1976). To ensure that the sugarcane reaches the mill soon after it is cut, most farms are owned by co-operatives, and migrant labour is hired not by farmers but by factories.

Ethnographic studies of rural India have long shown that women's labour is central to household survival, particularly in agrarian, caste-stratified contexts, even as norms around honour historically restricted women's wage work outside the home (Attwood, 1992; Dyson & Moore, 1983). While existing scholarship notes that women in Maharashtra exercise relatively greater autonomy compared to northern states, their work remains organized along gendered lines, with men and women occupying distinct spheres (Dyson & Moore, 1983; Kapadia, 1995). Within this broader pattern, the sugarcane economy in Beed presents a strikingly different picture. Here, drought-induced agrarian distress and recurring crop failures have pushed Dalit and Vanjari households into seasonal migration, transforming women into indispensable participants in the cane-cutting workforce (Singh, 2017). These shifts are deeply embedded in caste dynamics: landless Dalit women and poorer Vanjari women enter arduous manual labour, while wealthier Vanjari and Maratha farmers with canal irrigation are able to weather crises and consolidate holdings. Over time, Vanjaris have emerged as the single largest group of

sugarcane cutters in Maharashtra, supplying koytas, husband-wife pairs to factories across Western Maharashtra. As Gopal Guru (2023) argues, such occupational transitions are not merely economic but reflect the structural entanglement of caste and labour, with Vanjaris' contested classification within OBC and Nomadic Tribe categories further complicating their social positioning (Deshpande, 2010). This resonates with Alpa Shah's cross-regional research, which shows that even in states with high HDI such as Kerala, Tamil Nadu, and Himachal Pradesh, the cheapest and most exploited workforce comprises low-caste and tribal seasonal migrants from central and eastern India, performing arduous tasks that local Dalits and Adivasis increasingly avoid (Shah, 2006). In this context, women's bodies become critical sites through which production processes are sustained, revealing how gender, caste, and class converge in shaping labour regimes in Maharashtra's sugarcane belt.

Along stretches of barren land owned by factories, sugarcane cutters often construct makeshift houses using leftover cane, plastic sheets, and grass called *kopis*. If they cannot find space on factory property, they build these temporary homes next to land owned by local farmers near factories, for which they pay a monthly rent ranging from INR 400 to INR 500.

Image 1.1: Kopis near sugar factories



Image 1.2: Kopis near sugar factories



Image 1.3: Makeshift bathrooms near kopis



Labourers are recruited by a *mukadam*, a local contractor who is paid by a *thekedar* (a factory-appointed contractor). Each working unit, known as a *koyta*, typically consists of a couple, usually a husband and wife. Each *mukadam* manages groups called *tolis*, each made up of 10 *koytas*, and receives a commission from each *toli*. *Koytas* work at least 14 to 15 hours each day, performing strenuous tasks such as cutting, tying, loading, unloading, and transporting cane to the factory. In addition to these duties, women often spend additional time on unpaid domestic labour, such as cooking, fetching clean water, and caring for children. Each *koyta* is provided an advance payment known as *uchal*, which ranges from INR 50,000 to INR 100,000. To repay this advance, they are required to cut a daily quota of sugarcane. However, many *koytas* are unable to cut enough cane to match the advance they took. As a result, any unpaid amount carries over as debt into the next cane-cutting season. If a labourer misses work, they must pay a fine called *khada,* which ranges from INR 500 to 1,000 to another *koyta* who works in their place to help meet the daily target set for the *toli*.

Image 4: When cane farms are nearby, some mothers leave their babies in saree cradles in kopis.



After returning from cutting cane, often late, around midnight, *koytas* frequently need to travel to the fields again, within an hour, to fill tractors or trucks, with the harvested cane for transport to the factory. The urgency to transport cane arises because the sucrose levels in sugarcane can decline if the harvested crop is not processed within 24 hours of cutting, distinguishing the sugarcane industry from other crops and highlighting the challenges labourers face due to strict time constraints. The time-sensitive nature of sugarcane cutting is, thus, presented as a justification for the enforcement of *khada*, reinforcing labour discipline and setting targets for cane cutting, while systematically increasing the physical and economic pressures on the koytas.

It is critical to point out that the *uchal* is not always given as a lump sum; it is often provided in instalments without written documentation. Interestingly, during my conversations, female cane cutters have noted that although they do not receive written receipts for the pending *uchal* amount, *mukadams* often require their thumbprints on receipts for record-keeping. However, many *koytas* find it challenging to meet their seasonal targets due to recurring illness,

workplace accidents, and emergencies. As a result, any outstanding debts are carried over when they take the *uchal* the following year, trapping them in a cycle of debt—essentially a form of bonded labour.

In Beed, I found that many families marry off their young daughters as soon as they begin their first menstrual cycle and sometimes even before they reach puberty. For example, in Ariwadi, one of the two villages where I did extensive fieldwork, out of the 130 women interviewed across four generations of cane cutters, the youngest girl was married at just 4 years old, while the oldest was married at 16. In some cases, young girls were exchanged in marriage for token money that often exceeded the advance they earned from cutting cane. Some families adopted this strategy to make ends meet. Two main factors drive the early marriage of young girls among sugarcane cutters in my field sites. First, parents fear leaving their daughters behind in their home villages or taking them along during the migratory season. As a precaution, families often prefer to marry off their daughters as soon as they begin menstruating to ensure their safety, while early marriage is also viewed to shift the responsibility of providing for children (Subramanian, 2024). These weddings, which Subramanian refers to as "gate cane marriages," are typically arranged before the harvesting season and emerge as a survival strategy by creating a new working unit, the koyta or "mobile labour army."

Typically, there is not more than a two-year gap between pregnancies, and women often joke, "We are pregnant half of the year." Early childbearing, which often follows the first menstrual cycle, is seen as a means not only to give birth but also to create a family that can provide a surplus of labour, particularly with the hope of having male children. After delivery, with no social security or health benefits, many women return to work within two weeks. Refusing to work can lead to a loss of income, resulting in debt they must repay with additional labour in the next harvesting season. Routine domestic violence can occur if they are unable to perform labour due to fatigue, pain from illness, or menstruation. The combination of strenuous work

at the workplace and in the home, poor nutrition, and long hours during pregnancy increases the risk of miscarriages and infant mortality. Like the situation in Beed, economist Padmini Swaminathan argues that the demographic development and increased labour participation of women in Tamil Nadu does not necessarily indicate reproductive safety. For instance, in paddy farming, long hours of bending and squatting while transplanting crops can cause physical pain and exert pressure on the uterus. Obstetricians note that this type of strenuous labour can often lead to premature labour in the last trimester, increasing the risk of stillbirth and pelvic and uterine prolapse. Swaminathan argues that this dilemma between work and reproductive autonomy presents a 'Hobson's choice' for rural women (Swaminathan, 1997).

Further, the linkage between sterilisation and hysterectomy has been gravely under researched in the public health and social sciences. While the evidence is mixed, existing studies reveal a linkage between tubal ligation and increased risk of gynaecological morbidities and menstrual disorders such as longer menstrual cycles (hypermenorrhoea) and an increase in the amount of bleeding(menorrhagia) (Fiks, 2023; Hillis et al., 1998). Moreover, clinical evidence shows that women who undergo tubal ligation are 55% more likely to undergo a hysterectomy than their non-sterilised counterparts due to higher risk of menstrual disorders such as dysfunctional uterine bleeding and gynaecological morbidities (Prusty et al., 2018a). My conversations with government health practitioners also point towards the possibility of an infection post-sterilisation, which can lead to abdominal pain, white discharge and irregular bleeding.

Interestingly, there was a common thread tying the cases of women who underwent a hysterectomy after reporting their post-sterilisation symptoms in my field sites in Beed. As mentioned earlier, most women undergo sterilisation procedures in government hospitals. However, many doctors affiliated with these hospitals also ran private clinics and when women sought diagnoses from them, hysterectomy was often recommended, citing risks such as cancer, imminent death, or the perceived uselessness of the uterus after childbirth. While alternative,

non-surgical options were occasionally offered, they were often perceived as impractical because they required repeated visits, prolonged treatment, and potential income loss due to fear of payment of *khada* for each day of missed work. For many women, hysterectomy appeared to be the quickest and most definitive solution to restore health and resume work.

Private clinics reinforced this urgency by describing the uterus as "rotten," "full of holes," or at high risk of cancer, amplifying fears of both illness and financial instability. Consequently, the decision to undergo hysterectomy was less a matter of free choice and more shaped by economic compulsion, limited alternatives, and heightened anxiety. To afford the procedure, women frequently borrowed advances from cane contractors, amounts exceeding their annual income, creating debts that carried into subsequent years. In choosing to undergo a hysterectomy in hopes of preventing future illnesses and financial strain, and potentially increasing their capacity to work, they paradoxically face a future deterrent: the diminished ability to work following the surgery.

Existing Research and Theoretical Framework

Public Health and Social Anthropological Perspectives on Hysterectomies

While social anthropology or any qualitative study has rarely focused on the issue of hysterectomies, the available public health literature highlights the current trends and medical debates about the reasons and implications of this medical procedure in India (Desai et al., 2011, 2017, 2019, 2023, 2024; Dyson & Moore, 1983; Martin, 1989; Sardeshpande, 2014; A. Singh & Govil, 2021; Towghi, 2012). However, even in terms of data on hysterectomies, the first time the data on hysterectomies was collected was in NFHS 2015-2016. With no documentation prior to that, I am interested in tracing the life histories of women who had undergone these procedures not just in the past decade but ages ago, some dating as far as 40 years ago. This is particularly relevant as the existing media coverage on early-age

hysterectomies has focused on recent hysterectomies, almost framing these procedures as a recent medical intervention, without tracing it back to generations. Whereas my findings show that in many families, at least three generations of women have undergone a hysterectomy before 30 years of age.

Studies across India reveal that upon reporting, gynaecological morbidities, such as white discharge, women are presented with 'exaggerated warnings' about cancer (uterus and ovaries), even when non-invasive treatments are available (Desai et al., 2023, 2024). In many cases, without any internal examination or diagnostic tests, removal of the uterus is recommended as the only procedure, without any hormonal replacement therapy or follow-up(Moore et al., 2023). In a qualitative study from Pakistan, anthropologist Fouzieya Towghi notes that doctors admitted that hysterectomies were medically unnecessary (Towghi, 2012). However, women's social and economic conditions, rather than medical grounds, emerged as rationales for doctors suggesting these procedures. For instance, Towghi highlights the imaginaries that situate bodies within a social context, where hysterectomies are presented as part of a 'normal protocol' since women are poor and live in remote areas. Additionally, Towghi points out that a pan hysterectomy, which involves the removal of the uterus along with surrounding organs, is easier to perform than less invasive surgeries. This raises questions regarding doctors' surgical skills and limitations that may justify performing total hysterectomies. In my thesis, I explore this further through narratives from both doctors and women, revealing that women almost always consult general practitioners, who are also surgeons, rather than gynaecologists, for gynaecological issues. Therefore, the discussion regarding early-age hysterectomies extends beyond mere diagnosis to examine how doctors are trained to favour invasive medical procedures over non-invasive and less radical interventions, as well as the incentivisation associated with these procedures. It is critical to consider who performs these procedures and who bears the associated risks. Furthermore, I explore how the removal of the uterus and

surrounding organs, such as ovaries, has become a normalised practice, prompting a consideration of the surgical and pedagogical frameworks that predispose women's bodies and their organs to such disposability.

In her ethnography on hysterectomies, Towghi (2012) highlights the rationale offered by doctors for performing hysterectomies to treat mild gynaecological conditions. Towghi observes that doctors advocate for hysterectomies to alleviate symptoms like bleeding, if women would not seek non-surgical treatments. Towghi argues this perspective portrays women as "marginalised, rural, illiterate, poor, and unconcerned with self-care." She states that the reasons behind hysterectomies are not due to a lack of less invasive treatment options or the need to address severe gynaecological issues. Instead, these surgeries are often performed to eliminate symptoms, such as excessive bleeding, because doctors believe that women may not return for less invasive procedures. In my work, I build on this idea by exploring additional reasons why women may choose hysterectomies instead of opting for less invasive options. This exploration goes beyond the obvious challenges of travelling long distances for non-invasive treatments. Das and Hammer highlight that doctors dealing with general illnesses point out that while the WHO recommends administering ORS for children with diarrhoea, doctors believe that simply suggesting a mixture of salt and sugar in water may lead to losing patients (J. Das & Hammer, 2007). This is because another doctor might provide medications that a mother perceives as a more effective treatment for her child. Following this strand on what is 'perceived' as 'effective' treatment, in the context of hysterectomies, I am particularly interested in the everyday circumstances that lead women to view hysterectomies as a 'pragmatic investment'.

Health researcher Nilangi Sardeshpande in her work on the prevalence of hysterectomies among young women in Maharashtra studies the role of the private health sector in pathologising and, consequently, medicalising female reproductive processes (Sardeshpande,

2014). Sardeshpande views hysterectomies as opening a window to the concerns of accessibility to reproductive health services, such as economic barriers and inadequate health facilities for antenatal care or delivery. In India, the prevalence of hysterectomies ranges from 4% to 10%. Through extensive fieldwork in 14 villages in Pune and Satara in Maharashtra, Sardeshpande lists five broad reasons for a high level of acceptance of hysterectomies among women such as inadequate medical facilities and treatment, lack of trust in alternative medicines/treatments, deep-rooted fear of fatal diseases such as cancer or complications along with fears instilled by health practitioners, difficulties in everyday life to due to reproductive health problems and a community acceptance of hysterectomy as the norm. In many instances, Sardeshpande argues that the doctors hint that the treatment for cancer is expensive, the chances of which can be controlled by paying for the surgical procedure of a hysterectomy. Similarly, for some respondents, in case of reproductive health problems such as bleeding, it was easier to bear the one-time expense of a hysterectomy rather than paying for medications each month, along with the inability to pay for recurring visits to the doctor (travel costs and doctors' fees), and suffering loss of daily wages each time.

In India, hysterectomies have been correlated with profit incentives under the national health insurance scheme in India's highly unregulated private healthcare sector (Desai et al., 2011, 2017). The findings of a cross-sectional survey from Gujrat among insured and uninsured women in low-income rural and urban areas shows that hysterectomies are a leading reason for women to use health insurance (Desai et al., 2011, 2017). As opposed to uninsured women, the rate of hysterectomy was seen to be higher among insured women, wherein over one-third of all uterus removals were performed upon women under 35 years of age. A substantial proportion of the insurance schemes in rural areas are through community-based health insurance (CBHI) programs. CBHI schemes have been seen as having the potential to improve the quality and access of privately owned hospitals. Particularly in the case of hysterectomies,

the Self-Employed Women's Association's (SEWA's) Medical Insurance Fund provides financial assistance to women in rural areas. Hysterectomies account for the most common cause for which SEWA's medical funds are used (ibid.). A study conducted to assess the quality of care among cases of hysterectomies under SEWA revealed that several hysterectomies and oophorectomies (removal of ovaries) were conducted not due to any underlying symptoms or pathology on the medical investigation but on the insistence of women or on 'demand' of patients for non-medical reasons such as a confluence of religious, social and economic reasons such as not allowing women to enter temples or to cook during menstruation, increasing productivity in the field, among others (Desai et al., 2011). Moreover, in most cases, removal of ovaries along with the uterus was seen as a routinised procedure, with little to no post-operative care. Yet, there has been little to no information about the role of clinicians in discouraging these surgical interventions, particularly in cases where women lack awareness about the implications of such procedures. On the contrary, studies trace a linkage between financial incentives and why doctors encourage hysterectomies, for instance, in cases where a health practitioner is paid out of pocket for each procedure.

It is critical to highlight that the usage of invasive surgical procedures such as hysterectomies are not limited only to South Asia but are higher among black women than their white counterparts in western countries such as the United States of America. Emily Martin (2001), in her work, critically highlights the need to place reproduction and the framing of the female reproductive body within a racial and cultural context, for instance, the relationship between presumably powerful white doctors operating on 'relatively powerless' African American women (KJERULFF et al., 1993; Martin, 2001). After caesarean, hysterectomies account for the second most common surgery among women aged 18-64 years in America (Robinson et al., 2017). In 2020, over 50 black female inmates in a Georgia ICE detention centre reported being forced to undergo gynaecological procedures such as hysterectomies, mostly without their

consent (Fofana, 2022; Schickler et al., 2021). However, the predominant biomedical literature has overlooked the relationship between racial difference and 'minimally invasive surgery' for socially advantaged people vis-à-vis the use of 'older techniques' such as hysterectomies among the racial minorities. The reasons for young black women being treated using hysterectomies, despite the absence of any malignant tumour, are linked to the inadequate resources at hospitals and lack of healthcare facilities available to black women and under trained doctors performing surgeries as opposed to doctors treating white women. As discussed above in the case of Maharashtra, in America, too, hysterectomies among young black women between the childbearing age group of 18-44 years, particularly due to removal of ovaries, push many young women into the menopausal stage with an increase in mortality rate.

It is critical to note that not all feminist scholars view technological interventions and surgical procedures, particularly while giving birth, as a means of 'controlling' women. Critiquing the strand of scholarship that views women as passive subjects, scholars such as Catherine Riessman and Judith Leavitt view women as 'engaged agents' whose well-being has both benefited and suffered due to the medicalisation of their health (Hollen, 2003; Leavitt, 2016; Riessman, 1983). In the case of hysterectomies, health researcher Sapna Desai's (Desai et al., 2011, 2017, 2019, 2023) work documenting the narrative accounts of women undergoing hysterectomies brings to fore the complex question of agency, entangled between bodily suffering and socio-economic deprivations rather than mere submission of women to medical authority as 'passive victims'. Lock and Kaufret's (Lock & Kaufert, 1998) work on the medicalisation of women's bodies in cases of sterilisation and childbirth employs the notion of 'pragmatic agency'—where the decision to opt for or undergo certain medical procedures is driven by a response to the fear of gynaecological morbidities or hindrances in everyday work and domestic life, lack of information of potential health risks and compulsion to bear financial and caregiving responsibilities. Drawing from Lock and Kaufret, Desai (2016) employs

‘pragmatic agency’ as a key conceptual tool to unravel why women opt for/accept hysterectomies where women take charge of their reproductive lives and exercise agency not only by rejecting but also by embracing medical technology. Embedded in exploitative labour relations, gender norms and inadequate healthcare facilities, Desai states that the fear of fibroids, cysts and fatal illness transformed hysterectomy into both a ‘treatment and prophylaxis’ (Desai, 2016). These practices resonate with what I conceptualise as pragmatic investment, constrained yet deliberate decisions, such as hysterectomy, aimed at sustaining economic viability and caregiving responsibilities despite long-term health risks.

Chronicity, Tinkering, and Reproductive Suffering

Earlier works of anthropologist CJ Walley focus on the routinisation of female circumcision through surgical procedures such as clitoridectomies and infibulation among Kikuyu women in Kenya (Walley, 1997). Historically, while the prevalence of these procedures in Europe and America was used as a ‘cure’ for masturbation, in Kenya, these procedures were performed to prevent unmarried girls from having sexual relations or having extramarital affairs. Such practices rendered the bodies of women and young girls as ‘operable’ and as means to exercise control over the female body. Through extensive fieldwork in a Chennai slum, Villivakkam– also nicknamed ‘Kidneyvakkam’ due to the routinised use of surgeries for kidney transplants, anthropologist Lawrence Cohen (1999) argues that the selling of organs such as kidneys takes the form of a ‘temporary exchange of life for life’ since in cases where the kidney is exchanged for financial reasons, the donors are back into debt soon after (Cohen, 2003). Cohen’s engagement with the concepts of the ‘bioavailable’ and ‘operable’ bodies in the case of the organ transplant market in India has unveiled the intersection of surgical procedures and biomedical interventions with debt, poverty and conditions of severe deprivation to create ‘ethics of parts’ or ‘politics of the belly’ (Cohen, 2003; Scheper-Hughes, 2000). He defines ‘bioavailability’ as an index through which an individual’s body is made available to facilitate

certain relations between surgical techniques and market economies and ‘operability’ as a marker through which individuals ascertain their belonging to a group or community, based on the willingness or unwillingness to undergo these operations.

Cecilia Van Hollen in studying the high use of reproductive medicine among poor women in Tamil Nadu, highlights the routine use of IUDs after childbirth and abortions as a part of the family planning programme (Hollen, 2003; Van Hollen, 2018). Most of these procedures, Hollen argues, are carried out without informing the women or against their will–causing severe physical and psychological damage while the health practitioners justified the routine insertion of IUDs by citing the need to meet targets laid down by the State government(Hollen, 2003). Drawing on Hollen, Cohen argues that many women who decided to sell their kidneys had previously undergone tubal ligation, thus carving out the possibility of ‘operability’ and ‘bioavailability’ of their bodies for more surgical procedures. In the case of selling kidneys, the scars of the surgery, Cohen states, become a sign of both—the body serving as collateral and revealing the limits of this collateralisation where the real wound is poverty (Cohen, 2003). Anthropologist Bhrigupati Singh’s (2015) work among the Sahariyas holds relevance here. Examining the ambivalent nature of poverty, Singh quotes Appadurai- ‘Poverty is many things, all of them bad’ and defines poverty as being steered by a lack of capacity (B. Singh, 2015). To enhance this deficiency, state actors often focus on teaching the poor how to ‘save’ where ‘savings are presented to the poor as bearing a ‘salvational status, expected to increase the ‘potency’ of their lives. Singh contends that potencies could also be fatal- an individual might be threatened even by an increase. Thus, biomedical procedures and ‘operations’ are not merely medical procedures that entail risks or benefits but also bring to fore the question of agency–what Cohen refers to as citizenship (Cohen, 2003). While Cohen’s notions of bioavailability and operability illuminate how bodies become accessible for intervention, this thesis extends

these ideas through the concept of bioviability, which foregrounds the fragile threshold of bodily functionality required to sustain life and labour under exploitative conditions.

Scholarly literature on female sterilisation provides critical insights into tubal ligation in India, which is often portrayed as a choice cloaked in care or justified by enhanced medical practice (Chaparro-Buitrago, 2022; Fiks, 2023; Kapadia, 1995; Luksaite, 2016; Tarlo, 2000; Varley, 2023). However, these procedures frequently obscure the influences and pressures that shape such choices and do not simply frame these medical practices as binary oppositions of care versus suffering or choice versus coercion. In a study among Pallar women who performed heavy labour, social anthropologist Karin Kapadia highlights the usage of two predominant contraceptives–abortion and sterilisation (Kapadia, 1995). She points out that the unwarranted use of contraceptives had potential dangers for women's reproductive and physical health, particularly when performed in ill-equipped public health facilities. While many women did not opt for sterilisation due to a firm belief that it will weaken their ability to perform strenuous labour, particularly agricultural work, in the case where women undergo sterilisation, they are advised not to carry a heavy load for eight months. This, Kapadia argues would push Pallar women to starvation if they 'stayed off work' for such a long period (Kapadia, 1995). Another reason for not opting for sterilisation is rooted in women's belief that 'men do not like it' or will begin finding their wives less attractive. Julieta Chaparro (2022) notes that women in Peru who underwent sterilisation linked the surgery to their loss of strength and inability to perform labour. Reopening the wound during heavy work caused extreme discomfort; the unhealed wound made them feel their uterus as 'tender and weak' (Chaparro-Buitrago, 2022).

By debilitating women's bodies through sterilisation, she argues that women from marginalised communities endure prolonged violence that debilitates not only their bodies but also their life worlds. In a similar vein, Eva Lukasite describes surgeries such as sterilisation, abortions, and hysterectomies as ambivalent acts of care intertwined with reproductive suffering (Luksaite,

2016). For women in Lukasite's research, sterilisation emerged as an everyday care practice they adapted to manage their reproductive lives. This is particularly significant, as the existing literature on women's health in India reveals narratives where many women undergo tubal ligation ten years before having hysterectomies, with some perceiving sterilisation as temporary relief and hysterectomies as permanent. The desire for a permanent solution drives these procedures, and as Lukasite observes, they represent a recurring cycle between *cure* and *chronicity*. Annemarie Mol describes "tinkering" as the ongoing, practical adjustments that make care possible (Mol et al., 2010). My work applies this concept to reproductive health, looking at how tinkering unfolds across the life course and examines how such practices, framed as practical solutions, normalise and legitimise specific interventions while simultaneously shaping and debating women's bodies. I introduce the lens of filial operability to capture how operative norms, such as sterilisation and hysterectomy become embedded within kin networks, reproducing surgical decisions as intergenerational strategies of survival.

A key aspect of the literature this thesis examines is leukorrhea, also known as white discharge, *safed paani* or *dhaat* (Ilankoon et al., 2017; Krishnakumari et al., 2014; Nichter, 2010; Rashid, 2007; M. Singh & Khan, 2006; Trollope-Kumar, 2001; Varley, 2023). From a strictly biomedical perspective, white discharge is considered a symptom of a reproductive tract infection. However, it is not always indicative of an infection and despite its normality, it is often reported as a symptom. Existing scholarly work in South Asian countries such as India, Bangladesh, Sri Lanka, and Pakistan reveal how white discharge, which can often be easily treated through non-invasive procedures, is frequently pathologised by healthcare practitioners. This pathologisation can lead to recommendations for early age, unwarranted, hysterectomies, and as Emma Varley notes, health providers reinforce the economic and authoritative boundaries of care through this process (Varley, 2023).

While white discharge is often used to signify physical distress, cultural meanings of leukorrhea reveal how women also associate it with emotional concerns or indications of distress (Nichter, 2010). For example, Sabina Rashid's work among women in Bangladesh shows that they often link losing beauty and vigour or describe their bodies as becoming dehydrated and skinny due to the discharge (Rashid, 2007). Women also report symptoms such as burning sensations in body parts, backaches, and itching as consequences of white discharge. Studies contextualise white discharge and women's experiences within the political, economic, and social conditions that affect how women experience it (Rashid, 2007; M. Singh & Khan, 2006; Varley, 2023). For instance, a study in Bangladesh notes that women experiencing white discharge often related their symptoms to harassment, with one case involving police harassment and another referencing incident of mob killings (M. Singh & Khan, 2006). Across studies, a prevalent symptom related to white discharge is the feeling of *kamzori* (weakness). A study in Pakistan reveals that traditional healers, known as *desi tabs*, attribute watery vaginal discharge to fatness or uterine weakness (Varley, 2023). They believe that the uterus, or *bachedani*, needs to be cleaned, maintained, and closed after childbirth, as it can become impaired or weakened due to pregnancies or menstruation. They also think that *safed paani* opens the uterus, causing back aches and weakness in women.

The discourse on early-age hysterectomies can be juxtaposed against the literature on surrogacy, presenting both contrasting and parallel narratives, where the uterus emerges as a focal point of analysis (Rudrappa, 2015; Vora, 2015; Waldby & Cooper, 2008). In surrogacy, women's excess reproductive capacity, beyond a certain juncture in the life cycle of how the womb is valourised, diminishes in perceived domestic value. In the case of surrogacy, the uterus is reconceived as an 'empty space or room,' an essentially vacant entity awaiting 'occupation' and the surplus biological labour needs to be utilised in the process of 'renting' an 'unused' uterus (Vora, 2015; Waldby & Cooper, 2008). For instance, through the case of gestational

surrogacy clinics, Kalindi Vora (2015) demonstrates how the transmission of this vital energy from producers to consumers spreads its tentacles into the biopolitics of hypermobility. She contends that the process of outsourcing the facets of human life, which are deemed useful for reproducing life elsewhere, travel without the whole and extract fragments of life from some to support the existing forms of life or to produce new life for others. More particularly, she draws parallels between labour and human labour, where a part of a person's body is viewed as being 'extra' or not required in its current location. For instance, as observed in the case of Kidneyvakkam, a kidney is deemed unnecessary amidst grave socio-economic pressures, and thus 'free' or 'surplus', making it available for exchange (Cohen, 2003). In the case of commercial surrogacy, Vora argues, the surplus biological labour takes shape through the process of 'renting' an unused uterus (Vora, 2015).

Early hysterectomies, I argue, cannot be understood in isolation as discrete biomedical interventions; they are deeply entangled with the regimes of care and logics of operability outlined earlier. Building on Cohen's notion of bioavailability and operability, these procedures mark a critical threshold where women's bodies, already rendered operable through prior sterilisations or repeated clinical encounters, are repositioned as sites for further intervention. This transition is not simply surgical but temporal because it reflects the chronicity of reproductive suffering, where symptoms like leukorrhea and persistent pain, compounded by economic precarity, make invasive surgery appear as a pragmatic solution. In this sense, hysterectomy becomes part of the tinkering practices Annemarie Mol describes, iterative adjustments aimed at sustaining life and labour under constrained conditions, yet these adjustments often reproduce vulnerability by embedding women deeper into cycles of risk. Framed as acts of self-care, these decisions prioritise immediate relief over non-invasive treatments that could jeopardize wage labour, but they also expose women to new morbidities and debts. Thus, early hysterectomies illuminate how care, chronicity, and suffering converge

in the politics of operability, transforming the uterus from a reproductive organ into a negotiable threshold between bioavailability and bioviability, with longevity promised at the cost of enduring uncertainty.

Gender, Labour and Reproductive Health

Over the past few decades, there has been an increase in rural women's employment in agriculture, mainly of wage labourers. However, the impact of a multitude of factors that accompany their increased participation in the agrarian labour force on their health and well-being, such as seasonal migration, technological transformations and chronic poverty has not received adequate ethnographic and anthropological attention. Consequently, the relationship between women's employment and reproductive choice is seen as linear and causal, based on the assumption that with an increase in women's participation rate in the economy, there will be an increase in the autonomy they exercise within their household. Particularly in the case of the sugar economy, economic anthropologist Nandni Gunewardena's work on Sri Lanka's sugar economy explores the largely overlooked relationship between commercial sugar production and the multitude of forms through which gender parity is exercised (Gunewardena, 2010). Drawing on feminist political ecology literature, Gunewardena argues that women's increased participation in the agrarian sector is paradoxical, as their participation in the everyday wage work did not correspond with improved decision making roles within their household (Boserup, 2007). She argues that these 'disempowering consequences' are a part of the capital-intensive agricultural system that has systematically eroded the 'complementary and egalitarian gender relations' with the push towards the commercialisation of production (Gunewardena, 2010; Ong, 2010).

Since the 1950s, the cooperative sugar factories of Maharashtra have been described as constituting a critical part of the regional domination of the upper caste Maratha elites who have close links to powerful State and national-level politicians (D. Attwood, 1992; Baviskar,

1969). Historically, sugarcane is a crop known for exploiting slave labour by colonial plantation owners (Mintz, 1986). In post-colonial India, sugarcane farming continues to be emblematic of exploitation—through ownership, caste domination and power. Sugarcane farming has been considered an anomalous industry worldwide due to the close relationship between exploitative slave labour and growing fortunes of capitalist relations and colonial planters, particularly in the Third World agrarian economies. However, as opposed to the vast number of anthropological and historical studies that have focused on the primary sugarcane hotspots such as the Caribbean, Brazil or Central America (Handler, 1966; Mintz, 1986), the sugarcane industry of Western India has been largely overlooked. Anthropologist Donald Attwood (1992) delineates three key reasons for this. Firstly, India's export of sugar is meagre compared to heavy usage and sale in the local domestic market. Secondly, as opposed to the foreign-aided dairy cooperatives, the sugarcane cooperatives do not draw financial aid or donations from foreign organisations, international development agencies or public-relations machinery. Thirdly, the marginalisation of the Indian sugarcane cooperative is rooted in western India's political and cultural history.

Attwood notes two key reasons for this: first, the increased role and powerful positioning of rural leaders and chairmen of cooperative sugar factories in State politics and second, cooperatives are not a product of state planning and are not managed or organised by a state bureaucracy. Attwood defines enterprising peasant families as consciously evolving their skills to combat and cope with risk and take advantage of different opportunities. Particularly in the case of rural Maharashtra, he describes the ideal family as being a patrilineal, patrilocal and joint family consisting of an elderly married couple, their sons and their wives and grandchildren (D. Attwood, 1992). The family structure becomes an important site in understanding the peculiarity of sugarcane farming due to the dual functionality of the family enterprise, coordinating between the family as a social unit and the farm as a unit of production.

However, these two functions are not mutually exclusive. The family as a social unit needs to be continuously maintained and reproduced to facilitate surplus labour, in some cases, and provide education to at least one or more sons to get employed in a factory, or other white-collar jobs. The familial enterprise, with a husband and wife constituting a koyta and then the sons and their wives as another *koyta* thus emerges as an end to ensure that working units are continuously created and sustained within the household. While Donald Attwood's work is one of the most notable contributions to the anthropological literature on sugarcane farming in Western India, it was written in 1992. Since then, there has been a long gap in the sociological and anthropological literature that has focused on the sugarcane economy of Western India.

Moreover, while Attwood effectively brought the question of the family to the centre stage with his detailed ethnographic account of Malegaon, he acknowledges his limitation of failing to address the question of gender and sexual division of agricultural labour and thus, overlooked the role of women in the cane fields of Maharashtra. For instance, as also mentioned earlier, the question of familial unit in the case of sugarcane industry becomes critical as in her work on 'gate cane weddings,' highlighting the practice of child marriage among cane cutters in Maharashtra, Reetika Subramanian reveals how the integration of the marital unit into the labour force serves as a means for the sugar industry to sustain the practice of early marriage (Subramanian, 2024). This becomes particularly important as women, by becoming a part of the working unit, are not 'supplementary workers' but primary workers alongside their husbands in the *koyta* earning a family wage.

In rural Maharashtra, many regions face water scarcity and lack irrigation facilities after the rabi crop sowing season, leaving households without agricultural work (Abdul Jaleel C.P. & Chattopadhay, 2022). This leads to a seasonal migration of labourers from Beed to the irrigated sugarcane belt. The role of seasonal migration is particularly noted among sugarcane cutters in Maharashtra, where each year, for six months, Mahar, Mang and Vanjari labourers from Beed

and other districts provide inexpensive labour in the state's sugar belt, which is primarily controlled by upper caste Marathas. This observation resonates with Alpa Shah and Jens Lerche's point regarding capitalism's ongoing dependence on migrant labour, which is 'paid less, works longer, harder, more flexibly, and is more easily controlled than local workers' (Shah & Lerche, 2020b). They describe this phenomenon in developed regions of India, particularly in the sugar belt, as 'internal colonialism,' highlighting how casteism exacerbates the marginalisation of migrants. The seasonal nature of migration also fosters different forms of exploitation by intermediaries and complicates power relations of caste, gender, and class at both the origin and destination sites (Rai, 2020; Rao, 1981).

Additionally, existing research on seasonal migrants in Maharashtra reveals the fears and everyday threats faced by women migrants. As noted by Abdul et al., men typically determine women's re-migration, and despite women working alongside men in the fields, their husbands often take the wages from the *mukadam* (Abdul Jaleel C.P. & Chattopadhay, 2022). Women also report unsafe working conditions and uncertainty regarding their destination sites during migration, as they frequently move to new locations once, they complete their cane quota. Moreover, Abdul et al. (2022), indicate that about 36% of seasonal migrant women who are cane cutters in Maharashtra suffer from non-communicable diseases (NCDs), along with issues like hypertension, back pain, and joint pain. The physically demanding nature of cane cutting further contributes to the prevalence of musculoskeletal disorders among these women.

With an increase in women's employment in the agrarian sector, gender relations defined as power relations between men and women, particularly different practices such as the division of labour, roles and responsibilities, and structural relationships (Afshar & Agarwal, 1989a; Agarwal, 1994) have undergone a transition. Evolving gender relations, Agarwal argues, are characterised as hierarchical, steered by cooperation and conflict due to economic, political and social power. Within a broad framework, these contestations differ based on their form

(individual or collective resistance/action), content (ideological construction within distinct economic, social and political practices) and sites (the State, household, community or/and the market). While Agrawal carves out the relationship between land ownership and bargaining power through which social relations of power are contested or constituted within and outside the household, she only briefly touches upon a critical yet overlooked dimension, the complex relationship between reproductive responsibilities and bargaining position of women within the household vis-à-vis reproduction. In a short footnote in her seminal work, Agrawal (1994) points out that in South Asia, women's childbearing role is closely linked to weakening or strengthening their position in the household. Particularly in the case of employment in the agrarian sector, frequent childbirth heavily limits their employment opportunities by increasing their everyday labour for child-rearing, and the inability to bear a child carries with it the stigma of 'barrenness'. At the same time, giving birth to a son, instead of a daughter, might increase her bargaining power in the household.

As Agrawal notes, as opposed to the perception that women are unaware of their self-interest or their own wellbeing (also referred to as 'false consciousness'), their compliance to disadvantageous practices is not steered by trust in the legitimacy of these practices, but takes the form of 'resistance to gender inequities' (Agarwal, 1994). In understanding intra-household gender inequalities, Agrawal states that women often choose the interests of their family members over their own, but the notion of the family in itself may include the well-being of their children, for whom they choose to bargain with their husbands or the kin. The congruence between women and their dependent children vis-a-vis their bargaining power in the family is further dependent on factors such as private ownership and control over assets such as land, access to employment, access to communal resources, and external social support systems, NGOs and the State. It is critical to note that in case of loss of employment, where a woman is unable to contribute to the income of the household, her bargaining power also diminishes.

This raises a broader question: how do women navigate intra-household power relations when they face competing demands: on one side, pressure to contribute financially and pursue economic independence, and on the other, expectations of care work and social reproduction, including childcare and maintaining the household?

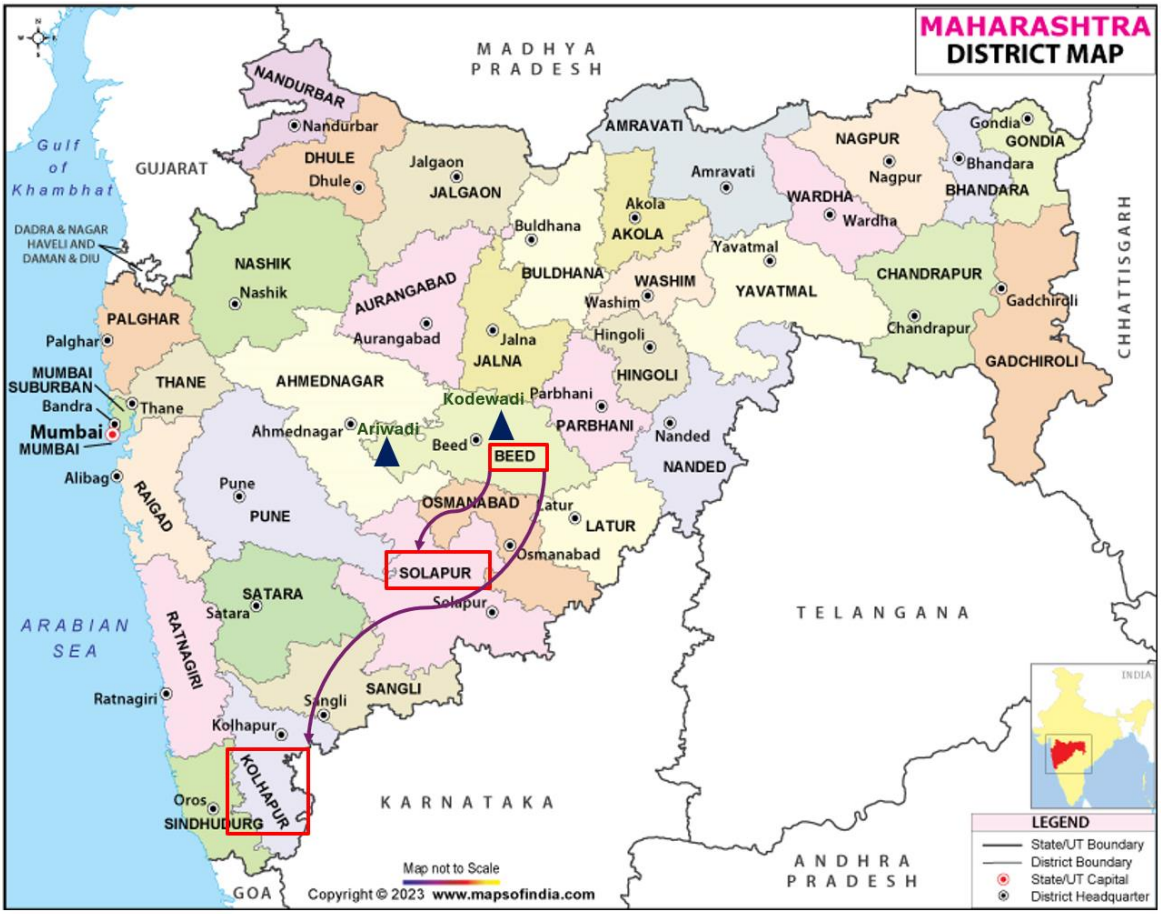
Methodology and the Field

Despite an influx of statistical and public health studies revealing patterns and hysterectomy trends globally and in India, there is scarce qualitative evidence on early-age hysterectomies. Without qualitative insights into these surgical procedures, the data will continue to have limits, with little to no avenues to bring to the fore women's voices, their narratives and their life course, in shaping these procedures beyond numbers. As a sociologist, I chose to examine these processes through an ethnographic lens. Although hysterectomies are a concern across India, understanding them requires attention to local contexts, political dynamics, rural precarity, caste hierarchies, capitalist regimes and their gendered implications on women's health. Without this situated approach, analyses risk becoming overly generalised, ignoring how "local biologies" shape the meanings and practices surrounding these procedures (Lock, 2006).

Employing an ethnographic approach, I utilised what MSA Rao refers to as a method of double-ended studies to trace the life course of female sugarcane cutters both at the place of origin (home village) followed by the eventual seasonal migratory destination of cane cutters (migratory site) (Rao, 1981). According to Rao, a processual understanding of migration helps trace migration processes at the village of origin and understand why some people migrate and some do not, even though they are similarly situated. Ethnographic fieldwork was conducted between May 2022 and May 2023 in different parts of Maharashtra. My fieldwork focused on three regions: Beed district, Kolhapur and Solapur (see map 1.1). Two villages within the drought-prone Marathwada belt of Maharashtra, which I call Ariwadi and Kodewadi, were the primary field sites for my research. The first phase of the ethnographic fieldwork focused solely

on the villages. In the second phase, the study encompassed these villages alongside sugar factories, sugarcane farms, private clinics, and hospitals across the state's Western sugarcane belt. Ariwadi is predominantly inhabited by the Vanjari caste group, which has nomadic origins in the State of Rajasthan and is officially recognised as Other Backward Classes (OBC) in Maharashtra. Kodewadi has a mixed population of Mahar and Mang castes. Both villages are home to sugarcane cutters, predominantly. Most families in these two villages, except a few, migrate for six months annually to work as sugarcane cutters in the booming sugarcane belt of the western part of the state.

Map 1.1: Location of Villages (Ariwadi and Kodewadi) and Migration Route from Beed to Kolhapur/Solapur



The spatial location of these two villages within the Beed district differs significantly. Kodewadi, within 12 km of the district headquarters, has closer proximity and access to the central district compared to Ariwadi, which is over 80 km away from Beed. The choice of these villages as field sites was intentional, driven by my interest in exploring how remoteness from the district might or might not influence hysterectomy outcomes due to varying access to healthcare services. The spatial location of these villages within Beed was critical in shaping the dynamics of my fieldwork and, ultimately, my research trajectory. Initially, I considered distance only within the context of access to healthcare; however, it appeared as equally significant in understanding the voices that shaped the hysterectomy narratives. My initial focus on hysterectomies and women's engagement with external factors, such as media, activists, and civil society organisations, was reframed by the spatial realities of these villages. Due to its proximity to the district, Kodewadi received considerable media attention and witnessed frequent visits from journalists and local activists alike. Conversely, Ariwadi, even absent from the district's map, remained mainly invisible to these actors, barring a few local activists or civil society organisations. Amidst constant media and active presence, or absence in the case of Ariwadi, a complex interplay significantly influenced women's hopes for change, often leaving them mired in uncertainty, scepticism, and suspicion, with only rare glimmers of hope.

The first phase (June-December) of the ethnographic fieldwork focused exclusively on the two villages and their inhabitants. During this phase, I conducted genealogical mapping and documented the life histories of 130 women, along with interviews with their in-laws, parents, children, and husbands. In the second phase (January-May), the study area expanded to include sugar factories, sugarcane farms, as well as private clinics, and hospitals across the state's Western sugarcane belt. Here, the interviews focused on owners, managing directors, and workers from nine sugar factories (8 interviews). These interviews were conducted in the sugar

factories and cane fields in districts of Kolhapur and Solapur–two of the highest sugarcane cultivating districts in Maharashtra. Among other districts that produce cane, these two are the hub for most seasonal migrant cane cutters from Ariwadi and Kodewadi for six months each year.

During the latter phase of research, a key area of focus was hospitals and clinics. In particular, I explored the local health landscape within home villages and subsequently in the districts where women migrate. This was particularly relevant as most of the women I interviewed recalled undergoing a hysterectomy either before the migratory period or at the very end of the migratory season. A few private practitioners were the standard go-to for hysterectomies in both Beed and the migratory sites. In particular, with the nearest private clinic being at a 21 km stretch from Ariwadi and the district hospital being more than 80 km away, it became salient to understand why these small, unregulated private clinics became avenues for women to undergo these procedures, many for even generations–none of which had a gynaecologist but only general surgeons or physicians. I visited four government hospitals and five private clinics. At the government hospitals, I interviewed the heads of the gynaecological departments, gynaecologists, and nurses. At the private clinics, I interviewed general physicians. In total, I conducted 11 such interviews. In addition, I also explored the role of pharmacies in facilitating or hindering the acceptance of non-invasive options for gynaecological morbidities, the role of over-the-counter medicines, and in some cases, traditional healers and even the role of relatives in providing medication from the '*shehar*' (city).

While ethnography was the primary research methodology of my study, ethnographic research demands attentiveness to historical context, not just as a distinct discipline but also as the backdrop of past attempts to give voice to marginalised communities. The intricate dynamics of Kodewadi, Ariwadi, sugarcane fields, factories and clinics/hospitals demanded an approach transcending traditional sociological and ethnographic methods. As a participant observer in

this complex space, I found myself deviating from formal protocols of interviews and survey tools. Instead, I delved into the seemingly mundane everyday interactions. I tried to immerse myself in women's lives, engaging in conversations beyond the immediate topic of hysterectomies. These interactions, the cornerstone of my ethnography, allowed me to listen attentively to their childhood stories, marriages, joys and struggles. In turn, I shared glimpses of my life, childhood experiences, and future. These conversations, while they might not have found a place in the research design, emerged as the foundation of my ethnographic work, not as an accident but as something I anticipated to emerge as a part of the method I was planning to pursue.

However, during my fieldwork, I encountered several challenges. The issue of hysterectomies, following extensive media coverage, had become highly sensationalised in many parts of Beed, for example, in Kodewadi. This created significant participant fatigue, as respondents were accustomed to media-style questioning, making it difficult for an ethnographer to carve out an independent space for inquiry. Compounding this was the challenge of being an outsider to Maharashtra, which made access particularly difficult in the private health sector. Securing interviews with doctors especially surgeons operating in unregulated private clinics was fraught with obstacles due to fears of scrutiny and concerns about documenting malpractice. Additionally, gaining entry to sugarcane farms and factory sites posed its own difficulties because of constant surveillance by local police and security personnel. I was able to navigate these barriers through the assistance of local workers and a few well-intentioned bureaucrats who supported the research. Nevertheless, achieving full immersion and maintaining a continuous presence in the field was often perceived as intrusive and, at times, as a potential threat.

My entry into the field unfolded across spaces marked by deep-seated vulnerabilities, female sugarcane cutters from Mahar, Mang, and Vanjari caste groups who had undergone

hysterectomies as early as age twenty and by years of physical and emotional violence woven into everyday life. Attending to Lefebvre's triad of space (physical, discursive, lived), I recognised how places like Kodewadi had already been fixed within a predetermined public story through sensational media portrayals (Lefebvre, 2014). As an outsider, I entered with local facilitators while staying alert to how gatekeeping can inadvertently shape access and expression. I adopted uneven immersion (Krause, 2021): flexible, ethically attentive engagement that deconstructs presumed familiarity and acknowledges the fluidity of rapport. Initially, husbands in Kodewadi and Ariwadi urged their wives not to "waste" time, fearing exploitation without change; my assurances of anonymity, no photographs, recordings, or names and talk of future interventions offered little comfort. To build trust, I offered the option to decline participation and, at times, left my phone, notebook, and pen behind to prioritise open-ended conversations rather than structured interviews. I thus embraced reciprocal vulnerability, allowing interlocutors to turn questions toward me and cultivating self-representation alongside "knowing the other."

I relied on participant observation, life histories, and verbatim quotes, refraining from embellishment or excessive theorising, and situating narratives within the interplay of media scrutiny, activist involvement, labour processes, and women's own trajectories. Drawing on Lock's 'local biologies', hysterectomy appeared not as a discrete episode but one invasive moment within a longer life course saturated with early marriage, closely spaced pregnancies, miscarriages, obstetric violence, workplace assault, recurring morbidities, and state-incentivised tubal ligations. In this sense, I sought to present "life as it is," keeping women's voices at the forefront and tracing how operative logics had sedimented over time, rather than reducing decisions to individual choice or isolated clinical encounters.

Ethically, I anchored the writing in reflexivity and intersubjective construction understanding that the "facts" of fieldwork are mediated by both participants' worlds and my own analytic

frames (Coffey, 1999; Rabinow, 1997). Following Scheper-Hughes, I treated writing as accountable action, even while acknowledging that my work would not immediately transform lives; following Geertz, credibility rested on genuinely "being there" and rendering that experience legible (Scheper-Hughes, 2008). Instead of doing away entirely with descriptive ethnography, I draw on Scheper-Hughes (2008), who aims to view her work and ethnographic method not as a mere interview but as a means through which an ethnographer, amidst the backdrop of the noise of the media, paves the way for an 'ethnographer-writer' whose pursuit should be steered towards giving voice to those who find themselves silenced, not just by the state, but also overlooked by non-state actors. My role was thus not to promise cure, but to centre women's narratives, amplify voices routinely silenced by state and non-state actors, and carry the work beyond publication toward potential grassroots interventions.

Moving beyond the conventional image of the detached observer, my ethnographic research in Ariwadi and Kodewadi sought to privilege a reciprocal exchange of personal narratives, a task that is often complex and fraught with practical challenges. As Oakley (1981) aptly notes, "There is no intimacy without reciprocity," this exchange fostered a profound sense of connection (A. Oakley, 1981). The aim, ultimately, was a "good enough" ethnography that preserves narrative integrity and remains answerable to participants whose lives have been repeatedly rendered bioavailable for labour and intervention. We became individuals sharing a common space, our lives intertwined through the threads of conversation. This mutual engagement challenged the notion of anthropological knowledge as passively 'extracted' (Scheper-Hughes, 1991) from unsuspecting informants. Instead, it emerged organically through dialogues and interactions, acknowledging the researcher's and participant's inherent subjectivity. This commitment to reciprocity became particularly poignant when faced with the raw vulnerability of young women's narratives. Hearing stories of infant deaths at factory sites, miscarriages, hysterectomies' long-term impacts, and forced marriages to men five times their

age, the pretence of objective neutrality became untenable (Rabinow, 1997). How could one remain detached when the research offered no tangible benefit to their lives, merely documenting responses deemed necessary for the academic project while dismissing the unsaid as irrelevant? This compels me to reconsider how research participants perceive the ethnographic process and what they hope to gain from it– wherein women's voices transcend the sterile realm of academic analysis, just as their hopes for a better life, once shared with media personnel, transcended empty promises.

Chapter Summaries

Chapter 1

Chapter One, *"How Will I Benefit from Talking to You?": Navigating the Vulnerable Amidst An Ethnographer's Guilt*, lays out the ethical dilemmas of doing ethnography when illness narratives and decades of structural violence across scattered medical and non-medical sites are mediated by pre-existing forces such as activism and media. Even when an ethnographer establishes rapport and trust with respondents and the community, I posit that critical questions persist: how can they convincingly differentiate themselves from the countless outsiders such as activists, local politicians, journalists who (intentionally or unintentionally) present the promise of a better life? In unpacking these questions, this chapter moves beyond academic pursuits to ask what ethical responsibilities ethnographers bear toward their respondents, and how they might address concerns about the intent and impact of their research.

Building on this ethical tension, the chapter explores how the pursuit of objectivity often considered foundational to sociological research becomes increasingly fraught when engaging with individuals whose life experiences diverge significantly from one's own. Through narratives about mediated spaces and voices, I argue that the act of immersion is inherently political and incomplete, carrying the potential to replicate the very inequities researchers aim

to critique. Detached conversations, often the hallmark of traditional ethnographic encounters, hold little value for the women I spoke with. Instead, they seek reciprocal exchange through stories that resonate with their lived realities and go beyond the confines of media or activist representations. This shift in ethnographic engagement, marked by uneven immersion and a willingness to meet women on their own terms, allows the ethnographer to challenge assumptions and reshape understandings of what constitutes the 'credible' and the 'normal.'

While ethnographers can only gain a partial understanding of these women's experiences, I argue that deeper connections emerge when narratives unfold in spaces shaped by the women themselves. These spaces reveal the fluctuations and compulsions of their lives not only in relation to hysterectomies but also through unexpected encounters that, while seemingly peripheral, emerged as critical in leading up to the procedure. This chapter, thus, contributes to broader debates on the ethics of fieldwork by asking not only what transpires in the field, but also how the act of witnessing and the 'doing of ethnography' raise critical questions about the ultimate purpose of academic research. It further reflects on how ethnographers might navigate this terrain with humility, accountability, and care.

Chapter 2

The second chapter of this thesis, titled *"Don't You Want Sugar in Your Tea? We've Got to Work for That: Booming Cane, Depleting Lives,"* explores the intertwined relationship between the political economy of sugarcane in Maharashtra, the gendered nature of labour practices, and how these entanglements shape the contours of health-related complications for women labourers. I examine the decision-making processes related to health that aim to enhance the productivity of reproductively capable bodies within the sugarcane fields, and provide critical, yet, unsettling insights, into the complex interplay of gender, caste, agrarian labour, and capitalist dynamics within one of India's most lucrative agrarian industries. To contextualise

these dynamics, I begin by introducing the setting and social landscape of two villages in Beed district (in the Marathwada belt) that I refer to as Kodewadi and Ariwadi inhabited primarily by Mahar, Mang, and Vanjari caste groups, most of whom are cane cutters. Here, I explore the local caste dynamics, ecological factors, and socio-political pressures that lead to seasonal migration to Maharashtra's sugar belt.

Building on this local context, I then examine the historical, social, and political dimensions of the sugarcane industry in Maharashtra, with a particular focus on regional labour arrangements and caste structures. The migration of labourers from Marathwada to the sugar belt of Western Maharashtra steered by the 1972 drought and sustained by recurring drought has become a persistent feature of the bourgeoning sugar industry. Despite mechanisation, this migration continues, especially among opressed caste groups such as Mahar, Mangs and Vanjaris. Employing a gendered lens, I critique existing literature on the sugar industry, which often overlooks the role of women in sustaining sugarcane farming, particularly within family-run enterprises where the '*koyta*', a husband and wife working unit is central.

Extending this analysis, I aim to address a fundamental question: "Who is a worker?" During my fieldwork, factory owners typically distinguished between permanent workers, seasonal workers, and sugarcane cutters. Yet, sugarcane cutters were largely excluded from official recognition as workers for whom the factory was accountable. Permanent workers were considered skilled and salaried, while seasonal workers received fixed monthly wages. In contrast, sugarcane cutters, often seasonal migrants, were recruited through a layered system of contractors (*mukadams*), which effectively distanced the factory from direct responsibility. This outsourcing mechanism allowed factories to absolve themselves from providing social security or insurance, despite claims to the contrary. The recruitment structure not only obscured accountability but also reinforced the precarious status of cane cutters within the labour hierarchy. It is here that I examine how female labourers from the Vanjari, Mahar, and

Mang caste groups navigate the complexities of being recognised as workers. I also explore how the mandatory requirement to hire husband-wife pairs as *koytas* leads to kinship reconfigurations and marriage strategies, including the pressure to marry daughters as early as 12 years old to form labour units. For instance, ethnographic snippets from my fieldwork reveal how, in this context, marrying daughters into non-cane-cutting households is considered marrying up, even if it means earning lower income because it offers an opportunity to escape the bonded nature of cane labour.

To further unpack the embedded violence and exploitative nature of cane labour, I examine the role of *uchal* (advance payment) and *khada* (fine), and how these mechanisms facilitate debt bondage. These financial structures not only entrench economic dependency but also shape gendered labour dynamics at the worksite. I explore how women's health is perceived, accommodated, and negotiated within these systems, particularly through gendered collateral mechanisms such as the employment of husband-wife dyads and the promise of debt-free advances. In doing so, I highlight the violence embedded within the productive-reproductive continuum where practices like hysterectomies are situated, thus, laying the foundation for the subsequent chapters.

Chapter 3

In the third chapter, titled *"Cane Money is Blood Money, But It is the Only Money We Have: The Healer and The Killer Sickle,"* I examine why certain women's bodies are predisposed to being in the 'bioavailable zone,' thus rendering them 'bioavailable' for disaggregation through hysterectomies. Hysterectomies, I illustrate, unveil a nuanced aspect of bioavailability, particularly underscoring the notion of what I refer to as viability i.e. securing the body's immediate ability to survive and get by. This casts the woman, I argue, as an essential 'organ' within the familial unit, prompting reflections on the expendability of her life.

To ground this conceptual lens, this chapter is particularly steered by multiple ethnographic narratives of women who underwent hysterectomies shortly after tubal ligation (hereafter referred to as sterilisation), due to complications or gynaecological morbidities arising from the sterilisation procedure. These accounts reveal how early-age hysterectomies, following sterilisation complications, emerge as a point where the public and private health sectors intersect. By employing an ethnographic approach, the contribution of this chapter is twofold. First, on an empirical level, I provide a grounded account of how hysterectomies are experienced, negotiated, and rationalised by women. This adds qualitative depth to the burgeoning quantitative and medical discourse that is drawing crucial links between sterilisation and the incidence of early-age hysterectomies (Desai et al., 2011).

Second, on a theoretical level, I introduce bioviability as a lens to extend Lawrence Cohen's notion of bioavailability. While Cohen conceptualises bioavailability as the extent to which bodies are made accessible for biotechnological intervention, bioviability foregrounds women's embodied agency across the life course, situating their choices within intersecting structures of caste, labour, kinship, and medical infrastructures (Cohen, 2003, 2007). Rather than framing hysterectomies as isolated clinical events or reducing women to passive victims or rational economic actors, this chapter ethnographically traces how these procedures emerge as pragmatic responses to post-sterilisation morbidities and broader biosocial pressures. By historicising women's decisions and locating them within political economies and everyday negotiations of care and survival, bioviability offers a nuanced lens through which to rethink agency, coercion, and the temporality of reproductive labour. I, thus, argue that bioviability signifies the strategies through which women sustain life under conditions that persistently threaten to render it untenable.

Chapter 4

The fourth chapter, *"If I can make 50,000 off a hysterectomy, then why not?": Labouring Bodies, Hysterectomies and Pragmatic Investments"*, introduces pragmatic investment as the central conceptual lens through which early-age hysterectomies among rural women in Beed can be viewed, not merely as medical procedures, but as calculated strategies to secure a viable present amid structural precarity. Through this framing, I examine how women's bodies become sites of negotiation between survival, labour, and care, shaped by both public health incentives and private medical economies. To ground this conceptual framing, the chapter opens with an ethnographic account of how medical practitioners in Beed present hysterectomies as urgent and necessary interventions. Women under 30 often recall being told their uterus had "holes," had "turned black," or would cause death or cancer if not removed in 'days' or 'weeks'. The lethal urgency embedded in this temporal logic driven by the biomedical imperative to swiftly 'fix' the body, I argue, neglects the lived experience of illness.

Further, these 'urgent' diagnoses are steeped in fear and risk and reflect a medical discourse that positions the uterus as expendable once reproductive labour is complete. Physicians, in turn, capitalise on these narratives to extract economic value, while women absorb the emotional, physical and financial costs of these exaggerated risks. Building on these accounts, the chapter then explores how such risk narratives intersect with broader structural conditions such as caste, poverty, and rural precarity to shape women's decisions. Drawing on Arthur Kleinman's work, I examine how local understandings of illness are translated into biomedical diagnoses, and how the uterus becomes pathologised through institutional framings.

Extending this analysis, a critical intervention the chapter makes is the employment of a life-course perspective, which is largely absent in global qualitative literature on hysterectomies. I argue that hysterectomies must be situated within a continuum of life stages, from birth to death

rather than as isolated clinical events. This perspective allows for a deeper understanding of how women's decisions are shaped over time, resisting binary framings of agency versus coercion. I argue that temporal sovereignty must encompass the right to resist, challenging dominant temporal regimes that render women's bodies perpetually bioavailable for intervention. This reframing enables a re-conceptualisation of temporalities of care, disrupting the capitalist emphasis on efficiency and prompting a deeper reflection on what it means to heal, to endure, and for whom these processes are truly designed.

Following this, the chapter turns to an analysis of how hysterectomies are framed within the categories of the Normal, Normative, and Pathological. I show how healthcare practitioners' framing of risk contributes to the production of pathological understandings of women's bodies, reinforcing the idea that the uterus, post-reproduction, is a liability. This framing enables a form of relational work, where women's bodies are negotiated within institutional, familial, and economic contexts. Through this lens, I argue that pragmatic investment becomes a way to navigate the contradictions of care and commodification.

Furthering this conceptual trajectory, I draw on Viviana Zelizer's shift from 'embedded' to 'constitutive' relations to reconceptualise hysterectomies as biosocial strategies shaped by relational work. I examine how economic transactions whether in cash, through illness, or in the form of regret about the hysterectomy, render the womb legible as a site of value. The question then becomes: which wombs are seen as commodifiable, not through preservation but through excision? The calculus women undertake, balancing a viable present against an uncertain future reveals how pragmatic investment is both a survival strategy and a form of embodied temporality.

Finally, building on Chapter 3's discussion of post-tubal ligation complications, the chapter concludes by examining how the logic of incentives operates across both public and private

healthcare sectors. While sterilisation is incentivised by the state, hysterectomies are framed as necessary expenditures—investments in continued labour and life. In this context, the womb is no longer viewed as an organ but as a hindrance. Its removal becomes essential to support "life as such." Through the lens of pragmatic investment, this chapter foregrounds how women's bodies are shaped by and respond to the intersecting forces of medicalisation, labour, and survival. Here, pragmatic investment emerges as a response to both medicalised risk and economic uncertainty, where the removal of the womb is seen to preserve health, labour capacity, and familial stability.

Chapter 5

In the fifth chapter, *"Panch Taanka, Kamzori aur Dard ki Goli" ("Five Stitches, Weakness, and Pain Killers")*, continuing from the life course perspective, I explore the short-term and long-term consequences of early-age hysterectomies on the biological, social, familial, and economic dimensions of women's lives. This chapter builds on threads from previous chapters by tracing how these consequences unfold over time and across generations.

To illustrate this, I draw on findings from generational mapping, which show that in many families, women from at least four generations have either undergone a hysterectomy or are considering the procedure. Expanding the scope of inquiry, I introduce the lens of 'filial operability' to capture the generational dimension of early-age hysterectomies. This concept helps explain why, despite witnessing the impact of the procedure on their mothers and grandmothers, women continue to undergo hysterectomies while participating in cane cutting. For example, when I asked one respondent, "What did your mother say when you told her about your hysterectomy? Did you not see the impact it had on her?" she laughed and responded, "What could she have said? I know she gained so much weight after the procedure. But what

could I have done? The doctor said I would die. What if I did? We are poor people. We cannot afford the risk."

Building on these generational narratives, the chapter then focuses on women's experiences with the onset of premature and surgical menopause following early hysterectomies. Through women's narratives, I highlight the physiological and psychological risks such as severe depression, body aches, declining bone density and increased morbidity that accompany these procedures. Clinical evidence, substantiated by my conversations with health practitioners, reveals that while hysterectomies performed with oophorectomy induce immediate surgical menopause, the removal of only the uterus leads to a gradual decline in ovarian function and raises the risk of premature menopause within a decade. This discussion foregrounds the gap in existing scholarship, which often overlooks the interplay between biological changes, subjective experiences, and the everyday lives of women, particularly in non-Western contexts.

To deepen this critique, the chapter challenges the notion of a universal biological clock. Aside from anthropologist Margaret Lock's work, the current conversation around female health does not sufficiently address how menopause and its relationship with bodily changes and subjective experiences affect women in their everyday lives. Feminist scholars criticise biological determinism for reducing women's bodies to mere reproductive sites, which leads to their political and economic marginalisation. Building on this critique, I argue that menopause and early physiological aging are not solely driven by biological factors; they are also influenced by non-biological factors that shape women's "local biologies."

Through the lens of early-age hysterectomies, I conceptualise aging as an embodied transition and explore how the experience of social and physiological aging is mutually constitutive in the everyday lives of women who undergo early-age hysterectomies to tackle socioeconomic deprivations and maintain familial viability. This, in turn, leads to premature menopause and

exacerbates the aging process. The biological timetable of aging fails to consider the imbricated nature of social and physiological aging, whose onset is not due to chronological aging but to the materialisation of women's bodies at an early age. These experiences, I argue, highlight how women's bodies are (re)formed by the fluctuations and compulsions of rural precarity.

Extending this analysis, the chapter further illustrates that while the biomedical framing of the menopausal body draws an analogy between the female body and 'a factory-producing substance' that renders the female body 'functionless' after the cessation of menstruation, an exploration of the 'local biologies' of female rural labourers, who exercise pragmatic agency by deciding to undergo hysterectomies, can be seen as a way through which the "post-menstrual" futility of the uterus is materialised. This transformation redefines what was earlier perceived as a "reproductive body" (childbearing body) into the "productive body" (labouring body), offering a critical lens through which to understand how women's bodies are reconfigured in response to economic and social demands.

Conclusion

This concluding chapter provides a recap of the intersecting economies of labour and biomedicine that shape the everyday lives and bodies of women in the sugarcane economy of rural Maharashtra. Two critical themes emerge: the caste-based exploitation of women's labour and the medical economy's entanglements with profit and biopolitical control. To capture the interplay of constraint and agency, I introduce three conceptual lenses: bioviability, pragmatic investment, and filial operability. Bioviability foregrounds the threshold of bodily functionality required to sustain labour and life under exploitative conditions. Pragmatic investment describes women's constrained yet deliberate decisions to undergo hysterectomy as a strategy to secure relief and continuity of income. Filial operability captures the intergenerational transmission and normalisation of hysterectomy within kin networks, where surgical

intervention becomes embedded in familial survival strategies. These concepts illuminate how women navigate structural violence, not through autonomous choice, but through embodied negotiations shaped by caste, class, and gender. Through a life course lens, the thesis traces how women's bodies are made bioavailable and bioviable, accessible for labour and surgical intervention within systems that demand endurance while offering limited care. These contributions extend biopolitical analysis to reproductive labour and offer a grounded framework for understanding agency within conditions of chronic precarity.

Building on these conceptual contributions, the chapter reflects on the ethnographic and analytical journey undertaken to understand early-age hysterectomies among female cane cutters in Maharashtra, situating these procedures within the broader political economy of reproductive labour. It contrasts the speculative, future-oriented framing of reproductive technologies like egg freezing in the Global North with the immediate, survival-driven logic of hysterectomies in agrarian India. Through the concept of bioviability, the chapter theorises how women's bodies are rendered economically "worthwhile" only through their capacity to endure and perform labour, even at the cost of long-term health. It interrogates the collusive dynamics between medical institutions, labour structures, and caste-based marginalisation, revealing how biomedical interventions become technologies of extraction rather than care. Drawing on feminist and anthropological scholarship, the chapter argues for a rethinking of reproductive agency, not as resistance, but as pragmatic negotiation within deeply exploitative systems.

The chapter offers a reflective synthesis of the ethical, methodological, and emotional complexities of conducting fieldwork in contexts marked by caste, gender, and labour-based marginalisation. Drawing on reflexivity as both a methodological and ethical tool, it interrogates the researcher's positionality and the co-constructed nature of data, while also grappling with the limits of academic neutrality. It reflects on the tensions between scholarly inquiry and the moral imperative to respond to systemic injustices, especially in the realm of

reproductive health. Influenced by critical anthropological thought, this thesis is an attempt to carry out a ‘good enough’ ethnography, one that is not only academically rigorous, but also socially responsive and policy-relevant.

In this concluding chapter, I argue that understanding early-age hysterectomy among cane-cutting women requires a multi-layered, intersectional approach that accounts for labour, caste, gender, and health system dynamics. I outline several future avenues emerging from this study. This research opens pathways for collaborative ethnography with cane-cutting communities, deeper longitudinal mapping of women’s health-seeking journeys, and engagement with familial and political actors shaping reproductive decisions.

Chapter 1

"How Will I Benefit from Talking to You?": Reflections on Ethnographic Method

"The ethnographer, like the artist, is engaged in a special kind of vision quest through which a specific interpretation of the human condition, an entire sensibility, is forged. Our medium, our canvas, is "the field," a place both proximate and intimate (because we have lived some part of our lives there) as well as forever distant and unknowably "other" (because our own destinies lie elsewhere). In -the act of "writing culture," what emerges is always a highly subjective, partial, and fragmentary but also deeply felt and personal record of human lives based on eyewitness testimony. The act of witnessing is what lends our work its moral (at times, it is almost theological) character. So-called participant observation has a way of drawing the ethnographer into spaces of human life where she or he might really prefer not to go at all and once there doesn't know how to go about getting out except through writing, which draws others there as well, making them party to the act of witnessing." (Scheper-Hughes, 1991)

Introduction

Geeta's presence had always been a quiet undertone, yet evidently present, during my recurring visits to women's homes in Kodewadi. She occupied a corner in a room amidst a group of women during my visits, often trying to speak yet keeping in check, perhaps ambivalent about my status as an outsider. One day, while wrapping up my day's *mulakaats* (meetings), I met Geeta while she was washing utensils outside her house. As I stood next to her on the doorstep, I immediately observed her weary eyes, swollen and burdened, with blemishes on her face seemingly wrought by nights drenched in tears. Sitting beside her, I asked her if we could meet the next day. The next day, within the confines of her small single-room house, Geeta spread a

chataai (mat) for us and sat in one corner on the muddy floor beside a *chaarpai* (traditional woven bed or cot), upon which her 85-year-old grandmother lay. Some cooking vessels and a makeshift stove occupied the other corner. After a few minutes of silence, I inquired about her well-being and the next second, clinging to her saree's edge with one hand and her wrist with the other, she burst into tears.

Geeta is a second-generation cane cutter belonging to the Mang caste community. Now in her 30s, she was married when she was 14 years old, and since then, she has been migrating each year to cut cane with her husband. Her parents, themselves cane cutters, had tried to shelter her from this labour during her formative years, hoping that her childhood would remain unmarred by the rigour of cane-cutting before she eventually got married into a cane-cutting family. For the initial years of marriage, she lived in a house made of *patr* (leaves) with her husband while they awaited the allotment of a house under the *Gharkul Yojna*[5]. However, soon after they had children, they decided to move to Geeta's mother's home, which had recently been allotted a permanent shelter back then. It has been 12 years since Geeta moved to her maternal household, and despite numerous letters to the sarpanch, they are yet to be allotted a home.

In April 2022, a few months before I met with Geeta, after returning from migration from the sugarcane farms, her husband suffered a grievous injury while unloading wood from a truck. *Lagad* (heavy wooden logs) crashed down upon his abdomen and chest, leaving a trail of internal damage to his intestine and spinal cord. He was rushed to the nearby private hospital in Beed, where the doctors informed him that he immediately needed to be operated on. The operation would cost Geeta INR 3 lakhs. In desperation, with no alternative recourse, she sought financial aid in the form of an *uchal* (advance) from the local *mukadam*– an upper-caste

[5] This scheme officially aligned with the Pradhan Mantri Awas Yojana – Gramin (PMAY-G) and aimed to provide pucca houses to homeless and economically weaker families in rural Maharashtra by 2022, under the mission "Housing for All". The scheme was executed through the Gram Panchayats, based on the 2011 Socio-Economic and Caste Census (SECC) data(Rural Development and Panchayat Raj Department, Government of Maharashtra., 2016).

Maratha. In exchange for the advance, she agreed to cut cane equivalent to the value of the money she borrowed for years to come, thus essentially binding her to a cycle of wage-less labour. Geeta's acceptance of this arrangement came as a complex negotiation weighed against her husband's deteriorating health and their limited alternatives. Her husband's hospitalisation extended beyond fifteen days, incurring daily charges of over INR 5,000—a considerable sum for a household whose annual earnings fluctuated between INR 50,000 and INR 1,00,000. One of the bills Geeta found amidst stacks of paper detailed the staggering expenses other than the surgery, ranging from INR 200 to INR 20,000.

Consulting fees	200
X-Ray	500
Bed Charges- general ward	6600
Doctor visit - general ward	5700
Nursing	2200
Surgeon charges	19000
OT charges	14000
Assistant surgeon charges	8000
Anaesthesia charges	6000
ECG	300
Monitoring charges	5500

O2 charges	3000
Blood transfusion	1200
Total	72,200

Five months preceding the accident, Geeta's eldest son, 19 years old, had succumbed to a benign bug bite that had turned fatal. Initially, when he came to her reporting the bite, causing itching, they hoped it would be a harmless insect bite and subside. However, he developed a high fever, diarrhoea and vomiting within a few days. The local doctor diagnosed it as a viral fever and gave him an over-the-counter medication. Within four days, his condition worsened, and he breathed his last with his head on Geeta's lap. Just four days after I met her for the first time, she noted that it would be a year since her son died. Her life, a series of interconnected trials, had compelled her to seek financial assistance from multiple fronts. Beyond *the mukadam's* loan, another burden emerged in the form of debts procured from local *sahukaars* (moneylenders). Over and above the *uchal* (advance) that Geeta owes the *mukadaams* (local cane contractors), she has taken an additional INR 3 lakh from the *sahukaars*. While her husband can walk now, the pain in his body is too enormous for him to cut the cane as he used to. Geeta, too, struggles to breathe and continues to experience chronic body aches and headaches (*dokecha dukhan*). With a faint smile, she said,

"Everybody says this will pass, and I should not worry. How can I not feel tension? The slightest conflict or problem makes my body shiver (*thar-thar*), and I get so nervous (*jasat ghabrat*). I do not feel like eating; I feel breathless. At times, I want everything to stop."

While my conversations with Geeta spanned months of visits, her question from our first meeting stayed with me: "How will I benefit from talking to you?" During her fieldwork amongst Balmiki women, Malavika Karlekar encountered a similar predicament (Karlekar,

2017). Upon expressing gratitude to her respondents for their invaluable assistance at the culmination of her research, they inquired about the potential ramifications of Karlekar's work on their lives. Poignantly, they asked, "'Bibiji, you will write your book or whatever else it is that you do but how will it change our lives?" (Karlekar, 2017). Like Karlekar, during the course of my thesis, this seemingly simple query transformed into a critical interrogation that challenged the very foundations of my ethnographic undertaking. It compelled me to look beyond the traditional perspective of the academic investigator and consider the value participants, particularly from marginalised communities derive from engaging with researchers. This introspection led to further questions about the responsibilities we, as ethnographers, hold towards the communities we study. Can prolonged participant observation indeed grant us unfettered access to the lived realities of those we research or aim to study? The inquiry extends further, particularly for women like Geeta and ethnographers. We must grapple with distinguishing ourselves from other external actors such as journalists and activists, and ask ourselves: Do our methodologies, roles, and ultimate goals differ significantly from other actors, such as journalists and activists, that these women continue to encounter, or do we risk becoming enmeshed within the same intricate network of external influences shaping the lives of these communities? Furthermore, how can we critically examine and acknowledge the potential for external actors, including ourselves, to inadvertently perpetuate the very systemic violence we aim to address and bring fore? The first chapter of this thesis delves into these critical questions by exploring the entry points to the field as an ethnographer. I argue that this is a particularly sensitive endeavour when conducting ethnographic research in all disciplines but particularly medical anthropology, especially when illness narratives, decades of violence, in different and scattered sites, both medical and non-medical are involved, especially when such narratives are mediated by pre-existing forces like activism and media.

The hysterectomies among sugarcane cutters in rural Maharashtra came into public light in April 2019 due to a series of media reports. These reports attributed the prevalence of hysterectomies to the *mukadams*' (jobbers-cum-foremen) deep-seated aversion to employing female sugarcane cutters during menstruation, citing their belief that menstrual cycles and pregnancies hampered productivity and constrained the physical capabilities of female workers (Chatterjee, 2019; Express News Service, 2019; Jadhav, 2019; Kalia, 2023). Official statistics from 2016 to 2019 revealed a staggering 4605 hysterectomies in the Beed district alone (Chatterjee, 2019). These reports, often shaped by the voices of activists and journalists, presented a diverse range of perspectives on these surgical procedures. Some reports, like '*Why women in Beed do not have a womb*,' presented statistically compelling figures, hinting at a possible nexus between *mukadams* and private healthcare practitioners(Jadhav, 2019). Some reports noted that, driven by financial gains, these practitioners were alleged to be encouraging misguided diagnoses, leading to unnecessary uterine removals.

A central insight that emerged from my conversations with over 150 women is that early-age hysterectomies were not isolated medical events, but part of a continuum of invasive reproductive experiences across their life course. Using Margaret Lock's concept of 'local biologies', these narratives, as I note in this chapter and further illustrate in this thesis, reflect cultural, social, and subjective factors that deeply influenced women's health trajectories (Lock, 2006). Hysterectomies were normalised through a lifetime of systemic violations ranging from child marriage and repeated pregnancies to obstetric violence and state-driven sterilisation. This highlighted a contradiction; while the media framed these surgeries as scandalous anomalies suffered by helpless victims, for the women themselves, they were emblematic of a broader, recurring and ongoing normalised violation of their bodies.

Despite the recent surge in media attention towards "hysterectomy stories", several critical blind spots remain. For instance, one significant gap in this coverage is the limited focus on

how media exposure affects the lives of women. Questions about the risks posed by non-anonymisation, the nature of any interventions that followed, and whether their lives improved or worsened after media involvement are still largely unanswered. Another issue is that existing narratives often depict hysterectomies as isolated surgical events, disconnected from broader social and historical contexts. These accounts fail to consider how certain bodies, especially those belonging to marginalised caste groups like the Mahar, Mang, and Vanjari communities, are subjected to repeated forms of violence throughout their lives rather than at a single moment.

Furthermore, media narratives tend to prioritise sensationalism over nuance and do not adequately situate the women's experiences within the continuum of healthcare, both before and after the procedure, across public and private systems. For me another concern is the erasure of older women's experiences those now in their sixties to eighties who underwent hysterectomies decades ago. Their absence from the discourse reinforces the perception of hysterectomy as a modern or recent medical intervention. Within this context, in this chapter, I posit that the ethnographer must carve out a distinct space- where it is not enough to be self-reflexive but go beyond that. I note that the goal is not only to avoid replicating existing methods and outcomes but also to pay attention to the participants' perceptions of the research process. This includes understanding their apprehensions and expectations and attempting to acknowledge and address them. Finally, the chapter will explore how, as ethnographers, we can attempt to mitigate and address some of the concerns participants may raise.

*Madam, Camera Kahaan Hai? (*Madam, Where is the Camera?)

"In the midst of a massacre, in the face of torture, in the eye of a hurricane, in the aftermath of an earthquake, or even, say, when horror looms apparently more gently in memories that will not recede and so come pouring forth in the late-night quiet of a kitchen, as a storyteller opens her heart to a story listener, recounting hurts that cut deep and raw into the gullies of the self, do you, the observer, stay behind the lens of the camera, switch on the tape recorder, keep pen

in hand? Are there limits of respect, piety, pathos-that should not be crossed, even to leave a record?"(Behar, 2022)

Two villages within the drought-prone Marathwada belt of Maharashtra, Ariwadi and Kodewadi, served as the primary field sites for this research. The first phase of the ethnographic fieldwork focused solely on the villages. In the second phase, the study encompassed these villages alongside sugar factories, sugarcane farms, private clinics, and hospitals across the state's Western sugarcane belt. Ariwadi, predominantly inhabited by the Vanjari caste, and Kodewadi, with a mixed population of Mahar and Mang castes, both have a predominant presence of sugarcane cutters. Most families in these two villages, except a few, migrated for six months annually to work as sugarcane cutters in the booming sugarcane belt of the western part of the state. Notably, the spatial location of these two villages within the Beed district differed significantly. Kodewadi, within 12 km of the district headquarters, enjoyed proximity and more effortless access compared to Ariwadi, which lay over 80 km away from the district.

The selection of these villages as field sites was intentional, driven by my interest in exploring how remoteness from the district headquarters might influence hysterectomy outcomes due to fluctuating access to healthcare services. Notably, the spatial location of these villages within the Beed district became a crucial factor in shaping the dynamics of the fieldwork and, ultimately, the research trajectory. Initially, distance was solely considered within the context of access to healthcare; however, it emerged as equally significant in understanding the nature and dissemination of hysterectomy narratives. My initial focus on hysterectomies and women's engagement with external interventions, such as media, activists, and civil society organisations, was reframed by the spatial realities of these villages. Due to its proximity to the district, Kodewadi received considerable media attention and was the subject of frequent interventions from both journalists and local activists alike. Conversely, Ariwadi, absent from the district's map, remained mainly invisible to external scrutiny. Despite this absence, local

politics prevailed, establishing a distinct discursive power structure within the village. This complex interplay significantly influenced women's hopes for change, often leaving them mired in uncertainty, scepticism, and suspicion, with only rare glimmers of hope.

Ariwadi, nestled amidst the hill (*dongar*) of the district, was a small village comprising no more than a hundred Vanjari families. Often mistaken for Narewadi, its spatially larger neighbour, Ariwadi, remained absent from official maps and shared its administrative unit (gram panchayat) with Gadewadi- an aspect I explore in greater detail in Chapter 2. As I unfurled a district map, seven women, who had graciously invited me for lunch, eagerly requested me to locate their village on the map. A collective sense of disappointment filled the room as we quickly identified the surrounding villages, yet Ariwadi remained elusive. This seemingly trivial exercise revealed the village's marginalised existence, largely untouched by the reach of the media or official records.

While welcoming me, the women in Ariwadi harboured a tinge of apprehension towards me. Their reservations stemmed from a recent encounter with a non-profit organisation spearheaded by a renowned Bollywood actor. The organisation had arrived with promises of facilitating a water supply as part of an ‘award’ to Ariwadi, for which all the members of Ariwadi were invited to do manual labour, such as digging, to facilitate the water supply. Ariwadi was allotted INR 30 lakh under this project, of which the workers were promised INR 200 for each day’s labour. Notably, all members of the village, including children and the elderly, participated in the project, contributing five hours of labour for 55 consecutive days. However, to date, the villagers have not received any form of compensation. One resident expressed her frustration, stating,

> “We were never informed that this was a *shramdaan* (*shram* means work/labour and *daan* means donate, thus translating to free labour) project. Only now do

> they claim it to be so. They removed our names from the beneficiary list and redirected the funds to the neighbouring village. Neither the water came nor the money."

Several villagers reported suspicions regarding the disbursement of funds. They allege that the allocated money was not deposited into the designated account but rather diverted to an unidentified one. Furthermore, they claim the organisation collected personal identification documents, including photographs, Aadhaar cards, and PAN cards, from the villagers under false pretences. Local speculation also centres on a wealthy former village headman (*sarpanch*) as the suspect who allegedly misappropriated the funds. This experience has understandably fostered a sense of wariness within the community, leading them to fear that my presence, similar to the members of the previous organisation, may represent yet another instance of unfulfilled promises and wasted effort.

Despite their initial apprehensions, the women of Ariwadi extended unwavering warmth throughout my initial stay in the village. I was frequently invited for meals, typically consisting of *murga* (chicken), *baingan* (brinjal), salt and buffalo milk, accompanied by *jowar* (sorghum) *papad* (thin Indian wafer), a special treat reserved for the visiting "*madam from Delhi.*" Their curiosity about me was evident, as one woman remarked, "*Aamhi vichaar karat hoto ki ti kaisi asel? Ti kaisi disel? Ti kaay mhnnel?*" (How would she be? What would she look like? What would she say?). Moreover, the women gently encouraged me to partake in their meals, often saying, "If you want to work hard in this village, please eat properly."

Notably, upon my arrival, especially in homes with pregnant daughters, these women would readily bring out household items typically reserved for special guests. This included table fans, considered a luxury item often designated for sons-in-law or their pregnant daughters. Furthermore, they offered a variety of food items, including dates*, panjiri*, *seviyan,* and dried

fruits. Traditionally reserved for daughters when they were expecting, these items were demonstrably offered to me without any reservation regarding cost. At no point did I feel that any expectation of reciprocation drove this exceptional hospitality. My role as a student researcher was made transparent from the outset, and my inability to offer any recourse to their problems was clearly communicated. Instead, the underlying motivation appeared to be a desire for attentive listening, acknowledgement, and hope. One woman poignantly said, “Hopefully, your work will be read and will improve the lives of our future generations.” While I was unable to offer such a concrete assurance about my work having any potential to impact their lives, the women continue to evoke a complex emotional response within me, a potent blend of gratitude for their generosity and a sense of guilt stemming from my inability to even partially reciprocate their kindness.

Ariwadi comprised three primary families from which all other families descended over the decades. My initial interactions unfolded in the household of Jaya, the sole family in the village exempt from sugarcane cutting. This exemption stemmed from Jaya's sister-in-law, Savita Mausi's, active involvement in local politics and the family's claim to extensive landholdings accumulated over generations. Notably, Savita Mausi's uncle held the previous position of a *sarpanch* in the joint-gram panchayat. While she frequently advocated for women's rights, she was also known to insist on a marriage alliance between her nephew who was suffering from a disability and the local *mukadam's (*cane contractor) daughter, stating,

“*Majhi behen shrimat ahe. Tu raja sarkhi rajya karshil. Iti motta ghar aahe - oos todiyachi garaj nahi*” (My sister is wealthy. You will reign like a king/queen. This is a big house - no need to cut sugarcane).

Unlike the majority of villagers, Jaya, her husband, and their immediate family were not seasonal migrants or sugarcane cutters. Jaya's husband cultivated a small plot of land, sowing

jowar, cotton, and soybean annually. When inquired about the landholding size, Jaya expressed her own lack of knowledge, deferring to the expertise of “Savita Mausi”. Their livestock comprised around five cows, two buffaloes (providing milk for both consumption and sale), four oxen, and seven to eight goats. One of the buffaloes, unable to conceive, was slated for sale. Additionally, they possessed a poultry flock of approximately 30-40 hens. The produce, including milk and eggs, was divided between household consumption and sale at the local bazaar called “*veeda*”. Intriguingly, rumours circulated within the village community regarding Jaya's sister-in-law's landownership, despite her frequent denials. According to these rumours, she owned approximately 20 acres of cultivable land to her.

Consequently, during the initial stages of my fieldwork, a local *gram sevak* maintained a conspicuous presence at the village entrance whenever I entered. On other days, Savita Mausi would attempt to be present during my visits to women's homes, seemingly curious about my inquiries regarding hysterectomies and the specific women I interacted with. These encounters prompted me to broaden the scope of my research. It became increasingly evident that a comprehensive understanding of local power dynamics, political structures, and the intricate web of familial relationships within the village and their relationship with the predominant cane labour in the region was crucial. Without this knowledge, approaching the investigation of social determinants of health and hysterectomies, their historical and biological underpinnings, and their potential connection to migration and sugarcane harvesting would be incomplete. This realisation led me to collect data on each household within the village, ensuring comprehensive coverage from the outset of my fieldwork.

The second field site, Kodewadi, situated within a 10-kilometer radius of the central district headquarters, is another village on a *dongar* (hilly area) like Ariwadi. Similar to its counterpart, Kodewadi has uneven and muddy roads. However, unlike Ariwadi's entirely unpaved roads and pathways, Kodewadi boasts occasional stretches of rudimentary charcoal roads, remnants of

the Pradhan Mantri Gram Sadak Yojna (Prime Minister's Rural Roads Scheme). The village is a small community, with approximately 180 families belonging primarily to the Mahar, Mang, and Lonari caste groups, with a handful of Maratha households. In contrast to Ariwadi, where land ownership is prevalent, Kodewadi's land is predominantly classified as *gayran zameen* (common land), an aspect discussed in further detail in Chapter 2. Interestingly, despite the geographical distance from the main district, the prevalence of hysterectomies in Kodewadi mirrors that of Ariwadi. However, access to medication and the frequency of other surgical procedures appear to be higher in Kodewadi. Furthermore, unlike Ariwadi's multi-generational tradition of sugarcane cutting, Kodewadi's residents have starting cutting cane relatively recently. Additionally, a segment of the population engages in *begari* work (forced labor) in nearby areas, when they are not migrating to the sugarcane farms.

Despite their differences, both Kodewadi and Ariwadi grapple with the lack of clean drinking water or toilets, contributing to kidney stones, *gachkaran* (ringworm), chikungunya, dengue, malaria and recurring illnesses. However, while being closer to the district headquarters grants Kodewadi a marginally better irrigation infrastructure than Ariwadi, it also exposed it to increased activist and media attention. Some of this focus centres on a small group of women collaborating with activists to introduce alternative, indigenous crops on their farms. According to women in the village, one such woman, Anjana, through her close association with activists, has secured media access for sugarcane cutters in the region and enjoys a relatively better economic standing than other villagers. Other women in the village note that Anjana's well-built house boasts two bedrooms, a proper toilet with running water, and modern amenities like fans which starkly contrasts their prevailing housing standards. Additionally, one of her sons is employed in the police force. Anjana began cutting cane at the age of 14, immediately after marriage, and has also been migrating to sugar factories in Karnataka and Kolhapur. From the

Mahar caste group, a mother of four children, with the eldest being 30 years old and the others born in quick succession, she underwent a hysterectomy at the age of 37.

During participant observation in the village, Anjana's frequent intrusions into my meetings with other participants emerged as a point of tension. While some women interpreted her presence as a sign of her commitment to staying informed, others expressed discomfort with sharing openly. These anxieties stemmed from concerns about information being relayed to Anjana, given her consistent presence and perceived closeness to a local activist. This, coupled with the women's vocalised anxieties regarding the role of activists and media personnel in the village, prompted a critical reflection on my position within the field. Recognising the need for a more nuanced approach to scheduling meetings, I prioritised individual discussions with women. This involved scheduling meetings with them when Anjana was unavailable or, in frequent instances, directly informing her of the necessity for these one-on-one interactions

This exemplifies the ongoing dilemma ethnographers face the challenge of achieving complete independence in the field. Particularly when conducting research outside one's own cultural landscape, or even within a familiar region, the assistance of gatekeepers such as local activists, researchers, or academics with prior experience becomes crucial for initial access and establishing rapport with the community. However, this very reliance introduces a paradoxical situation. Firstly, upon entering the field and identifying potential gatekeepers, researchers often gravitate towards individuals whose work resonates with their own research objectives. These gatekeepers are often perceived as inspiring, just figures representing the voice of the community the ethnographer intends to engage with. However, this initial perception may be entirely dissonant from the actual experiences and perspectives of the community itself. The researcher's understanding of the gatekeeper's role may not align with how the community perceives their presence and influence. Secondly, despite researchers' efforts to clearly communicate their research goals to gatekeepers and emphasise the need to withhold findings

until the research is complete, there is often pressure to “share findings” prematurely. This pressure extends beyond mere data sharing and delves into the trust participants have placed in the researcher by sharing sensitive narratives that they may not have shared with the gatekeeper in the first place.

I argue that while acknowledging the inherent limitations in establishing absolute neutrality, it is imperative for ethnographers to minimise bias and ensure that women's voices are preserved and remain at the forefront of the ethnographic narrative. This requires vigilance against introducing personal interpretations that could taint the narratives, recognising instances where gatekeepers may unintentionally hinder participants' expression due to concerns over their involvement, and avoiding unrealistic promises of improved lives through the research itself. My ethnographic role prioritised the unadulterated experiences of women who underwent hysterectomies. This meant avoiding embellishment, excessive theorising, or imposing my own interpretations on their narratives (Diaz, 2024). Additionally, I refrained from harbouring unfounded optimism about the potential for my work to radically transform the lives of participants. Simultaneously, this ethnographic approach, while not the best, but aimed to observe, listen, and situate the narratives of hysterectomy within the dynamic interplay of media scrutiny, activist involvement, labour processes, and the women's own life trajectories. Through this, I aimed to further explore the reasons behind the prominence of certain voices within these narratives, ultimately illuminating the complexities of the social landscape within the research site.

It is within this backdrop that the ethical dimensions of ethnographic practice come to the fore. A central concern arises: The women, whose lives are laid bare for public consumption, often remain unaware of the ultimate destination of their images such as google search engines through media portals and the potential consequences of their exposure. Who covers the impact of non-anonymised media coverage on vulnerable communities? How does one

approach ethnography in this mediated landscape permeated by recurring apathy? How does one transform into a participant observer? Even if an ethnographer establishes rapport and trust with respondents and the community, how can they convincingly differentiate themselves from the countless outsiders who promised them a better life? Beyond pursuing academic endeavours, what ethical responsibilities do ethnographers bear towards their respondents?

"Ha mahiti patrakaranna dekhil dyat ka?" (Will you also give this information to the journalists?)

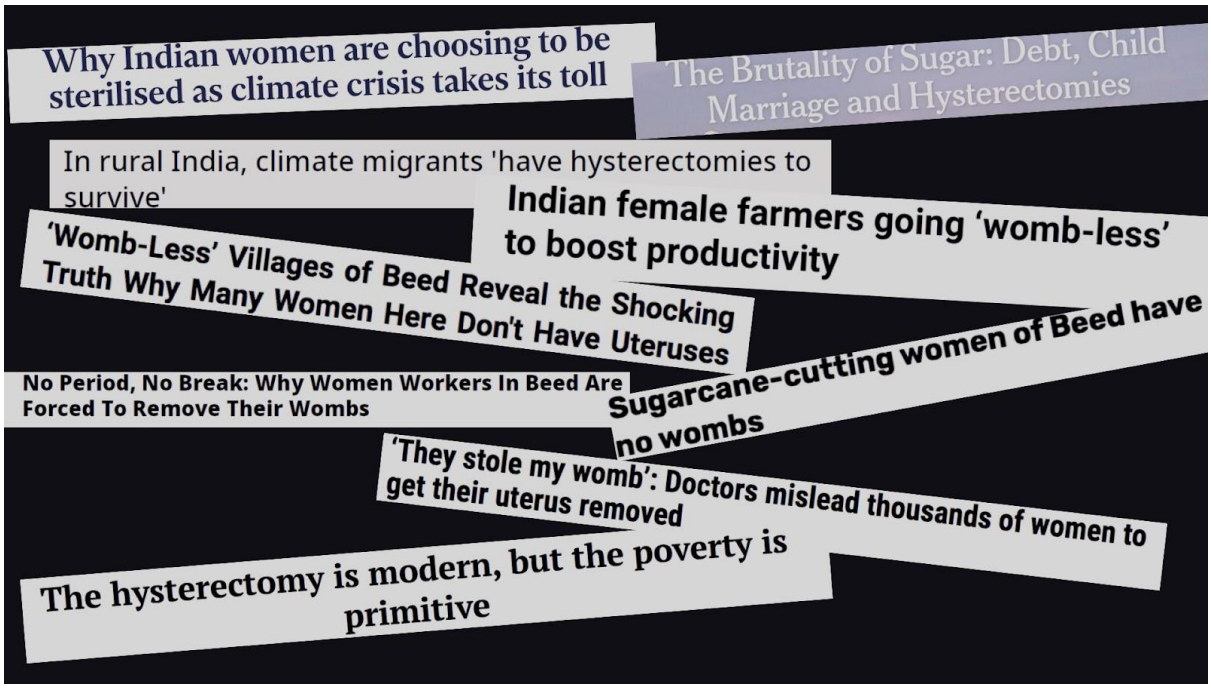


Image 2.1: News headlines about early hysterectomies in India

In 2013, a public health expert, Dr. Narendra Gupta, undertook a study to assess the prevalence of hysterectomies among rural women in Rajasthan (*Dr. Narendra Gupta v. Union of India and Others; Writ Petition (Civil) No 131 of 2013*, 2023). The outcomes of this study led Dr Gupta to initiate a public interest litigation (PIL) aimed at curbing unwarranted hysterectomies (Dr. Narendra Gupta Vs. Union of India, 2023). This legal action spurred governmental action, led to the inclusion of hysterectomy statistics in the National Family and Health Survey (NFHS-4)(Ministry of Health and Family Welfare, 2016). In response to the PIL, the Ministry of Health

and Family Welfare (MoHFW) formulated guidelines acknowledging that, unlike developed countries where hysterectomies are commonly performed on premenopausal women over the age of 40, India, particularly marginalised caste groups in rural settings, witnessed a trend of women aged 28 to 36 undergoing unnecessary hysterectomies (Ministry of Health & Family Welfare, 2023). According to data from the National Family Health Survey-4, the median age at which hysterectomies were performed was 37 years, with over two-thirds of these procedures being carried out in private medical facilities (Ministry of Health and Family Welfare, 2016). While the prevalence of hysterectomies in India is not a recent phenomenon, as these surgeries persist as one of the most frequent surgical interventions for women after cesarean deliveries, it was the extensive media coverage of the situation in Beed that compelled the National Commission for Women to issue a formal notice to the Maharashtra State government (Scroll Staff, 2019).

This notice prompted the establishment of a committee tasked with overseeing the alarmingly high rate of hysterectomies among female sugarcane cutters in the district, which, according to local activists, exceeded the state and national averages (Shelar, 2021). The committee recommended regular medical audits and health assessments for female sugarcane cutters and directed medical practitioners to adhere to established healthcare protocols. In cases where a hysterectomy was deemed the only viable option for women below 49 years of age, physicians were instructed to obtain documented consent from the affected women (Kalia, 2023; Shelar, 2021). At the national level, deliberations on hysterectomy practices highlighted three primary challenges: the necessity for clinical and population-level guidelines, the need for accurate information on the management of gynaecological morbidities at the primary healthcare level, and the imperative to regulate the treatment of gynaecological ailments using non-invasive procedures.

To contextualise Maharashtra's case within the broader national landscape of hysterectomies, it is imperative to put to fore trends in insurance claims across different states under government-funded health insurance schemes such as AB- PMJAY. Between September 2018 and April 2019, Chhattisgarh accounted for 21.2% of all hysterectomy claims, followed by Uttar Pradesh (18.9%) and Jharkhand (12.2%) (Iyer et al., 2025). In Chhattisgarh and Jharkhand, the majority of hysterectomy claims 94.5% and 96.7% respectively were made by private hospitals. Although early hysterectomies continue to be more prevalent in private medical facilities (amounting to 67.6% in Maharashtra), the response to the PIL highlighted data from the Ayushman Bharat-Pradhan Mantri Jan Arogya Yojna (AB-PMJAY), revealing that hysterectomies constituted a 2% of the total claims submitted. Notably, Chhattisgarh, Gujarat, Karnataka, Uttar Pradesh, and Jharkhand accounted for three-fourths of all submitted claims. Within the framework of the AB-PMJAY, the most prevalent hysterectomy package encompasses hysterectomy with or without salpingo-oophorectomy, involving the removal of the uterus alongside the excision of ovaries and fallopian tubes(National Health Authority, 2021). Similarly, under the Rashtriya Swasthya Bima Yojana (RSBY) in Bihar, over 700 young women were operated upon and their uteruses removed (Itimes, 2016; A. Mishra, 2016). However, the high concentration of these procedures in a single labour force made Maharashtra's case peculiar compared to the other high hysterectomy rate states. While in Gujrat, Bihar, and Andhra Pradesh, high hysterectomy rates were linked to financial assistance schemes and community-based health insurance programs (CBHI) and Rashtriya Swasthya Bima Yojana (RSBY), in Maharashtra, this was not necessarily the case, raising questions about the reasons for a high prevalence of these procedures in pockets in the region.

My recurring dialogues with journalists and activists unveiled the media's reliance on one assertion: the widespread occurrence of hysterectomies must be contextualised within the dichotomy of either autonomous choice exercised by female sugarcane cutters or undue

influence exerted by medical practitioners. The media's extensive coverage of hysterectomies in the Beed district stemmed from a confluence of factors, primarily driven by the pervasive influence of media at both national and international levels, coupled with the concerted efforts of local activists. Local civil society organisations and activists were pivotal in shedding light on the prevalence of hysterectomy procedures within the sugarcane cutter community. These organisations specifically focused on the compelling connection between exploitative labour practices and the prevalent adoption of hysterectomies. This collective endeavour elicited a response from the state government, culminating in regulatory guidelines to monitor unnecessary hysterectomy procedures. Notably, in April 2023, the Supreme Court of India mandated that all states and Union Territories implement comprehensive health guidelines within three months, including mandatory reporting of all hysterectomies performed on women under 40 years of age (Dhananjaya Y Chandrachud, 2023). While civil society organisations welcomed these guidelines, concerns regarding their effective implementation persist.

While the media coverage was pivotal in bringing the issue of early-age hysterectomies to light, behind the widespread media coverage lay latent consequences, particularly affecting women residing close to the district of Beed, who, due to their accessibility, became focal points for extensive media attention. During my fieldwork I encountered women planning pre-migration hysterectomies and others who, despite having undergone the procedure, lacked any meaningful follow-up support, either medical or financial, from state or non-state actors – a crucial lacuna in the media's coverage. A recent report published by Lokmat, a regional Marathi newspaper suggests a potential resurgence in hysterectomies performed in Beed district (Lokmat, 2023).

Notably, this renewed rise appears to have escaped the attention of international and national media outlets. Since 2019, media narratives surrounding hysterectomies in Beed have remained largely static, failing to capture the evolving situation. This includes a lack of investigation into

both the current prevalence of the procedure and the long-term impact on the lives of women who have undergone hysterectomies. Furthermore, the media has not explored the potential influence of its own coverage on the lives of these women whose stories were shared without anonymising their names, time and again.

The women of Kodewadi, many of whom had previously undergone hysterectomies, had become adept at navigating the complex interplay of media and activist presence. However, as I observed their interactions with journalists and activists, I sensed a growing weariness and fatigue bred by the constant demand for their "hysterectomy stories" by civil society and journalists alike. This fatigue underscored the need for a nuanced understanding of the media's role in shaping narratives of hysterectomies in Kodewadi. I posit that the media's selective focus, drawn to "shock value" and emotive narratives, stripped grief and agency from the stories of documented women, overlooking hundreds who, despite undergoing hysterectomies, did not fit the desired media template of what constituted stories that could become news or evoke a mass response from the audience. Moreover, women in their 50s and 60s who had undergone the procedure decades ago were rendered entirely invisible by these reports. Against this backdrop, I grappled with the challenges of conducting ethnography in a mediatised landscape. How could I establish a genuine rapport with my respondents when the media had repeatedly infiltrated their lives? How could I convince them my intentions were not merely to extract another sensational narrative?

From the initial days of my fieldwork in Kodewadi, I was often asked:

"*Madam, camera kahaan hai?*" (Madam, where is the camera?)

"*Kya aap un activist madam k liye kaam karti hain*?" (Do you work for that activist madam?)

"*Kya aap photo lengi? Udaas ho kar baiethein*?" (Will you take your photo? Shall I sit down and look sad?)

"*Madam photo nahi loge? Sab photo lene he aate hain*. (Will you not take our photo? Everybody comes here to take our photos.)

"*Yachi mahaitihi tumhi madhyamama denar ka?*" (Will you also give this information to the media?)

"*Aaplyala traas denaaryaa goshti ughad kel yaas aapan adchannit yeoo ka?"* (Will we get into trouble if we reveal the things that cause us problems?)

The local activist who introduced me to Kodewadi was the face of most of the national and international coverage on hysterectomies and represented all sugarcane cutters who had undergone hysterectomies in Maharashtra in all the state-level government meetings. However, at the grassroots level, the dynamic between the activists and these women differed greatly from what one would initially conceive of through media coverage. Other than a handful of women in the village who were working closely with the activist and had themselves become 'brokers' through the activist for international and national media journalists, the majority of the other women in the village had apprehensions, rightly so, about the role of activism and media in improving their lives or even ethically representing their voices. The women's frustration was palpable, as expressed by not just one, but many women who questioned the sincerity of the activist's and media's motives:

"They get money from these big places; what do we get? Our *gareeb paristhihi* (poor conditions) continue. Local leaders threaten us, *mukadams* threaten us."

For instance, Vrinda, a cane cutter, and her husband both returned to her husband's village a year ago after job losses in Mumbai due to layoffs steered by COVID forced them to take up cane cutting. Before returning to Kodewadi, Vrinda and her husband were salespeople in Mumbai, with Vrinda educated till grade 5 and her husband till grade 10. Speaking of the visits of activists to the village, Vrinda expressed a sense of discomfort.

“Their focus seems limited to women who they think will lend their voices to the media. The activist madam subtly conveys disapproval whenever I participate in meetings, often asking me to prepare tea. This selective engagement gives me the impression that they seek mere puppets for media consumption, rather than genuine collaboration with diverse voices within the community who may offer different perspectives.”

The widespread non-anonymised photo and video story coverage by prominent media organisations made it easy for anybody who had seen these stories on the internet to enter Kodewadi, ask for the woman whose photo was published for the ‘hysterectomy story’, and meet them. With photos published, with names of women not anonymised or changed, nor the names of the villages, many women often mentioned their discomfort with getting their photographs clicked. According to some women, the activists, often accompanied by journalists, would enter their homes unannounced, cameras in tow, to document their experiences with hysterectomies. One resident, Asha, recounted an incident where some local activists brought a group of local journalists to report on a dowry-related issue at her neighbour’s house. Despite assurances that their identities would be protected, the family’s faces were splashed across a local Marathi channel, triggering further harassment for the young woman involved. Since then, Asha recalls, women have become scared to talk to anybody about their problems.

In early 2023, an Indian American journalist from a prominent international publication contacted me regarding her report on hysterectomies among sugarcane cutters in Maharashtra. Drawing upon my own fieldwork findings and women’s concerns regarding journalists photographing them, I cautioned them against perpetuating the existing six-year-old media narrative unless her work offered new insights. I further suggested that they consider covering the impact of government guidelines on the prevalence of these procedures. Highlighting the potential risks of compromising anonymity, I questioned the ethical imperative of publishing

women's names and photographs, especially when their stories had already been publicly disclosed. The journalist, however, remained fixated on replicating past coverage, asserting that showcasing identifiable photos and individual narratives granted agency to the women involved. My counterpoint stemmed from the latent consequences and the potential threats and vulnerabilities arising from using non-anonymised photographs. To my inquiry, the journalist dismissed these concerns as “unintended consequences” beyond the control of media coverage, justifying it merely by “highlighting the issue” and in early 2024, these stories were published replicating the same narratives as any other media coverage.

Keeping aside the lack of sufficient exploration of the sugarcane economy, the role of caste, and the life course of the interviewed women, the coverage reflected my ethical concerns about the Western gaze of the photographer and journalist photographing women who had undergone these procedures. The first few photographs in the recent 2024 media coverage included an image of a woman's stomach with her saree lifted to show hysterectomy scars. The other photograph depicted the woman sitting in her home. This was accompanied by a wedding photograph with no faces blurred. This was followed by an image of the woman lying on a bed, gazing upwards with tiredness and sadness, her stitches visible. Her young son, no more than two years old, sat beside her, his face unblurred, eating chocolate. The same woman was then captured walking out of the field with her three children, all their faces visible. In another photograph, exhausted from a long day under the scorching sun, the woman sat down to rest in the afternoon and feed her children. The image captured her two young sons, not over a few years old, being fed water while her youngest sat on her lap. Like the other children in the photographs, their faces remained unblurred.

The next photo employed drone technology to capture a woman working in the field alone. An aerial shot depicted another woman working in the sugarcane fields. The article included a series of photographs of women inside their temporary accommodations at migratory

sites. Some images captured women holding unclothed infants while preparing them for baths, photographed from a distance without their knowledge. The lack of consent extended to a photograph of a baby sleeping amidst sugarcane leaves, its face exposed, and another image depicting three women in a line, readily identifiable due to their full portraits displayed as they lifted their sarees to reveal hysterectomy scars. The ultimate violation of privacy involved publishing a photograph of a woman's medical prescription from a local government hospital, complete with her name visible and the hospital she visited.

This approach by the media resonated with a sense of dissonance I encountered during my fieldwork. Sita Tai, whose 'hysterectomy story' was published in a leading international publication, expressed shock upon encountering her photograph online when I asked if she was aware, it was available on the internet. Further conversations with her revealed that her prior engagement with journalists was limited to a single interaction facilitated by an activist solely to understand the broader issue of hysterectomies. Another respondent, Aarti, who had also shared her story with the journalists, echoed Sita Tai's sentiment: 'We used to share our lives with media people, hoping they would help us get our rights or at least get access to basic medicines. They said it would make a difference. They take photos of our faces, up and close, make money from them, and then what? Will they share any compensation with us or help us get even one dose of medicine? It is like dangling a candy of hope before a child, only to snatch it away once the cameras are gone."

The role of local structures and actors (such as activists) in brokering these conversations between journalists and women who had undergone hysterectomies can be read parallel to anthropologist Linda Green, in her insightful commentary on Paul Farmer's work on structural violence, emphasises the crucial need to move beyond solely historicising large-scale international and national structures of domination and oppression(Farmer, 2004). She argues for a nuanced understanding of how these overarching forces of oppression manifest in the

quotidian realities of marginalised communities. Green, echoing John Gledhill's concept of "micrologics of power," emphasises how power dynamics permeate everyday social relations and institutions, generating local tensions, factions, and contradictions produced in political, economic, racial, and gendered terms" (Farmer, 2004; Gledhill, 2000).

What is Newsworthy? What is "Shocking"?

"Many people come, media people mostly. But all they want to know is about our pishvi. Nothing before it and nothing after. Nothing about our children's health, nothing about our health."

The second day of my fieldwork in Kodewadi brought me face-to-face with Aradhna, a woman whose life had been thrust into the public eye through media coverage of her early hysterectomy. As I approached her, her familiar face, emerged from behind a torn saree hanging outside her house as she fed her goats. I had seen her photograph in leading national and international news publications, a visual narrative of her struggles laid bare for the world to consume.

Asha, a fellow cane pointer pointed towards Aradhna and remarked,

"Do you know her? Is she a celebrity now? *Activist madam, sab media vaalon ko us se milwati hain*." (The activist madam introduces her to all the media people)

I consciously refrained from approaching Aradhna for over a week, mindful of the potential intrusion her life had already endured. The media narrative had dissected her personal experiences, delving into the impact of her hysterectomy on her conjugal life and the tragic loss of her two-month-old baby, who was run over by a tractor at the cane factory site. However, during a visit to Aradhna's neighbour's house, her daughter arrived bearing an invitation for tea. Hesitantly, I stepped into Aradhna's home, where she prepared a meal for her husband to take to her 15-year-old pregnant daughter's in-laws. As her husband departed, Aradhna's guarded demeanour emerged.

“Are you a *patrakaar* (journalist)? Are you from the government? Are you with the activist, madam?”

”No, Aradhna. I am a student here to observe and converse with you all about your health, especially the hysterectomies women have undergone.”

”Only here to speak with me? No photographs? We are often told not to smile during photos.”

”No, you do not even have to reveal your full name. I will not use any real names in my writing. I am here to listen to you.”

Her scepticism reflected the deep-seated mistrust that had developed in response to the media’s relentless reiteration of her experience with the hysterectomies and the loss of her child–of which she was now losing a count, and yet there was no change in her life.

“But do not ask me only about hysterectomies like the media people. My life, like many other women in the village, is a series of pain - from birth to the day we die. To understand us, you need to spend days with us.”

Aradhna belonged to the Mang caste community. She has been cutting sugarcane since she was 13 years old, shortly after getting married. Now in her early 30s, she is a mother of four daughters and one son. Tragically, her first daughter passed away when she was only three months old, run over by a cane tractor at the cutting site. At 22, fearing cancer after developing irregular menstruation as indicated by a private health practioner, Aradhna underwent a hysterectomy. This experience, along with the earlier death of her child, became the focus of media reports. However, these accounts often lacked context about the numerous biological and non-biological factors that shaped these events and continue to influence Aradhna's life.

Just months before the hysterectomy, Aradhna had undergone a state-incentivised sterilisation procedure (tubal ligation). After this, she stopped menstruating entirely. When this persisted

for months, she visited a private doctor. The doctor informed her that her ultrasound revealed a swollen uterus with a "knot" (fibroid), and warned that without surgery, within a week, she could develop cancer and die. Fearing the long-term financial and physical burden of such an illness, Aradhna paid Rs. 40,000 for the hysterectomy equating to almost one year's collective income. Despite asking about alternative treatments, the doctor insisted surgery was the only option. Within weeks, Aradhna was back working at the sugar factory and farms. However, she soon began experiencing body aches. Within two years of the hysterectomy and one year of the tubal ligation, she faced another surgery, an appendectomy, for which she paid another Rs. 60,000.

Since the hysterectomy, Aradhna has gained weight, noting, "I was as thin as you, not anymore." She also struggles with persistent body aches, anger, and sadness. Even minor problems feel overwhelming. In addition, she suffers from urinary tract infections and difficulty passing urine, with occasional burning pain. Working conditions at the factory are poor. "At times, we have to drink gutter water," Aradhna shares, describing dirty water, sometimes with floating plastic, as the only available option. "Everyone gets sick," she adds. Despite the lack of proper sanitation facilities at the factory site, which others inquire about, Aradhna says,

"What toilet? Before we migrate, the whole land is a toilet. It smells, but we clean and make our makeshift homes. There is no time or place for women to even take a proper bath. We wrap a saree around ourselves and bathe in the open."

While the recent media explosion of "hysterectomy stories" had undoubtedly sparked crucial conversations, critical blind spots persist. Firstly, scant attention is paid to the impact of media exposure on these women's lives. Questions regarding potential threats due to non-anonymisation, interventions implemented, and improvements (or deprivations) in their lives after media involvement remain largely unexplored. Secondly, existing narratives, as

exemplified by Aradhna's case, portray hysterectomies as isolated, decontextualised surgical events. They fail to examine how specific bodies – particularly those of marginalised caste groups like Mahar, Mang, and Vanjari communities become targeted for a series of violence throughout their lives, not just at a single point. These narratives, often prioritising sensationalism over nuance, neglect to situate the experiences within the broader context of both pre- and post-hysterectomy healthcare, encompassing both state-funded and private interventions. Thirdly, the prevalent narratives tend to overlook the experiences of older women, now in their sixties and eighties, who also underwent the procedure decades ago- thus positioning hysterectomies as "modern" and a "recent" technology. As Asha's poignant remark about Aradhna ("Is she a celebrity?") highlights, certain life stories garner undue attention while others remain invisible. Furthermore, these dominant narratives often stray from the complexities of the biomedical context, resorting to simplistic and linear framings. They tend to portray sugarcane as the sole culprit, driven by a supposed doctor-contractor nexus fuelled by profit motives.

While the sugarcane industry's exploitative nature and physically demanding labour undoubtedly contribute to women's health issues, my research suggests a far more nuanced reality. The decision to undergo a hysterectomy is often a complex negotiation shaped by diverse factors, including women's local understandings of biology, their prior medical encounters, and individual circumstances that extend beyond the clinic walls and the direct influence of the state. Crucially, my research found no evidence of a direct collusion between doctors and cane contractors facilitating hysterectomies. For many contractors, daily cane-cutting quotas were indifferent towards women's health or reproductive autonomy, regardless of their reproductive status. Therefore, I argue for a critical shift in perspective. Viewing hysterectomies as isolated biomedical encounters fails to capture the full scope of women's lived experiences. To meaningfully understand these procedures, we must employ a life course

approach- to trace back the threads of their lives, from birth to the very end (Chapter 3). Only then can we hope to unravel the intricate entanglements of biological, social, and economic factors that shape these decisions and their enduring consequences.

In their seminal work on Indian famines, Amartya Sen and Jean Dreze (1990) astutely observe the paradoxical nature of media attention to food scarcity (Drèze & Sen, 1990). While catastrophic events like famines, marked by sudden death, capture headlines, endemic malnutrition, a "slow and insidious form of hunger, often remains shrouded in silence despite claiming far more lives in the long run" (Drèze & Sen, 1990). This disparity reflects a deep-seated societal tendency towards sensationalism and shock value, overlooking the "less loud, less obvious" chronic suffering that lies beyond the realm of immediate crisis(Drèze & Sen, 1990). This phenomenon is evident in the recent media coverage on hysterectomies among sugarcane cutters in Maharashtra. Despite the procedures and their prevalence for decades, a sudden surge in reportage, followed by mere duplication within a year, overlooks the enduring nature of this issue and the complex social, political, economic, and biomedical factors shaping it across generations, with many families having more than two women in the last three generations, who have undergone hysterectomies. This selective representation, driven by public action focused on "fixing" the decision-making of women undergoing hysterectomies, perpetuates a limited view. Consequently, the long-term impacts on women's bodies, families, and daily lives–beyond the ability to labour are neglected. Oral histories gathered from women who underwent these procedures decades ago, as I will explore in later chapters, reveal early deaths and other long-term consequences often left unspoken. Often subjected to repeated interviews and photographs, their individual stories becoming stand-ins for a complex and multifaceted issue. The repeated dissemination of these sensationalised narratives has profoundly impacted the women themselves. Their families often express concerns about their safety and privacy, fearing local leaders and a lack of support or compensation. For instance,

often, I was asked, "*Madam, tumchi tankah kiti aahe?"* (Madam, what is your salary?) – often followed by inquiries about funding sources for my fieldwork.

While the impact of trauma reporting on journalists and its potential for empowering communities is well-documented, particularly in contexts of war, conflict, and health vulnerabilities, two critical gaps remain (Kaur & Arora, 2025; Payne, 2005; Surmiak, 2018). Firstly, scant attention is paid to the latent consequences, especially for marginalised individuals and communities exposed in media narratives. These marginalised populations, defined by gender, caste, religion, and class, face a hidden web of risks arising from their participation. This unexplored territory includes threats from local power structures (e.g., political leaders, upper caste contractors), the potential for exploitation through uncompensated interviews, the dangers of inadequate anonymisation leading to further vulnerabilities, and the ever-present reality of their plight remaining unchanged despite public exposure. Secondly, the voices of the participants themselves, those whose lived experiences form the core of these narratives, often go unheard. Women like Aradhna, who have recounted their harrowing tales of hysterectomy on multiple occasions, serve as powerful reminders of this silence. Despite their openness, they have witnessed no tangible improvements in their lives, no access to promised relief measures, no recompense for their time, and no escape from the cycle of poverty and marginalisation. This raises compelling questions about the ethics of such engagements, particularly when participants feel exploited while the stories continue to benefit others at a distance.

It is crucial to emphasise that this critique does not advocate for ceasing the documentation of narratives of marginalised communities altogether. Instead, it argues for the need to incorporate empathy and transparency as a core principle in research methodologies. This empathy transcends mere extraction and hierarchy; it necessitates acknowledging and addressing the potential discomfort felt by both participants, and by researchers while engaging with what

they see as being ‘uncomfortable’ and ‘uncontainable’ aligns with Wanda Pillow's(2003) concept of “uncomfortable reflexivity”- a reflexivity she terms as being grounded in seeking to know but simultaneously situating this very knowing as complex (Pillow, 2003).

Doing The “Good Enough” Ethnography: Three Stages of Doing Fieldwork

As Amanda Coffey posits in her work, ethnographers should consciously be cognisant of their and the fieldwork’s ability to ‘construct, reproduce and implicate selves, relationships and personal identities’ (Coffey, 1999). Building on this foundational insight, and in response to concerns raised by participants regarding the limitations of the “participant observer” role within increasingly mediatised research landscapes, this section seeks to engage with two interrelated questions. First, how might we conduct ethical ethnographic research that resists replicating the very inequalities it aims to uncover? Second, how can we meaningfully preserve the voices of our participants while acknowledging the inherent representational constraints of the discipline? As the subsequent chapters will demonstrate, this thesis heavily relies on verbatim quotes to present “life as it is” and foreground the women's narratives. However, this approach necessitates careful consideration, particularly within a context saturated by mediated communication. This section explores how ethnographic research can navigate this “turbulent landscape” and grapple with the ethical complexities of representation in the writing process. The following sections explore three key stages- entering a certain space, production of space and doing ethnography, that emerged as crucial in shaping the contours of my fieldwork and ethnographic method. These stages offer a framework for navigating the complex ethical considerations in the ethnographic encounter. While acknowledging that such a framework is not foolproof, it nonetheless proved valuable to me in fostering a nuanced approach to ethnographic practice.

In a way, my fieldwork finds inspiration in the phenomenological approach outlined by Paul Rabinow (Rabinow, 2001, 2011). Drawing on the work of Paul Ricœur, Rabinow proposes that

anthropological understanding emerges not from a pre-existing reality, but from the unfolding of the research process itself (Rabinow, 2001, 2007). He emphasises that the "facts of anthropology", the data gathered in the field are inherently interpretative. They are mediated by both the cultural lens of our subjects and our own analytical framework. Rabinow further characterises fieldwork as a "process of intersubjective construction of liminal modes of communication". This construction entails a collaborative effort, where both researcher and subject contribute to shaping the experiences and assumptions that emerge. Notably, this process occurs in a "public sphere" where communication, though often rooted in pain, is rarely opaque. Within the ethical considerations of conducting fieldwork, a recurring question thus emerges: how often do we, in positions of relative privilege, decline requests for a brief interaction from surveyors or salespeople who visit our homes? This commonplace scenario compels us to critically examine our expectations when approaching vulnerable communities, particularly those belonging to marginalised caste and class groups.

Peter Oakley (1995) notes in thinking about participation among rural people,

"Participation…cannot merely be proclaimed or wished upon rural people… It must begin by recognising the powerful, multi-dimensional and, in many instances, anti-participatory forces which dominate the lives of rural people. Centuries of domination and subservience will not disappear overnight just because we have 'discovered' the concept of participation"(P. Oakley, 1995)

As Paul Farmer aptly observes, ethnographic inquiry, in its pursuit of truth, often centers on the observable present, the "ethnographically visible" (Farmer, 2004). Hughes and Bourgois argue in their critical commentary on Farmer's work on structural violence, this focus can inadvertently obscure the unexpected and unwanted – the forms of violence whose visibility is masked by overarching global power structures (Bourgois, 2007). They therefore advocate for

a broader ethnographic gaze, one that actively seeks to unveil these “ethnographically invisible” contours, revealing the crucial connections between violence, suffering, and power.

In her critique of traditional research methods, Ann Oakley challenges the pursuit of absolute objectivity in interviews (A. Oakley, 1981). While unavoidable, she posits that the researcher's involvement should not be construed as a “dangerous bias” but rather as an essential element in navigating the intricate nuances of human interaction. Oakley further critiques the neglect of emotions within sociological research, attributing this oversight to the influence of a detached, “scientific” approach often associated with “male culture”. These concerns gain heightened relevance when considering ethnographic research, which traditionally employs participant observation methods that strive for both objectivity and immersion in the daily lives of research subjects. However, it is crucial to acknowledge the inherent power dynamics at play. Ethnographers often occupy positions of relative privilege compared to the marginalised communities they study.

Oakley further critiques the tendency in social sciences to translate research findings into academic publications, essentially drawing and documenting interpretations of people's lives, often without their direct participation or benefit (A. Oakley, 1981). This raises a critical question that echoes Geeta's inquiry: “How will I benefit from talking with you?” It is often challenging to provide a definitive answer that adequately justifies the impact of an ethnographer's intervention. While many anthropologists value their work as a means of empowering marginalised voices, the question of how research subjects perceive this agency still needs to be explored. As Oakley aptly notes, “The convention of interviewer-interviewee hierarchy is a rationalisation of inequality; what is good for researchers is not necessarily good for research subjects (A. Oakley, 1981)“.

While discussing my fieldwork plans with a colleague, I was advised to reside in the homes of the women I interviewed to gain a deeper understanding of "what they go through" or "obtain a complete picture of their lives". While this approach would undoubtedly offer valuable insights into the quotidian realities of research participants, I grapple with how to interpret these observations without situating them within the broader context of their life histories. For instance, how can I truly comprehend the lived experiences of a woman who was married off at the age of six for a mere INR 200, followed by multiple pregnancies, miscarriages, and a hysterectomy by the age of 22, and menopause at 25? Can ethnographers, then, claim the mantle of objective participant observers based solely on months of fieldwork, confidently asserting immersion into experiences shaped by decades of violence? Or as Pillow observes, 'Can we truly represent another?' Who really benefits from our attempt to 'represent'?(Pillow, 2003) The audacity of summarising, in a few hastily chosen words, the intricate narratives of violence and suffering that mark our respondents' lives raises ethical and epistemological concerns. Does such an approach genuinely constitute a "method" worthy of being designated as "real science", grounded in methodological and academic rigour?

Entering a Certain Space

Making an entry into a space marked by the deep-seated vulnerabilities of its respondents–in my case, female sugarcane cutters from Mahar, Mang and Vanjari caste groups who had undergone hysterectomies at ages as young as 20, a space where years of violence, both physical and emotional, have been woven into the fabric of everyday life, presents a formidable challenge for an ethnographer. The scars of neglect, etched by the state's abdication of its responsibilities, and the relentless exposure to media scrutiny, yet devoid of any tangible recourse or improvement in their lives, create a terrain fraught with ethical complexities.

The initial entry into this space is a critical juncture, demanding careful consideration of the approach and the role of intermediaries. Invariably, as an outsider, gaining access to certain

spaces often necessitates the assistance of local facilitators, activists, or other contacts. While these contacts may initially appear to be the most ethical and well-informed guides, it is only through deep immersion in the field that one uncovers the underlying complexities that can inadvertently introduce bias, even in the most well-intentioned intermediaries. However, the critical challenge emerges from understanding how one enters this certain space and becoming cognizant of these intricacies, which are often overlooked in the dominant discourse of 'doing ethnography'. Moreover, when entering a certain space where each space has been ridden with failure of both state and non-state actors, the ethnographer is initially perceived as another entrant. They are seen as someone there to replicate the hopelessness, failure, and a stark reminder of the shared violence of 'hysterectomies', the question which they seem to be interested in yet have no impact on the lives of the respondents. The respondents continue to recount the miseries of their lives over and over, only to be failed again, yet another privileged outsider benefiting from their violence, now as an academic pursuit. The challenge for the ethnographer lies in shattering the illusion of these assumptions, which are justified, and navigating a path to carving out the field from the space at hand.

Production of Space

In my ethnographic exploration of Kodewadi, I use Henri Lefebvre's conceptualisation of space as a product shaped by social dynamics (Lefebvre, 2014; Soja, 1991). Lefebvre's triad of space—encompassing the tangible (physical), the representational (discursive), and the experiential (lived), frames my investigation. Kodewadi's physical space manifests as a tangible entity, a geographical location marked by the presence of women who have undergone hysterectomies and other surgical interventions. However, this physical space is not merely a passive backdrop but actively shaped by the discursive forces and lived experiences that converge upon it. Kodewadi embodies a convergence of these spaces, particularly spotlighting discursive spaces moulded by media portrayal. These spaces define specific areas within Beed,

not only as locations where women have undergone hysterectomies but also as arenas where their experiences are repeatedly sensationalised, catering to a predetermined narrative aimed at eliciting shock and intrigue.

The shaping of this space, influenced by Lefebvre's theories, reflects the ethnographer's endeavour. It goes beyond merely interweaving the perceived, conceived and lived dimensions within the field of study. It is about carving out a space for ethnographic inquiry while remaining acutely aware of and challenging respondents' preconceptions. This necessitates the adoption of 'uneven immersion' as an ethical strategy by acknowledging the inherent power dynamics in ethnographic research and calls for a nuanced approach to immersion that is sensitive to the perceptions and experiences of those being studied (Krause, 2021). This approach seeks to deconstruct respondents presumed familiarity with the ethnographer, thereby facilitating a more nuanced engagement. It recognises the fluidity of access, rapport, and connection when working with different populations. Uneven immersion, in this context, emphasises a flexible and adaptable ethnographic approach. This is crucial to counter simplistic portrayals of the women, who have not only endured surgical procedures but also decades of systemic violence. As Farmer argues, structural violence is not solely rooted in political economy, but also intricately intertwined with historical and biological factors. My ethnography, through genealogical tracing and documenting life histories of the women, aims to elucidate this inseparable connection (Farmer, 2004).

Initially, especially in Kodewadi and Ariwadi, husbands often expressed skepticism, urging their wives not to "waste" time with me, fearing I would simply exploit their stories without bringing any change. My assurance of anonymity – promising not to photograph, record, or even note their names and emphasising the potential for future interventions through the narratives I capture, provided little comfort. I offered them the option to decline participation,

even going so far as leaving my phone, notebook, and pen behind to prioritise open-ended conversations, not structured interviews. As Malavika Karlekar aptly notes,

“If this is a problem with fieldwork, it is compounded when the camera enters the arena, even if it is a phone camera that might be less unobtrusive. Often, the appearance of photographic paraphernalia in remote villages is the cause of great excitement, agitation and at times unease. Generations of colonial photographers and post-colonial field workers may have chosen to overlook the Roland Barthesian notion of the disturbance caused by the photograph, but today it is no longer possible to do so. Responsible field workers need to acknowledge that their work with pen, laptop recorder and camera is often invasive.” (Karlekar, 2017)

Truthfully, I grappled with the uncertainty of my academic work's impact on their lives. Despite these initial hesitations, many women actively participated in conversations, especially when free from the pressure of cameras and fixed interview questions. Instead, they sought open dialogues, not ones designed to elicit pre-determined answers but to truly listen. They often took the initiative, asking about my work and experiences, shaping the conversation's direction. At times, I found myself becoming the subject of inquiry, allowing them to explore their own curiosities and concerns. This level of engagement underscores the necessity of deconstructing the inherent power imbalance within the interviewer-interviewee dynamic. It compels ethnographers to move beyond the traditional focus on “knowing the other” and instead prioritise developing adept self-representation. This approach acknowledges that, similar to the ethical expectations placed on participants, ethnographers also hold a significant responsibility towards those they engage with(Visweswaran, 1994). While acknowledging the persistence of subtle power differentials even with conscious efforts to flatten the hierarchy, I challenge the implicit expectation that ethnographic subjects are obligated to share their stories. Instead, I emphasise a shared responsibility between researchers and participants. This necessitates recognising our own vulnerabilities as researchers and embracing the possibility of reciprocal

vulnerability by becoming interviewees ourselves, answering questions whenever it fosters genuine dialogue and mutual understanding or as Ann Oakley notes, “both interviewer and interview are depersonalised participants in the research process” (A. Oakley, 1981).

Doing Ethnography

Ethnographic research demands attentiveness to historical context, not just as a distinct discipline but also as the backdrop of past attempts to give voice to marginalised communities. Farmer (2004) aptly reminds us that these attempts are embedded within broader social, economic, and political structures that shape both local biologies and the pain associated with them (Farmer, 2004). As we saw in the preceding sections, failing to carve out this space as an ethnographer, and ignoring the potential impact of our work on participants, undermines the very ethics of conducting such research.

The intricate dynamics of Kodewadi, mirroring the wider social landscape, demanded an approach that transcended traditional sociological and ethnographic methods. As a participant observer in this complex space, I found deviating from formal protocols of interviews and survey tools (Fujii, 2015, 2017). Instead, I delved into the seemingly mundane everyday interactions. I tried to immerse myself in the women's lives, engaging in conversations that extended beyond the immediate topic of hysterectomies. Moving beyond the conventional image of the detached observer, my ethnographic research in two Marathwada villages attempted to, if not successfully, privilege a reciprocal exchange of personal narratives. As Oakley (1981) aptly notes, “there is no intimacy without reciprocity,” and this exchange fostered a profound sense of connection. We became individuals sharing a common space, our lives intertwined through the threads of conversation (A. Oakley, 1981). This mutual engagement challenged the notion of anthropological knowledge as passively “extracted” from unsuspecting informants (Scheper-Hughes, 1991). Instead, it emerged organically through dialogues and interactions, acknowledging the inherent subjectivity of both researcher and

participant. This commitment to reciprocity became particularly poignant when faced with the raw vulnerability of young women's narratives. Hearing stories of infant deaths at factory sites, miscarriages, hysterectomies' long-term impacts, and forced marriages to men five times their age, the pretense of objective neutrality became untenable (Paul 1954). How could one remain detached when the research offered no tangible benefit to their lives, merely documenting responses deemed necessary for the academic project while dismissing the unsaid as irrelevant? This compels us to reconsider how research participants perceive the ethnographic process and what they hope to gain from it. Reciprocity transcends rapport-building; it necessitates creating a space where vulnerable participants can assess whether baring their pain serves a purpose beyond mere data collection. They deserve assurance that their stories transcend the sterile realm of academic analysis, just as their hopes for a better life, once shared with media personnel, transcended empty promises.

Over the course of countless conversations with over 150 women, a remarkable narrative emerged, not just of hysterectomies, but of the life course that led to them and the subsequent experiences that followed. Margaret Lock's (1994, 2006) concept of 'local biologies' proved invaluable in contextualising these narratives (Lock, 1994, 2006). Through this lens, I attempted to recognise that the women's experiences with early-age hysterectomies were not merely biological or socioeconomic in nature; they were deeply interwoven with cultural factors and the subjective experiences of the women themselves. This dialectic became increasingly evident during my interviews. When asked about their reproductive surgical history, hysterectomies emerged as one of many invasive encounters with biopower that women had endured throughout their lives–and not a standalone procedure that women registered for immediately. These encounters were often linked to early marriages as young as six years of age, multiple closely spaced pregnancies, miscarriages, caesareans, obstetric violence, marital rape, rape at the workplace, recurring morbidities, sex-based abortions, and

state-incentivised tubal ligations, all of which contributed to the normalisation of hysterectomies. For the media, early-age hysterectomies were a ‘scandal’, a sensationalised headline. But for the women, hysterectomies were merely one among many breaches of their bodily autonomy, a consequence of both the presence and absence of state interventions throughout their lives, a narrative that the media overlooked. These interactions, the cornerstone of my ethnography, allowed me to listen attentively to their stories of childhood, marriages, joys, and struggles. In turn, I shared glimpses of my own life, my childhood experiences, and future plans. These conversations, while might have not found place in the research design seemingly mundane, emerged as the foundation of my ethnographic work, not as an accident but something I anticipated to emerge as a part of the method I was planning to pursue.

In Nancy Scheper-Hughes’s (1991) seminal work, she delves into the transformative nature of anthropological engagement, emphasising its impact on the self while cautioning against altering or fragmenting the lives of those we encounter (Scheper-Hughes, 1991). While acknowledging the impossibility of conducting ethnography without leaving a trace, Scheper-Hughes emphasises the importance of ethical accountability and answerability to the communities studied. In her words, anthropology is a repository of the field of knowledge and a sphere of meaningful action. Even as I endeavoured to lend a voice to these women, their lived realities remained largely unchanged. Geeta, burdened by debt incurred to finance her husband’s medical care, continued her struggles. The women among my respondents who had undergone hysterectomies and were still paying off portions of the surgery remained in financial strain. The women who had experienced the physical and emotional toll of these procedures continued to face the challenges associated with their long-term health implications.

This sobering realisation was underscored by the tragic deaths of two of my respondents, one in her late 50s and one in her late 60s, who had undergone hysterectomies before the age of 30. Both succumbed to cardiovascular illnesses, one in the final month of my fieldwork and the other a month after I completed my research. Their passing served as a stark reminder of the enduring impact of these procedures on women's lives. Despite overcoming the challenges of doing ethnography, a question lingered: How had my conversations with Geeta and the other women impacted their lives? Had they gained anything tangible from our interactions? The answer, I realised, was both complex and humbling, and it aligned with what Scheper-Hughes (1991) notes as "compromise" - carrying out the practice of a "good enough" ethnography - one that acknowledges the cultural self (Scheper-Hughes, 1991). Flawed cultural translation and the baggage of the ethnographer persist, yet there remains a striving to give voice to those whose voices have become lost in the media landscape. The aim is to centre the lives of the women as a descriptive ethnography of what I call "life as is," grounded in compassion and empathy.

Here, I draw on Clifford Geertz (2007) who observes that the credibility of anthropologists does not depend primarily on the factual accuracy or stylistic elegance of their work (Geertz, 2007). Rather, it hinges on their ability to persuade the reader that their claims arise from having genuinely "been there" from a form of experiential penetration. Geertz emphasises that the way this process is conveyed is where writing plays a crucial role. I take inspiration from Hughes, who conceptualises ethnographic practice not merely as a series of interviews but as a relational and narrative method. Through her work, Hughes foregrounds the role of the ethnographer in navigating the cacophony of mediated representations, advocating for an "ethnographer-writer" whose task is to amplify voices that are routinely silenced—not only by the state but also by non-state actors (Scheper-Hughes, 1991). This perspective is particularly resonant in the context of women like Tarabai (whose narrative is explored in Chapter 3), who repeatedly

asked when I would return for a *mulaqaat*. Towards such individuals, the ethnographer holds a responsibility and accountability, not to theorise lives and trauma for academic pursuits, nor to present an ethnography that only seeks to answer a "hypothesis". Instead, it aims to connect the work to potential interventions in the near future. Ethnographers must strive to take their narratives beyond the silos of publishing and scholarly endeavours and use their privileges to at least attempt to pave the way for meaningful grassroots policy interventions.

Conclusion

"My debt to those who allowed me to enter into their lives, knowing I would write about them, will never be fully repaid. I cannot, ever, make myself vulnerable enough."- (Behar, 2022)

"We will forgive you Nanci. After all no one is here innocent" (Scheper-Hughes, 1991)

The first day of my fieldwork in 2022 unfolded within the hall of a local temple in Ariwadi. As I introduced myself to a group of women, I noticed the amused giggles of young girls peeking from the doorway. Swati, a nine-year-old girl, approached me readily, her hand finding mine with a smile. She asked, "*Dilli vali madam, Tumache lagna jhale ahe ka*?" (Are you married, madam from Delhi?). I responded, "Not yet, but soon". However, while speaking with her, a gold chain and dangling earrings caught my attention, unusual for young girls in Maharashtra, especially at her age. Jaya, one of my first respondents, in her late twenties, offered an explanation.

"Tai, that is a *mangalsutra*. Swati was married just two nights ago, around midnight, to her maternal uncle, who is thirty."

My gaze instinctively shifted back to Swati. "Do you know what your husband does for a living?" I asked. "*Sheti*", she replied simply, meaning "farming". Jaya chuckled and added.

“Tai, he is a sugarcane cutter. He paid Swati's family INR 2.5 lakh. Swati is now ‘booked’. You know, something must be wrong with him that he could not find a *mulgi* (girl) to marry before”.

Tarabai, another cane cutter woman in her late sixties, chimed in

“*Agobai* the boy barely earns anything. Who would give him a bride otherwise? She will stay with her mother for two years. After her *padi* (first period), she will join her husband, cutting cane with him by the time she is thirteen or fourteen”.

Laughing she added,

“I was married when I was six years old. One can only hope she does not end up having the same life as me.”

In such a scenario, among other narratives illustrated in this chapter, the pursuit of objectivity, often touted as a cornerstone of sociological research, becomes increasingly challenging when engaging with individuals whose life experiences diverge significantly from one’s own. I note that the act of immersion itself is inherently political and incomplete and carries the potential to replicate the very inequities that researchers aim to critique. In Kodewadi and Ariwadi, my interactions with women, many who were my age, who were married off as young as six, had become grandmothers at my age, and had undergone hysterectomies presented a unique set of ethical and emotional considerations. In such a context, the evocation of a “deeply emplaced” (Beatty, 2005) emotion is not one to be theorised or rationalised but rather embraced as a tool for navigating conversations that offer a glimpse into these women’s lives. While an ethnographer, no matter how immersed in the field, can only gain a partial understanding of these women’s experiences, in this chapter I posit that a deeper connection emerges in a space where their narratives can unfold on their own terms and lay bare the fluctuations and compulsions shaping their lives, not only focusing on hysterectomies but the unexpected encounters that might not seem apartment but were critical in leading up to the procedure.

Detached conversations, often the hallmark of traditional ethnographic encounters, hold little value for the women of Kodewadi and Ariwadi. They yearn for a reciprocal exchange, stories that go beyond the confines of newspapers, and narratives that resonate with their own lived experiences. This uneven immersion, this willingness to engage with the women on their own terms, allows the ethnographer to challenge their assumptions and reshape their understanding of what constitutes the 'credible' and the 'normal' (Krause, 2021).

In her reflections on ethnographic practice, Ruth Behar identifies a central struggle: the challenge of capturing and conveying the "ethnographic moment" (Behar, 2022). She grapples with the inevitable disparity between the lived experiences witnessed and the limitations of anthropological representation. The act of translating diverse voices into academic publications, often presented in comfortable settings far removed from the field, carries an inherent irony. Behar poignantly highlights the public nature of anthropological research, where the uncertainties experienced in the field and the voices of informants are often instrumentalised and can paradoxically transform into positions of authority back home. As I, too, illustrate through Geeta's narrative at the beginning of this chapter, the lives of research participants often remain unchanged or even worsen while anthropologists move on to disseminate their findings. Building upon Clifford Geertz's work, Behar seeks to address the looming gap in genre and language that, according to Geertz, fails to articulate the complexities of fieldwork (Behar, 2022; Geertz, 2007). This thesis, and this chapter in particular, aspires to contribute to the discourse on not only what transpires in the field but also take it a step forward and ask how the work of witnessing as a participant observer and the 'doing of ethnography' raise critical questions and concerns about the ultimate purpose of academic research and its distinction from the pursuits of journalists and activists.

Chapter 2

"Don't you want sugar in your tea? We got to work for that": Booming Cane, Depleting Lives

Introduction

"We have nothing to do with the cane cutters. We hire contractors who hire sub-contractors, who then hire cane cutters. They are not our workers."

"humara ganna katne valon se koi lena dena nahi hai. Hum thekedaron ke saath kaam karte hain jo mukadam se kaam lete hain jo fir ganna katne valon ko kaam dete hain. Yeh humare worker nahin hai"

- Managing Director of a sugar factory in Western Maharashtra.

The scholarly inquiry in this chapter is informed by a multi-sited ethnographic investigation conducted among sugarcane cutters from the Vanjari, Mahar, and Mang caste groups in the Beed district of the Marathwada belt in Maharashtra and the sugarcane belt of Maharashtra(Kolhapur and Solapur). Rooted in the context of recurring drought-induced seasonal migration, this chapter undertakes an exploration of the corporeal consequences experienced by female sugarcane cutters in the rural domains of Maharashtra. Drawing on extensive ethnographic accounts, I attempt to illuminate the lived experiences of female cane cutters, who are compelled to migrate alongside their families to the water-fed sugarcane belt of Western Maharashtra for six months. Through this, this chapter endeavours to discern how the modality of employing husband-wife dyads–known as '*koytas*' as a collective familial working unit interfaces with the manifold repercussions of socio-economic, political, and ecological transformations, resulting in the marginalisation of women to the vulnerable fringes of the rural periphery.

Against this backdrop, this chapter scrutinises the collective system of taking an advance or *uchal*, which entails the wage for the combined labour of both husband and wife and the subsequent impact on where, how, and on whom the monetary resources are spent. Often, this dynamic engenders the subordination of women's bodies, reinforcing adherence to capitalist and patriarchal regimes within the agrarian industry. Of particular significance is the focus on female sugarcane cutters who have undergone hysterectomy procedures as early as 22 years, an intervention predominantly financed through advance wages procured from cane contractors shortly before migration to the sugar fields. For women, these surgical interventions serve as biosocial strategies to mitigate imminent mortality or persisting morbidities arising from recurring gynaecological morbidities. By tracing the prevalence of unwarranted hysterectomies, which aim to enhance the productivity of reproductively capable bodies within the cane fields, this chapter seeks to offer critical yet unsettling insights into the intricate interplay of gender, caste, agrarian labour, and capitalist dynamics. Situated within one of India's most financially lucrative agrarian domains, it engages with the question of the medical-industrial complex, capital, caste oppression, and migration through an interdisciplinary lens.

While existing ethnographic literature on the sugar industry in India remains limited, in the context of the sugarcane economy in Maharashtra, sociologist Donald Attwood (1992) defines enterprising peasant families as consciously evolving their skills to combat and cope with risk and taking advantage of different opportunities (D. Attwood, 1992). Particularly in the case of the sugarcane economy in rural Maharashtra, he describes the ideal family as a patrilineal, patrilocal and joint family consisting of elderly married couple, their sons and their wives and grandchildren (Attwood, 1992). He further notes that the family as a social unit needs to be continuously maintained and reproduced to facilitate surplus labour in some cases, and education should be provided to at least one or more sons to secure employment in a factory or other white-collar jobs, although this is not always the case.

While Attwood effectively brought the question of the family to the centre stage with his detailed ethnographic account of Malegaon in Maharashtra, he acknowledges his limitation of failing to address the question of gender and sexual division of agricultural labour, therefore overlooking the role of women in the cane fields of Maharashtra. This gap is particularly significant given Radha Kumar's observation that, despite the amount of labour women carried out, their wages were seen as supplementary, even by the women themselves, even when this was not the case (Kumar, 1983). With an attempt to address this gap through a renewed gendered lens, this chapter brings to the fore the peculiarity of the contemporary sugarcane farms in Western Maharashtra, with a particular focus on the role of female labourers working in familial enterprises in sustaining the sugarcane economy of the region and the subsequent impact of the exploitative labour relations and precarious working conditions on their health and wellbeing. The physically taxing nature of sugarcane labour, which necessitates extended work hours, has resulted in the imposition of additional unpaid domestic labour on female labourers, further compounding the difficulties faced by this already marginalised workforce.

A study commissioned by the Maharashtra State Commission for Women in 2018 found that 36% of female sugarcane labourers in the State had undergone hysterectomy procedures(Shukla & Kulkarni, 2019). In June 2019, the Health Minister of Maharashtra, Eknath Shinde, revealed in the Maharashtra Legislative Assembly that 4,605 female sugarcane farmers had undergone the procedure over the past three years (Chatterjee, 2019). A recent study indicated that in 2019, 8.6% of female sugarcane cutters across eight districts in Maharashtra, including Beed, underwent hysterectomies, a rate four times higher than the state average of 2.6% (Ministry of Health and Family Welfare, 2016; Oxfam, 2020). While the prevalence of early-age hysterectomies continues to prevail among rural, low-income women, the heightened frequency of these procedures in a single labour force within a particular agrarian sector emerges as a particular point of juncture–thus prompting the need for an

ethnographic exploration into the relationship among labour practices, rural precarity and women's reproductive health.

In elucidating the case of rural Maharashtra, I aim to provide insights into the interconnectedness of the economy of female labourers' bodies within capitalist agrarian systems and the economy of their medical subordination, as manifest in the practice of early-age hysterectomies. The first part of this chapter delineates the paradoxes and *realpolitik* of seasonal migration, exploitative labour relations, gender norms, agrarian distress, and inadequacies within public health facilities leading to chronic afflictions. The second part of this chapter explores the ethnographic dimensions of agrarian economies in Western Maharashtra to examine how workplace precarity, the compulsion to labour as a cohesive unit or a dyad, and the obligation to share collective wages compel women to reconceptualise their 'reproductive bodies' as 'productive bodies'. This transition, I highlight is oriented toward fulfilling labour-intensive demands once their childbearing role is completed, at times exemplified by the recourse to hysterectomies. The chapter then sheds light on how the importance ascribed to familial well-being, propelled by the imperative of collective wage-earning, frequently pushes women to compromise their own health unless their physical well-being directly emerges as a hinderance to their ability to carry out recurring wage labour. Following economist Padmini Swaminathan's (1997) conceptualisation of women's labour as a 'Hobson's Choice'– the conundrum between work and reproductive autonomy, this chapter further unpacks causal relationships between labour and reproductive choices with a particular focus on the recourse to biomedical procedures such as hysterectomies as an expression of the reproductive-productive continuum (Swaminathan, 1997). Through ethnographic vignettes, I spotlight the reified inequities that emerge within women's home villages, finding fertile ground for facilitation and amplification within the migratory worksite.

Setting: Caste, Land, and Labour in Marathwada

During my 12-month multi-sited ethnographic fieldwork, I conducted research in two villages, designated here as Ariwadi and Kodewadi, situated in the Marathwada region. Additionally, I explored sugarcane farms and sugar factories in the western belt of the state, particularly focusing on Kolhapur and Solapur, where residents from Ariwadi and Kodewadi migrate annually for cane-cutting labour. Ariwadi features a mix of housing structures, including a limited number of brick-built homes, while the majority consist of rudimentary shanties constructed from tin sheets. In contrast, Kodewadi is characterised by semi-pucca houses. In both villages, dwellings typically comprise a single room that serves as both a sleeping area and kitchen for the entire family.

The physical accessibility of Ariwadi is significantly constrained due to the absence of a properly constructed road, resulting in a narrow, muddy path traversing expansive fields. Located approximately 80 km from the central district, Ariwadi faces considerable challenges in establishing connectivity with neighboring villages and the local administrative unit (tehsil). In contrast, Kodewadi is situated merely 10 km from the central district of Beed. Consequently, women in Ariwadi often recount experiencing transportation via bullock carts or motorcycles to reach the nearest *pakka* (metalled) road during labour (child delivery) or pregnancy-related complications. Compounding these issues, the village suffers from a severe lack of sanitation facilities; many homes lack basic amenities, such as toilets and bathrooms, thereby as respondents note, forcing villagers to resort to open fields for defecation.

Ariwadi is home to approximately 130 families, the majority of whom are engaged in cane-cutting labour. The village is predominantly populated by members of the Vanjari caste group, which constitutes over 70 percent of the cane-cutting community in Maharashtra(Deshpande, 2010). It is noteworthy that Ariwadi's geographical location on a hilly slope remains unrecognised on official district maps. Villagers attribute this oversight to the shared gram

panchayat with the larger neighbouring village, referred to as Gadewadi. Like Ariwadi, Gadewadi is predominantly inhabited by the Vanjari community; however, it boasts a larger population and greater political representation, including the influential position of Sarpanch. As one local from Ariwadi recounted, this lack of recognition has resulted in an inequitable allocation of resources and opportunities. One of the sugarcane cutters, Neeta, a resident of Ariwadi notes,

"All major development initiatives are directed towards Gadewadi. Government jobs are exclusively reserved for its inhabitants. Despite our collective efforts in constructing a pipeline under a government water scheme, the water supply primarily benefits Gadewadi. Consequently, we must continue relying on distant borewells for our water needs."

As in many villages across Marathwada, migration from Ariwadi and Kodewadi to sugarcane farms for cane-cutting labour dates to the 1972 *dushkaal* (drought), this practice has persisted across three generations as the primary source of livelihood. The 1972 drought ranks among the most devastating in Maharashtra's history, striking large swaths of the Marathwada region, including districts such as Beed, Latur, and Osmanabad (Jamwal, 2016). Since agriculture in Marathwada has long relied predominantly on rainfall, the drought wiped out most food crops and deprived farming households of income (Vohra, 2022). At the same time, the sugar industry in western Maharashtra was undergoing rapid growth (Kendre, 2011). Thus, this led to an increased movement of seasonal migrants, annually. Each year, families from both villages migrate to the cane plantations, taking their children and oxen with them, which are essential for transporting the harvested cane to nearby sugar factories. However, villagers emphasise the substantial financial burden associated with each ox, priced at approximately INR 1 lakh, which is exacerbated by the risks incurred during transportation. While some cane cutters occasionally secure insurance coverage for oxen injuries or fatalities within the designated "workplace," the ambiguous definition of this term often leads to denied claims. One respondent recounted an

incident from the previous migration season in which two oxen, en route to the factory in a truck, were involved in an accident, one ox's horn fatally pierced the other. The insurance company denied compensation, citing that the incident occurred outside the defined "workplace". Similarly, oxen often suffer ailments following the cane-cutting season due to extreme labour, yet these conditions are no longer considered work-related, thereby excluding them from compensation. To mitigate such risks and reduce fodder-related expenses, many families have adopted the practice of purchasing oxen shortly before migration and selling them upon returning to the village after the cane-cutting season.

The Vanjari or Vanjara, as referred to in older government gazetteers, were historically associated with itinerant trade and transport (Government of Bombay., 1910; Maharashtra Gazetteers Department, n.d.). They were known as bullock-caravan carriers of grain and salt, closely connected with kindred groups such as the Lamans and Lambadis. As caravan-based occupations declined with the rise of policing, railways, and new transport systems in the 19th and 20th centuries, the Vanjaris gradually abandoned mobility and "mostly settled down as agriculturists" (Government of Bombay., 1910). Earlier documents frequently used Vanjari and Banjari interchangeably, while later state advisories distinguished between Vanjari, listed as an Other Backwards Class (OBC), and Banjara/Lamani, recognised as a Denotified/Nomadic Tribe. A Bombay High Court judgment even traced these conflicting usages, quoting state gazetteer entries that grouped them, while acknowledging a Tribal Research Institute report which insisted they are distinct though of related stock (*Sanjay Dadaji Dhait vs State of Maharashtra & Others*, 2015).

The etymologies preserved in gazetteers connect "Vanjari/Vanjara" to *vanacara* (moving through forests) and to *lavana* (salt), underlining their identity as mobile traders (Government of Bombay., 1910; Maharashtra Gazetteers Department, n.d.). District gazetteers from Khandesh (modern day Gujarat) and the Berars (modern day Vidarbha in eastern Maharashtra)

repeatedly list Vanjaris among the “unsettled” groups who, as caravan commerce dwindled, adopted cultivation and established villages (Maharashtra Gazetteers Department, n.d.). In parts of Washim and Akola (Vidarbha region), Vanjari, Patils and Naiks exercised authority over clusters of villages, positions that carried hereditary lands and local leverage (Government of Bombay., 1910; Maharashtra Gazetteers Department, n.d.). Others cleared forest and wastelands, later regularising them through revenue surveys. Still others used their trading capital to buy land during cycles of cotton booms, famines, and distress sales, consolidating holdings while indebted cultivators lost ground (Government of Bombay., 1910).

By the mid-20th century, irrigation expansion in the Krishna and Godavari basins enabled a major crop shift: Vanjaris became early adopters of sugarcane, a high-water but highly profitable crop (*Sanjay Dadaji Dhait vs State of Maharashtra & Others*, 2015). In Ahmednagar, Beed, Osmanabad, Nanded, and adjoining districts, Vanjari cultivators entered the sugar economy, joining Maharashtra’s cooperative sugar movement that had begun in the 1930s and spread after Independence. Becoming shareholders in cooperative sugar mills brought not only steady cane procurement but also access to credit, subsidies, and pathways to upward social mobility. By the 1970s and 1980s, Vanjari leaders were visible in district-level cooperatives in Marathwada, standing alongside the dominant Maratha–Kunbi elite (D. Attwood, 1992). Sugarcane cultivation also facilitated land accumulation: families with medium holdings leveraged credit to reinvest in land, while those unable to manage cane’s high input costs often sold their plots. In this way, cane both stabilised existing Vanjari landholdings and enabled expansion in some regions. Finally, because sugar cooperatives were deeply intertwined with state politics, Vanjari participation in them translated into political visibility and legislative representation (Government of Bombay., 1910; *Sanjay Dadaji Dhait vs State of Maharashtra & Others*, 2015).

The 1972 drought or the *dushkaal*, however, exposed the fragility of this trajectory. Cane, being a thirsty perennial, withered on unirrigated lands, leaving smallholders indebted and many forced to migrate (Samuel, et al., 2009). The drought-induced social and economic precarity pushed the government to introduce the Food for Work program under the Maharashtra Employment Guarantee Act to support the affected population. However, with recurring droughts occurring every three to four years, the remaining population, predominantly from the Dalit and Vanjari caste groups, was forced to migrate to the cane fields to work as cane cutters (R. K. Singh, 2017). While wealthier Vanjari farmers with canal irrigation weathered the crisis and, in some cases, expanded their holdings, a large section of the community entered the seasonal migrant labour stream. Over subsequent decades, Vanjaris became the single largest group of sugarcane cutters in Maharashtra, supplying *koytas* (husband-wife) pairs to factories across Western Maharashtra. Thus, in present times, while only a minority of Vanjaris are established cane cultivators and cooperative leaders, the majority of cane-cutting migrants in districts like Beed, Osmanabad, and Latur come from Vanjari households.

The history of the Vanjari caste in Maharashtra reflects a complex reinvention of identity shaped by socio-economic shifts and caste-based classification. Historically associated with agricultural practices and certain nomadic structures, particularly in relation to cattle, the Vanjaris once held a foothold in agrarian life (Deshpande, 2010). However, the fragmentation of landholdings in Maharashtra led to widespread impoverishment among agriculturalists, pushing many, including Vanjaris, into landlessness and wage labour. This transition is particularly evident in their large-scale participation in the sugarcane cutting economy. As Gopal Guru has noted in his work on caste and labour, such occupational shifts are not merely economic but deeply embedded in caste dynamics (Guru, 2023). The Vanjaris' classification has also been a subject of legal and political contention, especially in relation to their distinction from the Banjaras. While both groups share nomadic roots, legal proceedings and committee

reviews have debated whether Vanjaris should be included among Scheduled Castes or classified under Nomadic Tribes. In Maharashtra, the Other Backward Classes (OBC) category itself is subdivided into multiple groups, further complicating the Vanjaris' position within the state's caste framework (Deshpande, 2010).

According to the locals, the Vanjari community traces its origins to Rajasthan, where its traditional occupation involved trading fodder and grain using oxen and cattle. As Rajeshwari Deshpande (2010) notes, a distinction has emerged between the Banjara and Vanjari communities despite their historically intertwined identities. Until recently, official records treated these groups as synonymous, categorising them under the generic label of nomadic tribes (Deshpande, 2010). Deshpande further observes that Vanjari caste associations became actively involved in state politics. Alongside the late Gopinath Munde a prominent Vanjari leader from Beed district and BJP politician these organisations pressured the Government of Maharashtra to establish a commission to resolve the status issue concerning the Banjaras and Vanjaris. These demands, rooted in the politics of reservation, sought Vanjari inclusion in the OBC category rather than grouping them with other nomadic tribes. In response, the government appointed a single-member commission to investigate the caste dynamics of the two communities, ultimately leading to their classification under distinct categories. The distinction between caste categories, then, must also be read alongside the shared economic vulnerability of Mahar Mangs and Vanjaris within the exploitative sugarcane labour system.

Often, along a stretch of factory-owned, barren land, sugarcane cutters construct makeshift houses using leftover cane, plastic sheets, and grass called *kopis*. If they cannot find space on the factory property, they build makeshift houses next to the factory, which are owned by local farmers, for which they pay a monthly rent ranging from INR 400 to INR 500. Labourers are recruited by a *mukadam*, a local contractor from Ariwadi, who is paid by a *thekedar* (factory-appointed contractor) hired by the factory. Each working unit, known as *koyta* consists of a

couple, usually a husband and wife. Each *mukadam* manages *tolis*, each toli comprising 10 koytas and receives a commission based on the amount of cane cut by each *toli*. *Koytas* work a minimum of 14-15 hours each day, performing strenuous tasks such as cutting, tying, loading, unloading, and transporting cane to the factories. In addition to these duties, women devote additional time to performing unpaid domestic labour, such as cooking, fetching clean water, and caring for children. Each *koyta* is given an advance payment, or *uchal*, ranging from INR 50,000 to INR 1,00,000, and is required to cut a daily quota of sugarcane to retrieve the amount for which they took the advance. However, in most cases, not all *koytas* can cut cane worth the *uchal* they have taken. Consequently, the pending amount gets carried on as debt to the next cane-cutting season.

In the event of missed work, labourers pay a fine, or *khada*, ranging from INR 500 to INR 1000, to another *koyta* who works on their behalf to achieve the daily target set for the *toli*. It is essential to note that *koytas* do not receive the *uchal* in one instalment but over six months and, sometimes, over a year. Additionally, the *koytas*, which travel with oxen to carry the cane to the factories, must pay a *gaadi*/*tyre bhaada* (bullock cart/tyre rent) of INR 50 daily. Even if a *koyta* decides to take a leave for a day, they still pay *the gaadi*/*tyre bhada*–failure to do so leads to a deduction of the pending advance/wages. After returning from cutting cane at midnight, it is common for *koytas* to be required to travel to the fields within an hour of returning to their *kopis* to fill the awaiting vehicle, be it a bullock cart, tractor, or truck, with the harvested sugarcane for transportation to the factory. This is due to the inherent urgency in transporting sugarcane, as the sucrose levels in the crop can decline if the harvested cane is not processed within 24 hours following its cutting. This feature of the sugarcane industry distinguishes it from other crops and underscores the challenges labourers face in adhering to strict temporal constraints (Mintz, 1986).

In contrast to other high-sugar-producing and cane-growing states, such as Uttar Pradesh, a peculiar distinction in the employment of cane-cutting labour is twofold: first, while in Uttar Pradesh, farmers are responsible for hiring cane-cutting labour, in Maharashtra, factories primarily facilitate it. Thus, the big sugarcane cooperatives, and factories recruit cheap labour, particularly small landholders and landless labourers from marginalised castes. Consequently, the interrelation between caste and occupation is reflected in the sugarcane economy of Maharashtra (D. M. Attwood & Baviskar, 1987; Baviskar, 1969, 1976). While Brahmins, Vaishyas and Marathas are the predominant landowning castes, very rarely would one find an upper caste worker as a part of the migratory sugarcane cutters and labourers. The migratory workforce comprises middle, lower, and lowest castes, including Mahars, Kumbhar, Nhavi, Lamani, Bhil, Banjara, and Vanjari (Asawa, 2016; Kendre, 2011). Second, in Uttar Pradesh, while a large proportion of workers are migrants, they are hired on either a daily wage, contractual or permanent basis–with individuals, children and whole families being employed alike. However, in Western Maharashtra, the employment of a working unit is usually in a *koyta* a couple, typically consisting of a husband and a wife. Moreover, even though over the years, migration from states such as Madhya Pradesh and Maharashtra borders such as Dhule and Nandurbar has increased, during interviews *thekedars* often note, "*Kaam ki gati aur 24 ghante mehnat Beed ke mazduron ki khasiyat hai*" (Pace of work and 24-hour hard work is the speciality of the labourers of Beed)

In highlighting why migrant labourers are relied upon by capitalist regimes, Alpa Shah and Jens Lerche notes that for a long time, capitalism regimes have relied on migrant workers, as they are paid significantly less, required to work longer and harder, and are also more easily controlled compared to local workers (Shah & Lerche, 2020b). Neoliberalism, she posits, has led to an increase in dispossession that has led to the exploitation of an ever-so-precarious migrant workforce (Guru, 2023).

Another *thekedar* points out:

> "Those who are from Beed have been working for generations. They are experts in cutting sugarcane, and those coming from the MP (Madhya Pradesh) or Maharashtra border, such as Dhuliya and Nandurbar, find this new help beneficial. All of this is of great assistance due to the increase in unemployment, which is causing them to struggle and even die. Speed of work, hard work, honesty, all these are the specialities of labourers."

As mentioned earlier, many families in both Kodewadi and Ariwadi are agricultural landowners. However, despite cultivating crops such as corn, bajra, cotton, and soya, the increasing droughts and climate irregularities have made the land either barren or prone to insect infestations that damage the crops. If the rain is good, they manage to sell soybeans and cotton but the high cost of inputs makes it difficult for them to generate a profit. One quintal of soya sells for Rs. 3,000-4,000, but the input cost for seeds and fertilisers is around Rs. 3,000 per month. Moharbai, one of the cane cutters in Kodewadi, shares:

> "We grow bajra and soya. One quintal of soya sells for Rs. 3,000-4,000, bringing in a total of around Rs. 30,000-40,000 every season. For instance, on a 3-acre land, we can get 3-4 quintals of soya, but at least 1-2 quintals' worth goes into fertilisers."

My ethnographic findings on land ownership patterns in Ariwadi revealed that the average landholding size is approximately 2.5 acres, predominantly owned by male family members. In Kodewadi, land is similarly held and primarily used for cultivating crops such as *bajra* (pearl millet), soyabean, cotton, and corn. These crops sustain household consumption and are sometimes sold in nearby weekly markets. Villagers, both in Ariwadi and Kodewadi, report that while bajra and soya are the most commonly grown crops, the costs of cultivation including

seeds, fertilisers, cattle fodder, and maintenance are rising annually. During visits to soybean farms, residents frequently pointed out plants that were rotting and infested by pests, as well as stunted growth, attributing these issues to erratic weather conditions and declining soil quality.

Most of the farmers who grow soybeans produce only 1-2 quintals per acre each season. However, the expenses involved are enormous. The farmers mentioned that one bag of seeds (25 kg) costs them Rs. 4,000, and their monthly fertiliser requirement is around Rs. 2,200. Additionally, there are costs for family labour, fodder, and maintaining cattle. Women note that with the recurring drought and erratic rainfall, the length of the soybean crop cycle has decreased, and the crops are increasingly affected by diseases. One quintal of soybeans now sells for only Rs. 3,000. Neeta, another sugarcane cutter whose family owns 4 acres of land joked and said, "We buy a sack for Rs. 30, but they (marketplace buyers) take that too, and we never get it back [laughs]."

As Gopal Guru notes, due to ongoing drought conditions and limited employment opportunities in Marathwada, a large number of Dalits, especially from the districts of Beed, Latur, and Aurangabad migrate to western and southern parts of Maharashtra to work in sugarcane harvesting (Guru, 2023). As their economic situation continues to worsen, some Dalits have attempted to cultivate government-owned wastelands, known locally as 'gayran'[6]. However, Guru highlights that these efforts have been met with significant challenges, including violent resistance from dominant caste groups (*savarnas*) and bureaucratic harassment from government officials.

[6] Gayran land refers to government-acquired land reserved for public utility purposes such as grazing cattle, collecting firewood, cremation grounds, and allocation to government offices. Ownership and control of this land rest solely with the government, and it is typically leased on a rental basis. Due to increasing encroachment, a policy was proposed to transfer such lands to tribal communities. However, this policy has not yet been implemented. Gayran land is not registered under any individual's name; instead, encroachments are recorded in official government Form 1-E. Historically, Gayran land was used only for grazing. Lack of oversight from government authorities and local representatives has led adjacent landowners to encroach upon these lands, even cultivating crops on them. This undermines the original purpose of supporting landless individuals and livestock grazing. To address encroachment, the government has mandated that detailed maps and information about Gayran lands be prominently displayed in government offices. Legal action must be taken against encroachers, with responsibilities assigned to local officials such as Talathis, Gramsevaks, and municipal officers. Failure to act may result in disciplinary measures from senior authorities (Gawade, 2023).

With the deterioration of land quality, women who were traditionally engaged in agricultural work lost access to their primary source of livelihood (Subramanian, 2024). Families belonging to the Mahar and Mang caste groups have been historically associated with *begari* (unpaid or bonded labour). Much of the land available to these communities was *gayran* (grazing) land, which offered limited agricultural potential. Similarly, communities from the Vanjari caste group, along with Dalit caste groups more broadly, were increasingly pushed into sugarcane cutting as the only viable livelihood option amidst shrinking agrarian opportunities.

> "Dr. VK Patil in Ahmed Nagar started the first co-op factory in Maharashtra. However, even before this, around 1928-35, two private factories were started. One was the Belapur Sugar Factory (Ahmed Nagar), and the other was the Maharashtra Sugar Factory. Further, in 1948, the Central Government thought that in areas where sugarcane crops are suitable, or water irrigation systems are good, permission should be given to expanding factories in such areas for farmers' welfare or national development. In such a situation, Maharashtra's political lobby is powerful. Leaders of state parties started investing in factories. From 1962 till now, about 205 (105 co-ops and 100 private) factories have been built in Maharashtra. Earlier, Brazil was number 1, but since 21-22, India has been number 1, both in production and cultivation. Uttar Pradesh was number 1 in India for 2 years but now is Maharashtra state."- Managing Director of a sugar factory in Solapur

In 2021-2022, India produced more than 5000 LMT of sugarcane, making it the world's second-largest exporter of sugar after Brazil (Press Information Bureau, 2023). With the Western state of Maharashtra being the largest producer of sugarcane, the sugarcane industry continues to be among India's most profitable agrarian economies. The growth of the sugar economy in Maharashtra can be traced back to the colonial era when the construction of

irrigation networks in the state's drought- and famine-prone districts paved the way for a boom in sugarcane cultivation and the establishment of sugar factories. As sociologist BB Mohanty (1999, 2005) notes, the primary beneficiaries of this expansion were the Marathas and Kunbis, who had dominant control over cultivation and ownership and, to date, continue to exercise hegemony over the sugar industry (B. Mohanty, 2005; B. B. Mohanty, 1999). However, with the growth of factories and cultivable land through State-supported irrigation facilities in Western Maharashtra, other drought-prone areas of Maharashtra, particularly Marathwada, continued to be neglected. Historically, many Marathas and Kunbi families have owned land since before the era of Shivaji, with positions such as Patil and Deshmukh typically held by members of these communities. In the Kisan Co-operative Sugar Factory of Kopargaon, Ahmednagar district, about 60 percent of shareholders were Marathas, and in 1961–63, ten of the fifteen directors came from the Maratha community. By 1992–93, Maharashtra had 99 sugar factories, 70 of which were in Western Maharashtra (Dahiwale, 1995). Lower in the caste hierarchy, the largest group among the untouchable castes were the Mahars (Pandit, 1979). While not every crop failed in the 1972 drought, the most affected districts of Poona, Ahmednagar and Solapur saw near-total losses of all crops except sugarcane, which largely survived (Ladejinsky, 1973). The scale of migration toward sugar factories has grown steadily since the 1972–73 drought (Kendre, 2011). By the 1976–77 sugar season, Maharashtra produced 1.565 million tonnes of sugar, 32.5 percent of India's total output from about half a million acres of cane (Chithelen, 1980; Shinde, 2023). Developments in sugar production, both directly and indirectly, spurred seasonal labour migration toward the sugar belt (Chithelen, 1980). This was driven by favourable agricultural policies, increased sugarcane cultivation, the establishment of sugar factories, and rising demand for seasonal labour (Shinde, 2023).

The roots of sugarcane expansion in the region go back to the post-World War I period, when government incentives, high agricultural prices, and cheap irrigation facilities encouraged

cultivation in irrigated areas of western Maharashtra and Khandesh (B Abnave, 2015). By 1945, a landmark cultivators' conference at Belapur Road in Ahmednagar presided over by economist D. R. Gadgil led to the registration of Maharashtra's first cooperative sugar factory in 1948. By 1959, the state had 18 cooperative factories alongside 15 private joint-stock ones. In the 1977–78 season, 66 sugar factories were operational, of which only 10 remained privately owned (Chithelen, 1980). In the broader context of British India, non-foodgrain output rose overall, though crop patterns varied considerably. Cotton, Maharashtra's main export from Khandesh and Vidarbha expanded markedly before 1911, while sugarcane only began large-scale growth in the Deccan shortly before 1931 (Omvedt, 1973).

According to the Divisional Commissioner of Aurangabad, in 2018–19, 71 out of the 76 talukas in Marathwada experienced a decline in static water levels. Despite a rainfall deficiency exceeding 65%, sugarcane requiring approximately 197.78 lakh litres of water per hectare was cultivated on over 27% of the region's irrigated land, particularly in the Aurangabad division (Divisional Commisioner Office, 2019). Despite Marathwada continuing to face an unprecedented agrarian crisis exacerbated by changing weather patterns and scattered irrigation, sugarcane, a high water-intensive crop (as opposed to cotton, soybean and tur), is given an irrigational preference for two reasons. First, sugarcane is perceived as a low-maintenance crop that can grow amidst erratic weather conditions and pests (Bhatt et al., 2023; Solomon, 2016). Second, a fixed market with an assured income by selling the crop makes sugarcane a preferred choice among farmers. Preference for cultivating cane is further linked to the perception of sugarcane being a 'political crop' due to the close connection between sugarcane cooperatives and the sugar lobby, constituted of upper-caste Maratha politicians who employ their association with thousands of sugarcane farmers as captive vote banks. Studies have noted that controlling a sugar cooperative and the vote bank also paves the way for easy access to economic capital (Solomon, 2014; Sukhtankar, 2012). Economist Sandip Sukhantar notes that

cane prices fall by at least INR 20 in politically controlled mills during election years (Sukhtankar, 2012). This decline is representative of the appropriation of surplus mill funds for electoral use, such as financing the electoral campaigns of politicians. He argues that the manipulation of administered prices on commodities like sugarcane has often been used to fund electoral campaigns, and the fall in prices is an 'indirect campaign contribution'. He further notes that often, the mill chairman who wins national elections, or if the party affiliated with him is in power, the mill often pays higher prices for cane the following year. This siphoning off money for political use thus reflects a growing consolidation between state politics and the sugar industry (Jitendra, 2019; Khapre, 2016).

Despite technological advancements such as harvesters for cutting cane, sugarcane cutting in Western India continues to be heavily dependent on migrant workers from the caste groups mentioned above from the drought-prone belt of Marathwada. The reasons for this are twofold. According to the factory owners and contractors I spoke to during the course of my fieldwork, the available harvester machine, along with being capital intensive, is unsuitable for clayey soil and often bears the risk of damaging the blades of the machine (Kumar, 2016b). These machines can also not be used on small plots of land and require a minimum of 10 acres of spread. Moreover, the harvesters imported to India are rarely compatible with the tractors used in the country. Additionally, as opposed to the manual cutting of cane that splits the cane into one to two pieces, the harvester chops the cane into several smaller pieces. This poses a risk of reducing the weight of the cane while selling it to the factory, along with reducing the sucrose content in the cane. Secondly, as mentioned earlier, a significant fraction of the rural population in Marathwada consists of small and landless labourers who migrate to sugarcane factories in Maharashtra after the harvest of Kharif crops. Sociologist Jan Breman (1978) argues that the considerably big sugarcane cooperatives and factories recruit cheap labour, particularly small landholders and landless labourers belonging to oppressed castes such as Mahars (Breman,

1978b), Harijans, and tribal castes such as Bhils, Vanjaris and Gamits, the regional pattern of caste distribution reflected the economic structure where high-caste families were the principal landowners. The recruitment of cheap, extremely informal labour without any social or economic liabilities thus emerges as a lucrative, non-capital-intensive option for the sugar factories.

Both Maharashtra and Uttar Pradesh are leading sugar producers in India, but according to factory workers, the two states have some notable differences. The Managing Director of a sugar factory in Maharashtra mentioned that farmers in Uttar Pradesh tend to own more land than those in Maharashtra. Additionally, Maharashtra has limited areas with water or irrigation facilities, whereas Uttar Pradesh benefits from abundant water resources, as much of the land is well-irrigated and under cultivation (Kumar, 2016a). Factory owners and cane contractors note that the environmental conditions, soil quality, and sugarcane growth also differ between the two states. In Maharashtra, sugarcane requires a suitable amount of water, and the overall conditions are favourable. The recovery rate of sugar in Maharashtra is generally better. In Uttar Pradesh, however, the Ganges River and other waterways provide continuous irrigation throughout the year, which can lead to over-irrigation and, as a result, negatively impact sugarcane production. Consequently, the recovery rate of sugarcane is lower in Uttar Pradesh. In Maharashtra, there is a variation in recovery rates depending on the region. For example, according to a cane factory employee,

> “Kolhapur has a recovery rate of 13%, which translates to 130 kg of sugar produced from 1 ton of sugarcane. In contrast, the recovery rates in Pune, Sangli, and Solapur hover around 115 kg per ton. Other regions, such as Ahmednagar, Marathwada, and Nandurbar, exhibit recovery rates ranging from 105 to 110 kg per ton. As we move from western Maharashtra (Kolhapur) to eastern Maharashtra (Dhule), the recovery rates tend to decrease.”

During the course of my fieldwork, I often interviewed factory owners and workers asking them about who according to them is a worker. The response, often detailed, almost never accounted for sugarcane cutters as workers. The owners and other factory workers often explained that there are two-three kinds of workers, "Permanent labour is actual labour, which is always useful. These are all experienced and skilled labourers. Permanent people get a salary according to their work. Then, there are seasonal workers, and we pay them INR 15000-INR 2000 per month."

The factory hires a contractor and provides a certain amount to pay the *mukadam* and the *tolis*. Through this arrangement, the factory distances itself from the cane cutters and any liability that might arise during the cane-cutting process. As one of the factory officials mentioned,

> "There is no direct relationship between the factory and the labourers. It is the contractor who is responsible, as it is decided between the factory and the contractor that, the contractor will handle all the issues. In case of any problems, the factory recovers the money it has paid to the contractor from them."

Since the hiring of sugarcane cutters is outsourced to factory-appointed contractors, the factory owners often refuse to admit any responsibility towards the cane cutters, particularly in cases involving insurance or other social security benefits. There is no contractual obligation between the factory and contractors, but only between the factory and the contractors it has pointed to and the *mukadams* from the villages where the *tolls* are collected. According to a an ex-*mukadam* who has now stopped working in this sector,

> "The contractor, who is also often the tractor owner, is given an amount of Rs. 5 to 7 lakhs by the factory to mobilise workers, but the remaining Rs. 3 to 5 lakhs must be paid from the contractor's own pocket. Therefore, the total cost amounts to Rs. 10 lakhs approximately Rs. 5 to 7 lakhs from the factory and Rs.

3 to 5 lakhs from the contractor's own funds. There are usually 10 people in a group (called a '*toli*'), and each person must be paid Rs. 1 lakh. A tractor owner can be anyone who believes they can own a tractor and manage the work of the *toli*. After this, the factory signs a notarised agreement with the contractor, retains documents such as the tractor's registration, insurance, Aadhaar, and PAN, and then provides Rs. 7 lakhs weekly. The factory maintains a backup of four contractors, meaning that if one fails to make the payment, the remaining three will cover the cost. If two contractors fail, the remaining two cover the payments. Afterwards, the contractor visits various villages and areas where workers are available for sugarcane harvesting. They find a "*mukadam*" (supervisor) who can bring in workers. The Mukadam provides the necessary documents, such as Aadhaar and PAN, and the contractors give them INR 7 lakh, but not all at once the payment is made gradually. The payments vary by region. For example, in Beed, INR. 1 to 1.5 lakh is paid per group, but in some areas, the cost might only be INR. 40,000 to 60,000 for the same work. When the workers arrive to cut the sugarcane, the factory directs them to the designated area. This is how the system operates.

The "chit boy" keeps track of all activities, such as when the crop was planted, the amount of land it covers, the variety of crops planted, and other key details for both the current and upcoming seasons. Based on this information, the Mukadam and workers are informed when the sugarcane is ready for harvesting. The Mukadam earns a commission of INR. 18,000 for every INR. 1 lakh worth of work, while the tractor owner receives a commission of INR. 20,000. Those who did not take an advance (INR. 5-7 lakh) from the factory receive a commission of INR. 25,000. However, the situation in this business has changed.

There were fewer risks in terms of money, labour, or even life in the past, but now, even life is at risk. Recently, a contractor who went to a village to recruit workers for sugarcane cutting was attacked and killed. The contractor had already paid the advance and was trying to secure workers, but the locals murdered him. This incident occurred in Madhya Pradesh, involving a contractor and workers from the Solapur area."

One of the factory-appointed contractors noted,

"As for the labourers who cut sugarcane, they do have insurance through the factory, but it is more advantageous to the factory. This insurance covers accidents and death in the field, though getting it is complicated. The cost of insuring one person is INR. 300, and for 1,000 labourers, that amounts to INR. 300,000. However, the policy only covers accidents or death, which happen rarely typically affecting just one or two workers. Labourers often lack understanding of insurance and paperwork due to a lack of education. If asked about their Aadhaar card, many do not recognise its importance. They also do not grasp the concept of money when it is given on paper, as whatever the *mukadam* hands them is either unclear or insufficient. Even if the Mukadam gives them money as an advance, it is in instalments, like INR 10,000 now and INR 20,000 a month later. The contractor then sends INR 50,000 per labourer to *mukadam*'s account when one or two labourers are involved. However, whether this money is used appropriately or not, or whether any legal cases arise, depends on the situation. While contractors can confirm if long-time labourers have received their payments, they cannot do the same for new workers. Contractors do not have official documents, and whatever remains with the workers stays with them; the courts and factories are not involved. Labourers

> might take money from multiple contractors, leave, or abscond, making it nearly impossible to track them down. Even though some workers may take money from several contractors and then abandon their jobs, contractors insist that lawsuits are necessary to maintain trust. *mukadams*, who are labour managers, oversee the workers, monitor their performance, and handle any legal matters. If a labourer runs away or does not show up, the *mukadam*, often a relative, helps to find them or bring in replacements."

However, none of the cane cutters I spoke with during the course of my fieldwork had ever received any insurance benefits, either due to an accident or death. The only time some of the cane cutters recalled receiving insurance was for their ox or oxen if they died during the migratory season. One of the cane cutters recalled, "There is no insurance for us when we are sick or on our deathbed. Maybe something will be given when we die, but one has to die to know that. It is better to die than to be sick."

A female sugarcane cutter noted in terms of who bears the cost if there is a health related accident, "If it is a small expense, INR 100–INR 1000, then the contractor… and even that is written down in a notebook. And if the expense is big, then we bear it". Another *mukadam* noted, "If we do cover it (expenses related to health), we make sure to document it in writing so that we can deduct it from their advance payment next season"

Mukadams are identified from within the labour groups themselves. The person who steps forward or expresses interest becomes the *mukadam*. People trust such individuals, and that trust forms the basis of their selection. There is no formal contract between the contractor and the *mukadam*. Contractors act as guarantors for each other. The factory has a separate agreement with the *mukadam.* One contractor mentioned that the *mukadam* and group he hired

had previously worked on his friend's farm, and the friend recommended them. This is how contractors find *mukadams* and labour groups.

Upon being asked about insurance, a contractor noted,

> "No, nothing… and even if there is, it's of no use. No one gets any benefit. Star Health Insurance people used to insure my labourers INR 2000 per person, I had 20 people in my group, so 20×2000 so I asked them, will we get any benefit from this? They said, no matter what happens, snake bite, or any accident… we will help them. But when two people in my group had an accident, we gave the full file with all documents, did the whole process still no use… nothing was given by them. Just kept saying your process is ongoing… now it's been 5–6 years, still "in process". Means even after insurance, it's of no use."

Often, particularly sugarcane cutters from the Mahar, Mang and Vanjari caste groups were referred to by upper-caste Maratha locals as living in '*gabale basti*'. Locals explained that the word '*gabale*' means 'strange or ugly condition'.

As one local noted while explaining me the reference,

> "You see, people who migrate for sugarcane cutting face many problems due to lack of water or facilities, which causes difficulty in staying clean. Because their clothes are not properly washed, they are unable to maintain their attire properly. Due to a lack of proper arrangements for food and living, they are forced to live in such strange conditions. Moreover, there is no other way because their livelihood depends on the money earned from cutting sugarcane. These sugarcane-cutting labourers survive the whole year on that money. In all these situations, the way their condition becomes living far from home, anywhere they get a place to stay, and the kind of work they have to do all day in the sun,

> dust, and soil because of this, wherever they are seen, they live together with their relatives, villagers, and nearby villagers. These groups are called "*basti*" (settlements). Moreover, based on their way of living, the local people of the village they go to call them "people of the *gabale basti*," or we can say they tease them."

Rooted in entrenched caste hierarchies between Maratha factory owners, *mukadams*, and sugarcane cutters from marginalised caste groups, the working conditions in the sugar industry are shaped by a system of advance-based bonded labour, with no provision for insurance or social security. This structure exposes the capitalist regimes that, through complex labour arrangements, attempt to erase sugarcane cutters as legitimate 'workers' of the factory. Instead, they are positioned as labourers managed by factory-appointed *mukadams*, thereby allowing factory owners to evade accountability and responsibility for the workers' well-being.

Gender and Labour and Family Enterprise

In Maharashtra, a working unit as mentioned consist of a dyad consisting of a husband and a wife- called the *koyta*. In Maharashtra, I particularly emphasise the gendered manifestation of collateral mechanisms, such as the employment these dyads as working units, where the contingent value derived from women's labour assumes primacy in the face of unforeseen incidents. The employment of labour in sugarcane farms solely as couples or working units presents a distinct practice compared to the sugar industry in Uttar Pradesh, where daily wage labourers or individual working units are hired. Anthropologist Donald Attwood (1992) highlights the need to move away from individualistic and structural approaches when considering agrarian labourers, emphasising the centrality of the family enterprise as both a social and productive unit (D. Attwood, 1992). According to Attwood, the productivity of a family enterprise can be maximised by combining the skills and services of a senior couple

with a toiling junior couple, thereby transforming the family into an autonomous entity. However, when this familial enterprise transitions from a landowning and cultivating caste to a cane-cutting enterprise operating on other farmers' fields, the mandatory recruitment of couples as *koytas* raises the need to explore the gendered implications of such arrangements. Moreover, while Attwood's observations from the 1990s indicated that men were primarily responsible for cutting cane, with women involved in ancillary tasks such as tying, cleaning, and loading, my ethnographic observation reveals women's active participation in cane cutting and other associated activities, equal to their male counterparts.

As mentioned earlier, migration to sugarcane cutting began after the 1972 drought in Maharashtra. In Ariwadi, at least the last four generations have continued to be involved in cane cutting. It is rare to find a family in the village whose son works in a Sarkari Nokari (government job), such as the army. Genealogical mapping predominantly shows that cane cutting is the dominant occupation. Even when families tried to escape the cycle of generational cane cutting, COVID-19 posed a hindrance. Subhadra, 35 years old, is one of the cane cutters in Kodewadi, along with her husband. Subhadra was employed by an international company as a salesperson in Mumbai, and her husband worked in marketing. Together, they were earning around INR30,000 per month. However, when the pandemic hit, both lost their jobs, making it hard to meet daily expenses in the city. With mounting costs and no money left to pay their children's school fees, they moved back to their village and have been migrating to cut cane each year since 2021.

Talking about her shift from the city to the village, Subhadra says it has not been easy particularly readjusting to life with her in-laws, who are also cane cutters. Their children, a 6-year-old boy and a 9-year-old girl, who were regular school goers in Mumbai, now migrate each year with their parents to cut cane. Due to stress and constant physical distress, Subhadra

suffers from persistent headaches. Her recent reports reveal that she has migraines. However, she says, “Headache, ‘tension’, and cutting sugarcane that is all that is left of life now.”

Women often note, “We do not even remember since when we have been cutting cane. This *peedan-peeda* or suffering has been going on for generations.”With seasonal migration for six months being the primary livelihood strategy for women sugarcane cutters, the key barrier to mobility outside of cane cutting is the discontinuity in education for children. For generations, this has been a common practice, with most men having only grade 5 as their highest qualification, and women continue to be illiterate. This can be traced back to a key aspect of the migration strategy, wherein the mushrooming of small hostels for education in nearby tehsils has led some parents to admit their male children to these hostels. For instance, the only children admitted to these hostels in Ariwadi or Kodewadi belonged to the local *mukadams*. *bada mukadam* (big contractor) and *chotta mukadam* (small contractor), who continue to have a larger hold on economic resources than the cane cutters.

When I visited Ariwadi once the migration had started for the season, most of the houses were locked. Only the elderly parents usually above 60 years of age who now found it difficult to cut cane, stayed back. All children, including newborns and school-going children, leave their schools in the village for six months to migrate with their parents. In most families, young daughters are often married off as soon as they enter their first menstrual cycle or even before puberty. In Ariwadi and Kodewadi, among the 130 women interviewed across four generations of cane cutting, the youngest recorded age of marriage was 4, and the oldest was 16. In some cases, young girls were exchanged in marriage for token money, which often doubled the advance received for cane cutting, a strategy adopted by a few families to make ends meet (For instance, Swati whose case I mentioned in Chapter 1 was married off to her maternal uncle, who was in his 30s, while she was only nine years old).

At the cane site, as I started walking around 12 PM most of the people were off to work. However, one would often find a *kopi* (a cradle made from a saree) hanging open, with a baby left inside it. While I was meeting a few people, I came across Manisha, a 21-year-old I had met earlier in Ariwadi. She said, "*Madam, aap yahan? Itni laam*?" (Madam, you here? So far?). Smiling, I asked her why she had not gone to cut cane. With a sad smile and tears in her eyes, without saying a word, she gestured toward the *kopi*, indicating that her husband was lying inside, drunk.

I asked her to walk with me, and limping, she got up and started walking beside me. I asked, "What happened?" She said, "He has been drinking since last night. We were supposed to leave for work at 5 AM, but he has been passed out drunk. I tried to wake him, and he pushed me and grabbed my hair, warning me not to disturb him. *'Nuksaan toh ho gaya na din ka?'* (The day's loss has already happened, right?) *Kya karun, madam?* (What can I do, madam?)"

Decoding the Gendered Nature of Advance Wage, Accumulating Debt and Familial Enterprise

> "*Ganna kaatna aurton k live vanvaas hai*."
>
> (Cutting sugarcane is like a live exile for women)- Raya Bai a 45-year-old sugarcane cutter and Asha's Mother

> "Tai, last season my husband was sitting on the tractor, and his shawl came under the wheel of the tractor. The tractor ran over his leg. Initially, the *mukadam* said he would handle the treatment expenses. However, later he informed me that the treatment cost INR 2 lakh, and since he paid for it, I would have to cut cane for the next three years without any wage. My husband is bedridden, and my children are so young. I will work as *ardhya koyta*(half a working unit) next season. We also took INR 30,00 last year for removing my

> *pishvi* as *uchal*. I have no choice. The debt is mounting. They (the *mukadam*) threatened to take away our oxen and make my children work in the field if I did not pay off this amount. It is the *koyta* that gives us income that will kill me one day."- Asha, a 24-year-old cane cutter and a mother of five.

Bereft of jewellery, with their feet and hands covered in mud and bearing visible bruises from cane and sickle, their skin began to flake due to prolonged exposure to over 14 hours of work in the scorching heat. Mansha, one of the respondents, shared her experience of lacking proper toilet facilities, stating that the entire land served as a toilet before their arrival.

> "Tai, what toilet? Before we come here, this whole land was a toilet for everybody. We clean it and try to make it our home- with just pieces of plastic or leaves. If we have to take a bath, we wrap a saree around us and take a bath. Anyone can see us. We do not have any privacy to shield us from prying eyes. We eat the same food as the dogs there".

In the cane fields, women commonly wear full-sleeve cotton overshirts and pants. They often bring their children to the work site, occasionally leaving them unattended in vacant *kopis* in temporary cradles made from sarees. These children, as young as five years old, assist their parents in tying bundles of cane. Meanwhile, infants often lie amidst scattered cane scraps, vulnerable to potential risks such as snake or scorpion bites. As husbands depart for the cane fields at 4 AM, women typically wake up an hour earlier to engage in care work, including cooking, cleaning the *kopi* (a makeshift house), fetching water from nearby sources, and heating water for their husbands' baths. Moreover, in the absence of bathroom facilities, women wake up early to ensure that they bathe before the men wake up. To mitigate the challenges posed by the lack of sanitation, women often recall refraining from consuming heavy meals or drinking water at night to avoid the need for nighttime bathroom visits. Working in the

scorching heat from 5 AM until late into the night, often until 9 PM or even midnight, women endure physically demanding labour, depending on the loading requirements for tractors or trucks headed for the factory. Unless living near the farms, women frequently walk over to the cane fields 4-5 km daily.

The employment of the *koyta* system as a familial enterprise and working unit, previously mentioned briefly, hinges upon the pursuit of "financial security" for contractors and *mukadams*. Contractors aim to fulfil daily targets and receive daily commissions, while *koytas* seek to cut enough cane to match their advance payments for the year and settle pending *uchal* (outstanding debts). However, it is imperative to scrutinise the implications of this "security" for women employed in the familial enterprise. The *mukadams* who manage the *koytas* often share close kinship ties with the workers, usually as immediate or distant kin. While this familial connection may provide a semblance of safety and security, many women perceive the *mukadams,* despite their kin-relation, as employers solely concerned with ensuring profitability.

As Swati, a cane cutter notes,

> "Many of the labourers who join the group are also drunkards. If they run away, leaving their wives behind, is it the responsibility of the *mukadam* or the contractor to complete the work? Moreover, how is the work completed in that half-hour? Then, the woman will only be able to work for half the amount, and whatever is left will be used to pay the money next year. We do not know who goes into whose *kopis*. There is no control, no safety. The *koyta*, the sickle we use for cutting cane is not just a tool. It is a symbol of violence. I have seen it held to the necks of women, young girls, older women, it does not matter. They say things like, "Just need two bottles and some mutton chicken," and behind

their backs, anyone can take advantage of their wives. It happens. Especially for women who are new to cane cutting the chances of them getting harassed are high. If a 14-year-old girl is left behind in the kopi, and the *gaon gund*, the village's bad elements are around, anything can happen. The fields touch the highway. Anything can happen there. However, they are watching what is happening and looking for a chance to take advantage. Wherever we go, harassment follows. It is not safe. The village is not safe. Moreover, if someone dares to speak out against the harassment, they are pushed into wells."

Men commonly seek additional advances from contractors, often for alcohol, extending beyond what they have already received for the year. Some women revealed instances where husbands surrendered their land papers to contractors as collateral in exchange for small amounts of money for alcohol. In the cane site, I encountered women whose husbands either absconded for days after borrowing money from the contractor for alcohol or spent their workdays in their *kopis,* under the influence of alcohol. In both cases, women were left to work alone as *ardhya koytas* to repay the *uchal* they had taken for the year. Sakkubai, one of my respondents who has been cutting cane since she was 11, notes,

"My husband ran away for almost a week after taking INR 3000 from the *mukadam*. The *mukadam* was my distant father-in-law. I cried for days, not knowing where my husband went. The next day, fearing that my *sasur* (father-in-law) would beat me, I tried hiding in other people's *kopis*, but when could I do that? My *sasur* threatened to take our oxen away to pay off the *uchal.* He taunted that I should get a new husband. Otherwise, he could help me find one. I was back to cutting cane alone, with four children. My son was six months old. I put him in a saree, tied him on my back, and continued working. For days

> when my husband was gone, I fed my children stale food–as hard as a brick. Tai, the *koyta* that feeds us, also will kill us one day."

Violence against women in the cane fields, stemming from the pressure to settle *uchal,* manifests in various forms. Domestic violence inflicted by husbands, abuse from contractors, and distressingly, cases of rape reported by women involving contractors, truck drivers, or men from other *tolis* (groups) were uncovered during interviews. Of the 130 women, 81 reported experiencing violence at the cane site, ranging from verbal abuse to physical violence by husbands, *mukadams* or other men at the worksite. Alongside the prevalent violence, accidents within the cane cutting worksites constitute a distressingly common occurrence. As evident in Asha's case, when a partner sustains an injury, the labour burden falls on women who continue to toil, even in the face of their own illnesses, injuries, pregnancies, and the immediate postpartum phase. It is a common sight in the cane fields to witness women applying mud from the fields to the injuries they sustained while cutting the cane with a sickle, swiftly returning to work. However, given that many *koytas* migrated with their children or when wives were expecting, infant mortality, child deaths, and miscarriages became distressingly recurrent in the cane fields. Bhadamai, a 23-year-old cane cutter pregnant with her third child, shares,

> "Three years ago, I was sleeping alone in the *kopi* with my 3-month-old baby. My husband had gone drinking with other men in the *toli*. There is barely any light for anybody to see anything around. Our *kopi* was next to the main road that goes to the factory, and many trucks and tractors often passed by the whole night. I remember I was having very heavy *paadi* (menstruation). I woke up to go change the *kapda* (cloth). When I returned, I noticed that a tractor had run over our *kopi* while the baby was lying inside. He died there itself."

Bhadamai resumed cutting cane within two days. Tearfully, she recounts,

> "The *mukadam* and *thekedars* threatened us, insisting that we bury the child promptly, fearing the possibility of us filing a police report. What else could we do? He was my firstborn. We had already taken the *uchal* for the year. There was no time to mourn. Everyone told me we could have more children, and I should focus on working rather than grieving. My husband blames me to this day, but what would that change? Now I have another child, and I take her along wherever I go, even if I must go to the bathroom. Getting insurance for our cattle is easier than for ourselves or our children."

Like Bhadamai's loss of a child at the factory site, numerous accidents involving young children and women in Ariwadi and Kodewadi were observed, including tractor-related fatalities and snake or insect bites. Additionally, due to most deliveries taking place at the farm site, reports of early infant death occurring within months of birth were alarmingly frequent among mothers. Women attribute the primary causes of child death to high fevers from extreme weather conditions, insect bites and poor nutrition. Fearing loss of daily wages and additional *khada* (fine) associated with hospital visits, they often attempt to manage symptoms independently, hoping they will subside. Suman, a 25-year-old cane cutter who lost her child 12 days after birth, recounts,

> "When he was born, he developed a high fever within two days, and his stomach became swollen. My mother and I took him to the nearest government hospital near the factory. However, the nurse merely administered saline and asked us to return home. In the following days, his swelling only worsened, and on the 12th day, he passed away in my arms. The next day, we buried him, and I was back to cutting cane."

Infant deaths due to illness and accidents persist as recurring tragedies in the cane fields. Moreover, miscarriages resulting from strenuous everyday labour emerged as another critical factor affecting women. Of the 130 female sugarcane cutters interviewed in Ariwadi and Kodewadi, 53 reported experiencing miscarriages at various trimesters in the cane-cutting site.

Table 3.1: Prevalence of miscarriages among cane cutters at the worksite

Number of women interviewed	Miscarriages at the cane site	First Trimester	Second Trimester	Third Trimester
130	53	12	21	20

The causes of miscarriages among women in the cane fields, though varied, are fundamentally tied to the relentless and demanding labour they are compelled to perform, often lasting 12 to 16 hours, even up to the day before their delivery. Common triggers for miscarriages include experiencing intense pain and bleeding while squatting and lifting a cane or fetching water. Yet, after delivering a baby and experiencing a miscarriage, women reported returning to cutting cane the very next day or within a week, disregarding the physical and emotional toll. Rayabai, Asha's mother, narrates,

> "Tai, I had three miscarriages. There was no time to feel anything pain or grief- these are for the rich. Even during my other deliveries, I cut cane hours before entering labour. There is no time to rest. Husbands do not understand. After each delivery, within days, I used to tie my baby behind my back and go to cut the cane. We cannot afford to rest. The blame of unpaid *uchal* always falls upon us, no matter how sick we are."

Narratives of early marriage, particularly following the onset of menstruation, were commonly reported in Ariwadi and Kodewadi. These early marriages were frequently followed by early and repeated pregnancies, with some women becoming pregnant as young as twelve years old. Many reported labour-induced miscarriages, often attributed to poor nutrition and exploitative working conditions in the sugarcane fields. One woman recounted, “I had gone to urinate in the middle of the night or to fetch water and just started bleeding and lost the baby.”

In alignment with Revathy Subramaniam’s observations, my ethnographic findings reveal that although child marriage has long existed in drought-prone areas, its prevalence has deepened over time, becoming entrenched in the region’s social and economic systems especially with the rise of marriage-based labour arrangements, particularly the *koyta* (Subramanian, 2024). She further highlights that quick, often rushed marriages have become more common, with little time between engagement and the actual wedding, reflecting urgency driven by labour demands.

While child marriage was historically prevalent, the emergence of cane cutting and the recruitment of *koytas*, typically comprising husband-wife pairs has further accelerated the practice. Early marriages are further steered by concerns over the safety of leaving young daughters behind during annual migration or bringing them along to cane sites, both of which, according to cane cutting families to present, pose significant risks. Consequently, early marriage has come to be viewed as a pragmatic solution to these dilemmas. This is in tandem with what Reetika Revathy Subramanian observes in her recent work that in drought-prone regions such as Marathwada, marriage has evolved into a strategic response to economic precarity, particularly within the sugarcane industry (Subramanian, 2024). Women, she notes, not only contribute to everyday cane labour alongside their husbands but also become part of arrangements that relieve their natal families of dowry obligations and financial responsibilities. She refers to such marital alliances as “gate-cane” marriages that as she notes are shaped by

caste, land ownership, and access to water, thus reflecting broader socio-economic adaptations to environmental and economic pressures (Subramanian, 2024).

The age range of each *koyta* varies, with many having wives as young as ten years old and husbands as young as fifteen. Early marriage has been critical in Ariwadi and Kodewadi, as it ensures the immediate addition of another *koyta*, a working unit contributing to household income. As Subramaniam notes, and as I also found during my fieldwork, marriage negotiations are increasingly influenced by the sugarcane industry, with *mukadams* acting as intermediaries who arrange alliances to secure reliable labour. *Mukadams* actively seek new labourers and often facilitate marriages between the children of workers in their group to ensure loyalty and continuity of labour(Subramanian, 2024). In citing a case from Botswana, she notes that in drought-affected regions, marriage negotiations reflect water scarcity, symbolising how women's roles are tied to managing essential resources paralleling similar dynamics in Marathwada.

The peculiar structure of the *koyta* system, I assert, significantly influences the health-seeking behaviours and decision-making capacities of women cane structure. Despite engaging in equally strenuous tasks such as cane cutting, women are perceived as supplementary workers. This perception of women as supplementary workers within the *koyta* system is evident in their limited or absent control over the *uchal*, the advance payment received by the *koyta* from the *mukadam*. It is here critical to point out that Section 4(2)(a) of the Bonded Labour System (Abolition) Act, 1976, explicitly prohibits the provision of any advance under, or in pursuance of, the bonded labour system following the implementation of the Act (The Bonded Labour System (Abolition) Act, 1976, n.d.). Although legally prohibited, the practice of lending *uchal* remains embedded in complex and exploitative caste-driven labour arrangements, with women workers often carrying the heaviest brunt. This burden becomes especially acute when they face health-related costs, such as ongoing medical visits or the need for regular medication. In

such contexts, procedures like hysterectomy though financially demanding are often perceived as a one-time solution. The financial and physical burden of these procedures is shouldered mainly by women, even as husbands frequently perceive post-childbirth gynaecological morbidities as impediments to the routine demands of labouring life. Within these exploitative labour conditions, the ostensibly private decision to undergo hysterectomy among female sugarcane workers in Beed emerges as a mechanism that facilitates capitalist relations in the public domain of the cane fields.

With pregnancies occurring frequently and in close succession, women spend most of their trimesters cutting cane. Amidst inadequate nutrition, basic sanitation facilities, and arduous working conditions, taking time off becomes an unattainable luxury. This pressure to continue working is further intensified by husbands unless faced with an emergency. Consequently, women are compelled to disregard their symptoms or resort to self-medication with unprescribed over-the-counter tablets to alleviate pain, often consuming expired medications while cautiously managing their limited supply. Interestingly, I observed that while women's illnesses, even during pregnancy, continue to be neglected, many husbands seek regular treatment in nearby clinics for conditions such as skin itching, heart disease, and piles.

Studies show that women's domestic work and childcare are often unaccounted for when men and women are employed in the same labour setting. This becomes evident through a series of time allocation studies suggesting that women spend longer working hours than men in rural households, whereas men often find time for leisure activities such as smoking cigarettes, drinking liquor, and playing cards (Jain, 1996). Moreover, outside the household, extreme labour-intensive work by women in the agrarian sector exposes them to grave health hazards such as arthritis, intestinal ailments and gynaecological morbidities. Yet, as is evident in the case of Ariwadi and Kodewadi, with mandatory employment of a husband and wife as a combined working unit, despite the reluctance to pay for recurring treatment-related expenses,

the one-time expenditure on the removal of the uterus–particularly post reproduction was seen as a means of 'pragmatic prevention' for hindrances in the everyday wage labour. As Sita, a cane cutter, notes,

> "The *koyta* (working unit/also the sickle) that kills us every day, is also the *koyta* that feeds us and we ironically are called a *koyta*."

As Jeffery and Jeffery note from their work in rural Bijnor, A wedding song from the bride's perspective highlights the irony of marrying a "man who plows", a common fate for most rural women(Jeffery & Jeffery, 1996). The songs documented in their work reflects desires that are often unattainable, such as marrying a man in "service" (urban, white-collar employment). A similar tension between ideal and reality emerges in Ariwadi and Kodwadi, where I argue that the distorted sex ratio resulting from decades of sex-selective abortions has led to a situation in which men struggle to find brides. To overcome this, it was common for men to provide substantial sums ranging from INR 2 to INR 3 lakh to parents in exchange for marrying their young daughters–as young as eight. This practice serves as a strategic measure for the families to avoid migrating during the season or use this exchange as an additional income to pay off existing debt. Interestingly, in Ariwadi, while most families married their daughters in the cane-cutting families, where girls rarely could find grooms involved in agriculture, it was considered as "marrying up" and in fact, the only time a groom would get a hefty dowry. Even if the annual income of the groom was less than what the earnings would be from cutting cane, mothers, in particular, often narrated,

> "Look at us. Look at our bodies. Our condition is worse than animals. We have debt. Do you think we can ever cut cane that equals the advance we take each year? Go to any house. You would not find a single family who does not have pending *uchal*. At least our daughters can have better lives than ours."

Sadhna, one of the cane cutter notes,

> "Life is difficult. Still, there is no difference between animals and humans. Even after going there, the work never ends all day. The children also suffer a lot. If they sleep in a corner or try to work, they still face great hardship. In thorny bushes anywhere, whether it is a snake or a scorpion, they have to deal with it. If it is a group of 20–30 people, usually there are *koytas* and they have to stay and sleep in one corner. Some people manage food and water, and then there are many other troubles. Even if the *kopi* is separate, the situation remains the same. Anyone can enter from the outside. The situation of unmarried women is terrible."

In thinking about early hysterectomies, particularly in the case of Marathwada, the concentration of these procedures among sugarcane cutters points to the urgent need to recognise the role of sugar cooperatives in shaping labour regimes in Maharashtra and in perpetuating the brutality of debt bondage. Caste-based exploitation and the role of local politics further underscore the systemic nature of this violence. This context also highlights the global supply chain dimension, how corporations like PepsiCo and Coca-Cola indirectly sustain exploitative labour practices, which the media often identifies as key perpetrators and holds accountable for their role in these injustices. However, I also ask: what about the accountability of politically active Maratha sugar barons, many of whom are leading politicians at both the state and national levels? The nexus of politics, local caste hierarchies, economic marginalisation, and private healthcare systems facilitates the everyday debilitation of women cane cutters' bodies. Sarla, a cane cutter notes,

> "Sometimes, when we borrow money from *mukadams* and try to work outside the cane fields to repay it, we are forced to return the money with 5–10% interest.

That is how the *gulami* continues. Even if someone in our *toli* dies, the work cannot stop. Each of us has to contribute INR 1,000, not to mourn a life lost, but to make up for the labour lost.

There are no working hours. If the tractor comes at 12 in the night, we must be awake and ready. There is no provision for ration, so we carry our own, which often gets spoiled or damp at the worksite. Even when a woman needs to relieve herself, we are stared at. I say this honestly, the *mukadams* stare at us. But what can we do? If we speak out, who will give us work? How will we earn? Our husbands often drink, and many do not even work. That means we women have to do double the labour. After both my deliveries, I went back to the fields within five days.

The *mukadams* are mainly from the Maratha, Vanjari, or Lamani castes. And it is not just about them; caste discrimination happens every single day in the fields. There are no toilets. We have to defecate in the open. If we happen to do it in a Maratha's field, they beat us, and sometimes even make us pick up our own faeces. Sometimes *mukadams* lie. They say they are taking us to one factory, and then they take us somewhere else. We do not get to decide where we work. I ask why is it that we produce everything for them, yet we have no value? Why are we not treated like workers or *karamcharis*, the way others in factories are? I remember what happened to my neighbour's daughter-in-law. She fell while cutting the top of a sugarcane stalk and injured her spine. At first, the *mukadam* gave them INR 1,00,000 as compensation. However, later, he said they would have to work for him for the next two years for free. He said he would pay them just INR 10–INR 20 a day."

The realities of violence and exploitation in labour practices are central to this work, examined through the interconnected lenses of economic sociology, the sociology of labour, and medical anthropology. These disciplinary perspectives are intended to be used in conjunction, offering complementary insights that deepen our understanding of labour dynamics. are at the forefront, wherein I argue that brutality in the cane fields especially in the context of experimenting with bodies and the forceful nature of these practices lays the foundation of capitalist cane structures, wherein certain bodies, communities, and populations are positioned as having the potential of being 'bioavailable' and 'operable', and are thus pushed to opt for bioviability within market economies (see Chapter 3, 4 and 5). Early age hysterectomies as a liminal process and strategy, thus, become an instance of what it means for women cane cutters bodies to be disposable- as a bridge between bioavailability and operability in the eyes of the state, the clinic, or the market. Through the findings from this ethnography, I argue for the need to trace the intersection between operability, biopolitical regulation, and poverty, and the transformation of various actors such as clinicians, bureaucrats, factory owners, and *mukadams* into biomedical brokers.

Hysterectomy amidst the Productive-Reproductive Continuum

> "I was loading a cane on the tractor around 10:00 PM. As I got down, I realised that I had started bleeding. Since then, whenever I used to sit down to cut cane or stand for the next few weeks, it felt like a part of my body was coming out. I recall waking up one day and telling my husband that my abdomen was hurting and that I would be unable to cut cane for the next few days and would like to visit the nearest doctor. He told me I had been sickly since I underwent sterilisation, and I was making excuses not to work. Fearing he would beat me if we lost the day's wage, I tore a piece from one of my sarees and rolled it into a thick cloth, hoping it would absorb the blood for a few hours. I continued

working with the same bleeding for at least 18 hours daily." - Deepa, a 32-year-old cane cutter

Ashabai, a young cane cutter of 26 years of age, has been cutting cane since she was married at 12. A mother of three children, she experienced two miscarriages, one in her second trimester and the other in the third trimester, while cutting cane. With all her deliveries at the cane site, during her first pregnancy at the age of 15, in the seventh month, she recalls tying a bundle of cane and experiencing severe abdominal pain–inducing premature labour. She delivered her son prematurely when rushed to the nearest private hospital. Consequently, he was in a neonatal intensive care unit before discharge. Ashabai recalls that her parents, also cane cutters, paid the cost of the hospital stay and took additional advance to pay for her treatment.

Ashabai underwent tubal ligation at the age of 25 after her last delivery. However, she began experiencing abdominal pain soon after her in a few months. For the past three months, she has been on medication for a 'bulky uterus' due to fibroids, which doctors suspected she had even during pregnancy. She is regularly taking painkillers–as prescribed by government hospitals. With migration season due in a few months and her pain not subsiding, she visited the nearest private clinic. The doctor suggested that if she does not get her uterus removed now, it might cause her further distress while working in the cane fields. Now, Ashabai is saving money to remove her uterus before migrating to the cane fields. I asked her if she had consulted anybody about getting the uterus removed, "Tai, my husband says that it is better to spend money once than again and again. I am in pain; what can I do? Even my sister-in-law got her uterus removed six years ago."

Of the 130 women, all sugarcane cutters in Ariwadi and Kodewadi, 51 reported having undergone hysterectomies, predominantly before 40. With all of the procedures having taken place at the private clinics, after performing sonography, women reported receiving a standard

diagnosis: “Your uterus has burnt”, “Your uterus has holes in it”, “You will die in a few days if you do not get it removed!” or “You might get cancer if you delay removing the uterus!”. Women often reported being told, “Is it not better to get it removed? Otherwise, you will have to pay for cancer treatment later”. Thus, once a woman had completed her responsibilities of childbearing and had undergone sterilisation, retaining a uterus in times of severe abdominal pain, the future risk of illness and consequent treatment-related expenses and irregular and increased menstrual bleeding was perceived as a hindrance to everyday wage labour.

Data from the Municipal Council of Beed revealed that, despite 57 private hospitals, only 7 government facilities are available in Beed, thereby augmenting women’s reliance on unregulated private medical care (District Beed, Government of Maharashtra, n.d.). Additionally, there are no pharmacies or private clinics within a 21 km stretch of Ariwadi, and the nearest government hospital is 80 km away. Despite the low out-of-pocket healthcare expenditures in government hospitals, many women in Ariwadi cite travel costs, loss of daily wage labour due to travel, and overburdened public health facilities as the primary factors that force them to seek private medical care. Health experts have noted that the inadequacy of medical facilities in the public health sector for gynaecological procedures, counselling facilities, and post-operative care has transformed the bodies of female sugarcane cutters into “hunting grounds” for the private medical industry (Shukla & Kulkarni, 2019).

There are two critical trends vis-a-vis hysterectomies among women in Ariwadi and Kodewadi. First, in contrast to the states of Gujarat and Andhra Pradesh, which are linked to financial assistance schemes and community-based health insurance programs (CBHI), the availability of disposable wages in the form of an advance can be traced. Often perceived as an ‘investment’ for preventing future expenses on cancer along with avoiding loss of daily due to recurring pain, hysterectomies take the form of pragmatic investment for securing a viable present that serves to preserve the immediate need for sustenance, both to maintain personal

and familial viabilities to keep the wheels of daily life turning (Desai, 2016). As one of the respondents, Tarabai's husband, who underwent a hysterectomy at 22, notes,

> "Madam, what is the use of a body that only incurs more expenses with every visit to the doctor? What if she developed cancer? I cannot afford to pay for expensive treatments. We already had one son and did not want any more children. We prioritised providing for our family, and I could not manage everything alone. The doctors know best, and at least she is alive."- (Hanumant, Tarabai, a cane cutter's husband)

Secondly, due to the collective income, my recurring conversations with female cane cutters reveal that men- usually the male head of the family– husbands or fathers-in-law- exercise control over the advance wages. This aligns with what economist Bina Agrawal (1997) notes: in male-headed households, even if women are significant and, in this case, equal or majority contributors, they exercise no control over the cash income, as wages, even when meant to be paid to women are taken over and controlled by men. In Ariwadi and Kodewadi, men often use a significant proportion of their wages to purchase liquor instead of spending on essential items or taking on more debt. With mounting debt accompanied by little to no access to wages, the disproportionate impact of lack of control over household income and the critical implications on health outcomes for female cane cutters through early-age hysterectomies become evident. Tarabai recalled, "If we work today, we will survive tomorrow. If I cannot work today because I am bleeding, how can we think of a future?" In thinking about rural poverty and the precariousness of daily life, for Tarabai, the future is often perceived as uncertain and distant. At the same time, the present holds immediate possibilities for survival and sustenance. This perception is reflected in the prioritisation of short-term gains and the willingness to accept potential long-term risks to alleviate immediate needs and ensure the present well-being of oneself and the family. Through the cessation of recurring pain, hysterectomies emerge as a

means for women to achieve “normality”, normal in terms of not interfering with their ability to perform daily wage labour and cater to everyday familial responsibilities.

During interviews with female sugarcane cutters who had undergone hysterectomies, it was not uncommon for husbands to undergo treatment for their health problems. One of the key reasons for husbands supporting hysterectomies was rooted in the need for a quick redressal to the symptoms experienced by women–both for preventing future expenditure on cancer as specified by private health practitioners and for avoiding recurring out-of-pocket expense for travel to hospitals, cost of medications and slow redressal of the symptoms. However, for instance, in Tarabai’s case, while undergoing pain before her hysterectomy, her husband underwent treatment for piles, frequently visiting the nearest private hospital. Despite the severity of Tarabai’s condition, her husband refused to pay for her follow-up visits to any local doctor. Similarly, another woman, Vijaymala, underwent a hysterectomy at 21. Her husband continued to accompany his father to a private clinic while they migrated for heart treatment. With a debt of INR 3 lakhs from his treatment, her husband added, “Madam, a heart problem is a big problem. Uterus cannot kill you, but a heart attack can”.

In the narratives shared by female sugarcane cutters, all of whom underwent hysterectomies at ages as young as twenty, a prevalent theme is their negotiation between enduring gynaecological morbidities or opting for non-invasive, long-term treatment pathways, and the decision to undergo the removal of the uterus for immediate relief from their symptoms. The decision to choose hysterectomy was deeply influenced by the dilemma surrounding workplace productivity, the fear of wage loss due to recurring illness, concerns over childcare in the event of illness or death, and the escalating financial burden posed by the future risk of cancer. These narratives reveal stark calculations related to both biological and social temporality. These women faced dire choices: the removal of their uterus within four days to mitigate the risk of developing cancer or facing potential death or experiencing the loss of income and means of

subsistence when opting for long-term, non-invasive medical interventions, which could lead to the development of chronic morbidities and possibly fatality in the future. In most conversations with women who had undergone hysterectomies, it was evident that many had opted for the procedure weeks or a month before migrating to the sugarcane fields positioning hysterectomies as a biosocial strategy to navigate the complex conundrum between employment and reproductive autonomy.

Desai et al. (2011) suggest that rural women, particularly those engaged in agricultural labour, are more susceptible to uterine prolapse due to the extensive lifting and the strenuous nature of agricultural tasks they undertake (Desai et al., 2011). In a similar vein, economist Padmini Swaminathan, through her study in Tamil Nadu (1997), contends that demographic development and the increased participation of women in the labour force do not necessarily equate to reproductive safety (Swaminathan, 1997). This conclusion is substantiated by the notable decrease in fertility rates alongside the hazardous risks posed to women's reproductive health. Specifically, in the context of paddy farming, the prolonged hours spent in a squatting position during the transplantation of the crop are likely to cause physical discomfort and exert undue pressure on the uterus. Obstetricians have also raised concerns that such physically demanding labour could precipitate premature labour in the final trimester of pregnancy and escalate the risk of stillbirth (Swaminathan, 1997). Swaminathan critically examines this dilemma between labour and reproductive autonomy, characterising it as a 'Hobson's choice' for rural women. By advancing Swaminathan's argument, it becomes imperative to explore the causal relationship between labour and reproductive choice more rigorously.

Contrary to the notion that women are oblivious to their self-interest or well-being, a concept referred to as 'false consciousness', Agarwal (1997) observes that their acquiescence to disadvantageous practices is not due to a belief in the legitimacy of these practices but rather manifests as 'resistance to gender inequities' (Afshar & Agarwal, 1989b; Agarwal, 1994).

When considering intra-household gender inequalities, Agarwal notes that women often prioritise the interests of their family members over their own. This concept of the family inherently includes the well-being of their children, for whom women are willing to negotiate with their husbands or kin. The alignment between women and their dependent children, in terms of their bargaining power within the family, is further influenced by factors such as private ownership and control over assets like land, employment access, access to communal resources, and external social support systems, including NGOs and the State. It is pivotal to acknowledge that the loss of employment significantly diminishes a woman's bargaining power within the household. This is corroborated through interactions with female sugarcane cutters who reported that, as mentioned earlier, for every day of missed work, a cane cutter is expected to pay a penalty or *khada* of INR 500-1000. In instances of illness, particularly menstrual pain or bleeding, if they opted to take the day off, husbands or *'malak'* (employers) often expressed frustration over the loss of income due to their illness.

Conclusion

In this chapter I examine the gendered and caste-based dynamics of labour, reproduction, and economic survival within the sugarcane economy of drought-prone regions in Maharashtra, particularly Ariwadi and Kodewadi. In alignment with Revathy Subramaniam's observations, my ethnographic findings reveal that while child marriage has long existed in these areas, its prevalence has deepened and become embedded in the region's socio-economic landscapes. Marriage-based labour arrangements such as the *koyta*, a unit composed typically of a husband and wife have become increasingly common, with *mukadams* playing a critical role in negotiating such alliances to ensure labour supply (Subramanian, 2024). These rushed and early marriages, often involving children as young as ten or fifteen, are driven not only by social norms but also by the pressing demands of the sugarcane industry to create a ready-to -labour working unit.

These findings are corroborated by fieldwork that illustrates how women, including those who are pregnant, continue working under conditions of extreme physical strain, inadequate nutrition, and limited access to healthcare. Time off is rarely an option due to *khada* or fine for each day of missed work, and symptoms are often managed through expired or unprescribed medications, while male workers routinely access local clinics for minor ailments. Moreover, I also highlight two critical trends in the uptake of hysterectomy among women in Ariwadi and Kodewadi. Unlike states such as Gujarat and Andhra Pradesh, where such procedures are often linked to financial assistance schemes and community-based health insurance programs, the context in Marathwada reveals a different logic (Debnath et al., 2022; Desai et al., 2011). Here, the availability of disposable wage often provided as advance payments or *uchal* also enables women to perceive hysterectomy as a form of pragmatic investment. It is seen to pre-empt future medical costs, particularly those associated with cancer, and to avoid the loss of daily wages due to recurring pain.

The escalation of female participation in agricultural labour has not only intensified women's workloads but has also brought about a transformation in gender dynamics. This is further shaped by regional and caste distinctions. In contrast to cane-producing states like Uttar Pradesh where farmers hire labour directly, often on daily or contractual terms Maharashtra's factories and cooperatives mediate labour recruitment. Here, caste plays a defining role: labourers are predominantly from marginalised castes, such as Mahars, Mangs, Kumbhars, Nhavis, Lamanis, Bhils, and Vanjaris, while landowning castes such as Brahmins, Vaishyas, and Marathas are rarely involved in cane-cutting (Asawa, 2016; D. M. Attwood & Baviskar, 1987; Baviskar, 1969; Kendre, 2011). As evident from the narratives of sugar factory employees, migrants from Beed are particularly sought after, with *thekedars* emphasising their endurance and work ethic.

Even among landowning families, recurring droughts, high input costs, and market constraints have made agriculture increasingly unviable. Crops like soybeans yield little profit after factoring in seed, fertiliser, and labour costs. As a result, many families have little choice but to migrate seasonally for cane cutting. The increasing involvement of women in agrarian work has precipitated shifts in traditional gender relations, long understood as the interplay of power between men and women. As delineated by Agarwal (1994), these relations encompass practices such as the division of labour, roles, responsibilities, and structural hierarchies within households and communities(Agarwal, 1994). These gendered relations are hierarchical yet negotiated through cooperation and conflict, shaped by broader economic, political, and social forces. Agarwal outlines how social relations of power are either contested or constituted within various arenas such as the household, state, market, and community and highlights the connection between land ownership and women's bargaining power.

However, Agarwal also notes a critical, often overlooked, aspect of these power dynamics: the relationship between reproductive responsibilities and a woman's bargaining position in the household(Agarwal, 1994). In the agrarian sector, frequent childbirths hinder women's employment opportunities, increasing their domestic labour burden, while infertility carries the stigma of barrenness. Conversely, bearing sons may strengthen a woman's status within the household. In the sugarcane sector, as my ethnography illustrates, these dynamics take on particular forms: women often defer hysterectomy until after sterilisation, suggesting that tubal ligation functions as a rite of passage. Following this, reproductive morbidities are addressed not through non-invasive treatment but through surgical uterus removal. This raises critical questions about the point at which the uterus is seen not as a vital reproductive organ, but as expendable once its function in reproducing a family is deemed fulfilled. In this way, I posit that the removal of the uterus becomes a biosocial strategy not merely for managing health, but for maintaining a woman's economic and familial viability, transforming her into an organ

necessary to sustain both her household and the regional sugar economy. The structural violence embedded in such practices thus I argue is not incidental, but foundational to the functioning of the cane economy, wherein women's bodies are rendered operable and disposable.

Chapter 3

Cane Money is Blood Money, But It is the Only Money We Have": The Healer and The Killer Sickle

"For poor women like me, every day is a risk."

"I was so young when I visited the clinic for my menstrual bleeding. It looked like there was not even a single bed available–each bed had a young woman who was there to get her uterus removed. I, too, was one of them."

Ang bahir eta hota; Sharircha pishvi kadil bhag baahir et hota"

(A part of the uterus was coming out of my body)

Introduction

In the preceding chapter, I delineated the political economy of sugar, focusing on how female labourers from the Vanjari, Mahar, and Mang caste groups navigate the dilemma of being recognised as "workers." I examined the political, ecological, and capitalist frameworks, highlighting the gendered nuances of India's sugar economy that have been largely overlooked in existing ethnographic literature. By analysing the recruitment of familial enterprises, or *koyta* (i.e., the husband-wife dyad), as the mandated unit for earning a livelihood, the chapter illustrated the impact of this unique labour structure on women's health and well-being. This challenges the traditional interpretation of a linear association between women's labour force participation, financial autonomy, and reproductive choice, where economic agency is assumed to enhance household autonomy. Instead, it necessitates further ethnographic scrutiny into how the employment of *koyta* as the sole working unit, the practice of giving advance (*uchal*), and the annual seasonal migration to cane fields collectively contribute to the debilitating health status of women both within their households and in the fields.

Drawing upon National Family and Health Survey-4 and 5, it is observed that in India, women from rural areas predominantly those belonging to Other Backward Classes (3.6%) and SC/ST categories (2.7%) and employed as agricultural labourers are significantly more likely to undergo hysterectomies compared to their counterparts in other sectors (Ministry of Health & Family Welfare, 2019; Ministry of Health and Family Welfare, 2016). Studies indicate that hysterectomies are more common among women engaged in any form of wage-related work. Compared to 5% of urban women, 7% of rural women face a greater risk of hysterectomy. Furthermore, the incidence of hysterectomy increases among women who were married or began cohabitation at an earlier age, particularly below 15 years, while those who began cohabitation after 20 years of age exhibit a 55% reduced likelihood (Datta & Tiwari, 2024; Kumari & Kundu, 2022). While these statistics offer a national overview, there exists a paucity of qualitative or ethnographic investigations into these ostensibly non-biological factors across a woman's life course that contribute to early-age hysterectomies. This chapter draws on this gap and examines why and how hysterectomies have come to symbolise an intrinsic hope or embody the potential for "extending lives" and facilitating "life/time warranties" in this case, the removal of the uterus as a means to extend the lives not only of the women themselves but also of their families (Hogle, 2003; Nahman & Weis, 2023).

This chapter builds upon the discussions initiated in the first two chapters. Chapter 1 introduced the media portrayal of hysterectomies as a recent phenomenon affecting recent generations of women, also characterised as a precipitous decision taken by women, which, I argued, did not take into account the various processes that condition women's bodies and influence their decision-making, compelling them to regard hysterectomies as a feasible option. Building on Chapter 2, this chapter makes visible the pronounced linkages between labour practices, caste affiliations, seasonal migration, and rural precarity as the foundations for the predominance of hysterectomies among rural Indian women, thus, examining the feminisation of poverty and

the distinct impacts of production processes on women in the context of hysterectomies (Boserup, 2007). Broadening these discussions, I position this thesis and particularly this chapter as an ethnographic examination of hysterectomies among women engaged in agricultural labour, specifically cane cutting, and explore the influence of labour, employment, kinship relations, and familial dynamics in shaping the prevalence and acceptance of hysterectomies as a viable choice by women.

Within the domain of medical anthropology, I engage with Lawrence Cohen's conceptualisation of supplementarity, operability, and bioavailability in the context of organ selling and extend it to early-age hysterectomies. I provide an additional layer to the framing of bioavailability by introducing the lens of "viability." Cohen critiques the figure of the neoliberal rational economic agent 'choosing' to sell her kidney by examining the agency of women as kidney sellers and situating their choices within a sociological and socioeconomic setting, where poor neighbourhoods become *kidneyvakkams* through structural violence. While Cohen's framing offers critical insights, I argue for recognising women's choices, moving away from solely victimhood narratives. I posit that the discourse on "bioavailable" and "operable" views the body as being to a economic site, does not adequately account for the waxing and waning nature of life and varied biosocial strategies(Cohen, 2003, 2007; B. Singh, 2015). I build on the concept of bioavailability through the introduction of 'bioviability', which seeks to historicise women's agency and situate it within a biological life course perspective. Lending this lens to the case of early age hysterectomies, I ethnographically challenge dominant media narratives that oscillate between portraying women as either passive victims or autonomous economic actors. I resist framing this as a binary of agency versus structure, as both positions are present in media discourse and are analytically insufficient. I extend Cohen's work by foregrounding life course histories and situating women's choices within the socio-structural frames that shape their lives over time. This expanded understanding of *bioviability* draws on

two intersecting lenses, political economies of sugarcane and medical infrastructures, each offering insight into how women's embodied experiences and economic trajectories unfold across the life course.

Expanding on Cohen's work, in this chapter, I delve into the multifaceted and processual nature of *bioavailability*, highlighting the significance of this concept in understanding hysterectomies not as isolated medical procedures but through a series of events spread across various life stages and spaces beyond the clinical setting, including sugarcane fields, homes, public hospitals, local clinics, and pharmacies (Nahman & Weis, 2023). My ethnographic research revealed a direct link between complications following early-age tubal ligation and the practice of private practitioners offering hysterectomy as the sole treatment option. I specifically illuminate this through ethnographic narratives of women who underwent hysterectomies shortly after tubal ligation (hereafter referred to as sterilisation) due to complications or health issues stemming from the sterilisation. Many women reported trying to consult the same doctors who performed the sterilisation in public hospitals. However, the barriers of long waiting times, distant hospital locations, and sometimes being advised by the public hospital doctors to seek them out in their private practices led these women to opt for services at private clinics. Here, I argue, the realms of the public(through state incentivised sterilisation) and the private(unnecessary hysterectomies) intersect, appropriating the post-sterilisation gynaecological morbidities as a means for performing early-age hysterectomies. At the same time, this reframes hysterectomies as a means for women to take charge of their own lives, as a form of "care" towards the self, even though it is detrimental in the future (Mol et al., 2010).

Women's Narratives of Early Age Hysterectomies

"You should ask, where does it not hurt?": Tarabai

I met Tarabai for the first time while heading towards my auto-rickshaw after finishing my interviews scheduled for the day. Walking towards me with the support of half a cane in her hand, she called out to me and complained: "You have still not visited my house for a *mulaqat*(meeting)." The following morning, Tarabai was waiting at the village entrance. As she led me to her semi-pucca house, I noticed the swelling on her legs and the limp in her step caused by inflamed varicose veins. Tarabai tried sitting on the floor with her grandson on her lap but wailed in pain every time she tried. Finally, her eyes swelled up with pain when she sat on the floor. Pulling up her saree, she showed me her swollen knees. She pulled my hand, put it on her thighs, and said, "Can you feel it? They are as hard as a stone. Every part of my body hurts since I got my *pishvi* removed, *khoob trass* (too much pain)." I asked her, where does it hurt the most? Smiling, she responded, "You should ask, where does it not hurt?"

Tarabai, in her early 60s, is the eldest of five siblings of her mother, Jijabai, who is also a resident of Ariwadi. Talking about her childhood and marriage, Tarabai notes,

> "Since I was born, all I recall is spending my childhood in cane fields. My father died when I was just six years old, but my mother continued to cut cane as half a *koyta.* She had taken a *uchal* from the *mukadam* but could not cut the same amount of cane as she would have if she had another person in her *koyta*. Two of my sisters have polio. On most days, we had no food to eat and no water to drink. I remember my mother telling me I would get married tomorrow. I was told by my *Aaji*(grandmother) that my husband's family had offered to give my mother INR 300 in exchange for me. I must not have been more than seven years old at that time".

I asked Tarabai if she knew how old her husband was at the time of marriage. Laughing, she responded: “Who knows? I still wonder how old he is now. He had a long beard and a moustache then and has a long beard and moustache now.”

A mother of four, Tarabai had her first pregnancy at the age of 13 and her last child at the age of 22. Except for her final delivery, she gave birth to all her babies with the help of women at the factory site. However, she experienced two miscarriages during her pregnancies in the second and third trimesters, respectively. Tarabai recalled, “Both times, I remember eating one *bhakri* (a form of bread made with jowar/sorghum) daily and lifting bundles of cane over my head. I had gone to fill some water, and as I bent to lift the bucket, I started bleeding and fainted.” However, it was while discussing her last delivery that Tarabai became inconsolable.

During the last trimester, she continued to experience acute abdominal pain. One day, while cutting cane, Tarabai began to experience severe abdominal pain. After being admitted to a government hospital for a week, she returned to cutting cane the next day. With acute stomach pain that evening, she was readmitted to the hospital for delivery. Typically, the placenta is discharged from the body within half an hour of giving birth. In Tarabai’s case, the placenta did not fully detach from the uterus after childbirth. This condition, called a retained placenta, can lead to severe complications, such as heavy bleeding, infection, and even death, if not treated promptly. As a result, Tarabai suffered continuous bleeding from her nose and mouth, which she called a *rakt pichkari*, or a spout of blood.

Tarabai wiped away tears from the corner of her saree as she recounted her harrowing experience, her voice quivering. She said,

> “I never thought I would make it through that day. Everywhere I looked, there was blood. The only thing on my mind was what would become of my child if I did not make it. A part of me wished that my baby would pass with me. After he was born, I handed him to

my mother without wrapping him in a cloth. I pleaded with her to leave him on the hospital steps, hoping someone might take him or that he might pass away unnoticed. But he survived. Even my mother tried to end his life by stuffing biscuits in his mouth, but he still lived."

After two months of giving birth, Tarabai underwent what women locally call *lekrach operation* or tubal ligation in the nearby government hospital. However, within weeks of the procedure, Tarabai developed heavy menstrual bleeding and severe abdominal pain. She recalls,

"I got so scared of eating or drinking because I feared that if I had to urinate, the blood would never stop, or a part of my body would collapse. I used to stand, and my *nauvari* (long-form Marathi saree) used to get drenched in blood. There were days I used to put a cloth to dry, and by the time I returned, it had still not dried. I used the damp cloth many times. I was worried about how I would cut cane if this continued. We had already taken advance payment for the year."

With only a few weeks left before the migratory season, Tarabai visited a nearby private clinic. When Tarabai explained her symptoms, without any sonography or other medical tests, the doctor informed her that her 'uterus had developed holes', and she would die in four days if she did not get her uterus removed. Tarabai felt the same desperation she had during childbirth and considered suicide, but she could not bear the thought of leaving her children behind. The next day, she underwent a hysterectomy and bilateral oophorectomy (removal of both ovaries). She and her husband took an additional advance from a contractor to pay INR 20,000 for the procedure. Tarabai was only 22 years old.

During my fieldwork, I spent several days with Tarabai's mother, Jijabai. Now in her late 80s, Jijabai underwent a hysterectomy in her mid-20s. A mother of five, Jijabai had undergone three operations during the course of her life. After her fourth pregnancy, she underwent tubal

ligation when she was only 23 years old. However, the surgery, which Jijabai referred to as *ardhya tanka* (half a stitch), was improperly done, resulting in her fifth pregnancy. After delivering her baby, the doctors performed sterilisation again, which she referred to as *teen tanka* (three stitches). Months after the procedure, Jijabai began to feel her uterus bulging out, along with acute back pain– "*Ang bahir eta hota; Sharircha pishvi kadil bhag baahir et hota*" (A part of the uterus was coming out of my body). When she showed it to a nearby private doctor, she was informed that she had developed a case of uterine prolapse, which, according to the doctor, could only be cured by removing the uterus. Jijabai paid INR 10,000 and underwent a hysterectomy. Like Jijabai, all her daughters, including Tarabai, had undergone hysterectomies before they were 30.

"Tai, we leave our homes for six months yearly. Even if I had some reports, they might have been misplaced during travel.": Vijaymala

I met Vijaymala for the first time when she was coming from the fields with her husband, sitting on a bullock cart. As she saw me walk past, she called out, "Madam, come home tomorrow. I will make *gud vali chai* (tea made out of jaggery) for you". The next day, as we sipped tea, sitting in her house made of tin sheets, Vijaymala abruptly got up, went to the corner of the room and began searching through an old, rusted steel trunk. Frustrated, she came to me with a *pishvi*[7] full of papers and sat beside me. Amidst the clutter of documents, including electricity bills and strips of expired medication, Vijayamala mentioned she wanted me to look at her 'medical reports'. Since she could not read, she handed me every paper she could find, including a brochure of a standing fan, a pamphlet endorsing IVF treatment from a private hospital, and documents of her husband's motorcycle, among others. Yet, there were no reports

[7] *Pishvi* refers to both uterus and a bag in local Marathi dialect.

of her hysterectomy or any other medical procedure she had undergone. Repeatedly trying to reach her lower back to ease the pain, she added,

> "Tai, we leave our homes for six months yearly. Even if I had some reports, they might have been misplaced during travel. But I know when I asked the doctor for the report for my *pishvi*, he said why do you need it now? I have removed it successfully."

Vijaymala, now in her early 30s, has been migrating for six months each year to cut sugarcane since she was seven years old, earlier accompanying her parents and now as a part of the *koyta* with her husband. Married at the age of 12, a month after her first *padi* (menstrual cycle), Vijaymala had her first pregnancy within months of marriage. With tears in her eyes, holding on to the corner of her saree, she recalls,

> "I must be in the fifth month of my pregnancy. I had come back from cutting cane around 10 PM at night. I walked to the *kopi* to pick a stack of wood for fuel. As I bent to pick them up, I felt this unbearable pain in my abdomen, and as I looked down, my legs were already full of blood."

Vijayamala, who weighed not more than 40 kg then, was rushed to the nearby private clinic by her husband and father-in-law on a motorcycle. This was the case of her first miscarriage a few months before she turned 13. Within the next two days, Vijaymala was back to cutting cane. "I could not afford to miss work. It costs us money every day." Two months after her miscarriage, Vijayamala had her second conception. With little to no time to rest, she recalls working 18 hours a day, most days, until a day before her delivery. During her third trimester, just two weeks before her delivery, Vijayamala experienced severe swelling all over her body. Her husband called her parents and asked them to admit her to a private hospital as they could not secure a bed in a government hospital, and her husband refused to pay for a private hospital.

Doctors speculated that she developed severe food poisoning from eating stale and rotten food at the factory site.

After being admitted for a week, the doctors informed her family that she should be admitted till she does not go into labour. However, with mounting bills from the hospital, Vijayamala forced her parents to get her discharged. “Tai, my parents spent all their money in this one week. They are too old to cut cane. What kind of a daughter am I?” The next day after her discharge, she was back to cutting cane. Within a week, she had delivered a baby through a caesarian. With a gap of one year between each pregnancy, by the age of 19, Vijaymala, now a mother of four, had experienced another miscarriage and a sex-based abortion. Soon after her last delivery, she underwent tubal ligation in a government hospital. A few months after the procedure, while carrying a bucket of water from a borewell, Vijaymala experienced acute stomach pain again.

In days that followed, she recalls, “The blood just did not stop. I had never experienced *padi*(menstruation)like this. I kept changing a cloth every 2 hours.”. With no hospital or clinic at a 21 km stretch from Ariwadi, she and her husband hired a jeep for INR 2000 and consulted a private doctor. The doctor performed sonography and informed Vijaymala that her ‘uterus had gone bad’. She was also informed about an appendix–which, according to the doctor, required her to undergo surgery to remove both her appendix and her uterus, or she would not be able to survive for more than a week to ten days. The next day, she underwent both surgeries–panhysterectomy[8] and removal of her appendix which cost her INR 35,000.

> “I was so young when I visited the clinic for my menstrual bleeding. It looked like there was not even a single bed available–each bed had a young woman who was there to get her uterus removed. I, too, was one of them.”

[8] This is an invasive gynaecological surgery in which the uterus and cervix are removed, along with both fallopian tubes (salpingectomy) and both ovaries (oophorectomy). The procedure is typically performed to treat or prevent serious conditions such as gynaecologic cancers, severe endometriosis, or chronic pelvic pain. Because the ovaries are removed, the patient will enter surgical menopause immediately following the operation.

Within a week of the two surgeries, it was time to migrate to the cane fields and like every other hospital encounter, she was back to cutting cane soon after.

> "Tai, where do you think the money for my *pishvi* came from? We had to take an additional advance from the *mukadam*. Now, we have to pay it off. If I do not cut cane, we will be in debt. What will happen to my children? Who will feed them? One does not have time to wait for medicines to work."

> **"I must be in the fifth month of my pregnancy… my legs were already full of blood.": Subha Tai**

Subha Tai began working as a sugarcane cutter at the age of 12, the same year she got married. Her husband is at least 12–13 years older than her. Subha Tai had three children, two sons and a daughter. Tragically, her middle child, a son, died at the age of 12. He had gone to take the cattle to the nearby pond for fodder, but when he didn't return, the family found him drowned. Her other two children also work as sugarcane cutters.

Over the past 20 years, she has had four surgeries: two for hernia, one for sterilisation, and one hysterectomy. Fifteen years ago, while working in the fields, she developed chronic stomach pain along with white discharge. A doctor found a lump near her uterus caused by a hernia, and she underwent a combined operation for both hernia and hysterectomy. Within a year, she needed a second hernia surgery. The hysterectomy cost ₹18,000, and the two hernia operations cost ₹6,000 and ₹8,000 respectively. Despite these efforts, she continues to suffer from persistent pain, body aches, and swollen knees. When asked why she didn't seek care in a government hospital, she said simply, "They are not good."

Currently, her family has a loan of ₹6,000 at 8% interest from a local bank. Their monthly expenses come to around ₹20,000. Subha Tai reflected,

"Who likes to leave their own home? We have land, but no water. We'll have to keep cutting cane as long as our hands and legs can move."

Chronologies of Care: Hysterectomy, Chronicity, and the Life Course

"Even a good enough person is reduced to half after a hysterectomy"

"This *pishvi* (cloth bag) is as empty as the other *pishvi* (uterus) which is now gone"

In contrast to the dominant emphasis in existing literature (Chaparro-Buitrago, 2022; Luksaite, 2016; Majumdar, 2018b; Swaminathan, 1997; Van De Wiel, 2022; Vora, 2009), the narratives of Tarabai, Jijabai, Subha Tai and Vijaymala presented above illustrate that chronicity in its varied forms permeates the entire life course of women, rather than being confined solely to the domain of reproductive health. This observation underscores the need to critically engage with and deconstruct the concept of local biologies, and to attend to the deeply situated nature of women's health shaped through the interplay of biological, social, and cultural determinants (Lock, 1994; Lock & Kaufert, 2001).

Building on this reconceptualisation of women's health as a temporally situated and socially embedded phenomenon, a particularly troubling gap exists within the global qualitative literature on hysterectomies: the minimal, if any, incorporation of a life course perspective (Desai et al., 2024; G. Mishra et al., 2023; G. D. Mishra et al., 2010; G. D. Mishra & Sarah E, 2013). This perspective is essential for understanding hysterectomies not as isolated biomedical events, but as deeply embedded within a continuum of pivotal life moments, from birth to death. These stages significantly shape both the emergence and contextualisation of hysterectomies in women's lives. It is through this lens that I have framed my ethnographic accounts of women in Beed who have undergone hysterectomies. During my fieldwork, I intentionally organised their narratives around various life stages, including childhood, menarche, and menopause, to foreground the temporal and embodied dimensions of their experiences.

In the context of hysterectomies, employing a life course lens is particularly vital. It compels us to ask: how can we understand hysterectomies by examining the often-overlooked influence of early life exposures and the social, biological, cultural, familial, and economic compulsions that shape both the acceptance of and experiences with the procedure? This includes life post-hysterectomy, particularly the prevalence of non-communicable diseases (NCDs), which I explore in the subsequent chapter.

My interest in applying the life course perspective to hysterectomy narratives stems from two key motivations. First, it facilitates a shift away from the dominant framing of women's health as limited to reproductive and maternal health, encouraging a broader focus on life stages and events that, while not immediately medicalised, significantly influence health outcomes and lived experiences when viewed across the life span. Second, the life course perspective is crucial for reevaluating the positioning of hysterectomies within the broader spectrum of structural violence experienced by women. It prompts us to consider whether hysterectomies stand out as exceptional events or become entangled with other forms of violence, everyday precarity, and systemic healthcare failures rendering them critical, yet not necessarily, distinct. For instance, when asked whether they had undergone any surgical procedures, women typically mentioned only appendectomies or sterilisations unless they were specifically prompted about hysterectomies, which were otherwise not acknowledged.

Kuh and Ben-Shlomo (Kuh & Ben-Shlomo, 2004; Kuh & Hardy, 2002)conceptualised life course epidemiology as an inquiry into the long-term biological and psychosocial processes that connect health and disease risk to physical or social exposures at various life stages such as gestation, childhood, adolescence, and early adulthood across generations. This framework posits that diverse biological, behavioural, and psychosocial mechanisms link adult health outcomes and disease prevalence to early-life events and exposures (Alwin, 2016; Kuh & Hardy, 2002). Research indicates that the incidence of hysterectomy (G. D. Mishra & Sarah E,

2013) is associated with socioeconomic factors, Body Mass Index (BMI), socioeconomic status (SES), and weight gain during adulthood, reflecting the influence of life course trajectories. The life course perspective further emphasises the social pathways individuals navigate, which are embedded within institutions (Alwin, 2016). Building on this, the concept of an institutionalised life course helps explain how individuals' trajectories are shaped by and negotiated through social structures. This becomes particularly salient in the ethnographic narratives of women, where hysterectomies are influenced by life stages preceding the procedure and, in turn, shape the trajectory of life post-surgery.

Building on the experiences of child marriage, early pregnancy, and motherhood discussed in the previous chapter, I relate the varied stages outlined by Tom and Mishra (2010?) such as prenatal life, childhood, adolescence, social life, and socioeconomic status to the occurrence of hysterectomies. Mishra et al. (2010) highlight how the life course approach provides a lens to analyse how social, economic, and biological factors "cumulatively and interactively" influence health. For instance, a study based on DLHS-4 (District Level Household and Facility Survey-Round 4) showed that over one-third (36%) of women undergo hysterectomies before the age of 40 (G. D. Mishra et al., 2010). It also found a fivefold increase in the risk of hysterectomy among women who have had two or more children. Women with higher levels of education reported lower rates of early-age hysterectomies compared to those with no education (Geetha et al., 2019). More specifically, women with no or only primary education were more likely to undergo hysterectomy than those who had completed matriculation or higher (G. D. Mishra & Sarah E, 2013). Singh and Govil also show that hysterectomy rates are higher among women from the OBC caste group and among those engaged in agricultural labour (A. Singh & Govil, 2021). Mishra et al. draw further linkages between disadvantaged socioeconomic conditions, early childbearing, and a younger age of sterilisation averaging 27.5 years (G. D. Mishra & Sarah E, 2013).

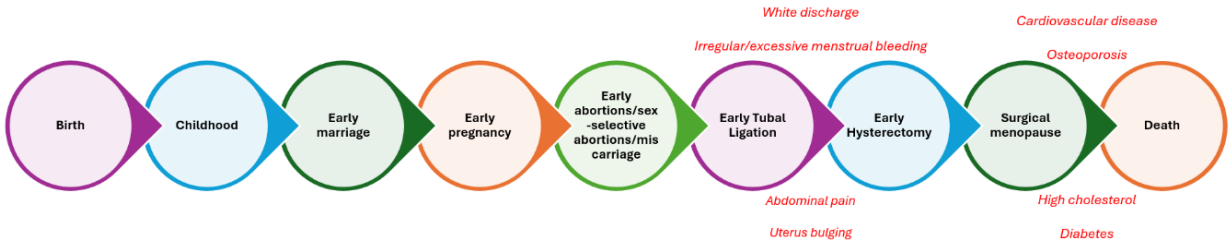
Narratives of early marriage, particularly following the onset of menstruation, were commonly reported in Ariwadi and Kodewadi, as discussed in Chapter 2. These early marriages were frequently followed by early and repeated pregnancies, with some women becoming pregnant as young as 12 years old. Many reported labour-induced miscarriages, often attributed to poor nutrition and exploitative working conditions in the sugarcane fields. One woman recounted, "I had gone to urinate in the middle of the night and just started bleeding and lost the baby."

Alongside these experiences, a strong preference for male children was evident in most households. This often led to sex-selective abortions, frequently carried out in clinics along the Maharashtra–Karnataka border. Locally, there were widespread rumours of mobile abortion services conducted in 'omni vans' that visited cane fields or nearby villages. For instance, Rajubai was married at the age of 10 in exchange for INR 400. She had 11 children, five daughters and one son and underwent three abortions because the foetuses were female. Two of her children died: one was stillborn, and the other passed away at seven months due to illness.

It is important to note that Maharashtra continues to rank among the Indian states with a below-average sex ratio, largely due to the prevalence of sex-selective abortions (Ministry of Health & Family Welfare, 2019)[9]. In Ariwadi, I interviewed a 17-year-old female sugarcane cutter named Mansha, who was already a mother of two daughters. During her second month of pregnancy, she shared that her husband was insistent on determining the sex of the foetus and terminating the pregnancy if it was female. Three months later, at the factory site, she revealed that they had indeed aborted the pregnancy before migrating, as the foetus was female. Mansha and her husband had travelled to a private clinic on the Maharashtra–Karnataka border, where her husband paid ₹60,000 for the procedure.

[9] The overall population has a sex ratio of 966 females for every 1,000 males, while among children under the age of seven, the ratio drops to 920 females per 1,000 males(Ministry of Health & Family Welfare, 2019).

Figure 4.1: Situating hysterectomies in the life course in Ariwadi and Kodewadi



Bleeding, Discharge, Pain and Diagnosis: Symptomatic Pathways to Hysterectomies

In alignment with existing public health literature on hysterectomies (Davis, 2019; Desai, 2016; Desai et al., 2011, 2024; Towghi, 2012), my fieldwork, as evident in the narratives of women above, revealed that one of the most common reasons for undergoing a hysterectomy was irregular or painful menstrual bleeding, often accompanied by abdominal pain. For example, Tarabai described being so fearful of urinating due to excessive bleeding that she avoided eating or drinking, convinced that her body might collapse. Similarly, Vijaymala recounted that her bleeding did not cease following childbirth.

Another frequently cited reason was persistent white vaginal discharge. In several cases, these symptoms were accompanied by a medical diagnosis though not always conclusive, including conditions such as fibroids, cysts, uterine prolapse, and pelvic inflammatory disease (PID), among others. For instance, Subha Tai's account illustrates how her experience of white discharge and abdominal pain led her to opt for a hysterectomy. These conditions, which could often be cured through non-invasive procedures, when presented to private practitioners, are treated as grave symptoms requiring a hysterectomy.

From a biomedical perspective, vaginal discharge can result from reproductive tract infections or sexually transmissible diseases. However, the way women perceive white discharge significantly differs from the biomedical perspective, often falsely equating self-reported

symptoms with specific diseases (Rashid, 2007; M. Singh & Khan, 2006). As Kumar notes, white discharge is a 'polysemic symptom' that expresses both physical and emotional distress, making it a medium through which women communicate their bodily experiences (Trollope-Kumar, 2001).

In a study conducted in Bangladesh, women referred to white discharge as "*kosha*," meaning the drying of the body. Symptoms associated with this condition included reduced but discoloured urine (often red), pain, and a burning sensation during urination. Some women also correlated feelings of weakness experienced during marriage and household work with the occurrence of white discharge. Additional factors contributing to an increase in white discharge included sexual activity, menstruation, and weakness induced by hot and humid weather. Women noted that white discharge led to various discomforts, such as a burning sensation in the hands and throughout the body, dizziness, joint pains, backache, and itching in the genital area. As a result, they perceived white discharge as a serious illness (M. Singh & Khan, 2006).

Women's perceptions of white discharge were also extensively shaped by family members (M. Singh & Khan, 2006). Another study from Bangladesh shows how young women correlated poverty, tension, and everyday stress with white discharge (Rashid, 2007). Rashid notes that women reported weakness as both a cause and consequence of discharge, often due to the loss of calcium, nutrients, and the body wasting away, what they refer to as '*chinta rog'* (worry illness), an expression of weakness that serves as a metaphor for social, political, and economic deprivation. Studies from Sri Lanka also show that women delayed treatment for white discharge, thinking that any type of white discharge is normal (Ilankoon et al., 2017). This was compounded by the fear of mixing vaginal discharge with STD-related discharge or avoiding treatment from male doctors. Studies note that women differentiate normal from abnormal discharge by its duration (lasting more than 24 hours), the amount of water required to clean it, or if it wets the petticoat (Rashid, 2007).

In my fieldwork, these broader cultural narratives are vividly embodied in the experiences of women for whom white discharge along with other symptoms became a pathway to a hysterectomy. For instance, Raebai reported experiencing severe and persistent body pain, particularly along her spine, accompanied by extreme fatigue, weakness, and frequent dizziness. When her youngest child was four months old, Raebai was in her late teens. Around that time, she began experienced recurring white vaginal discharge. Upon consulting a doctor, she was diagnosed with a uterine fibroid and was advised to undergo a hysterectomy. The surgery, which cost her INR 10,000, was deemed necessary as the pain was significantly affecting her ability to work, and the doctor warned that her condition could become life-threatening without intervention. Since the operation, Raebai has experienced chronic pain throughout her body. Tasks she once performed with ease such as lifting heavy bundles of sugarcane have become impossible; she now struggles to lift even a bag of papers. Additionally, she has developed kidney stones and suffers from persistent insomnia. She shared that she cannot recall a single night of restful sleep since the surgery.

Similarly, Suman Tai, who has been engaged in sugarcane cutting since the age of 15 and is now 50 years old, comes from a lineage of sugarcane workers and both her parents were also cane cutters. A mother of five, she recalls working in the fields until the ninth month of her pregnancy. During that time, her husband had to take on the role of an *ardhya koyta* (a half-share cane cutter) to support the family. She vividly remembers preparing meals for him from the very day she gave birth. Approximately 15 years ago, she underwent a hysterectomy. After experiencing persistent white discharge, that led her to change cloth number of time everyday. When she consulted a doctor and was diagnosed with Pelvic Inflammatory Disease (PID). She subsequently had her uterus removed; a procedure that cost INR 15,000. Since the surgery, she has suffered from chronic body pain, particularly on the right side. She describes the pain as unbearable, accompanied by sensations of *thar-thar* (trembling) and *ghabrat* (anxiety), noting

that even witnessing conflict around her triggers distress. Recently, she has been diagnosed with a kidney stone (*mutkada*), adding to her ongoing health challenges.

These individual narratives resonate with broader public health concerns. In 2013, Dr. Narendra Gupta, a public health expert, conducted a study to assess the prevalence of hysterectomies among rural women in the states of Bihar, Chhattisgarh, and Rajasthan (*Dr. Narendra Gupta v. Union of India and Others; Writ Petition (Civil) No 131 of 2013*, 2023). Upon uncovering concerning trends, Dr. Gupta initiated a public interest litigation (PIL) to curb unwarranted hysterectomies, prompting the inclusion of hysterectomy data in the National Family Health Survey (NFHS-4). Many women during my fieldwork reported complications after tubal ligation, such as irregular menstruation, chronic pelvic pain, body aches, and discomfort during intercourse.

Dr. Gupta's findings underscored the need to explore the linkages between sterilisation procedures, particularly tubal ligation, and subsequent hysterectomies. Clinical evidence indicates that women who undergo tubal ligation face a significantly heightened risk fourfold within five years of requiring a hysterectomy, often due to conditions like dysfunctional uterine bleeding (Prusty et al., 2018b). The long-term impact of tubal ligation, a permanent contraceptive method often performed before the mandated age of 22, remains inadequately scrutinised. While earlier studies have yielded conflicting results, they suggest a potential correlation between tubal ligation and increased risks of menstrual disorders, such as hypermenorrhea and menorrhagia, in addition to gynaecological morbidities (Fiks, 2023; Hillis et al., 1998).

My ethnographic research unveiled a direct correlation between complications arising post-early-age tubal ligation and the provision of hysterectomy as the sole treatment option by private practitioners. This echoes a 2013 report highlighting a surge in hysterectomies among

women in Dausa district, Rajasthan, shortly after tubal ligation in government camps (Prayas, 2013). Women reported developing abdominal pain and irregular bleeding within one to five years post-tubal ligation and were advised hysterectomy despite the availability of less invasive treatments.

From Sterilisation to Hysterectomy: The Continuum of Operability

Studies have shown that women who undergo sterilisation are significantly more likely by as much as 55% to later undergo a hysterectomy compared to women who do not opt for sterilisation (Prusty et al., 2018b). This correlation emerged as a salient and recurring theme in my ethnographic fieldwork, where early hysterectomies were frequently reported within months or a few years following sterilisation. The pattern raises critical questions about the long-term health implications of sterilisation and its entanglement with broader reproductive health outcomes in rural India.

In Beed district, as in much of India, the most common form of female sterilisation is tubal ligation or tubectomy. Tubal ligation is defined as the "intentional occlusion or partial or complete removal of the fallopian tubes to provide permanent contraception." This procedure is typically performed in hospitals within 24 hours after childbirth. Alternatively, laparoscopic sterilisation involves the insertion of a laparoscope and the placement of plastic rings on the fallopian tubes, followed by suturing at the site of incision near the navel. This method is more commonly conducted in sterilisation camps (Fiks, 2023). As of 2019–2020, sterilisation via tubal ligation remained the dominant form of contraception among Indian women, with approximately 37.9% having undergone the procedure (Jayakumar, 2024).

In the villages of Kodewadi and Ariwadi, tubal ligation was routinely practiced, either in government hospitals or through mobile sterilisation camps. Hospital-based sterilisation typically occurred within a week postpartum. Locally, the procedure was colloquially referred

to as *bache bandh karne ka operation* (the operation to stop childbearing*), lekrach* operation, or the *teen tanka vala operation* (the three-stitch operation). Women often recalled receiving a monetary incentive, ranging from INR 500 to 600, for undergoing the procedure. Notably, when asked if they had undergone any surgical operation, many women cited sterilisation as the only operation they had experienced often failing to mention hysterectomy unless prompted specifically. This suggests a perception of sterilisation as the most defining or legitimate medical intervention in their reproductive history.

The high prevalence of sterilisation in both villages is attributable to a confluence of structural and socio-cultural factors. Most women opted for the procedure upon reaching a "complete" family size, typically defined by having at least one male child. This decision was further influenced by the limited availability and accessibility of alternative contraceptive methods. In Ariwadi, options such as condoms, intrauterine devices (IUDs), or oral contraceptives were largely absent due to the village's remote location, the lack of a nearby pharmacy, and the minimal presence of Accredited Social Health Activists (ASHAs). Only women undergoing fertility treatment reported any significant use of non-permanent contraceptive methods.

In contrast, Kodewadi, located closer to the main town, exhibited slightly broader contraceptive usage, particularly of IUDs like the copper-T. However, the use of condoms remained limited. One particularly revealing ethnographic account involved a woman from Kodewadi who visited a local chemist seeking oral contraceptives. She was given an I-pill an emergency contraceptive which she then consumed repeatedly for three consecutive weeks, believing it to be a routine contraceptive, as per the chemist's advice. Following this, she began to experience irregular menstruation, severe abdominal pain, and fluctuating menstrual flow. This illustrates the critical role that chemists play as the first point of care in rural areas, often in the absence of trained health professionals. In Beed, many chemist shops double as general stores, raising serious concerns about the conflation of healthcare with retail business and the qualifications

of those dispensing medical advice. These concerns were substantiated when, between April and October 2023, the Maharashtra Food and Drug Administration revoked over 300 licenses to enforce pharmaceutical compliance (Health, 2023).

As Rishita Nandagiri notes, the median age of sterilisation in India is 25 (Nandagiri, 2022). These forms of reproductive violence are deeply stratified. Dalit, Adivasi, and Muslim women whose fertility is socially and politically constructed as "excessive" are particularly targeted (Nandagiri, 2022). Their bodies are legitimised as sites for reproductive control (Jena & Biswal, 2015). An estimated 7% of women experience sterilisation regret (Bansal & Dwivedi, 2020), often due to poor quality services that reflect broader gendered and structural injustices. NFHS-3 (2005–06) and NFHS-4 (2015–16) data show that one in three women were not informed that sterilisation is permanent, and two in three were not told about its side effects(P. Singh et al., 2021). Sterilisation and abortion must be understood as part of a larger institutional failure an inability of the state to provide safe, accessible, and non-invasive contraceptive options (Nandagiri, 2022). While Nandagiri frames target-driven sterilisation as an indirect form of structural violence, I argue that it is, in fact, an explicit one.

For instance, according to the guidelines issued by the National Health Mission, sterilisation should be performed only on women aged between 22 and 49 years (Family Planning Division, 2016). The mean age of sterilisation in India stands at 26 (Jayakumar, 2024). Moreover, health facilities are mandated to issue a sterilisation certificate within one month of the procedure or after the first post-operative menstrual cycle. However, in both Ariwadi and Kodewadi, many women reported having undergone sterilisation well before the age of 22, and few possessed any formal documentation of the procedure. This discrepancy can be attributed to the early age of marriage and childbearing prevalent in these villages, with many women becoming grandmothers by the age of 28. In Ariwadi and Kodewadi, women who later underwent

hysterectomies frequently traced the onset of gynaecological symptoms to the period following sterilisation.

Aradhna, whose narrative was introduced in Chapter 1 of this thesis, underwent sterilisation at approximately 21 years of age, shortly after the birth of her last child. Following the procedure, she experienced a complete cessation of menstruation for several months. Concerned by the prolonged absence of her menstrual cycle, she visited a local private clinic operated by a general physician. An ultrasound revealed that her uterus had become swollen and had developed a *gahnt* (knot), which, according to the doctor, could lead to cancer if left untreated. Alarmed by the prognosis, Aradhna underwent a hysterectomy at the age of 22. The surgery cost her INR 40,000.

Aradhna's experience is not an isolated case. Similar patterns of post-sterilisation complications leading to hysterectomy emerged in the narratives of other women in the field. Bhadamai, now around 35 years old, recalls beginning menstruation two years after her marriage, suggesting that she was married at approximately 10 or 11 years of age. She had been engaged in cane-cutting labour since the age of eight, working alongside her parents. At 20, following the birth of her three children, she underwent sterilisation. Soon after, she began experiencing acute abdominal pain, particularly while cutting cane, accompanied by continuous heavy bleeding for ten days. Upon visiting a nearby private clinic, she was informed that her uterus was swollen and had developed a knot. The doctor also diagnosed her with appendicitis, warning that failure to operate would result in death from cancer within a month. The following day, she underwent a hysterectomy and appendectomy. She recalls the doctor showing her the removed uterus, describing it as "black" and "rotten." The combined procedures cost her INR 30,000.

The trajectory of surgical interventions following sterilisation is further illustrated in the case of Barkubai, now in her 60s, who has been cutting cane for over five decades. Married at the age of eleven and a mother of five, she has undergone four surgeries over her lifetime. Her first was a sterilisation procedure at the age of 19, performed in a hospital following the birth of her last child. Within six months, she experienced a significant increase in menstrual flow. A visit to a nearby private doctor led to a diagnosis of a "dirty" uterus. The doctor recommended what she referred to as a "*kriting ka operation*," which was a curettage procedure dilation and scraping of the uterine lining to remove abnormal tissue. This surgery cost her INR 10,000. Although her symptoms temporarily subsided, she continued to suffer from recurring abdominal pain. The same doctor later advised a hysterectomy, citing a "rotten" uterus. She underwent the procedure at the age of 20, at a cost of INR 20,000, for which her husband had to take a loan at a 5% interest rate. Within months, she required another surgery for what she described as "food" in her stomach likely bloating or gas caused by a stitch left inside during the previous operation. This surgery cost her INR 25,000. By the age of 23, she had undergone four surgeries. Reflecting on her experience, Barkubai shared, "I used to reach the hospital like an animal on the bullock cart; people used to watch me (*log dekhte the*) when I was all covered up in cloth. Earlier, everyone was scared of me. I was so strong. Now, these four operations have ruined my life. Every problem in my life is attached to cane. I never took a leave unless I felt I was dying."

Indu's story further reinforces the recurring pattern of post-sterilisation complications leading to hysterectomy. A 37-year-old cane cutter, Indu was married at the age of 12 and is a mother of four. She underwent sterilisation at around 22 years of age. Days after the procedure, she developed acute abdominal pain that made it difficult for her to cook or walk. Two years later, a doctor diagnosed her with a knot in her uterus that required surgical removal to prevent death. However, during the operation, the doctor informed her that her entire uterus needed to be

removed. She underwent the hysterectomy at the age of 24, paying INR 25,000 for the procedure.

These narratives are echoed by broader medical and institutional perspectives both from my fieldwork and existing public health literature. Conversations with multiple doctors reveal that while there is no direct anatomical linkage between sterilisation and hysterectomy since sterilisation involves the fallopian tubes and hysterectomy involves the uterus, improperly performed sterilisation, especially at a young age, can lead to complications such as infections, abdominal pain, white discharge, or even unintended pregnancies. Several studies have documented heightened post-ligation morbidities, including pelvic pain, pelvic inflammatory disease (PID), menopausal symptoms, increased menstrual bleeding (menorrhagia), irregular menstrual cycles (polymenorrhea), and prolonged menstruation (hypermenorrhea) (Fiks, 2023; Hillis et al., 1998; Moore et al., 2023; Sadatmahalleh et al., 2023). This has been linked to poor quality of sterilisation camps in India thus pushing them into hysterectomies at a later stage (Babbar et al., 2024).

In addition to complications arising from tubal ligation, a significant health concern reported by women in Ariwadi and Kodwadi is the protrusion of the vaginal canal, clinically identified as uterine prolapse. This condition is notably prevalent among women in rural settings such as Ariwadi, where engagement in physically demanding labour is common. Uterine prolapse, often characterised as a predominantly rural health issue, results from the weakening of the pelvic floor muscles and ligaments that support the uterus. According to biomedical literature (Ravindran et al., 1999; Kumari et al., 2000; Swain et al., 2020), uterine prolapse is classified into three degrees: in the first degree, the uterus descends into the vaginal canal with the cervix visible at the vaginal opening; in the second, the cervix reaches the vulva; and in the third, known as procidentia, the uterus and vaginal walls protrude entirely beyond the vulva.

Findings from both clinical and ethnographic research indicate that the risk of uterine prolapse is exacerbated by factors such as frequent childbirth, vaginal deliveries, gynaecological surgeries, early pregnancies, inadequate maternal and postpartum healthcare, and intensive manual labour. Among agricultural labourers, the immediate resumption of work following childbirth further heightens this risk. While non-invasive treatments and pharmacological interventions are effective for most cases, surgical intervention through hysterectomy is generally advised only for third-degree prolapse. However, barriers such as limited access to public healthcare, misdiagnosis by medical practitioners, lack of familial support, loss of income due to travel for treatment, and financial constraints often lead to delays in seeking medical care. Consequently, many women ultimately undergo hysterectomies as a last resort.

Sapna Desai's research indicates that most informants who underwent hysterectomies had previously undergone tubal ligation within the last ten years(Desai, 2016; Desai et al., 2011). While the medical fraternity debates the causal relationship between sterilisation and hysterectomy, my fieldwork reveals two key patterns: first, a notable increase in gynaecological morbidities following sterilisation; and second, a recurring narrative of surgical escalation, where sterilisation often marks the beginning of a series of invasive interventions. Consequently, these morbidities are often used by health practitioners as justifications for recommending hysterectomies, frequently invoking the threat of cancer, or even death, to prompt immediate surgical intervention. This framing of risk becomes a tool in shaping women's decisions, especially when they are already experiencing debilitating symptoms post-sterilisation.

A striking pattern emerged across the narratives of women who underwent hysterectomies following sterilisation: many initially sought care in government hospitals but were redirected to private clinics run by the same doctors. Due to long queues and extended waiting times in public facilities, women were often advised to consult the doctors' private practices, where they

were more readily recommended for hysterectomy. This overlap between public and private healthcare spaces reveals a troubling dynamic in which the same actors operate across institutional boundaries, blurring lines of accountability and care.

Moreover, hysterectomy is sometimes perceived as a form of sterilisation itself. However, in my fieldwork, no woman had undergone a hysterectomy without first having a tubal ligation. For instance, during my ethnographic fieldwork, I did not encounter any woman who was a widow and had undergone a hysterectomy. For instance, the use of condoms particularly after undergoing sterilisation was often perceived as unnecessary, as condoms were primarily understood as a method of contraception rather than as a means of protection against sexually transmitted infections (STIs). Furthermore, many women reported experiencing a series of unintended pregnancies, especially in contexts where condoms were not used- thus leading to sterilisation into the only viable option. This sequencing suggests that sterilisation is not only a prerequisite but also a normalising step toward further surgical intervention. Eva Fiks, in her work among women in Chandrapur, observed that while women initially viewed sterilisation as a temporary solution to their gynaecological issues, they came to see hysterectomy as the only route to permanent relief(Fiks, 2023).

This layered understanding of reproductive interventions is further complicated by the broader discourses on contraception. Eva Lukasite draws on Russell (2000) to distinguish between contraception as birth control a personal, individual decision and contraception as population control, which frames reproduction as a national concern(Luksaite, 2016; Russell & Russell, 2000). Lukasite critiques the dominant narratives that either celebrate sterilisation as a form of modern citizenship or condemn it as state control over women's bodies. Instead, she argues that sterilisation is often negotiated within more complex frameworks, where many poor women strategically engage with state incentives to meet their own needs.

My fieldwork supports Lukasite's argument. Many women described sterilisation as a means of securing relief from the constant fear of unwanted pregnancies. However, I extend this analysis by raising further questions: Who is being sterilised in India, and why are these procedures disproportionately concentrated among rural women? How does sterilisation create a pathway toward hysterectomy? What does it mean to be 'operable'? Does one surgery normalise the body for further interventions? And how are post-sterilisation morbidities interpreted and managed by both women and healthcare providers?

In India, the median age for female sterilisation remains below 30, with the majority of procedures occurring in rural areas. In contrast, urban women are more likely to use alternative contraceptive methods such as intrauterine devices (IUDs). Women from economically disadvantaged backgrounds particularly those from Other Backward Classes (OBC), Scheduled Castes (SC), and Scheduled Tribes (ST) are significantly more likely to undergo sterilisation. According to the National Family Health Survey (NFHS-5, 2019–21), sterilisation rates in Maharashtra are highest among women from these communities, many of whom are engaged in agrarian or wage labour (Ministry of Health & Family Welfare, 2019).

This intersection of caste, class, and labour is also evident in the work of social anthropologist Karin Kapadia who studied Pallar women engaged in heavy agricultural labour(Kapadia, 1993, 1995). She found that abortion and sterilisation were the two most common contraceptive methods, often used in unsafe and ill-equipped public health settings. Many women avoided sterilisation due to fears that it would weaken their bodies and impair their ability to work. For those who did undergo the procedure, doctors advised avoiding heavy lifting for up to eight months, a recommendation that, if followed, would push many women into starvation. Kapadia also notes that some women resisted sterilisation due to concerns that their husbands would find them less attractive or desirable.

The convergence of early-age hysterectomies and post-sterilisation complications marks a critical site where public and private healthcare systems intersect. Julieta Chaparro (2022), in her study of women in Peru, similarly found that sterilisation was linked to a loss of physical strength and labour capacity (Chaparro-Buitrago, 2022). Women described their unhealed surgical wounds as making their uterus feel "tender and weak," and the reopening of these wounds during strenuous work caused extreme discomfort. Chaparro argues that sterilisation debilitates not only the bodies of marginalised women but also their broader life-worlds, exposing them to prolonged structural violence. In Ariwadi and Kodewadi, this dynamic is particularly visible in the role of government doctors who, during their private practice, perform hysterectomies on women experiencing complications from sterilisation. These clinical practices reflect a pedagogy that no longer views the womb as a vital organ but rather as a hindrance once reproductive capacity has ceased. The uterus, in this framing, becomes a disposable entity and its removal justified as necessary for restoring bodily function and sustaining life itself.

A comparable logic of incentive emerges in both public and private healthcare sectors. While women receive monetary compensation for undergoing tubal ligation, the cost of hysterectomy is framed as a necessary investment to maintain daily survival. As Desai (2016) notes, this investment is seen as a pragmatic step toward securing a viable present: preserving the ability to work, care for family, and keep life moving (Desai, 2016). Over time, the perceived utility of the uterus shifts: it is seen at times as an asset, at others as a burden or liability but rarely as integral to a woman's overall well-being.

"How Will We Work If the Blood Doesn't Stop?": Bioviability, Hysterectomy, and the Ethics of Getting By

> "I still remember clearly when I was not more than 7-8 years old, my mother started experiencing menstrual bleeding. Within days, she got her uterus removed at a

khajgi(private) clinic. She was never the same again after that. The doctor has told her that her uterus has burned and if she does not get it removed, she will not survive for more than a month. Back then, it cost her INR 20,000. She must be your age. My parents took extra advance from the contractor to pay for her treatment. However, since the surgery, she used to be in pain all the time and used to start crying suddenly–while cooking, while tying cane or anything. Within months, she started seeing a *bhoot(*ghost) from the *karkhana*(factory). I remember my younger sister passed away due to high fever, when she was just 6 years old, and my mother kept saying that the *bhoot* from the *karkhana* killed her. She used to keep saying that the *bhoot* would kill us all one day. One day, she tried to kill herself by jumping into the well near our house, but someone from the village found her before she drowned. Some years after she got her *pishvi* removed, she developed a kidney problem. The doctor said her kidneys were 50% damaged. We had no money. I remember even during days she could not move; she continued to cut cane so that we could get food. Each year, my parents kept taking *uchal*, but each year, her ability to cut cane kept declining and the debt kept increasing. Within a year, the doctor said that she had cancer and would not survive for more than a few months. We had run out of money, and within weeks, she died. Till the time she was in her deathbed, she kept saying that the *bhoot* from the *karkhana* would kill us, and I feel that is what took her life." – Kavita, a 27-year-old cane cutter

In his seminal work (Cohen, 2003), Lawrence Cohen introduced the concept of supplementarity, characterising it as the acquisition of another's "organic form" to extend life or secure longevity. Within the context of kidney transplantation in India, Cohen conceptualises bioavailability as an index reflecting the extent to which an individual's body is rendered accessible, facilitating specific interactions between surgical techniques and market-driven economies (Cohen, 2003, 2007, 2011). Although the term bioavailability initially emerged in pharmacology, referring to

the degree of a substance's absorption and availability in a living system, Cohen repurposed it to indicate the ease with which an individual's body or organ can be dissociated and reallocated. When applied to kidney transplants, this reinterpretation unveils the intricate dynamics between technological advancements, market influences, and socioeconomic disparities, fostering an "ethics of parts" (Cohen, 2003; Scheper-Hughes, 2000).

While analytically productive, the concept of bioavailability primarily frames the body as a site of extraction or surgical manipulation. The discourse on 'bioavailable' and 'operable' bodies treats the body as a static economic site, failing to account for the waxing and waning nature of life and the varied bodily strategies through which individuals enter and exit certain thresholds and moments in life. These movements, particularly when situated vis-à-vis collective experiences, become critical junctures. This limitation becomes evident as Nahman and Weis inquire: what does it mean to be available? (Nahman & Weis, 2023) How does bioavailability come into being? Taking a cue from the processual nature of bioavailability: viewing humans not as 'beings' but 'becomings', hysterectomies unveil a nuanced aspect of bioavailability, particularly underscoring the notion of viability: securing the body's immediate ability to survive and get by (Ingold & Palsson, 2013). I argue that securing life's viability entails a constellation of processes that extend well beyond the clinical encounter. These processes are constituted by social, economic, and environmental forces, unfolding across spatial and temporal registers that are often overlooked in the biomedical framing of availability. As such, women's bodies are rendered vulnerable to classification within a persistent 'bioavailable zone,' a status that is unevenly distributed across caste, class, and gender lines (Clarke et al. 2003; Nahman and Weis 2023). This casts the woman as an essential 'organ' within the familial unit, prompting reflections on the expendability of her life, analogous to a kidney that might be offered for economic advantage. The advocacy of early-age hysterectomies for women, portraying them as a strategy to enhance life's 'potency,' highlights

the inherent contradiction of such potencies where an individual's life might be threatened even by a potential enhancement (B. Singh, 2015).

This was poignantly illustrated during my last visit to Ariwadi, just before the migratory season, when it was revealed that Tarabai had experienced a stroke. Furthermore, it was discovered that her daughter, in her early 30s and a sugarcane cutter and mother of three, had been diagnosed with pelvic inflammatory disease and is contemplating undergoing a hysterectomy. This case transcends a purely medical evaluation of the risks and benefits associated with hysterectomy. It compels us to delve deeper into the concept of "pragmatic agency," as outlined by Sapna Desai (Desai, 2016). Desai argues that within exploitative labour relations, restrictive gender norms, and inadequate healthcare facilities, hysterectomy becomes a strategy for women to exert agency over their reproductive health. This agency manifests not only in refusing medical interventions but also in embracing them. Desai suggests that for these women, hysterectomy offers a path toward freedom from the burdens of chronic pain, the fear of future debilitating illnesses, and the anxieties associated with unwanted pregnancies. It becomes a way for them to negotiate their healthcare beyond the confines of the clinical setting. As she emphasises, the constant threat of fibroids, cysts, and potentially fatal diseases transforms hysterectomy into a procedure that functions as both "treatment and prophylaxis". In the context of Ariwadi and Kodewadi, "pragmatic agency" and "pragmatic prevention" through hysterectomies for women like Tarabai, Subha Tai, Indu, Vijaymala and many others become the mechanisms that enable women to do what it takes to live and get by. The interaction between the biological and cultural are, thus, in constant exchange, as Lock and Kaufert posit, shaping both the biological and non-biological correlates in the processual nature of early hysterectomies (Lock & Kaufert, 2001).

The transition from a body being available for biomechanical disaggregation to itself becoming the means for securing a 'viable present' leads me to conceptualise bioviability as the potential

presented in the operability of a body or organ where its presence or disposal holds the hope for not only enhancing the longevity of life but also a pain free life and improving its quality of liveability. Yet, these aspirations are intermeshed with the ephemerality of this very viability and must contend with deadly calculations and temporality. The hope for sustenance among women in Ariwadi and Kodewadi through the removal of an organ is not only invested in the maintenance of the biological body but also in the preservation of the *relational self*, a self-constituted through interdependence and obligation. In this sense, a woman's life is a *condensed life*, lived alongside and through others (for instance, her husband within the *koyta*), particularly when the threat of death looms without surgical intervention). In the case of hysterectomies, it is not merely the availability of invasive biomedical procedures that makes women's bodies bioavailable. In thinking beyond the bioavailable bodies of women as economic sites, the varied nature of contracts women are compelled to enter often not through a singular biomedical encounter but across different life junctures from birth to death or through other exchanges that constitute the political economy becomes a vital area of ethnographic focus.

In my reading, Cohen's deployment of bioavailability and operability is meant to counter a static and reductionist agentive approach that assumes people sell or donate organs simply because they "need the money," and that it is therefore not our place to judge their choices. Cohen challenges this false liberal notion of choice by showing how certain geographies and populations are structurally circumscribed to produce bioavailable bodies, people who are offered this absurd and constrained form of "choice" in the first place. What appears as an individual decision is in fact made possible by deeply entrenched structural conditions that shape who can afford to "choose" and at what cost.

In my own work, I find drawing upon bioavailability to challenge the media critique that celebrates these women as autonomous agents who "choose" freedom from menstruation and

its burdens. At the same time, bioavailability strengthens media narratives that portray these women as helpless victims. I argue that both these framings are ahistorical and ultimately inadequate. The victim narrative erases women's capacity for agency and survival, while the empowerment narrative ignores the structural and historical conditions that limit their possibilities in the first place. What I am arguing for, therefore, is an approach that holds both of these dimensions together. I want to trace how women's lives are structurally circumscribed in ways that leave them with very few viable options (as I discuss in Chapter 2), while also taking seriously their agentive strategies, the ways they navigate, resist, and survive within these constraints. This is where I locate my concept of viability: in the tension between structural limitation and agentive endurance. Viability, for me, captures how women make life possible under conditions that continually threaten to render it impossible.

Bioviability, then, refers to the potential embedded in a body or organ's operability where its use, presence, or disposal holds the promise of prolonging or securing life. Longevity in this context extends beyond the lives of women to include the perpetuation of deferment of financial strains associated with ongoing medical consultations for non-invasive treatments for gynaecological conditions, the potential mortality risk in the absence of a hysterectomy, loss of income due to illness, and concerns over the care of children and families during illness or in case of death. The temporality of viability is often short-lived and subject to contingent, and sometimes deadly, calculations. As many women expressed during the course of my fieldwork, "How will we work if the blood does not stop?" Doctors, in turn, were often reported as saying, "If you do not get your uterus removed, you will die in a few days", laying bare not merely the debilitating imbrication of everyday wage, household labour, and bodily functionality but also the functionality of life itself. Thus, in contrast to bioavailability, which makes visible the structures that produce women's bodies as being available for intervention, my positioning of early-age hysterectomies through the lens of bioviability offers a complementary lens, which

recovers women's situated agency. These two concepts work in tandem to illuminate the systemic nature of reproductive exploitation and help us move away from the reductionist media narratives of helpless victimhood vs individual choice.

As Aaron Goodfellow (2014) highlights in the context of HIV testing, "...the normalised relationship of diagnostic tests to sustaining life illuminates the ways attachment to life and living emerges through scenes of instruction, where subjects gain training in the multiple agencies born of relations between things... This elucidates how one must learn life's relation to death and how such an education does not necessarily facilitate distinguishing between living and dying" (Goodfellow, 2014). Drawing on Goodfellow, the lens of bioviability can be used to understand the perceived 'disposability' of the uterus as a means through which women negotiate their lived realities. This negotiation involves the (re)interpretation and (re)valuation of the conditions under which the meanings of life and living are constituted. In this context, I draw on Didier Fassin's (Fassin, 2007) concept of life as both biologically embodied and socially constructed, shaped by political and institutional frameworks wherein the project of 'making live' involves implicit and often inequitable processes within healthcare systems and social policies, which I posit (re)determine the contours of viability.

Women in Ariwadi often recalled "*Panch taanka, kamzori aur dard ki goli*" ("five stitches, weakness, and painkillers") as the means for 'getting by' post an early hysterectomy. It is here that I posit that it is only with the transition from bioavailability to bioviability, masked under the promise of sustenance while systematically debilitating women's bodies, that means of biological citizenship can be claimed by accepting hysterectomies as the only cure to recurring gynaecological morbidities. This is not in an attempt to secure a certain kind of future but to regain a viable present because the future is seen as unanticipated, improbable, and only possible, if the present is secured.

Conclusion

This chapter traces the complex and layered trajectories that culminate in early-age hysterectomies, revealing them not as isolated medical events but as deeply embedded within broader structures of violence, precarity, and systemic healthcare failures. Narratives of women like Jijabai, Tarabai, Vijaymala, Indu, among others make it evident that hysterectomies are rarely perceived as exceptional; instead, they are entangled with a continuum of reproductive interventions and violations. The absence of spontaneous mention of hysterectomy, unless specifically prompted, underscores its normalisation within a landscape where sterilisation is often regarded as the most legitimate or defining surgical experience.

I further illustrated how in villages such as Kodewadi and Ariwadi, tubal ligation is routinely practised and colloquially framed through terms like *bache bandh karne ka operation*, *lekrach operation*, or *teen tanka vala operation*. These procedures are incentivised through modest monetary compensation and are often performed postpartum in government hospitals or mobile camps. While medical literature debates the causal link between sterilisation and hysterectomy, my fieldwork reveals two consistent patterns: a marked increase in gynaecological morbidities post-sterilisation, and a recurring narrative of surgical escalation. Health practitioners frequently invoke the threat of cancer or death to justify hysterectomy, especially when post-sterilisation symptoms already debilitate women thus framing risk as a persuasive tool in clinical decision-making.

Early hysterectomies were not merely perceived as biomedical interventions aimed at the techno-medical disaggregation of the body; instead, they were also embedded within broader regimes of care, wherein women were compelled to make significant financial and emotional investments. These investments, framed as acts of self-care, I suggest were often made to mitigate the ongoing physical, economic, and affective toll of repeated clinical encounters that yielded minimal immediate relief, allowing women to carry out everyday household and wage

labour. This form of care, as I illustrated, involved prioritising immediate symptomatic relief over non-invasive treatments, which, while addressing the underlying causes of disease, could lead to an inability to engage in everyday labour, resulting in wage loss and recurring, severe and non-affordable physical distress. I also show that, despite the significant financial cost and potential future health risks, early hysterectomies, when conceptualised as a form of 'care,' revealed the complex nature of the contracts women entered. Furthermore, I explored how the act of crossing specific biomedical thresholds by choosing to undergo or forego such procedures became a pivotal point for tracing the liminal nature of bodies that are transitioning from bioavailability to bioviability. In this transition, the operability of a body or organ, along with its potential removal or retention, is presented by private health practitioners as an opportunity to enhance longevity, albeit with a risk of morbidities, chronicity, and even death.

Broader discourses on contraception further complicate this layered understanding of reproductive interventions. Building on Eva Luksaite's critique of the binary between contraception as birth control and as population control, this chapter supports her argument that sterilisation is often negotiated within complex socio-economic frameworks(Luksaite, 2016). Many women described sterilisation as a strategic choice to mitigate the fear of unwanted pregnancies. Extending this analysis, this chapter raised critical questions about the demographic targeting of sterilisation, its disproportionate concentration among rural women, and its role in rendering bodies 'operable' where one surgical intervention paves the way for others.

It is here that I draw on and expand Lawrence Cohen's conceptualisation of bioviability to describe the fragile and contingent ways in which women sustain life within intersecting medical, economic, and social constraints. While bioavailability reveals how structural forces render certain bodies available for intervention, bioviability shifts attention to how those same bodies labour to remain viable within and against such conditions. This analysis is substantiated

by a historicisation of the female life course, within which hysterectomies are nested. I aim to highlight survival or viability, not as a given, but as a continuous process of negotiation and bargaining, constituting an active biosocial strategy i.e. early hysterectomies through which women make life possible amid systems that both sustain and endanger it.

Chapter 4

"If I can make 50,000 of a hysterectomy, then why not?": Labouring Bodies, Hysterectomies and Pragmatic Investments

Cancer was not Surekha Tai's first surgery. At one point during my many visits to her, she pulled down her petticoat to show me the surgical stitches from her hysterectomy. She had undergone the procedure right after her last pregnancy, at age 28. After delivery, she began experiencing heavy bleeding, especially during daily labour work. Initially, she tried traditional methods like sitting in river water to ease the symptoms. But as the bleeding continued and the pressure to keep working mounted, she visited a doctor.

The doctor did not perform any tests. Instead, he showed her a picture of a uterus with holes and said, "Yours has rotten. Either get it removed in 5 days, or you will die." She joked, "I do not even know if it was my report. Maybe they have one uterus with holes and they show it to everyone." The operation was conducted the same day at a private hospital and cost INR 25,000. With travel and other expenses, the total cost came to INR 40,000. She and her husband worked longer hours cutting sugarcane and used all their earnings from one harvest season to cover the surgery. However, the financial stress caught up. They had to take a loan of INR 30,000 from a local bank. With interest, that amount grew to INR 1.5 lakh by the time it was repaid. She didn't receive any post-operative counselling. She was just told to eat vitamins to regain strength. But after the surgery, her condition worsened. She could not sleep for a month and had frequent sweating. The removal of the pishvi (uterus) made her already weak body feel worse. She suffered from back pain, irritability (chid chid), bloating, and constant fatigue.

She was diagnosed with breast cancer and has been undergoing treatment since. She brought out a plastic bag containing all her reports and bills carefully collected. Surekha

is registered under the PMJAY scheme and has an Aadhaar card. According to the scheme, she was eligible for a certain credit amount during each chemotherapy session. But she said that despite the scheme, she had to pay INR 5,000 each time she visited the OPD.

She underwent two operations for breast cancer first in Ambajogai and then in Barshi. Only the first chemotherapy session was free. For the rest, she had to pay INR 400 per injection, and each chemo session required three injections. The hospital is 60 km from her village in Ariwadi, adding travel costs on top of medical expenses. According to both their Aadhaar cards, Surekha and her husband were born in 1948. Their son, who was standing behind her, said there was at least a 10-year age difference between his Aai and Vadil. When I asked Surekha how old she was when she got married, she said she did not remember her age, but it was the same year she started menstruating. When I asked about her husband's age at the time, she smiled and said, "I do not know, but he had a beard."

Surekha has five children, two sons and three daughters and the eldest daughter is 55, and the youngest child, a son, is 39. When I asked about the gaps between her pregnancies, she said she did not remember but estimated that they could not have been more than two years. But that did not match up with the 16-year gap between her eldest and youngest child. That's when her son added that between these pregnancies, she had two more children who died within 2–3 months due to chickenpox. During pregnancy, she had to take unpaid leave. She also had to pay ₹600 to the mukadam each time she took a day off. She said, "We had to beg for food when I was pregnant because we were paying heavy fines specially during the last days of pregnancy."

Introduction

This chapter examines the gendered dimensions of medical negligence within the medical economy, arguing that structural violence is enacted upon women through both public and private healthcare systems. It illustrates how the relationship between the public and private sectors facilitates a cycle of exploitation in which doctors employed in government hospitals perform botched sterilisation procedures that lead to gynaecological morbidities and subsequently refer women to their own private clinics for hysterectomies. Through this process, women's reproductive organs become sites of profit, revealing how medical practice monetises the uterus. During fieldwork, women frequently described two categories of doctors: those practising entirely in the private sector and those affiliated with government institutions who also engage in private practice. Women typically consulted the same doctors in their private capacities. As the chapter illustrates, hysterectomies were predominantly performed by private practitioners, especially general physicians or surgeons (and not gynaecological surgeons), in particular clinics which many women visited for these procedures. These practitioners frequently exaggerated the risks of cancer or death, often medically unfounded, leaving women with little choice but to undergo surgery.

The chapter contends that this capitalist economy of organs, where the uterus is rendered redundant and its removal normalised, constitutes a profound form of medical negligence. Such practices disregard the uterus's significance to women's overall health and well-being. The analysis situates these interventions within a life course understanding of medical violence, shaped by women's restricted access to quality medical care. From caesarean sections and other operative procedures to the social construction of race, caste, and class, women are persistently positioned as delinquent patients within the medical system. The chapter demonstrates how the lack of medical documentation forms part of this systemic neglect. Doctors often justify the

absence of records by citing women's itinerant or migrant status and the likelihood of losing documentation.

Hysterectomies, in this context, embody a form of exchange and investment that will be examined more thoroughly in latter half of this chapter. In tandem, as discussed in Chapter 3, positioning hysterectomies as forms of contingent bioviability, I further conceptualise them as pragmatic investments: investments, monetary or otherwise that women make to do what it takes to get by. I align the conceptualisation of early hysterectomies as a form of pragmatic investment that serve as efforts to 'find more bearable ways of living in or with reality' (Mol, Moser, and Pols 2010). Through ethnographic narratives, this chapter posits that despite their hefty financial cost and risk of future illness, when viewed as a form of pragmatic investment, early hysterectomies constitute a bargaining/negotiation between different treatment options, associated costs, and socio-economic circumstances driven by caste marginalisation and rural precarity.

This framing of hysterectomies as pragmatic investments opens up questions about how such decisions are embedded within broader epistemic and normative structures of health and illness. To understand why the uterus becomes disposable after childbirth, it is necessary to situate these investments within systems of meaning-making that govern bodily utility and medical categorisation. I indicate that this redefinition of bodily utility post childbirth becomes deeply entrenched in broader systems of meaning-making within and outside medical categorisation of pre- and post-hysterectomy symptoms. Drawing on Arthur Kleinman's conceptualisation of illness, disease, and sickness, this chapter examines how local understandings of women's health and reproductive illness intersect with formal biomedical systems (Kleinman, 1986, 1988). Specifically, it investigates how embodied experiences of illness are translated into disease categories within medical discourse, revealing a negotiation

among women, medical practitioners, and other social agents regarding the utility of the womb after childbirth. To further this analysis, I also engage with Canguilhem's conceptual framework of the normal, the normative, and the pathological to interrogate how gynaecological morbidities, often treatable and curable through non-invasive procedures, are pathologised. In this framing, any morbidity following childbirth is construed as an anomaly requiring intervention, and the only acceptable 'cure' is the disposal of the uterus (Canguilhem, 1989). Hysterectomies, in this context, I argue, embody a form of exchange and investment that will be examined more thoroughly in latter half of this chapter. In tandem, positioning hysterectomies as forms of contingent bioviability as discussed in Chapter 3, I further conceptualise them as pragmatic investments: investments, monetary or otherwise that women make to do what it takes to get by. I align the conceptualisation of early hysterectomies as a form of pragmatic investment that serve as efforts to 'find more bearable ways of living in or with reality' (Mol, Moser, and Pols 2010). Through ethnographic narratives, this chapter posits that despite their hefty financial cost and risk of future illness, when viewed as a form of pragmatic investment, early hysterectomies constitute a bargaining/negotiation between different treatment options, associated costs, and socio-economic circumstances driven by caste marginalisation and rural precarity.

From Hysteria to Hysterectomy: Tracing the Medicalisation of the Female Body

The prevalence of early-age hysterectomies among women in Ariwadi and Kodewadi I argue demands urgent attention within the broader historical and theoretical discourse on hysteria, the womb, reproductive health and overall women's health. As evident in the narratives and life histories of women shared in the preceding chapters and sections to follow, women from marginalised caste communities particularly those engaged in agrarian labour such as sugarcane cutting are disproportionately subjected to biomedical interventions such as early hysterectomies. Situated at the periphery of political and economic structures , these women

experience a form of embodied debilitation shaped by intersecting regimes of labour exploitation and medical neglect (Gunewardena, 2010). Their reproductive bodies become sites where structural violence is enacted, both through the physical demands of labour and the normalisation of invasive medical procedures. However, this seemingly contemporary phenomenon and reportage is rooted in a longer historical trajectory.

Studies note that the term hysteria comes from the Greek *hystera*, meaning womb. It was used as a "wastebasket diagnosis" for approximately 4,000 years to explain a broad umbrella and range of symptoms in women, from Ancient Egypt to the 1950s (Kapsallis, 2017; Raynor & Baslet, 2021). Kapsallis notes that historically hysteria has been linked to behaviours such as reading novels, masturbation, and homosexuality and symptoms included irrationality, seductive behaviour, and paralysis. Moreover, women diagnosed as hysterics were often labelled as liars and deceivers. However, in the 19th century, hysteria became a lucrative diagnosis. Kapsallis further goes on to note that physicians claimed that three-quarters of medical practice dealt with “diseases of women,” making them an economic boon for doctors Tracing back to the 19th century, medical literature reveals that hysteria was frequently diagnosed through gynaecological symptoms such as uterine prolapse, diseased ovaries, and complications during childbirth. Laura Briggs (2000) critically examines how these diagnoses were deeply racialised, constructing a dichotomy between the ‘savage womb’ of Black women and the ‘civilised womb’ of white women (Briggs, 2000). Within this framing, Black and poor women were routinely subjected to experimental surgeries such as caesarean sections and other high-risk procedures often without consent. These women were reduced to clinical material, stripped of agency and subjectivity, and positioned as instruments of medical advancement rather than as patients deserving care.

McVean outlines the history of hysteria as a sex-selective disorder, believed to affect only individuals with a uterus (McVean, 2017). Ancient medical theories linked symptoms such as

anxiety, fainting, and irritability to the uterus, reinforcing gendered assumptions about health. In ancient Egypt and Greece, hysteria was attributed to a 'wandering womb', with treatments including vaginal applications, genital stimulation, aromatherapy and sneezing to coax the uterus back into place (Jones, 2015; Kapsallis, 2017). However, marriage and childbirth were considered the ultimate cures, believed to satisfy the uterus's supposed craving for semen along with extreme treatments such as surgical removal of the ovaries and burning of the clitoris (Kapsallis, 2017). Physicians believed hysteria stemmed from retained menstrual blood or "female seed," and prescribed marriage and regular sexual intercourse as cures, based on the belief that male semen had healing properties. Eventually, hysteria became a major point of contention for second-wave feminists, who criticised its use as a tool of medical and social control over women.

Briggs further notes that medical discourse reinforced racialised distinctions, portraying white women as delicate and in need of intervention, while non-white and poor women were objectified as experimental subjects (Briggs, 2000). Building on this, Cara Jones offers a critical distinction between the uterus as a biological organ and the womb as a cultural symbol of femininity and reproduction. In medical discourse, these concepts are frequently conflated, reinforcing the notion that women's identities and illnesses are inherently rooted in their reproductive anatomy (Jones, 2015). This conflation, I note, becomes particularly significant when examining early hysterectomies as a liminal process- one that produces what can be viewed as liminal bodies, caught in a continuous oscillation between the symbolic and the anatomical. While the uterus remains present as a physical organ, it is rarely acknowledged for its broader physiological functions beyond reproduction. Instead, it is symbolically reduced to the womb a vessel for childbearing and once its reproductive purpose is fulfilled, it is rendered disposable.

This disposability is further reinforced through the normalisation of hysterectomy, particularly in cases where women experience menstrual disorders post-childbirth. Symptoms once considered tolerable or manageable before motherhood are now medicalised as pathological, often framed by healthcare practitioners as potential threats to life. In such contexts, hysterectomy is presented not merely as treatment, but as an indispensable intervention, an act of safeguarding against exaggerated risks of cancer or death presented by health practitioners. The uterus, once central to reproductive identity, is reclassified as a source of dysfunction, its removal justified through a discourse of fear and risk management. The hysterectomy, thus, becomes a threshold, a moment of transformation where the reproductive body is redefined as a labouring body, valued not for its reproductive capacities but for its economic and social viability. As discussed in Chapter 3, this shift is grounded in broader structures of bioavailability obscuring the complexity of women's health and legitimising invasive interventions that reinforce gendered norms of bodily utility and disposability. As Jones further interrogates, the theory of uterine dominance and the belief that the uterus governs a woman's entire body and mind has historically been used to justify medical treatments such as hysterectomy (Jones, 2015). She argues that conditions like endometriosis are framed as modern iterations of hysteria: disorders characterised by vague, wide-ranging symptoms that are often dismissed or psychologised. The treatment of such conditions through surgical interventions reflects a persistent desire to control and regulate women's bodies, laying bare historical patterns of medical authority and attempts to discipline bodies of women.

Sarah Pinto challenges the dominant Eurocentric narrative by revealing that hysteria did not simply arrive from Europe but developed in parallel within South Asia, shaped by its own historical, cultural, and colonial contexts (Pinto, 2022). This broader genealogy, Pinto notes, complicates the understanding of hysteria as a purely Western phenomenon and highlights how medical and psychiatric categories have been historically entangled with racialised and

gendered power structures. Toril Moi critiques psychoanalytic theory for constructing femininity as a problem to be solved a riddle to be decoded which positions women as the "other" (Moi, 2018). Moi argues that psychoanalytic theory equates femininity with lack, passivity, and castration traits historically associated with hysteria. This pathologisation reinforces the idea that women are inherently unstable or irrational. In response, Moi calls for abandoning femininity theories rooted in hysteria and instead proposes the concept of finitude i.e. universal human condition of limitation and mortality. She critiques the notion that femininity is synonymous with castration or lack, arguing that such a framework is both sexist and philosophically flawed.

"Only They (doctors) Know What Was Left": Medical Illegibility of Hysterectomy Without Documentation

In none of the cases during my fieldwork did any woman report receiving proof of a hysterectomy, such as a surgical summary or a prescription. This lack of documentation in Ariwadi and Kodewadi stands in stark contrast to the findings of Chatterji et al., who observe that in India, patients often possess and actively use their medical records to assert claims within clinical and familial contexts (Chatterji et al., 1999). In contrast, in the Netherlands, medical records are institutionally controlled, fragmenting the patient into bureaucratic categories and limiting their agency. Yet, the situation in Ariwadi and Kodewadi diverges from both these contexts. These surgeries are often conducted by private practitioners who deliberately withhold documentation, thereby erasing any trace of any form of clinical intervention, thus, making the partial presence or the complete absence of "paper truths" as means to obscure or distort the lived realities and clinical experiences of women (Tarlo, 2003).

As Chatterji et al. further argue, the materiality, portability, and visibility of medical records can serve as a weapon of legitimacy, particularly in contexts where verbal testimony is routinely dismissed (Chatterji et al., 1999). Yet, this potential is entirely absent in Ariwadi and

Kodewadi. Many women are unaware of the specifics of their surgeries whether only the uterus was removed or the entire reproductive system, which they colloquially refer to as the 'whole set' (removal of the uterus, ovaries and cervix). This lack of documentation forecloses the possibility of using medical records as counter-discursive tools or means through which women might assert their lived realities against patriarchal denials of suffering either within the clinic for post-operative complications in the household or in the cane fields. This absence is especially significant in cases where contractors or husbands trivialised or questioned the chronicity of women's pain and illness in their quotidian lives. For instance, women recounted being told by husbands. "You are always sick. There is always something or the other going on with you". Husain and Ghosh (2017) emphasise the distinction between perceived and actual health, particularly in the Indian context, where gender operates as a foundational axis of inequality. They argue that women's poor health outcomes are often normalised, rendering their suffering invisible within both medical and social frameworks (Husain & Ghosh, 2017).

The absence of medical records becomes particularly significant since most women consulted the same one or two private medical practitioners, based on word of mouth. These practitioners, however, were rarely qualified gynaecologists. Instead, the procedures were typically conducted in small, unregulated clinics by general practitioners or surgeons. Laxmi, a sugarcane cutter, between the ages of 32 and 39, underwent four gynaecological procedures: Sterilisation (locally referred to as *lekhrach* operation); dilation and curettage (described as a "cleaning" of the uterus); a hysterectomy, costing approximately INR 20,000; a subsequent abdominal surgery for a condition she described as *fooga* (a bloating or ballooning sensation in the stomach), costing INR 25,000.

> "I used to reach the hospital like an animal on a bullock cart, completely covered in cloth because people would watch (*chaar log dekhte the i.e.people used to watch)*." When treated for *fooga* I was prescribed "*500-power*" pill. I had no energy to eat it. I could not

even swallow it. My fatigue was so severe and debilitating that I would feel tired before even beginning to walk-"*Swas kundto (*I feel suffocated)"

After her sterilisation, the doctor informed her that 'one stitch was left' and 'something was left to be done' referring to the need for her hysterectomy. She responded, "Only they know what was left." Midway through our conversation, she paused to say, "I am coughing a lot can you give me some medicine?"

When asked about her pregnancies during her years of labour, she poignantly mentioned: "Who should I tell? Who even cares?" Once known for her strength, she reflected, "Everyone used to be scared of me because I was so strong and active. But four operations have ruined me. Every problem in my life is attached to cane. It takes so much energy just to lift it." During pregnancy, she carried loads of 30, 40, even 50 kilograms. Sighing, she notes: "As you tie it [cane], the weight increases. *Arrey mai*. We do not take leave. Unless we feel like we are dying."

It is crucial to underscore that none of the women, regardless of whether their hysterectomy was accompanied by oophorectomy or not, reported having heard of, let alone accessed, menopausal hormone therapy (MHT). This consistent absence of awareness points to a broader systemic gap in post-operative care and counselling, revealing how structural neglect continues to shape women's experiences of reproductive health, particularly since none of the doctors who performed these procedures were gynaecologists but general practitioners. This local gap in care mirrors broader global disparities in access to MHT. A systematic review of health disparities in MHT usage highlights that surgical menopause is often associated with more severe vasomotor symptoms (VMS), such as hot flashes and night sweats (Conklin et al., 2024; Flore et al., 2024). Despite this, the review notes that Black women who are statistically more likely to undergo surgical menopause are significantly less likely to be prescribed MHT compared to their white counterparts. Furthermore, the likelihood of receiving MHT is

positively correlated with higher levels of education and income. The review also emphasises that MHT is more commonly prescribed by gynaecologists than by general practitioners thus underscoring the intersection of pedagogical training and expertise with race, class, and institutional access in shaping women's experiences of menopause and post-surgical health.

This intersection of medical authority and structural inequality is further illuminated in Emily Martin's seminal work (Martin, 2001). She recounts the narrative of a woman who observed that many women who underwent dilation and curettage (D&C), a procedure often described as 'cleaning' or 'scraping' the womb subsequently underwent hysterectomies. The woman in Martin's work reflected, "The hysterectomy was a way of punishing women. In an indirect way. I am not saying that the doctor said, 'I am going to punish you.' It was a way for him to make money." These dynamics are further reflected in the treatment-seeking patterns observed in Ariwadi and Kodewadi. Women rarely sought second opinions after being advised to undergo hysterectomy. This was primarily due to the limited availability of alternative healthcare providers, exceptionally qualified gynaecologists, or accessible government hospitals, which were often distant or perceived to offer substandard care. As a result, many women underwent the procedure within a day or two of the initial recommendation, sometimes even immediately. This was particularly evident in cases where women were told, "You will die if you do not get your uterus removed in a few days," a standard and common narrative that women consistently recalled being told by doctors.

In Ariwadi and Kodewadi, several women recalled being hospitalised for a few days following the surgery, especially in cases involving complications such as excessive blood loss. Notably, most of these hysterectomies were performed via abdominal incisions; laparoscopic or vaginal approaches were virtually absent. Post-surgery, many women reported being prescribed multivitamins, supplements, or what they locally referred to as *taakat ki goli* (strength pills). Post surgery, women were advised to rest and avoid lifting heavy objects for at least three

months. However, these surgeries often occurred just days or weeks before the migration season, leaving little to no opportunity for recovery. Despite the physical demands of post-operative care, none of the women recalled being informed about potential side effects, nor were they encouraged to consider non-invasive alternatives or delay the procedure. In contrast, health practitioners almost always general practitioners consistently emphasised the urgency of surgery. In many cases, they warned of imminent death if the procedure was not performed, a claim rarely supported by diagnostic evidence.

This pressure to adhere to specific timelines or temporal frameworks can be viewed through the lens of temporal sovereignty, as posited by Surasya Guduru, who critiques Western biomedicine's emphasis on rigid and linear temporal structures (Guduru, 2025). She notes that, patients from racialised communities are often disproportionately labelled as 'non-compliant' or 'resistant to treatment' when they engage with healthcare on timelines that differ from biomedical norms, masking the structural roots of disease burden and health disparities. Such framings, she argues, are deeply rooted in colonial and capitalist logics that define how healing should be conceptualised and at what pace.

I argue that, alongside health, it is critical to account for the capitalist logics that governs the space, timing, and legitimacy of medical intervention. This opens up the possibility of expanding the notion of temporal sovereignty to include the right to refuse clinical timelines that render the bodies of women from marginalised communities disposable, particularly when biomedical time imposes a binary choice between rapid surgical intervention and prolonged suffering under chronic illness. The deadly nature of this temporal calculation, rooted in the biomedical imperative to *fix* the body quickly, disregards the lived experience of illness. I would argue that temporal sovereignty should also include the right to resist as opposed to temporal regimes which rely on bodies of women being made perpetually bioavailable for

intervention. This allows for a re-conceptualisation of temporalities of care, challenging the capitalist logic of efficiency and redefining what it means to heal and endure and for who.

Arthur Kleinman (1988) differentiates between illness and disease by defining disease as the clinician's view of a health problem, essentially a disruption in biological structure or function. In contrast, illness refers to the deeply personal and human experience of suffering (Kleinman, 1988). Kleinman also implies that sickness is shaped by societal norms, expectations, and institutional responses. It encompasses how communities and systems such as families, workplaces, or governments respond to someone who is ill, whether through support, stigma, or neglect. He uses the term 'sickness career' to describe how chronic somatisation can evolve into a long-term social identity, even when the biomedical disease has been treated.

In the context of early-age hysterectomy, as evidenced in my fieldwork, this tripartite framework offers a powerful lens. Before the procedure, a woman may report symptoms of bodily distress. Although she is socially recognised as being unwell, she may not necessarily receive support within the household or at the worksite. The symptoms women experience includes abdominal pain, excessive menstrual bleeding, and white discharge. These symptoms are presented as disease categories, often ambiguous, such as a 'rotten' uterus, a 'swollen' uterus, a uterus with 'holes,' or framed as a risk of future cancer or imminent death. After hysterectomy, the sickness career remains unchanged. Illness symptoms persist while bleeding and white discharge may cease, pain continues and is replaced or accompanied by body aches, headaches, weakness, night sweats, and depression. The disease categories also shift, now taking the form of osteoporosis, cardiovascular conditions, and other chronic ailments.

Medicalising Women's Bodies: Expertise, Risk, and Pedagogical Formation Amid Blame, Neglect, and the Political Economy of Hysterectomy

The reasons for opting private facilities phenomenon are twofold. First, reaching/accessing government or public health facilities was significantly challenging due to high travel costs, uncertainty in finding a doctor despite reaching the hospital, and prolonged waiting times. Aarti, one of the cane cutters, contemplating a hysterectomy, recounted that when she presented her medical reports from a private clinic to a government hospital, the staff claimed they could not interpret them and instructed her to return at a later date. This occurred although the same government facility lacked the infrastructure to conduct any diagnostic tests (and was sending patients to private testing facilities). Second, the standard treatment protocols in these public health facilities often predominantly relied on medication as the first line of treatment, which, according to the women, often provided only temporary or no relief, with symptoms frequently recurring or subsiding only for a while.

These factors are further embedded within the broader political economy of healthcare, particularly the proliferation and rapid mushrooming of private clinics across India, including in Maharashtra and Beed. These clinics, comprising both registered and, more commonly, unregistered or loosely regulated establishments, have become hubs for procedures such as early hysterectomies. Notably, these procedures do not necessarily require specialised gynaecological expertise but can be performed by general surgeons, which may explain why most women reported undergoing abdominal hysterectomies. Moreover, none of the procedures were substantiated by formal documentation such as medical reports or bills, leaving no tangible evidence of care received. Hunter et al note that despite the existence of regulatory frameworks, Maharashtra's private healthcare sector has continued to be long operated with little regulation and oversight (Hunter et al., 2022). The sector's rapid growth since the 1970s, coupled with instances of poor-quality care, has led to an increased public and

activist scrutiny in the 1980s and 1990s. They further note that a series of investigations lay bare widespread non-compliance, including missing registrations and outdated data. Through legal channels and public campaigns, activists pressured the state to enforce the Bombay Nursing Homes Registration Act (BNHRA) (Hunter et al., 2022). However, the government countered these efforts by stating that public hospitals needed reform before regulating private ones. Hunter et al point out that this reluctance was compounded by resistance from private healthcare providers and the Indian Medical Association (IMA), which opposed the Clinical Establishments Act (CEA), fearing excessive government interference (Bagchi, 2021; Hunter et al., 2022). Although studies illustrate that federal support and international funding (e.g., World Bank's Maharashtra Health Systems Development Project) encouraged public-private collaboration, regulatory efforts stalled. The Maharashtra government's attempt to draft a state-level version of the CEA in 2015 was ultimately shelved, reflecting the powerful influence of private sector lobbying and professional dissent (Hunter et al., 2022).

Bagchi et al. (2021) aptly note that the Indian government's failure to fund public healthcare adequately has led to a growing dependence on market forces. Studies note that this underinvestment was not incidental but part of a broader strategy that weakened public healthcare infrastructure and encouraged private sector expansion. The responsibility for the decline of state-funded healthcare lies with government policies that favoured privatisation. A key shift as Bagchi et al. (2021) illustrate, was the introduction of the National Health Policy (NHP), which attempted to redefine the role government plays in healthcare. Rather than strengthening public services, the policy emphasised the importance of involving the private sector (Bagchi, 2021, 2022; Chakravarthi et al., 2023; Hunter et al., 2022).

In her ethnography on hysterectomies in Balochistan, Pakistan, Fousieyha Towghi (2012) highlights how doctors routinely recommend hysterectomy for relatively mild gynaecological conditions (Towghi, 2012). These recommendations are often based on the assumption that

rural women will not pursue non-surgical treatments. Towghi argues that such reasoning constructs women as "marginalised, rural, illiterate, poor, and homogeneously rural subjects unconcerned with self-care." This framing not only erases the complexity of women's lives but also legitimises invasive interventions under the guise of biomedical rationality.

A similar logic operates in Ariwadi and Kodewadi, where medical practitioners justify the removal of uteri and often ovaries by invoking biomedical ethics while simultaneously shifting responsibility onto women. Women are portrayed as neglectful of their health or as seeking surgery for convenience, comfort, or low pain tolerance. In this framing, hysterectomy becomes a form of 'clinical care' administered to 'irresponsible' women, reinforcing gendered hierarchies of blame and care.

When asked about the high prevalence of hysterectomies, a private doctor explained:

> "It is bilateral both the patient and the doctor play a role in how hysterectomies happen. From the patient's side, especially women in the perimenopausal age group, there's a mindset. They feel they will get two to three months of rest, be pampered. Many have already had children and say, 'I do not want my menses anymore.' Everything from white discharge to abdominal pain linked in their minds to menstruation. Since menarche, their entire routine housework, functioning in the home has revolved around managing their periods. So they think, 'If the uterus is removed, I would not have to deal with any of it anymore. From the doctor's side, there are two categories: indicative and non-indicative cases. Indicative means the surgery is medically necessary. Non-indicative means it just happens patients insist, and sometimes doctors go along. If I tell a patient, 'You do not need a hysterectomy; your white discharge is due to cervical erosion or an STI and can be treated with medication, they will often switch doctors. And if I want to retain my

patient, I have to consider that a normal delivery earns INR 10,000, while a hysterectomy earns INR 50,000. So why would I not?"

Another practitioner noted:

"Even general surgeons perform hysterectomies. I feel that if it's going to happen anyway, it should be done by a professional who knows the risks. Though I personally avoid non-indicative cases, the pressure is real. Uterus-related issues are not always work-related. Cysts are more common now due to PCOS, especially in women aged 30–35. Fibroids have increased because pregnancies have decreased. Cervical erosion, cancer, STIs these are real concerns. But fibroids are not common in younger women. Uterine prolapse often results from delivery practices bearing down too early, perineal tears, and early sterilisation. If sterilisation is not done properly, it leads to infections, white discharge, and abdominal pain, and women keep returning to doctors. Ultimately, many women say, 'I do not want it anymore.' That mentality drives a lot of what we see."

This rhetoric of blame is further exemplified by a male doctor at a local government hospital, who remarked:

"[Pointing to a visibly pregnant teenage girl] Look at her! She is a cane cutter [laughs]. They come to us with haemoglobin as low as 3–5, have no concept of contraception or hygiene, and have a fertility rate of at least five. If I tell her she needs to be admitted, they cry, saying we will lose wages."

In medical anthropology, the concept of 'thingification' offers a useful lens to understand how symptoms are reduced to discrete, manageable entities(Taussig, 1980). This reduction enables the promotion of hysterectomy as a definitive solution to complex, chronic conditions. The framing of hysterectomy as a pathway to a "viable life" by private practitioners raises critical questions about the commodification of reproductive bodies under the guise of care, as

exemplified in Chapter 3. This perspective nuances the logic of bioviability, suggesting that viability itself is constructed and shaped through the discourses of medical practitioners. Moore et al. (2023) argue that hysterectomies can be seen as an extension of India's national family planning programs of the 1970s, where sterilisation was incentivised through property grants and surgical bonuses (Moore et al., 2023). What distinguishes the current hysterectomy trend, they note, is the use of 'exaggerated warnings' about the risk of uterine or ovarian cancer even in asymptomatic women as a justification for surgery.

As one doctor summarised:

> "For me, the biggest reason behind their health problems is lack of education and hygiene. Every day, I see the consequences of this. Women don't take delays in their periods seriously. Hygiene is extremely poor. Almost daily, I get five patients with swollen wrists or muscle depletion. There are broken bones, cases of alcoholism, fever. No one is vaccinated. I see uterine prolapse in women who are far too young. It usually happens around 50 or 60, but now it's showing up much earlier. But everything comes down to development and education. That's the root of it all. Women come to me in the last stages of uterine TB. They only come when the problem becomes completely unbearable. The upper-caste Maratha workers at least know their symptoms. But those from Madhya Pradesh the Adivasis they do not know anything."

One must ask, then, whether the "hole" lies in the uterus or in the medical system itself. As the head of the Department at a local government hospital candidly remarked:

> "We doctors are complacent. If the child is not delivered properly or a woman is not sterilised properly, it is the first or maybe the last nail in the coffin, which paves the way for a hysterectomy. It is an insult to the bodies of women. Doctors are misleading women who believe nothing else can be done to heal them other than removing the uterus. In

men, endorphins contribute to emotional well-being and are not significantly affected by the removal of the testicles, whereas in women, estrogen plays a critical role in long-term health. Its decline after hysterectomy or menopause is associated with increased risks of cardiovascular disease, osteoporosis, and cognitive decline. In government hospitals, we strictly do only indicative hysterectomies. However, if a colleague opens a private clinic worth crore tomorrow, not everyone has a heart of gold to turn away a patient by suggesting non-invasive procedures. They will say that she will get it removed anyway, so why not me?"

Following media exposés on the high rates of hysterectomy in Beed district, the Maharashtra state government mandated that all private surgeons submit monthly reports of hysterectomies to civil surgeons. While this intervention, along with national media coverage, led to a temporary decline in the number of procedures, hysterectomies remain prevalent particularly within the largely unregulated private health sector. Despite being India's second most populous state, Maharashtra exemplifies the deep disparities between public and private healthcare systems. As Jaffrelot and Jumle (2020) note, Maharashtra is one of three Indian states (alongside Uttar Pradesh and Karnataka) facing a severe imbalance between these sectors (Jaffrelot & Jumle, 2020). Nearly three-fourths of all patients in the state seek treatment in private hospitals, with 73.7% of all hospitalisations (excluding childbirth) occurring in private facilities (Shaikh, 2020).

The consequences of this privatisation are visible in everyday clinical encounter. As one government doctor explained:

"I see them every day people living hard lives. They work constantly, just to make food. They are always migrating, always poor. They eat whatever they have. Nutrition is a big problem. Because of that, there is anaemia. There's a lack of protein, which leads to

weight loss and weakness. Even when they go back home, they do not get anything. Their health just keeps declining, slowly. Emotional health is another issue there's no communication with others, no recreation. Wherever they live, it is so cold. Children are picked up by animals. There is always a threat. Breastfeeding women are malnourished. Many suffer from excess menses. They do not get supplements. They don't come to us we have to approach them. They have no time. If they get time on a Sunday, the hospital is shut. There's no post-pregnancy care. They start working immediately after pregnancy. They feed their babies there, while working. HIV is another issue. They are not regular with their drugs. They say, 'I am fine right now.' For them, the problem is: 'I need to feed myself.' Ninety percent of cases are through unprotected sex. Truck drivers are often involved. They use condoms without understanding that it's not just for contraception it's for safety. One woman, a Scheduled Caste cutter, knew her child had HIV, but still went ahead."

These accounts reflect the structural violence embedded in the everyday lives of rural and migrant women where health is subordinated to survival, and care is contingent on access, time, and mobility. The rapid expansion of the private health sector in Maharashtra began in the 1970s, but until the 1990s, there was little data on the number of registered hospitals (Hunter et al., 2022. A significant portion of the private sector is operated by practitioners trained in Ayurveda and homeopathy, many of whom are employed in allopathic settings to address shortages in medical personnel and reduce staffing costs.

During my repeated visits to the state-run civil hospital in Beed, I observed a recurring pattern: female migrant cane cutters were routinely issued prescriptions referring them to a "bigger" public hospital in Aurangabad over three hours away from their home villages. With no specialised departments and only emergency, OPD, and diagnostic wards, the Beed hospital

was staffed primarily by nurses rather than specialists. Patients bore the financial burden of repeated visits, often with no guarantee of treatment. As women in Ariwadi frequently noted:

> "If we go to the hospital in Beed, we know they will refer us to Aurangabad. Beed is not near either. There is nobody (the doctor) to see us there either. It is over 80 km away. If we go to Aurangabad, we do not know if or when our chance will come. We might as well give the amount we spend travelling to both Beed and Aurangabad to a *khajgi* (private) doctor."

In 19th-century America, the rise of obstetrics and gynaecology as specialised medical fields marked a significant shift in the treatment of women's health. Surgical interventions such as ovariectomy and clitoridectomy were routinely prescribed for conditions like hysteria and perceived sexual excess. These practices reflected a broader medical ideology that privileged surgical solutions and positioned physicians as authoritative interpreters of women's private experiences, mediated through the lens of scientific rationality (Kasper, 1985; Scully, 1980). Building on this historical trajectory, Anna Kasper critically examines the professional formation of obstetrician-gynaecologists (OB-GYNs), emphasising how their training and institutional culture shape their clinical approach. Although OB-GYNs are ostensibly trained to care for healthy women, Kasper argues that their education disproportionately emphasises pathology often addressed through surgical means (Kasper, 1985). This dual identity as both generalists and surgeons fosters a clinical mindset that favours intervention, even when non-invasive options are available.

Kasper draws on sociologist Marcia Millman's observation that surgeons inherently trust in the efficacy of surgery to resolve medical problems (Kasper, 1985; Millman, 1977). This belief, coupled with cultural norms that render the female reproductive system as problematic or expendable post-childbearing, contributes to the normalisation of hysterectomy as a routine or

preventive measure. Economic incentives and professional pressures further reinforce this orientation. Kasper cites gynaecologist R.C. Wright, who advocates for routine hysterectomy after childbearing, describing the uterus as a "useless, bleeding, symptom-producing, potentially cancer-bearing organ." To deepen this critique, Kasper engages with Sue Fisher's influential work on doctor-patient communication (Fisher, 1980). Fisher's analysis reveals that treatment decisions such as hysterectomy are often the product of structured, strategic exchanges in which physicians use questioning, framing, and persuasion to guide patients toward specific outcomes. This asymmetry in communicative power allows physicians to shape not only the treatment path but also the patient's understanding of her own body and health. Kasper argues that this dynamic contributes to the routinisation of surgical interventions in women's healthcare, even in the absence of clear medical necessity (Kasper, 1985). Moreover, studies note that African American and Asian women were less likely than white patients to receive minimally invasive surgery such as Total Vaginal Hysterectomy (TVH) and Total Laparoscopic Hysterectomy (TLH) compared with Total Abdominal Hysterectomy (TAH) for benign conditions (Ranjit et al., 2017).

My fieldwork in Ariwadi and Kodewadi reveals the complex and often troubling dynamics of gynaecological care in rural settings. Women seeking treatment for gynaecological concerns frequently reported consulting general surgeons or general practitioners rather than specialised OB-GYNs. A recurring pattern emerged in which diagnostic centres particularly those conducting ultrasounds routinely referred women to private general surgeons, subtly implying the necessity of surgical intervention. This referral loop reflects a pervasive surgical orientation within general medical practice, even in the absence of specialised expertise. General surgeons, despite lacking formal training in gynaecological health, often approached the female body through a lens of operability. Most hysterectomies were performed via abdominal incision, a method favoured for its procedural ease. Many women showed me scars from these surgeries,

with several reporting post-operative infections at the incision site. These findings resonate with broader clinical literature. Aboulfotouh et al. (2020) note that while abdominal hysterectomy may involve shorter operative time compared to laparoscopic procedures, it is also associated with greater blood loss and significantly higher rates of late postoperative complications (Aboulfotouh et al., 2020). Similarly, Cohen et al. (2014) highlight increased risks of bladder and ureteral injury associated with total abdominal hysterectomy, underscoring the clinical drawbacks of this approach when performed without specialised training (S. L. Cohen & Einarsson, 2014). Spilsbury et al. (2006), in a population-based study from Western Australia, further emphasise that vaginal hysterectomy carries a 20% lower risk of serious complications compared to abdominal procedures (Spilsbury et al., 2006). Yet, in Ariwadi and Kodewadi, the high prevalence of abdominal hysterectomy over less invasive alternatives appears to stem from two interlinked factors: the limited surgical training required for abdominal procedures and the financial incentives tied to performing major surgeries.

In the Indian context, Harish Naraindas challenges conventional models in medical anthropology that rely on the disease/illness dichotomy to explain healthcare-seeking behaviour (Naraindas, 2006, 2014). Focusing on childbirth, Naraindas notes that women who resist medicalisation are framed as endangering their unborn children, thereby compelling compliance with biomedical norms. He introduces the concept of nosopolitics the politics of disease classification and treatment across systems to interrogate how risk is constructed and managed within medical institutions. This framework, I posit, is particularly relevant to understanding early age hysterectomy, which cannot be adequately explained through traditional anthropological models of illness. Instead, it involves ontological enactments such as the production of bodily realities through clinical discourse and intervention of women from specific caste groups and communities. In this view, the uterus is not merely a biological organ

but a site of contested meaning, shaped by medical pedagogy, institutional logics that attempt to shape socio-cultural narratives of femininity, productivity, and risk.

With a focus on unpacking the question of the medical-industrial complex, capital, caste oppression and migration within an interdisciplinary frame, this ethnography brings the question of healthcare and the role of practitioners to the centre stage. Economists Jishnu Das and Jeffery Hammer(2007, 2014) address the competence of practitioners and their knowledge of diseases by emphasising what kind of questions a practitioner asks about a patient's history upon being presented with symptoms (J. Das & Hammer, 2007, 2014). What diagnostic tests were required or necessary? Most importantly, what was the appropriate treatment option that was made available for that particular disease? Drawing from social anthropologist Veena Das's conceptualisation of health as a 'good' or a commodity, an expert is expected to be more adequately aware of the benefits or the bane of the 'good' than the consumer. This transforms healthcare into a 'credence good' (J. Das & Hammer, 2007, 2014). The dissemination of asymmetrical information between female sugarcane labourers and healthcare practitioners plays a critical role in framing healthcare as a *credence good* one that is shaped by exaggerated warnings and perceived risks of future illness or death. These dynamics influence the decision to undergo early hysterectomies, which I interpret below as a form of pragmatic investment.

Embodied Costs, Economic Calculations: Early Hysterectomy as Pragmatic Investment

The discourse on early-age hysterectomies can be juxtaposed against the literature on surrogacy, presenting both contrasting and parallel narratives, where the uterus emerges as a focal point of analysis (Majumdar, 2018b; Rudrappa, 2015; Vora, 2009). In surrogacy, women's excess reproductive capacity, beyond a certain juncture in the lifecycle of how the womb is valorised, diminishes in perceived domestic value. In the case of surrogacy. the uterus is reconceived as an 'empty space or room,' an essentially vacant entity awaiting 'occupation' and the surplus biological labour needs to be utilised the process of 'renting' an 'unused' uterus (Vora, 2009;

Waldby, 2012). In Ariwadi and Kodewadi and early-age hysterectomies, undertaken due to the medically constructed and structured, yet unfounded, risk perceptions of imminent death or cancer propagated by healthcare practitioners accompanied by the dread of lost wages due to chronic illnesses, family financial hardships and burdens, symptoms that are otherwise manageable are underscored as justifications for the removal of the uterus. Consequently, post-sterilisation, the uterus transitions from being viewed as an asset for reproduction at a certain life stage, to a liability; where a one-time treatment or 'cure' is its disposal. If retained and treated over an extended duration, it harbours the risk of potential death or financial strain with no immediate remedy for the symptoms, a continuous deterrent to daily labour, accruing debts or advances, a pervasive fear of life-altering illness, and even fatality. Hysterectomies, thus I note that when presented by health practitioners or perceived by women as a pragmatic investment to do what it takes to get by, end up presenting a hindrance to the very viability they aim to achieve. Hysterectomies can also be viewed as a form of what Lauren Berlant refers to as *cruel optimism*, an attachment wherein, despite the belief that it will help improve our lives, it might be something that is compromised (Berlant, 2020). This presents a double bind: hope on one hand and systemic debilitation on the other. Berlant's notion of *crisis as ordinary*, where crisis is not necessarily dramatic or exceptional but embedded in everyday life and deteriorates life slowly and gradually, is useful here (Berlant, 2020). As evident in my ethnographic findings, hysterectomies become that 'something' and present the idea of a 'good life', wherein, despite the harms both short-term and long-term on women's health, the procedure is steered by the hope for a better life.

The significance attributed to the uterus in the overall health of women is consequently overshadowed by a precipitous drive for an "immediate cure.". As Jan Breman elucidates within the context of rural India's poverty, prevailing income levels and lifestyles sideline concerns for the future, perceived as unforeseeable, propelling the necessity to prioritise the

immediate needs of both family and individual (Breman, 2007). Thus, although distinct, the scenario resonates with that of surrogacy, where the surrogacy fee provides a woman and her family with immediate financial support, akin to selling a kidney to alleviate debt. The cost of surgery in the case of hysterectomies, albeit not financially profit-driven for women, envisages paying a substantial one-off fee for a hysterectomy not solely as an investment into future health to avert illness or future financial burdens ensuing from illness, but as a strategy attempted at securing the present and not a future.

Lock and Kaufert (1998) introduce the concept of "pragmatic agency" to describe how women's decisions regarding medical interventions such as sterilisation and hysterectomy are shaped by a confluence of fear, limited information, and socio-economic pressures (Lock & Kaufert, 1998). Building on this, Desai (2016) argues that hysterectomy has become normalised as a default treatment for gynaecological issues, especially in contexts where non-invasive alternatives are rarely offered (Desai, 2016). These decisions, made within constrained environments, reflect broader structural inequalities and power hierarchies embedded in biomedical institutions (Nguyen & Peschard, 2003). Lock and Kaufert further emphasise the importance of contextualising women's knowledge and responses to biomedical technologies, highlighting their subjectivity and agency within lived experiences. Their work reveals the complex and often contradictory ways women engage with medicalisation, not merely resisting or complying, but practicing what they term "selective resistance" and "selective compliance." By focusing on "pragmatic women," they show how women strategically navigate biomedical systems to pursue their own goals while maintaining a degree of autonomy. In this light, I argue that hysterectomy exceeds the biomedical calculus of surgical risk and benefit, becoming a site of negotiation shaped by structural constraints and personal agency.

I conceptualise early hysterectomies as such investments, involving substantial financial and corporeal costs that women undertake to survive. This aligns with Annemarie Mol and colleagues' assertion that such actions reflect efforts to "find more bearable ways of living in or with reality" (Mol et al., 2010). Hysterectomy becomes a pragmatic investment, thus encompassing the logic by which women make bodily decisions such as undergoing hysterectomies within constrained economic and social conditions. Hysterectomy, then, becomes more than a medical procedure; it is a material, financial, and emotional investment in care. Here, care is not limited to treatment but encompasses a series of decisions that prioritise immediate relief and bodily functionality over long-term, non-invasive alternatives that may hinder a woman's ability to work and support her household (Mol, 2008; Mol et al., 2010). As previously discussed, women are frequently compelled to take advances from cane contractors often equivalent to their annual income, in order to undergo hysterectomy at an early age. This additional advance transforms into a debt that carries over to the following year, thereby engendering a persistent financial burden. Choosing to undergo a hysterectomy in the hope of avoiding future illness, economic strain, and to potentially enhance their work capacity paradoxically becomes a long-term deterrent, as it often diminishes their ability to work post-surgery.

The narratives of women above, like many others, oscillate in and out of medical experiences over their lifetimes, their experiences serving as focal points for various health interventions. Among several families, genealogical mapping of affinal or consanguineal relationships indicates the recurrence of hysterectomy cases. In Ariwadi, specific households are identified as those where women have died from complications following hysterectomy, like Kavita's mother. Here, the practice of hysterectomy has persisted across four generations, where each successive generation of women underwent early-age sterilisation followed by hysterectomy.

Scholars have long emphasised that reproductive practices are shaped by intersecting systems of gender, caste, class, and racial politics, producing what Colen (1996) famously termed stratified reproduction, the unequal distribution of reproductive autonomy, labour, and resources (Becker, 2023; Colen, 1996; Ginsburg & Rapp, 1991; Rapp, 2004; Shreffler et al., 2015). This stratification of women's bodies and removal of their uterus is disproportionately enacted upon women from marginalised caste and class backgrounds, whose bodies are rendered disposable. Private healthcare providers, acting as biomedical brokers, capitalise on structured risk and systemic vulnerability to convert reproductive organs into sites of profit. This notion of the womb's disposability, I posit, is deeply embedded in medical- industrial complex and its capitalist logics, hidden under the rhetoric of care and clinical urgency. The monetisation of risk, often calculated against a woman's annual income or labour potential, transforms existential fears of illness and death into quantifiable economic transactions.

Drawing on insights from medical anthropology and economic sociology, I conceptualise these unwarranted hysterectomies as forms of what Viviana Zelizer calls relational work: the ongoing negotiation of economic and intimate life vis-à-vis the decision to undergo early hysterectomies within social relationships (Zelizer, 2000, 2012). Zelizer's framework moves beyond the idea of economic and social spheres as merely 'embedded' to argue that they are mutually constitutive (Zelizer, 2000, 2012). This shift I argue offers a critical lens through which to examine hysterectomies not as isolated medical events, but as biosocial strategies that emerge as responses to the fluctuating demands of labour markets, kinship obligations, and survival imperatives. In this context, the womb acquires shifting meanings and values across different actors, domains and stages of a woman's life: as a site of fertility, as a source of illness, as a burden, and ultimately, as a liability to be removed. In Ariwadi and Kodewadi, the economic transactions surrounding hysterectomies take multiple forms; sometimes involving direct cash payments to private practitioners, and at other times manifesting as intangible

exchanges visible only through the aftermath of illness, grief, or death. These exchanges, I probe, raise a critical question: which wombs are rendered commodifiable not through their presence, but through their removal? Framing hysterectomies through Zelizer's concept of relational work challenges the binary between the economic and the intimate (Zelizer, 2012). It reveals how the removal of the uterus becomes a negotiated strategy for navigating precarious lives, where the value of the womb is contingent, relational, and deeply contextual.

Conclusion

In this chapter, I positioned and examined early-age hysterectomy as a liminal process, one that reconfigures both anatomical structures and symbolic meanings attached to the female body. The uterus, while physically present until its surgical removal, is discursively reduced to a reproductive vessel, its broader physiological functions obscured by narrow biomedical and sociocultural framings.

Through narratives of women, I note that the predominance of invasive abdominal surgical approaches, the absence of alternative techniques, and the lack of post-operative care bring to the fore the systemic neglect embedded in a series of medical encounters across women's life course. Drawing on Kleinman's tripartite framework of disease, illness, and sickness, this chapter has also illustrated how women's embodied distress is translated into ambiguous disease categories that justify surgical intervention (Kleinman, 1986, 1988). At the same time, their post-operative suffering remains largely unacknowledged. The persistence of symptoms and emergence of new chronic conditions post-hysterectomy reflect a continuity in the sickness career, wherein biomedical resolution does not equate to relief, but highlights the paradox of presumed finality of surgical intervention as a 'cure' and to endure embodied suffering.

I argued for tracing a comparable logic of incentives that operates across both public and private healthcare sectors wherein while sterilisation is financially compensated, hysterectomy

is framed as a necessary investment for survival, an act of pragmatic decision-making to preserve work capacity and familial responsibilities. As Desai (2016) notes and I echo, this investment is seen as a means to secure a viable present (Desai, 2016). Over time, the uterus shifts in perceived value, from asset to liability, rarely considered integral to a woman's well-being. The financial burden of hysterectomy, often covered through advances from cane contractors, transforms into long-term debt, paradoxically undermining the very work capacity it was meant to restore.

Chapter 5

"*Panch Taanka, Kamzori, Azaar aur Dard ki Goli*" (five stitches, weakness, illness and pain killers): The Life After a Hysterectomy

When I turned 35, I started having unbearable stomach pain and terrible periods for two months. The doctor told me that if I did not get my *pishvi* (uterus) removed, it could turn into cancer. The very next day, I got it removed in Beed. I paid INR 18,000. There were no tests, no sonography. After that, I was given a laal *goli* (a red pill "for strength") for a month, but it did not help. I started gaining weight, and now it's even harder to work in the fields. I touch my head and feel pain all over. I feel low all the time, and there's this shaking feeling inside me (*thar thar*) that I cannot even explain. It does not stop. Someone got me two *poodis* of ayurvedic powder from Pune. I mix it in water and drink it. It cost me INR 600, but there has been no relief. I have swollen knees. My daughter-in-law is a sugarcane cutter too. She said she has been feeling severe abdominal pain. The doctor said it is a stone that needs treatment. She is drinking two huge bottles of ayurvedic tonic with *ashwagandha* (Indian ginseng). It costs her INR 3,000 every month. However, she has not found any relief either. She had a sonography done at a private hospital, but the problem is that if we take private reports to a government hospital, they say it is wrong and ask for government tests. If we take government reports to private doctors, they also say it is wrong. If we try to go from one government hospital to another, we are made to wait for months. By then, we will be dead."- Sarla Tai, a 40-year-old cane cutter

This chapter shifts the focus to the post-hysterectomy landscape in Ariwadi and Kodewadi, tracing the imbricated nature of the invasive medical practice of hysterectomy and the gendered embodiment of both the symptoms that lead to the surgery and the complications that follow. It also examines the myriad ways in which care, or its absence becomes evident, particularly

through chronic illness, surgical menopause, and the social and cultural entailments that accompany these experiences. Primarily, this chapter centres on women's lived experiences of premature and surgically induced menopause resulting from early-age hysterectomies. Clinical insights, supported by discussions with healthcare professionals, indicate that hysterectomies involving oophorectomy trigger an immediate onset of surgical menopause. Moreover, procedures that remove only the uterus tend to cause a progressive decline in ovarian function, significantly increasing the likelihood of premature menopause within ten years of the surgery.

By examining these early surgical interventions, I conceptualise ageing as a deeply embodied process in which the physiological and social dimensions of ageing are interwoven. I further explore how as illustrated in the preceding chapters, the specific positioning of rural women's bodies, particularly those from marginalised castes and economic peripheries across the interlinked domains of the clinic, the agricultural field, and the household, offers critical insights into rethinking the often-assumed chronological nature of the ageing process. Here, I argue that it is not chronological age alone that marks the onset of ageing, but rather the intersection of *social ageing* with recurring morbidities and the eventual cessation of their capacity to contribute 'economic value' to the household following early hysterectomies that emerges as a key marker of the aged body.

The Life After a Hysterectomy: Removed but Not Relieved

> **Sita Tai: "Peeth dukhat, pota dukhat(back hurts, stomach hurts). I am in so much pain."**

Sita Tai is around 50 years old, belonging to the Mahar caste group. Her father died when she was just two, and her mother supported the family through *begari* casual, low-paid labour. By the age of 13, She was married and began cutting sugarcane with her husband as part of a *koyta*. She remembers it vividly, saying it was when the *uchal* (wage advance) was just INR 4000

annually. She continued this work until two years ago, but this year, she and her husband will return to the fields out of necessity.

Sita Tai has given birth to five children all born while she was working in the factory. One died just 12 days after birth. She recalls how his stomach swelled and how, even after being rushed to the government hospital and put on saline, he died before the drip finished. She went back to work just five days after each delivery, tying her newborns to her chest with a saree while cutting cane. Around 15 years ago, while squatting every day to cut cane, she noticed something emerging from her body, what seemed to be a case of uterine prolapse. A doctor told her it was due to a "growth" on the uterus that needed immediate removal. She paid INR 25,000 for the surgery and slipped into a coma for three days, needing three bags of blood. Since then, her body continues to ache, she has gained weight, and often feels emotionally low and stressed, as she narrates. "It's not that I do not want to work, but I have not had the energy since my *pishvi* was removed. When one of us falls ill, someone else in the *toli* has to be paid to make up the lost quota". When I met her after a few months in the cane fields, her skin was tanned and flaking, her face marked with black spots. She broke down, clutched my hand, and said, "*Peeth dukhat, pota dukhat*(my back hurts, my stomach hurts). I pray to die," she wept. "I cannot bear this anymore."

Jayashri: "The Whole Village Knew When I Menstruated"

Jayshri Tai, around 50 to 52 years old, belongs to the Mahar caste community and has worked as a sugarcane cutter for over thirty years. Since the age of 20, she and her husband have migrated seasonally to Sangli and Kolhapur for cutting cane annually. Jayshri gave birth to all her children in the fields, never stopping work until the end of her pregnancies. "Who will feed the child in our stomach if we rest?" she asks. Despite the harsh conditions, there was no option to take leave. If someone from their *toli* (group of workers) fell sick, everyone else had to contribute INR 500, a heavy burden for already-struggling debt-ridden families. About 15 years

ago, soon after tubal ligation Jayshri began experiencing intense abdominal pain and menstrual issues. Her neighbour recalled how painful her periods were, saying the whole village would know when Jayshri menstruated. Eventually, doctors told her she might develop cancer, prompting her to undergo a hysterectomy in Beed. The surgery cost INR 30,000, again borrowed from the *mukadam*. Since the hysterectomy, her health has deteriorated. She now suffers from kidney stones and persistent weakness.

Sitamati: "I'm just an old sugarcane cutter without a uterus"

I met Sitamati Tai during a visit to Surekha Mausi's house. Her own house, made of uneven stones stacked one over another, stood right across. When I asked her if it was not risky to live in a house like that, she laughed and said, "*Gareeb mansasadthi tochaja dhoka asto*" (for poor people, even a minor injury can be fatal). From our first meeting, she was constantly holding her knees. When she sat down and lifted her saree, I noticed a kneecap brace. Now in her early 60s, Sitamati has been cutting sugarcane since she got married at the age of 11. She had her first period at 13 and soon after became pregnant with her eldest daughter, who is now 45. She has seven children, six daughters and one son, all born with one to two-year gaps. All of them were delivered at sugarcane work sites. She lost one daughter at 1–2 months old due to chickenpox. Interestingly, when we asked her how many children she had, she replied, "*Ek mulga*" (one son). Only after further prompting did she mention her six daughters, a moment that revealed how the son, who sends money home, was instinctively recognised as her only child. All of her daughters are married to sugarcane cutters and are cutters themselves. She lives with her husband and 95-year-old mother-in-law. Her youngest child, her son, is around 25–26 years old and is studying engineering in Hyderabad while also working. They sold all their land to fund his education. He had been preparing for the IAS exam since 2018, but due to COVID, had to start working.

Sitamati said that during each of her pregnancies, she continued cutting sugarcane. She laughed, recalling that she had not even had time to wash her face. When I asked how she could laugh at something so complex, Surekha and Kavita interjected, saying, “What problem does she have? Her son will become a collector.” Sitamati looked down, still holding her knees, and said with a faint smile, “Even you know he will never come back to take us.” She returned to work within 7 days of each delivery because missing even a day would cost the couple INR 600.

Her husband, too, has chronic pain from a spine injury sustained while driving a sugarcane truck, yet he still plans to migrate next season. Sitamati has had three surgeries: a hysterectomy at age 35 after reporting heavy bleeding, an appendix operation caused by complications from that surgery (INR 30,000), and a more recent one for a knot in her waist (INR 20,000). For the hysterectomy, she was shown a diagram of a uterus with holes and told to get operated. She paid INR 25,000 at a government hospital in Beed after taking an advance from the *mukadam*. Their monthly household expenses come to about INR 10,000, and though they have 3 acres of land, it is unsuitable for cultivation. They grow low-water crops for consumption. Despite everything, Sitamati often laughed through her recounting, even mimicking the motion of a sickle. One day, as we were leaving, she called us in for tea. She showed me her only medical document, an X-ray report that revealed dislocated, swollen knees and a chronic case of osteoporosis, which she attributed to her hysterectomy. These days, she often smears her knees with a paste of wet mud and salt, hoping it will bring some relief from the pain.

Kaushalya: “Who would take leave to collect reports?”

Kaushalya’s house sits beside the fields, tucked into the corner of the road that leads up to the rest of the homes in Ariwadi. At 60 years old, Kaushalya recalls being married off when she was just five. Her husband, she remembers, had a long moustache and was likely around 22 years old at the time. She began cutting sugarcane at the age of ten and continued the work until just last year, despite her deteriorating health. Kaushalya has six children, two

of whom died shortly after birth. One passed away nine days after delivery because he was not feeding on her milk; the other was born dead. She delivered all her children herself.

At around 42, Kaushalya stopped menstruating for three years. Then, suddenly, she began experiencing heavy bleeding daily. She went to a private doctor in Ambajogai, who told her that her *pishvi* (uterus) had gone bad due to the blood flow and needed to be removed. Within two days, she underwent surgery. She recalls significant blood loss during the procedure. The surgery cost INR 20,000, and the hospital charged an additional INR 5,000 for blood. When I asked if she had any medical reports, she replied, "All my family was in the sugarcane farms, who would take leave to collect reports?" Since the surgery, her family says she barely eats, struggles to digest food, and is mentally distressed. She now has a hearing impairment, which she believes began soon after the operation.

Surgical Menopause, Morbidities and Life-Post Hysterectomy

Embodied Aftermaths, Medical Models, and the Politics of Menopause

Across the narratives of Kaushalya, Sita Tai, Jayshri Tai, and Sitamati, a striking commonality is the prevalence of early-age hysterectomy, often performed without diagnosis, counselling, or postoperative care (as also illustrated in Chapter 3 and 4). These surgeries, framed as urgent solutions to heavy bleeding or prolapse, were embedded in contexts of relentless labour and debt. While initially perceived as offering relief, particularly the cessation of menstruation that enabled uninterrupted migration and wage work, the long-term aftermath reveals severe consequences. Women describe chronic pain, musculoskeletal injuries, and persistent fatigue, accompanied with repetitive squatting and bending that caused backaches, joint ache, and spinal injuries. Post-hysterectomy morbidities, as reported by women, also include kidney stones, digestive issues, emotional distress, and declining ability for both household and wage labour. As Sita Tai laments, "It is not that I do not want to work, but I have not had the energy

since my *pishvi* was removed." These embodied aftermaths, I note, mark the entry point into the politics of surgical menopause and its associated morbidities, demanding closer attention to how medical models intersect with structural precarity and familial economies.

In both Ariwadi and Kodewadi, women who had recently undergone a hysterectomy typically within the past few months reported experiencing relief from symptoms, particularly heavy bleeding, due to the cessation of menstruation. This immediate sense of relief was often framed in relation to their ability to resume daily routines with greater ease, particularly while migrating to cane sites and carrying out daily wage labour. However, among women who had undergone the procedure some time ago, the narratives shifted and varied markedly. Driven by a sense of regret, these women described a range of recurring morbidities, including chronic pain in their back and health along with chronic fatigue which they attributed to the long-term effects of the surgery. The long-term impact also included a diminished ability to engage in both household and wage labour, altered dynamics in marital relationships, and a general decline in physical and emotional well-being. Commonly reported symptoms among women in Ariwadi and Kodewadi also included persistent irritability (*chid chid*), episodes of depression, joint pain, hypertension, and chronic physical discomfort, often expressed through phrases like *doka dhukat* (head hurts).

These risks are compounded by structural barriers to healthcare access. As one woman explained during one of the conversations:

> "We have no time. And no money. If someone gets sick, they often do not continue the medication if? it takes too long. We try to get ASHA workers involved, but even then, people do not take the medicines. They just keep tolerating it. There are PHCs and *Gramin Rugnalayas* (rural hospital) available. But if we are living on land given by

the factory, it's 7–8 kilometres away. If we are living on our own, then even getting vaccinations and medicines becomes a problem."

Cardiovascular health is another area of concern post-hysterectomy. Studies have established a strong association between early hysterectomy and increased cardiovascular disease (CVD) risk(Davis, 2019; Desai et al., 2023; Ingelsson et al., 2011). The timing of surgery particularly the age at which hysterectomy and oophorectomy are performed is critical. Surgical menopause, especially before age 50, leads to an abrupt decline in estrogen and testosterone levels, resulting in premature ovarian failure and hormonal imbalances that adversely affect vascular health. These changes contribute to elevated cholesterol, increased LDL, atherosclerosis, and heightened CVD risk (Ingelsson et al., 2011). A recurring theme across the narratives of women who have undergone early-age hysterectomies regardless of whether the ovaries were removed is the consistent onset of symptoms associated with premature or surgical menopause.

These embodied experiences resonate with broader critiques of biomedical and feminist models of menopause. Goldstein(2000) observes that the biomedical model tends to pathologise menopause, framing it as a hormonal deficiency disorder (Goldstein, 2000). In contrast, feminist perspectives have challenged this pathologisation, viewing menopause as a natural life transition shaped by sociocultural contexts. Yet, as Goldstein notes, both frameworks often fail to fully account for the lived, somatic experiences of women. Menopause resists objectification due to its amorphous symptoms, fluctuating hormonal markers, and lack of clear diagnostic boundaries. The consequences of hysterectomy, particularly when performed at a young age, and with oophorectomy, are well-documented in medical literature. Research links the procedure to increased risks of chronic conditions such as diabetes, stroke, and certain cancers. Studies also indicate elevated all-cause mortality when bilateral oophorectomy is performed at younger ages, especially among women who do not use menopausal hormone therapy (MHT) (McCarthy et al., 2012; Wilson et al., 2019). For instance, an Australian study reported 40.1

deaths per 10,000 person-years after hysterectomy with bilateral oophorectomy (Wilson et al., 2019), which is close to the upper limit of the normal mortality range for women aged 40–60 (around 18–42 deaths per 10,000 person-years) (Wilson et al., 2019).

Medically, menopause is defined as the cessation of menstruation due to the natural depletion of ovarian oocytes. Etymologically, the term derives from the Greek *men* (month) and *pausis* (pause) (Pinkerton, 2024). However, the framing of menopause as a medical category emerged only in the late 18th century. The earlier concept of the *climacteric*a period of transition associated with both vitality and mortality gradually gave way to a more pathologised understanding of menopause, particularly for women (Downham Moore, 2022b). By the end of the 18th century, the *climacteric* lost scientific credibility and was replaced by a discourse that emphasised the dangers of menstrual cessation (Downham Moore, 2022a). The World Health Organisation (WHO) in the past has defined menopause as an 'estrogen deficiency disease', a classification that legitimises medical intervention through hormonal treatments (P. A. Kaufert & Gilbert, 1986; P. L. Kaufert, 1986). This biomedical framing positions the ovaries as the quintessential female organ, central to the essence of femininity, and defines menopause through the lens of hormonal deficiency (Leng, 1996). Consequently, menopause becomes a condition with identifiable symptoms primarily the absence of ovarian estrogen and the cessation of menstruation requiring medical management. Yet, as Margaret Lock's comparative work in North America and Japan demonstrates, menopause is not a universal biological event but a culturally mediated experience. Her concept of 'local biologies' foregrounds the dialectical relationship between bodily change and social context (Lock, 1994, 2001b; Lock & Kaufert, 1998). Feminist scholars have similarly critiqued the medicalisation of menopause for reducing women's bodies to reproductive functions, thereby reinforcing their political and economic marginalisation (Ferguson & Parry, 1998; Orgad & Rottenberg, 2024).

Emily Martin (1988) further interrogates the biomedical vocabulary surrounding menopause, noting its reliance on metaphors of decline, degeneration, and withdrawal (Martin, 1989). She provocatively asks, "What are women for?" a question that challenges the reduction of the female body to a reproductive machine. Martin critiques medical texts that liken the post-menopausal body to a 'disused factory' or a 'failed business', rendering it functionless after the cessation of menstruation. Premenstrual and menopausal symptoms such as fatigue and backache are thus interpreted as failures to fulfil normative roles of fertility and motherhood.

Timing, Duration, and the Gendered Trajectories of Ageing: A Life Course Perspective

To better understand gendered health disparities, the concepts of timing and duration, central to life course theory, offer valuable analytical tools (Ghosh et al., 2017; Husain & Ghosh, 2017). Timing refers to the chronological point at which a transition occurs in an individual's life, emphasising the significance of age and life stage. Duration, by contrast, captures the length of time an individual remains within a particular life stage or condition. Together, these concepts illuminate the cumulative and temporal dimensions of health and social inequality across the life span. For instance, the long-term consequences of early marriage (timing) and the closely spaced sequence of pregnancies and miscarriages (duration) play a pivotal role in shaping a woman's ageing trajectory.

From a biological standpoint, ageing is often defined as a "persistent decline in the age-specific fitness components of an organism due to internal physiological degeneration" (Rose, 1991). However, this biologically deterministic framework anchored in a linear, chronological model fails to capture the complex interplay of social, economic, and physiological processes that shape ageing, particularly for women. Neugarten and Datan (1973) offer a more nuanced understanding of time by distinguishing between three interrelated dimensions: the life cycle, social time, and historical time (Neugarten & Datan, 1973).

Traditionally, the life cycle has been conceptualised as a biologically determined sequence of transitions from infancy to old age. Yet, as Neugarten and Datan argue, chronological age alone provides a limited framework for understanding the diverse social and psychological factors that shape the ageing process (Neugarten & Datan, 1973). They illustrate this with an example: while a 14-year-old girl in the United States may still be in school, her counterpart in the Near East might already be a mother of two. Such disparities highlight the disjuncture between biological and social time, where transitions such as from youth to marriageability are governed by culturally specific norms rather than biological maturity. This divergence is particularly evident in the life histories of women whose trajectories are shaped by the political economy of their region. Early marriage sometimes as young as six was not merely a cultural practice but a survival strategy to secure the well-being of their natal families. Similarly, early childbearing, initiated immediately after menarche and followed by successive pregnancies, was driven by the socio-economic imperative to produce not only children but a labouring family unit (Mamdani, 1976). As Tarabai, whose narrative is discussed in Chapter 3, explained:

> "I had four daughters, but my husband needed a son. You see, I love all my children, but you have to understand that our daughters will get married and go to other villages. We cannot ask them or their husbands for money or to help us with cane cutting. But our son and his wife live with us. We could afford to take extra *uchal* because we knew our son would help. You know if I die while cutting cane, at least I can hope that our son will cut cane on our behalf to pay off the debt."

In such contexts, the onset of menopause and early ageing cannot be understood solely through biological decline. Margaret Lock's concept of local biologies challenges universalist assumptions about bodily processes, emphasising that menopause is not merely a physiological event but one shaped by socio-economic conditions and reproductive histories (Lock, 1994, 2001b; Lock & Kaufert, 1998). Women's bodies, particularly in rural and labour-intensive

economies, often undergo premature ageing due to cumulative reproductive stress, nutritional deprivation, and chronic physical labour. Empirical studies support this ethnographic insight. Sivakami and Syamala (2005) highlight that women from lower socio-economic backgrounds especially those engaged in agricultural labour tend to experience menopause earlier than their counterparts in other occupational sectors (T. S. & Sivakami, 2005). Early pregnancies and the cessation of childbearing at a young age are also associated with premature menopause. Clinical research further links tubal ligation to menstrual irregularities, including prolonged bleeding, dysmenorrhea, and heightened premenstrual distress (Peterson & Marchbanks, 2000; Shobeiri & AtashKhoii, 2005). Women sterilised between the ages of 20 and 29 are particularly vulnerable to these complications.

Despite its significance as a marker of early ageing and the end of reproductive capacity, premature menopause remains underexplored in both public health and social science literature. This neglect disproportionately affects rural women, who face heightened risks of chronic conditions such as osteoporosis and cardiovascular disease (Heslop et al., 2001; V. Singh & Sivakami, 2014). Data from NFHS-4 and NFHS-5 (Ministry of Health & Family Welfare, 2019; Ministry of Health and Family Welfare, 2016) reveal that states like Andhra Pradesh, which report high rates of hysterectomy, also exhibit elevated levels of premature menopause.

Menopause, Medicalisation, and the Limits of Normativity: Reproductive Transitions in Ariwadi and Kodewadi

A life course perspective offers a more nuanced understanding of these transitions (Desai et al., 2024; Gupta, 1995; G. D. Mishra et al., 2010). Rather than viewing menopause or hysterectomy as isolated events, this approach conceptualises aging as a continuous process shaped by cumulative social, economic, and biological transitions. In Ariwadi and Kodewadi, ageing must be understood through both biological and social registers. Tarabai's life exemplifies this intersection. Married at six and a mother by thirteen, her transition into adulthood was dictated

not by biological maturity but by the economic imperative to sustain her family. Her entry into wage labour cutting sugarcane by the age of seven, further blurred the boundaries between childhood, adolescence, and adulthood. As she recounted:

> "I do not even remember a year where I did not have to cut cane... I could not even hold the *koyta* (sickle), but I kept trying... We had to earn money to feed ourselves."

The medicalisation of estrogen has played a pivotal role in shaping biomedical understandings of femininity, wherein hormonal transitions are framed as biological thresholds of womanhood. The identification of estrogen as the primary female sex hormone in the 1920s marked a critical moment in this discourse. Although multiple forms of estrogen circulate in the female body, only ovarian estrogen was legitimised as the authoritative marker of female sexuality. This re-centring of the ovaries as the singular site of reproductive transition from puberty to menopause rendered the female body, in Braidotti's terms, a "useful, purposeful body that can produce knowledge" (Braidotti, 1991). Such framing reinforces a biologically deterministic view that obscures the social and political conditions under which this knowledge is produced.

In rural India, this biomedical framing intersects with the lived realities of women whose reproductive and labouring bodies are shaped not by linear biological time, but by the demands of kinship, economy, and survival. The narratives of women reveal how kinship roles and economic responsibilities, rather than chronological age, define the experience of ageing. Tarabai reflected:

> "My children joke that the age difference between their *Aai* (mother) and them is so little... I had children calling me *Aaji* (grandmother) when I was just a few years older than you."

These accounts illustrate how the "socially aged" body emerges not from discrete life stages but from the cumulative burden of labour, caregiving, and reproductive demands. Tarabai's

hysterectomy marked a turning point in her physical capacity and social role, “I have been cutting cane for so long... but ever since I got my *pishvi* removed, I struggle even to lift a baby in my arms.”Her son mentioned: “Aai has not been the same since the surgery... She could not work the same way she could before. “Her daughter-in-law added: “She stopped cutting cane when she was not even 40... We also have kids; till when will we feed her?”

In such contexts, the compartmentalisation of life stages such as childhood, youth, old age should be reevaluated. Instead, the imperative to sustain life and labour weaves these stages into a continuous and imbricated complex thread. For many women in Ariwadi and Kodewadi, the body becomes a site of value production both within the household and in the labour market. Yet, medical interventions like early hysterectomies, while often undertaken in the hope of alleviating suffering or preventing illness, accelerate physiological ageing and undermine the very viability they aim to preserve.

Through these diverse narratives, I critically examine the meanings and boundaries surrounding the concepts of normal, normative, and pathological in the context of menopause as a discursive formation. Georges Canguilhem's conceptualisation notes that normativity is not a static condition but a fluid capacity, the individual's ability to adapt to changing internal and external environment(Canguilhem, 1989)s. For Canguilhem, pathology extends beyond mere deviation from a biological standard; it signifies a reduction in one's adaptive capacity, marking a diminishment of normativity rather than an objective anomaly. Within this conceptualisation, I note that surgical menopause emerges as a crucial site for investigating how the body is discursively constructed as both an indicator of health and a potential source of dysfunction. Dominant biomedical narratives often frame menopause as a hormonal deficiency or failure, thereby categorising it as pathological. However, through Canguilhem's lens, the menopausal body can be reconceptualised as one that actively negotiates new norms, recalibrating its physiological and social rhythms in response to changing bodily circumstances.

However, importantly, in cases of surgically induced menopause such as early-age hysterectomies, the biomedical framing of menopause as a 'deficiency' or 'failure' becomes further intensified. This is particularly significant because, unlike the natural menopause that typically occurs in women's late 40s and is a gradual process, surgical menopause is abrupt and often necessitated by medical interventions. As a result, it becomes more susceptible to pathologisation, which can affect women's bodies and their capacity to adapt compared to those undergoing a natural menopausal transition. In the absence of comprehensive care and hormone replacement therapy, the inquiry into 'pathology' in relation to natural menopause reveals that the surgically menopausal body can be viewed as an aberration from reproductive normalcy, thereby highlighting the limitations of biomedical categorisation. The aging process, while influenced by physiological changes, cannot be exclusively defined by these biological factors. Instead, it is shaped by the intricate interplay of biological, social, and discursive forces that collectively define what it means to age, transition into surgical menopause as young as 22 years of age.

"We would have died with it (uterus), and we are dying without it.": Embodied Viability and Filial Operability

> Aarti, 25, was married at the age of 12. She has three children, two daughters aged 12 and 9, and a son aged 8. After her first pregnancy, she suffered two miscarriages, both within three months of gestation. The third miscarriage, in 2016, ended in a stillbirth. All of her deliveries occurred during sugarcane cutting season at the field site. Each time, doctors pointed to a swollen *pishvi* (uterus) caused by intense labour.
>
> In 2019, Aarti underwent sterilisation. She showed me her medical report and sonography from February 2022, conducted at a clinic in Kolhapur, referred by a doctor at the "factory." The report indicated pelvic inflammatory disease and a retroverted uterus. Aarti has been in constant pain since her first delivery several years ago. However, she

does not take any medication as her husband refuses to give her money for it. He still taunts her for spending INR 1500 on the sonography. Her parents, also sugarcane cutters, paid for all her deliveries and miscarriages, selling their only piece of land to do so.

Aarti is married to her father's sister's son. After her first delivery, she returned to work within nine days. She recalls her husband making her parents pay for the missed day of work and the bullock cart rent even on days they did not work. Despite her diagnosis and chronic pain, she could not afford the INR 2500 medication. Her menstrual cycle is irregular, ranging from once every three months to bleeding for fifteen days continuously. Still, she continues to cut cane.

She showed her reports to a government hospital, but they said they could not understand them since they were from a private clinic and asked her to return later with revised tests. The facility had no provision for diagnostic tests. While we were speaking, her mother-in-law left to fetch some of Aarti's medication to show me. As soon as she left, Aarti whispered, "Tai, there are days I do not feel like working, but my husband forces me. My body has been in constant pain since the miscarriages. He beats me every night. I even showed him the reports, but he still forces me to have sex with him." When I met her again a few weeks later, she had lost more weight and developed small white patches on her face, evident signs of anaemia. I noticed a bruise on her hand and asked her to show it to me. She hesitated, saying I would become "impure" if I touched her while she was menstruating. After some reassurance, she handed me her hand and said, "You are the first person ever to touch me without fear when I am on my period. I used to feel like I had a contagious disease."

She had revisited the doctor recently, but this time, she was given only tablets, no reports. She now experiences pain while urinating. The private doctor has suggested she get her

uterus removed. While we were talking, her husband came and sat next to us. I asked him to leave, saying I needed to speak to her alone. He waved his hand and walked off with a smirk-“Private meeting.”

I asked Aarti calmly if she experienced pain during intercourse. She said she felt extreme pain both during and after, but her husband never stopped. She also experiences heavy white discharge. When I asked again if he still hit her, she denied it. I looked at her and smiled. With tears in her eyes and a faint smile on her lips, she touched my face and said, “Tai, nothing will change.”

Aarti had revisited the doctor recently, but this time, the doctor did not provide any reports, only a prescription for medication- a painkiller. She continues to experience pain and a burning sensation while urinating, and the doctor suggested a hysterectomy, an option she has no choice but to consider, by borrowing money from the contractor.

Aarti’s mother and mother-in-law too have had an early age hysterectomy. Yet, despite seeing the impact of the procedure on them, she is still considering a hysterectomy at the age of 25. As evident in cases throughout this thesis and particularly during this chapter, It is striking that in most families in Kodewadi and Ariwadi, at least one woman and often several within the immediate or extended kin network had undergone a hysterectomy. For instance, in Tarabai’s case, she, her mother Jijabai, all her sisters, and now her daughter have undergone hysterectomies.

Cohen conceptualises operability as the degree to which belonging to the state and making legitimate claims upon it are mediated through invasive medical commitments, how surgical interventions become entangled with citizenship and modernity (Cohen, 2007). Extending this idea, I propose filial operability to capture a different but related dynamic: the intergenerational transmission of surgical intervention as a normalised and accepted strategy for managing

reproductive morbidities within familial networks. These biosocial patterns I argue reveal how women, even while witnessing the debilitating consequences of hysterectomy, become conduits for sustaining and legitimising surgical solutions across generations. A genealogical mapping as evident in this thesis illustrates families in which mothers, mothers-in-law, sisters, daughters, and daughters-in-law have all undergone hysterectomies, underscoring how kinship and domestic economies of care, and not only state imperatives, shape the normalisation of operative interventions.

As Meera, a cane cutter who underwent hysterectomy at age 28, poignantly stated, "We would have died with it (uterus), and we are dying without it." Hysterectomies thus emerge as pragmatic investments, where the absence of the uterus continues to be felt through post-operative morbidities. For women like Jijabai and subsequently her daughters, including Tarabai, hysterectomy emerges as a strategy to (re)claim the fragile promise of viability. Here, embodied violence is reconfigured as a necessary condition for survival, reproduced across generations in response to recurring gynaecological morbidities, fear of losing daily wages, repeated doctor visits for non-invasive procedures, and the burden of recurring fines (*khada*). In this context, hysterectomy framed as a one-time expense offers immediate relief from reproductive morbidities, rendering it a viable alternative despite the long-term health consequences that may manifest years after surgery. The immediacy of relief vis-à-vis the lens of bioviability is privileged over deferred risks, reinforcing the patterned operability of women's bodies within familial and economic logics.

Conclusion

This chapter demonstrates that biomedical framings of menopause often reduce the female body to a "factory" rendered functionless once menstruation ceases (Martin, 1989). Yet, the lived realities of rural women reveal a striking contradiction: far from becoming redundant,

their bodies remain central to both productive and reproductive economies. Their continued participation in arduous agricultural labour exposes the gap between biomedical discourses of decline and the everyday imperative to sustain bodily functionality despite chronic illness and pain.

Early hysterectomy intensifies this contradiction by transforming menopause into an abrupt, pathologised state that accelerates physiological ageing and diminishes adaptive capacity. A life-course perspective makes visible how these embodied disruptions are inseparable from the social and economic conditions shaping ageing in rural India. Situating menopause within the interplay of social time, economic imperatives, and local biologies moves us beyond universalist models to reveal how reproductive transitions are deeply contingent on context, labour, and kinship economies (Lock, 2006).

For women like Aarti, the decision to undergo surgery, even at the age of twenty-five, reflects not only individual suffering but a patterned normalisation of operative solutions across generations. This intergenerational transmission, persisting despite visible post-operative morbidities, underscores what I term filial operability: a logic through which surgical intervention is legitimised and reproduced within familial networks as a strategy for survival. In this framing, embodied violence is recast as viability, privileging immediate relief over deferred risks and reinforcing the cyclical medicalisation of women's bodies within rural economies.

Conclusion

A Recap: On Bioviability, Pragmatic Investment and Filial Operability

This thesis has examined the intersecting economies of labour and biomedicine that shape the everyday lives of women and their bodies in the sugarcane economy of rural Maharashtra. As is evident across chapters, two critical themes have been brought to the fore in this thesis: first, the sugarcane economy, with its deep-seated structures of caste-based labour exploitation and disproportionate burden of this labour on women; and second, the medical economy, with its entanglements of negligence, profit, and biopolitical control. These two seemingly separate yet imbricated domains illuminate the processes through which women's bodies are rendered indispensable and expendable at the same time: indispensable to the reproduction of wage labour and household economies, and expendable within capitalist and biomedical regimes that profit from their systematic debilitation. Moving beyond reductive framings that depict these women either as helpless victims of structural violence or as pragmatic agents freely choosing surgical interventions for seeking 'ease' or 'freedom' from menstrual discomfort, I have sought to develop an analytic that complicates and also holds both these dimensions together: one that traces the structural constraints that leave women with few viable options, while also illuminating how they navigate, resist, and endure within these constraints.

To capture this complex interplay of limitation and agency, across chapters, I have introduced three interrelated conceptual lenses: bioviability, pragmatic investment, and filial operability that together illuminate the layered biosocial economies through which women navigate 'viability', and do what it takes to get by under conditions that continually threaten to delimit it. A central contribution of this work lies in its **economic framing of reproductive labour**. While economic analysis has typically focused on production, it has rarely addressed reproductive contexts such as sterilisation or hysterectomy. Drawing on Lawrence Cohen's

(2003, 2007, 2011) theorisation of bioavailability **and** operability, the thesis reinterprets these processes as part of broader biopolitical economies (Cohen, 2003, 2007, 2011). Cohen conceptualises bioavailability, the extent to which bodies are made accessible for biotechnological intervention and operability, which captures the subjective and relational positioning of individuals who accept or resist medical procedures. Building on this, the concept of **bioviability** foregrounds the threshold of bodily functionality required to sustain life and labour. The woman's body emerges as an essential "organ" within the familial and economic unit, raising critical questions about expendability and survival (Cohen, 2007; Nahman & Weis, 2023). Bioviability, as I have argued, lays bare the tenuous potential for sustaining life and labour when both are structurally foreclosed. It points to the embodied calculus by which women decide to "fix" their bodies, often through surgical means, to remain productive members of the *koyta* and sustain everyday viability. Within the sugarcane economy, this is made visible through the multiple layers of exploitation that conspire to produce physical and social exhaustion: hazardous work conditions, sexual harassment, absence of rest or insurance, the exploitative structures of labour hiring through the *koyta* system, and the crisis of masculinity that compounds women's vulnerability. These historical and ecological marginalisations have produced an economy of survival in which continued labour, even at the cost of women's health, becomes both a moral and material imperative. It is within this nexus that bioviability operates—as a hope for the 'good life'. Bioviability thus encompasses not only the capacity to endure but also the temporal and economic calculations that shape women's decisions to avoid financial strain, reduce illness-related income loss, and meet caregiving responsibilities. The temporality of viability is precarious, contingent, and often fatal, as expressed poignantly by women who asked, "How will we work if the blood does not stop?" and doctors who warned, "If you do not get your uterus removed, you will die

in a few days." These exchanges reveal the entanglement of wage labour, bodily endurance, and moral obligation.

This precarious temporality of viability sets the stage for understanding how structural forces transform biological bodies into political labouring bodies, thus reflecting the gradual normalisation and assimilation of violence into the everyday lives of sugarcane labourers in Beed. This process, in turn, reconfigures the relationship between the state and the bodies of female labourers, laying bare how migration, caste, and regional identity shape the othering of female labouring bodies. Within these contexts, I introduce and situate the concept of bioviability to reveal the boundaries of how much labour a body must perform to remain economically "worthwhile." This viability is retained only by transitioning the reproductive body into a labouring one. Certain bodies, particularly those of women from marginalised caste, class, and religious groups, have historically been bioavailable. They become bioviable by paying for their 'belonging' to specific peripheries through the experience of pain inscribed on their bodies and the expectation to endure "pain, suffering, and injury" (Chaparro-Buitrago, 2022). I argue that the fluid contours of medical institutions provide critical signposts to trace both the suffering and the participatory strategies of women who, in order to survive, accept the very biopower that threatens to exhaust their existence in the name of short-term economic survival.

In the context of the medical economy, the chapters in this thesis further trace the complex circuits of care and neglect that entangle public and private medical settings. Here, for instance, as illustrated in this thesis, some doctors in state hospitals, often responsible for conducting sterilisations, redirect women to their own private clinics for costly hysterectomies, constructing a perverse moral economy where the uterus is redefined as redundant and expendable. In particular, I note that although debates persist within the medical fraternity

regarding the causal link between sterilisation and hysterectomy, my fieldwork highlights two salient patterns: first, a marked rise in gynaecological morbidities following sterilisation; and second, a recurring trajectory of surgical escalation, wherein sterilisation frequently initiates a sequence of invasive procedures. These morbidities are subsequently invoked by health practitioners to justify hysterectomy recommendations, often employing the spectre of cancer or mortality to elicit immediate consent. Such risk framing operates as a decisive influence on women's choices, particularly when they are already contending with severe post-sterilisation symptoms. These practices expose how medical professionals exploit both the state's failure and women's need to get by, monetising the uterus under the guise of treatment and survival.

Within this context, I conceptualise hysterectomies as forms of pragmatic investment, that is, as constrained yet deliberate decisions through which women seek to secure continuity of income, relief from chronic morbidity, and assurance of life in the face of medical and economic precarity. These investments, I argue, while fraught with long-term health risks, lay bare women's pragmatic agency: the capacity to make life-enduring decisions based not on free choice, but on the limited, asymmetrical and exaggerated risks presented by health practitioners. The notion of pragmatic investment, drawn from Desai's theorisation of pragmatic agency (Desai, 2016; Desai et al., 2023; Lock & Kaufert, 1998; Quah, 2008), further elucidates how women negotiate suffering. Accepting post-operative pain and long-term complications becomes a rationalised strategy to mitigate economic hardship and sustain livelihoods. In this sense, hysterectomy signifies not emancipation but an adaptation to structural violence. Such decisions, I posit, however, must also be understood as reflections of structural inequities of caste, class, and gender that have historically devalued the reproductive and social worth of marginalised women's bodies.

The thesis also attends to what happens *after* hysterectomy, what it means to live and age with its consequences, and how these experiences reconfigure familial and generational relations.

Here, I put forth the lens of filial operability to describe the intergenerational transmission and normalisation of hysterectomies as an accepted means of managing reproductive health within families and kin networks. As illustrated across the chapters, ethnographic narratives of women reveal how, in many cases, mothers, daughters, and daughters-in-law all undergo hysterectomies, often within the same family, reproducing a learned logic of bodily operability that links care, endurance, and surgical intervention, despite witnessing the debilitating impact of these procedures on women's lives—yet pushing women across generations to undergo these procedures. Filial operability, thus, captures both the social inheritance of biomedical rationalities and the familial circuits, revealing how the appropriation of women's bodies for labour and medical intervention begins early: through early marriages for *koyta* work, early pregnancies, sterilisation, and premature hysterectomies, culminating in a lifetime of managed debilitation. The procedure thus becomes embedded in familial strategies of survival, where the uterus transitions from asset to burden to liability, yet, is rarely recognised as key to women's overall health and well-being.

Through the **life course approach**, this thesis demonstrates that the appropriation of women's bodies for both labour and medical intervention begins early with child marriage, early pregnancies, sterilisation, and hysterectomy and extends into ageing. The life course is, thus, examined through **two interlinked lenses**: the sugarcane economy and the medical economy. These lenses reveal how women's bodies are made *bioavailable*, accessible for labour and intervention and then *bioviable* sustained as productive and disposable bodies within exploitative systems. It is not that women act as neoliberal rational agents making autonomous choices; rather, their actions are shaped through the structures of **bioavailability**, operationalised through **bioviability**, which together define the conditions under which agency becomes possible. Women's decisions and bodily negotiations must therefore be understood not as expressions of individual rationality but as socially situated responses to intersecting

pressures of survival, productivity, and care. Even in the post-reproductive phase, the body remains enmeshed in **filial operability**, where intergenerational obligations and economic dependency sustain women's labour into old age. Menopause, rather than marking the cessation of productivity, signifies its reconfiguration within new moral and economic circuits. The menopausal and post-hysterectomy body, therefore, is not a symbol of decline but a site where the contradictions of gendered labour, medical modernity, and survival converge.

I contend that, beyond health considerations, it is essential to recognize the capitalist logics shaping the space, timing, and legitimacy of medical interventions. Recognizing these logics opens up the possibility of an expanded understanding of temporal sovereignty, one that includes the right to reject clinical timelines that render the bodies of marginalized women disposable. These timelines do not operate neutrally; rather, they often impose a stark binary between rapid surgical intervention and prolonged suffering under chronic illness. This binary reflects a lethal temporal calculus, driven by the biomedical imperative to "fix" the body quickly, which disregards the lived experience of illness. In response, I argue that temporal sovereignty should also encompass the right to resist temporal regimes that keep women's bodies perpetually bioavailable for intervention. Such resistance enables a reimagining of care that challenges the capitalist logic of efficiency and invites a redefinition of what it means to heal, endure, and for whom.

Building on this argument, we see that across both the sugarcane and medical economies emerges a historically layered narrative of bioavailability transformed into bioviability: from bodies made available for labour and extraction, to bodies that strive to remain viable within systems that continuously undermine that very viability. Through this lens, the thesis mobilizes bioviability, pragmatic investment, and filial operability to reframe women's endurance not as passive suffering but as a form of constrained agency embedded within structures of

exploitation. This framing foregrounds women's strategies of survival as simultaneously pragmatic, agentive, and structurally determined. Ultimately, understanding these dynamics requires recognising women's constrained, yet, consequential agency within the intersecting economies of labour and biomedicine that structure rural life in contemporary India.

Ethnography at the Margins: Field Encounters, Ethical Dilemmas, and the Limits of Objectivity

During my visits to the factory sites to meet women from Ariwadi and Kodewadi, I was once stopped by two policemen who questioned my presence. I showed them my student ID and explained that I was a doctoral student. However, their scepticism persisted. It was only when the women from Kodewadi and Ariwadi told the policemen, "She is with us," that I was allowed to remain at the factory site, though still under a cloud of suspicion regarding what I was documenting and to what end.

Throughout my doctoral study, I remained mindful of my positionality. Apart from being a woman, I shared no other identity with the women whose lives I was attempting to understand, lives shaped by multiple layers of marginalisation, violence, and oppression. I was not from Maharashtra, nor from a cane-cutting family. I did not belong to the Vanjari, Mahar, or Mang caste groups. I had not experienced restricted access to healthcare or basic health facilities, nor undergone a hysterectomy or any other medical procedure. As a student, I was attempting to document, through an ethnographic lens, the everyday lives and the embeddedness of female cane cutters and their quotidian lives in the political economy of sugarcane, and the continuum between home and migratory labour sites. I did not treat these as isolated domains, but sought to understand what shapes this continuum, what hinders it, and how hysterectomies emerge as biosocial strategies within it.

While the intent of my study was academic, it was also driven by a desire to offer a counter-narrative to the highly sensationalised and fragmented media coverage. I aimed to present this work as a potential case study on hysterectomies in India, particularly among agrarian labourers, highlighting and unpacking their 'local biologies' (Lock, 1994, 2006). These biologies, while tied together by the shared experience of hysterectomy, differ starkly due to the compulsions and fluctuations shaping their lives: local caste and village dynamics, political contexts, and external influences such as media and activist interventions.

Reflexivity, while central to my ethnographic engagement with early hysterectomies, also draws on what Davies notes: that reflexivity in social research is a complex and layered concept influencing every stage of the research process (Davies, 2012). It ranges from what she points to as personal introspection, such as a fieldworker's journal, to collective expressions like rituals, and from implicit awareness to radical self-reference. She further asserts that at its most intense, reflexivity can become self-consuming, where researchers endlessly reflect on their own reflections, potentially undermining the research itself (Davies, 2012). These reflections for instance became profound during the course of my fieldwork particularly when women, like Sunita shared gruesome realities of their own lives with me during the course of my fieldwork. In one of our conversations, she recalled,

> "When I was in Karnataka, my *mama* (mother's brother) was the *mukadam*. In the first season, things were okay. We did not have to pick up much, so the work was manageable. However, everything changed in the next season. We had a child, and the need to pick up a larger *uchal* was increasing each day. My husband had been an alcoholic since our marriage. If I said anything to him, he would beat me, not just once, but every night. One time, when he was drunk, he got into a fight with the *mukadam*. The *mukadam* came into our house and beat both of us. My husband ran away, leaving me and our children behind. I was terrified. I ran out and tried to hide in someone else's *kopi*, but even there, there

was a drunk man. I did not know what to do. If I went outside, the *mukadam* might beat me again. If I stayed inside, I feared I could be raped. I felt trapped, unsafe everywhere."

Initially viewed as a methodological problem to be minimised, Davies highlights that reflexivity has evolved into a critical tool for understanding the co-constructed nature of data and the researcher's active role in shaping it (Davies, 2012). This shift, she suggests, has led to a deeper appreciation of the social and ethical dimensions of doing research, especially in the context of ethnographies, wherein the researcher's presence and their perspective become inseparable from their findings or analysis. This was particularly relevant during the course of my fieldwork, where I encountered women my age who were already grandmothers, or had undergone two to three surgeries, including hysterectomy. A grassroots activist, who once cut cane herself, shared:

"I come from a family where at least five generations have been cutting cane in Maharashtra. I remember the drought in 1972. Back then, alcohol was not common. Now, it is everywhere. Men spend 50% of their advance income on alcohol. Contractors get them addicted, so they keep coming back to the same place every season for more *uchal* to buy alcohol. Rape and sexual exploitation are common. Women are used to crying silently; we do not tell our families. The men leave early in the morning. Once the truck is loaded, there is a massive line at the factory. Women are left alone; anything can happen. The *mukadam* and other men in the field can easily take advantage. If a woman wants to bathe, she has to do it at least an hour before everyone wakes up at 3 AM. One woman stopped eating because she had to go to the bathroom during the day, and she developed an infection.

So many deliveries have happened on the bus. Some women have been bitten by snakes. Diseases like typhoid, weakness, and cholera are common. Beed is known as the *dhabba-*

wala (blot) district and for female foeticide. Abortions are common, but no one talks about them openly. They cost around INR 30,000 to 40,000. There are no doctors at night. I took my sister-in-law to a government hospital. The *mausi* (equivalent to a nurse) told her to keep quiet, saying she should not have married. The *mausi* did the stitches herself. 'What is the need for a doctor?' she said."

In such scenarios, the pursuit of objectivity becomes untenable and unrealistic for the ethnographer, and perhaps devoid of the empathy that I argue should be central to any ethnographic research, not just in medical anthropology, but across all disciplines. Capturing the loss of an infant at the worksite, run over by a tractor, or a woman undergoing a hysterectomy under the pressure of private practitioners often falsely leveraging risk of death or cancer for unclear, non-indicative symptoms, demands more than detached observation. It becomes critical to introspect not only on the academic pursuit that brings to light malpractices in the health sector tied to the cane economy, but also to re-centre and interrogate the purpose of conducting research itself: what value is the research bringing? As Gerald D. Berreman aptly notes in his critique of anthropology's ethical stance, the discipline must serve human purposes (Berreman, 1968). He challenges the notion of value-free research, arguing that a discipline devoted to studying human beings must engage ethically and thus, anthropologists, he insists, should abandon the positivist ideal of neutrality and instead use their knowledge to address the real problems faced by the communities they study. Berreman echoes the concerns of people from marginalised and colonised communities who ask: Has anthropological work helped solve their problems? Has it even acknowledged them? If not, then the discipline itself becomes complicit in systems of oppression and exploitation (Berreman, 1968). Heavily influenced by Berreman's provocative framing, my work, while not aimed at transforming the lives of the communities, attempts to carry out a 'good enough' ethnography, as discussed in Chapter 1. As I elaborate in the latter half of this concluding chapter, I seek to contribute to a practical,

implementation-driven evidence base that holds potential for actual ethnographically informed, policy-based interventions to curb these procedures and improve the life courses of women living at the very margins.

Rethinking Agency: Divergent Logics of Care through Hysterectomies

The case of early-age hysterectomies, as illustrated in this thesis, foregrounds the economic dimensions of reproductive labour. This stands in contrast to existing and emerging work on surrogacy and global reproductive economies such as egg freezing in the UK and US where insurance, investment, and promissory language commodify disaggregated parts of the female body. For instance, Van de Wiel frames egg freezing within the logic of financialised capitalism, wherein financialisation entails the extension of debt into underserved communities (Van De Wiel, 2015, 2020, 2022). In this framing, fertility and its treatment become sites of investment, debt, and capitalist market expansion. However, among cane cutters who undergo early-age hysterectomies, these procedures are not situated within any bioeconomy. Instead, as illustrated through their agentive nature and interpreted through the lens of bioviability, hysterectomies emerge as biosocial strategies shaped by the compulsions of everyday cane labour and exploitative labour structures. While egg freezing or fertility treatment akin to the organ selling described by Cohen are directed toward securing future potential, hysterectomies are oriented toward immediate relief (Cohen, 2003, 2007, 2011). In this context, every form of violence becomes an opportunity to secure the present, even if it entails the gradual and long-term debilitation of women's bodies and their everyday lives.

This contrast illustrates how clinical spaces mediate reproductive futures: in some cases by preserving fertility and securing future potential, and in others through surgical erasure, where socioeconomic and familial compulsions drive biomedical finality. Kaushik Sunder Rajan conceptualises biocapital as the co-emergence of life sciences and capitalist enterprise, wherein

biological knowledge becomes a site of speculative investment (Sunder Rajan, 2006). He notes that this is particularly evident in the grammar of venture science, which relies on promissory discourse, hype, and future-oriented valuation. I assert that this speculative grammar stands in stark contrast to the promissory discourse surrounding hysterectomy as shaped by private health practitioners. These are not future-oriented interventions, but pragmatic investments aimed at immediate relief. While egg freezing and genomics are framed as technologies of anticipation, hysterectomies emerge as technologies of bioviability.

Within the **sugarcane economy**, women's labour is produced and reproduced through multiple layers of structural exploitation. The neglect of occupational safety, the absence of sanitation and privacy, and the sexualised nature of worksite relations together create conditions of severe physical and social vulnerability. The structural mechanisms of labour hiring such as *koyta* systems that channel wages through men, the *khada* penalties for absence, and kin-based relations with *mukadams* deepen women's dependence and restrict their access to rest, wages, and autonomy. These exploitative arrangements are further shaped by a broader history of marginalisation, ecological degradation, and debt that compels women to sustain continuous labour as a means of survival. Within this context, women's capacity to work, even while ill, becomes a measure of endurance and agency. The concept of **bioviability** captures this dynamic: the ability to maintain bodily function in order to remain economically productive. Agency here is not oppositional but pragmatic, shaped by necessity and constrained by the social and economic structures that demand unceasing labour.

The **medical economy** mirrors and reinforces these logics of extraction. The collusive relationships between public and private healthcare providers exemplified by coercive sterilisation practices, unconsented hysterectomies, and the commercialisation of reproductive health reveal how women's bodies are rendered as sites of profit and biomedical

experimentation. The portrayal of the uterus as a redundant organ for post-reproductive women justifies invasive interventions while erasing its role in women's overall well-being. Women's decisions to undergo hysterectomy, often financed through loans, reflect not passivity but a **pragmatic investment**, a calculated response to chronic pain, lack of access to quality care, and the fear of mortality. Their agency, however, operates within the confines of medical misinformation, economic compulsion, and gendered subordination. The medical economy, thus, reproduces structural inequalities while presenting technological interventions as solutions to social problems. hysterectomy.

Future Directions

An important avenue for future research involves developing more detailed documentation of patient journeys across the life course. Mapping these trajectories would allow us to capture the full spectrum of health-seeking behaviours and their evolution over time. For example, tracing the sequence of health practitioners consulted, from birth onward, could reveal critical shifts in decision-making, such as transitions between public hospitals, private facilities, traditional healers, and home-based remedies. This would provide deeper insights into how women navigate care options and the factors influencing these pivotal choices.

Another area that requires further exploration is the documentation of family members' perspectives, particularly those of mothers-in-law, fathers-in-law, husbands, and other relatives, regarding women's gynaecological health and decision-making around the uterus. Although I was able to capture some insights from husbands, this was constrained by their absence during home visits and by my positionality as a woman researcher, which affected the comfort level in discussing gynaecological issues with male respondents. This area is especially significant in the context of the koyta system among cane cutters, where the familial enterprise plays a critical role not only in productive labour but also in shaping reproductive choices and broader

health decisions, including surgeries and the timing and type of treatment sought across the life course. I also see scope for future engagement with politicians who are also sugar barons. I did not incorporate their perspectives due to the sensitivity of the issue and concerns about exposing women cane cutters to potential vulnerabilities. I was also concerned that this could place the doctoral work itself under scrutiny, potentially compromising both participant safety and the integrity of the research process. However, such engagement could provide critical insights into the structural dynamics of the sugar industry.

Finally, the exclusive focus on cane cutters and the geographic concentration on Maharashtra was a methodological choice, as the ethnographic approach necessitated in-depth engagement with one region and one community. The selected villages were primarily inhabited by cane-cutting populations, which limited the scope of the research in terms of capturing, comparing, or contrasting the prevalence of hysterectomies among other labouring groups. While existing literature suggests that the prevalence of hysterectomies outside this context is relatively low, there is limited ethnographic evidence to substantiate this. A comparative ethnography in other cane-cutting states such as Karnataka and Uttar Pradesh could offer critical insights into the prevalence and patterns of early hysterectomies among female labourers. This focus on Maharashtra also opens up possibilities for extending the inquiry to other high-prevalence states where hysterectomies may not be concentrated within a single form of labour, but rather distributed across various sectors such as domestic work, agrarian labour, and daily wage employment. Exploring these contexts would be essential to understanding how the case of Maharashtra contrasts with other regions in India where hysterectomy prevalence is high, but labour dynamics and reproductive health decisions may differ.

Looking ahead, there are some key avenues through which this doctoral research can be extended. First, the SAHELI study: *Study and Action on Hysterectomy: Evidence on Women's Health Through the Life Course in India* offers a significant opportunity to further investigate

the individual, health system, and social drivers of early hysterectomy in India (Desai et al., 2024). The study focuses on three states with high prevalence of hysterectomy: Punjab, Bihar, and Telangana. It aims to conduct large-scale surveys of women aged 25–49 years, followed by in-depth qualitative interviews with women who have undergone hysterectomy or sought gynaecological treatment, as well as with health care providers and other influential actors in women's lives. These findings will be synthesised with existing evidence and further enriched through consultations with women's groups, health care providers, and policymakers (Desai et al., 2024).

As a Research Fellow at the George Institute for Global Health, I am involved in this study with a particular focus on leading the qualitative research component in Punjab, my home state. I view this engagement as an opportunity to respond to a recurring question posed by women during my fieldwork: *How will this research benefit us?* The SAHELI study will generate first-time evidence on hysterectomy and women's health in India, with a focus on understanding the influences on women's health across the life course. It will offer insights into women's treatment choices and health care options in response to gynaecological morbidity, as well as the physical and social consequences of early hysterectomy. By integrating diverse forms of evidence, the study aims to produce policy-relevant insights that can inform interventions to improve women's health in India and similar contexts. I am hopeful that some of the insights from SAHELI can be extended to Maharashtra, particularly to inform policy responses. Moreover, I see my involvement in this study as a way to address one of the limitations identified in this thesis i.e. its focus on a single site and state. SAHELI's multi-sited approach offers a comparative lens to understand local biologies and to map the similarities and differences in how decisions around early-age hysterectomy are shaped across regions (Desai et al., 2024; Lock, 2006).

As a postdoctoral area of focus, I am keen to build on what I have already initiated in Chapter 5 of this thesis. In both social anthropology and public health, there remains limited theoretical engagement with menopause, often framed as a private and inevitable stage of transition and its relationship to the realpolitik of everyday labour carried out by female labourers (Kaufert & Gilbert, 1986; Lock, 1994, 2006; G. D. Mishra & Sarah E, 2013; Singh & Sivakami, 2014; T. S. & Sivakami, 2005). This gap warrants scholarly attention. Drawing on anthropological scholarship that positions family and neighbourhood as critical sites shaping lived experience, this proposed study will examine how menopause, whether induced by hysterectomy or through the natural process of aging is defined, understood, and experienced by female labourers undergoing early hysterectomies. In this context, I aim to investigate how clinics and hospitals become pivotal spaces where socio-political realities intersect with the grammar of biomedicine, rendering health care a form of "credence good" for women undergoing early hysterectomies (Das & Hammer, 2014). My ethnographic inquiry will be closely aligned with Margaret Lock's comparative work on menopause in North America and Japan, with the intention of conducting a similar scholarly investigation in India (Lock, 2006). However, my focus will be specifically on surgical menopause induced by hysterectomies at ages as young as 24. This research will seek to understand the social, biological, familial, and economic ramifications for women who undergo early menopause, and how these experiences differ from those of natural menopause. It will also explore how these experiences are perceived and understood within the family, and how they impact women's everyday wage labour and household responsibilities.

Concluding Reflections

As a contribution to social anthropology, this thesis pushes the anthropology of body and biomedicine and nests it within agrarian labour regimes, presenting the need and potential of ethnographic work as a thread tying varied sites of the clinic, the cane fields, hysterectomy

statistics and life narratives. It also wrestles with the boundaries of the ethnographic method by bringing to the forefront an ethnographer's uneven immersion and reciprocal ethics, particularly in field sites that are highly exposed to media, NGO and activist intervention. Further, the thesis contributes to the anthropology of agriculture and the anthropology of work by illustrating the process of incorporation of marginalised caste women and men into koytas and tolis within relationships of kinship, and their continued bondage through the instruments of debt such as *uchal* and *khada* within the sugarcane economies of western India. It contributes to critical agrarian studies by tracing the embeddedness of labouring processes within exploitative cooperative, caste-driven politics - all of which together reconfigure gender, caste and migration dynamics, rendering bodies of women as bioviable (and thus, available for labour) through surgical debilitation. As a contribution to the domain of public health, this thesis highlights and reiterates the need for a life-course approach across women's lives, along with gynaecological care that recognises early life-events such as child marriage, early childbearing, abortions and miscarriages, morbidities after sterilisation, premature and surgical menopause, followed by NCDs.

I have outlined how the uterus comes to be imagined as being both disposable and rotten after cessation of childbearing post-sterilisation, thus, becoming the pathway through which reproductive suffering translates into what I present as the construction of the labouring body. Across chapters, I have illustrated how hysterectomies should not be viewed as isolated or 'one-off' procedures but instead how they come into being amidst the criss-crossing tempos of caste-based labour, seasonal migration, cycles of debt or 'bonded labour' and biomedical rationalities, which women navigate through pragmatic strategies that become means of securing immediate viability in precarious economies of care. The three analytical lenses of bioviability, pragmatic investment and filial operability respectively trace the fragility of bodily functionality and viability; the constrained yet deliberate calculations and negotiations that prioritise this

viability over the uncertainty of the future; and the intergenerational acceptability of the procedure despite its evident debilitating impacts on women's bodies and everyday life. Steered by Margaret Lock's conceptualisation of local biologies and Mishra et al's assertion about the significance of the life course approach, this thesis lays bare the structure-agency dynamic, not as a binary but as situated temporality, within which women act, but within layered constraints that present hysterectomies as a form of care, both as necessary, but also life-threatening (Lock, 1994, 2006; G. Mishra et al., 2023; G. D. Mishra & Sarah E, 2013).

By foregrounding the narratives of the women who have undergone hysterectomies, this thesis offers a small contribution to conversations on reproductive health, labour, and caste within and beyond academia. While it cannot ameliorate their suffering, placing these accounts in the public domain underscores the urgent need to confront whose bodies come to matter, particularly those of women from marginalised caste groups, and to question the stages at which their organs, particularly the uterus is deemed as expendable. The shifting value attached to the uterus across the life course, this thesis argues, makes visible the continuous and often painful negotiations women undertake as they navigate bodily debilitation, reproductive expectations, and the demands of survival or what I conceptualise as ‘bioviability’.

I hope that this thesis also compels a reconsideration of what constitutes violence in the lives of women at the margins. What might appear to researchers as a brutal surgical intervention, an early hysterectomy, often represents, for these women, just another episode within an ongoing continuum of structural violence. Caste peripheries, extractive labour, and the endless demands of everyday survival shape their lives, in which, the question is not why hysterectomies occur, but when was life ever free of the forces that have systematically debilitated them to begin with. Thus, the temporal calculations women are pushed into, and intensified by biomedical pressures to ‘fix’ the body, swiftly ignore how illness is actually lived and endured.

These dynamics, then, raise critical questions about how time, care, and endurance are embedded in women's lives. The limited room women have for delaying, refusing, or influencing the timing of medical interventions (hysterectomies, sterilisation, sex-based abortions, among many others), whether hysterectomy or any other form of care- all possibilities that are eroded by intersecting pressures of labour, kinship, and medical authority. This thesis has therefore sought to foreground women's voices, not as clinical subjects whose narratives are compressed into surgical events, but as embodied individuals whose lived experiences and life trajectories have been continually shaped by structural violence, gendered marginalisation, and the sociopolitical conditions that delimit their possibilities for care.

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Walley, C. J. (1997). Searching for "voices": Feminism, anthropology, and the global debate over female genital operations. *Cultural Anthropology : Journal of the Society for Cultural Anthropology*, *12 3*, 405–438.

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Bio-Note

NEYMAT CHADHA

CURRICULUM VITAE

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EDUCATION

Indian Institute of Technology, New Delhi

(2020-2026)

PhD, Sociology

Thesis Area: An Ethnographic Study of Prevalence, Causes and Long-term Impact of Early-Age Hysterectomies among Women Laborers in Rural India.

Research Areas: Medical Sociology, Women's Health, Equity in Research Methods, Obstetric Violence Invasive Medical Technologies, Epidemiology, Labour, Climate Change and Gender.

Delhi School of Economics, University of Delhi

(2017-2019)

M.A. Sociology

Jesus and Mary College, University of Delhi

(2014-2017)

B.A.(Honors) Sociology

PROFESSIONAL EXPERIENCE

Teaching Assistance

Indian Institute of Technology, New Delhi (February 2021- December 2023)

Courses:

Social Science Approaches to Development

Technology and Governance

Introduction to Indian Sociology

Research

Civil Society Engagement Mechanism (CSEM) for UHC2030

Consultant

(April 2026- Present)

The George Institute for Global Health, India

Research Fellow, Health Systems Science

(December 2023- Present)

Independent Research Assistant

Project: Digital Literacy and Health Practices Among Rohingya, Bangladesh

(May 2020-September 2020)

SPRF India

——. Senior Associate and Coordinator- Research and Partnerships

(April 2020-September 2020)

——. Research Associate

(November 2019-March 2020)

Jesus and Mary College, Delhi University and University Grants Commission (UGC)

Field Researcher- UGC Innovation Project Grant

Project: Everyday (In)Security and (Re)Securing the Everyday: Violence Against Women of South Delhi

(May 2016-May 2017)

AWARDS AND GRANTS

John Chalmers Award

John Chalmers Doctoral Award 2025

Health Systems Global

Full Scholarship, Eighth Global Symposium on Health Systems Research (HSR2024)

Wenner-Gren Foundation

Wenner-Gren Dissertation Fieldwork Grant 2022

Azim Premji Foundation

Awardee: Research Funding Programme 2021; Labour, Livelihoods and Employment (foregone)

Delhi School of Economics, Delhi University

Shri Shiv Lal Sawhney Scholarship

Jesus and Mary College, Delhi University

UGC Innovation Project Grant

COURSES/WORKSHOPS

Course- Reimagining Global Health led by Dr. Madhukar Pai and Dr. Shashika Bandara, McGill Summer Institutes in Global Health, June 9-June 13, 2025.

Workshop- Three-Day Hybrid Workshop on Realist Evaluation for Health Policy and Program Evaluation, Institute for Public Health, Bangalore, July 3-July 5, 2024.

Certificate Course: Social and Behavioural Research (Basic/Refresher)- Collaborative Institutional Training Initiative (CITI Program), Bates College, USA

INVITED LECTURES AND PRESENTATIONS

Chadha, Neymat. (2024, December 10). Panch taanka, kamzori aur dard ki goli: Early hysterectomies, 'normalcy' and an imaginary of the 'good life'. Presentation for the Scheme for Promotion of Academic and Research Collaboration (SPARC), Government of India & Department of Liberal Arts, Indian Institute of Technology Hyderabad, 'Lifestyles in Conflict Chronicity and Healing in Contemporary India'.

Chadha, Neymat. (2024, December 9). Not just reproductive: Addressing women's gynaecological health through the life course in South Asia. Presentation for the Health Equity Network (HENI), George Institute for Global Health and Institute for Public Health, India.

Chadha, Neymat. (2024, August 31). Equity in the conduct of research - What has been done and what could be done? Presentation at the 15th World Conference on Injury Prevention and Safety Promotion (Safety 2024).

Chadha, Neymat. (2024, June 21). (How) Can communities drive change?: Evidence, advocacy and on-the-ground experiences of community action for health to achieve health reform for all. Presentation for the Health Equity Network (HENI), George Institute for Global Health and Institute for Public Health, India.

Chadha, Neymat. (2024, April 2). Pragmatic bodies, bodily suffering: Women's narratives of hysterectomy. Presentation for the Humanities and Social Sciences Winter School of Indian Institute of Technology, New Delhi and Sorbonne Health Campus, Sorbonne University, Paris.

Chadha, Neymat. (2023, January 12). Are humans designed for change? Tech talk for Dr. Reddy Laboratories in collaboration with X-Leap.

Chadha, Neymat. (2022, October 28). Social precarity and bioviability: Hysterectomy narratives of female labourers in rural Maharashtra. Presentation for the Medical Anthropology Workshop - Illness Experience and Society, Department of Sociology, Shiv Nadar University, Greater Noida.

CONFERENCE PAPERS AND PRESENTATIONS

Chadha, Neymat, Anusha Seelamantula, & Devaki Nambiar. (2026, June 8-10). From Monitoring to Action: A Discursive History of Community Action for Health in India. 5th Edition of the EPHP Conference (Evidence-based Public Health), IPH Bengaluru.

Seelamantula, Anusha, Neymat Chadha, Shweta Marathe, & Devaki Nambiar. (2026, June 8-10). Pathways of Community Action for Health in India: A Realist-Informed Synthesis of Published Evidence. 5th Edition of the EPHP Conference (Evidence-based Public Health), IPH Bengaluru.

Chadha, Neymat. (2025, December 15-17). From Teen Taanka (Three Stitches/Sterilisation) to Paanch Taanka (Five Stitches/Hysterectomy): Early Hysterectomies, Gendered Biosocialities, and the Politics of Normalcy in Rural India. First STS India Network Conference Co-shaping of Science, Technology and Society in India(foregone)

Chadha, Neymat. (2025, September 10-12) Panch Taanka, Kamzori aur Dard ki Goli" ("Five Stitches, Weakness, and Pain Killers"): Early Hysterectomies, 'Normalcy' and an Imaginary of the 'Good Life'. Medical Sociology Conference 2025. British Sociological Association.

Nambiar, Apoorva; Chadha, Neymat; Nambiar, Devaki (2025, July 19-23) Community Action for Health in India: At What Cost?16th IHEA World Congress on Health Economics, Bali, Indonesia

Chadha, Neymat, & Nambiar, Devaki. (2025, June 22). Who leads for health? Understanding

the evolution of 'Communitization' under India's National (Rural) Health Mission. Presentation at the European Conference on Social Medicine, Oslo, Norway.

Chadha, Neymat. (2024, November 20). Just enough: Tools and processes to enhance equity and fairness in the conduct of HPSR. Presentation at the Global Symposium on Health Systems Research, Nagasaki, Japan.

Chadha, Neymat. (2023, June 7). Relational work, biosocial strategies and the commodification of the womb: An ethnography of hysterectomies among female labourers in Maharashtra, India. Paper presented at The Many Lives of Money: Exploring Familial, Social and Political Relationships in South Asia Day 2023, Oxford Department of International Development (ODID), University of Oxford.

Chadha, Neymat. (2023, April 18-19). Operable bodies, bio-viable lives: Ethnographic reflections on climate change, seasonal migration and early hysterectomies in rural Maharashtra. Paper presented at the Centre for South Asian Studies Spring Symposium on Climate Change and South Asia, University of Hawaii at Mānoa, Hawaii.

Chadha, Neymat. (2023, April 21-22). Operable bodies and precarious lives: Hysterectomy narratives of female labourers in rural Maharashtra. Paper presented at the Body Politics - Harvard Graduate Student Political Anthropology Conference, Harvard University, Cambridge, Massachusetts.

SELECT PUBLICATIONS

Journal Articles and Book Chapters

Mishra, Shraddha; **Chadha, Neymat**; Esandi, María Eugenia; Serrao, Camila; Acuña, Rodrigo Hernan; Surendran, Surya; Saini, Amandeep; Aristegui, Ines; Nambiar, Devaki. (2025). Inclusiveness of social participation for health reform: findings from a realist review. The International Journal for Equity in Health (forthcoming)

Pham, Phuong Mai., Dinh, Linh Trang., Han, Dinh Hoe., Truong, Van Hai., Nguyen, Ha Thu., Nguyen, Thu Trang., Le, Thanh Trung., Nguyen, Thi Kim Dung., Nambiar, Devaki., **Chadha, Neymat.**, & Le, Minh Giang. (2025). "Knowledge about Universal Health Coverage among TB-related community-based organizations in Vietnam and associated factors." Journal of Health and Development Studies, 09(04). https://doi.org/10.38148/JHDS.0904SKPT25-004

Nambiar, Devaki, **Chadha, Neymat**, & Buse, Kent. (2025). What can organizations do to enhance the equity orientation of global health research? *Health Policy and Planning, Oxford Academic.* https://doi.org/10.1093/heapol/czaf054

Nambiar, Devaki, & **Chadha, Neymat.** (2025) "How communitization begets and endures sarkarikaran: a witnessed history of community action for health in India's national rural health mission." *BMC Health Services Research* 25(1)940 https://doi.org/10.1186/s12913-025-13058-0

Chadha, Neymat., Nambiar, Devaki., Goodman, Catherine., Pratt, Bridget., Ryan, Carmen(2025). What's in your EquiTree? Exploring approaches for enhancing equity in HPSR. *BMJ Global Health* What's in your EquiTree? Exploring approaches for enhancing equity in health policy and systems research - BMJ Global Health blog

Desai, Sapna, Afsana, Kaosar., **Chadha, Neymat.**, Govil, Dipti., Mankani,Neha., & Kumar, Ramya(2025) "Not Just Reproductive: A Roundtable on Addressing Gynaecological Health through the Life Course in South Asia." *Sexual and Reproductive Health Matters* https:// doi:10.1080/26410397.2025.2521031

Nambiar, Devaki., Nambiar,. Apoorva,. **Chadha, Neymat**,. Keshri, Vikash R., Nanda, Prabodh, Nair, Nirmala, Gope, Rajkumar, Bagal, Dhanashri, Kakade, Dhananjay, Patil, Hemraj, Khan, Ameer, & Dhandapani, Suresh. PATANG: Promoting Community Action for Health- A Co-Produced, Technology-Enabled Platform to Achieve National Goals. Wellcome Open Res 2025, 10:238 https://doi.org/10.12688/wellcomeopenres.24080.1

Chadha, Neymat. (2023). Constructing the labouring body: An exploration of early hysterectomies, premature menopause and ageing among women labourers in rural India. In S. I. Rajan (Ed.), *Handbook of aging, health and public policy*. Springer Nature Singapore. https://doi.org/10.1007/978-981-16-1914-4_205-1

Chadha, Neymat. (2019). The unrestricted canvas: Exploring childhood through painting at the Valley Art Village. Working Paper Series 2018-2019/II. D.S. Kothari Centre for Science, Ethics and Education.

Journal Articles Under Revision

Chadha, Neymat, Anusha Seelamantula, & Devaki Nambiar. (2026). How Policy Constructs Community Participation: A Policy Discourse Analysis of Community Action for Health in India. *Social Science and Medicine – Health Systems.*

Chadha, Neymat, Nambiar, Devaki, Sivaram, Sharmada, Bhagal, Dhanashri, Kalundia, Sarita, Agavane, Vaibhav, Patel, Urvi, Navya, M. S., Roy, Swati, Schleiff, Meike, Srinivas, Prashanth N., Desai, Sapna, & Mukherji, Arnab. (2025). Understanding pathways from primary health care to universal health coverage outcomes: A realist review. *Frontiers, Public Health Policy*

Chadha, Neymat. (2025). Ask Where It Does Not Hurt': Bioviability, Pragmatic Investments and Early Hysterectomies in Maharashtra, India. In Special Issue: Uterus Speaks, *Medical Anthropology*

Journal Articles Submitted

Mishra, Shraddha; **Chadha, Neymat**; Esandi, María Eugenia; Serrao, Camila; Acuña, Rodrigo Hernan; Surendran, Surya; Saini, Amandeep; Aristegui, Ines; Nambiar, Devaki. (2025). Inclusiveness of social participation for health reform: findings from a realist review. *The International Journal for Equity in Health*

Book Reviews

Chadha, Neymat. (2022). Book review: *Worlds of care: The emotional lives of fathers caring for children with disabilities*, A. Jackson. *Exertions - Sociology for the Anthropology of Work*. https://doi.org/10.21428/1d6be30e.a32ea27b

Chadha, Neymat. (2021). Book review: *For the public good: Women, health, and equity in rural India*, P. Antoniello. *Political and Legal Anthropology Review*, October 5, 2021. https://doi.org/10.1111/plar.12458

Chadha, Neymat. (2021). Book review: *Unexpected: Parenting, prenatal testing and Down syndrome*, A. Piepmeier, with R. Adams & G. Estreich. *Sociology of Health and*

Illness. https://doi.org/10.1111/1467-9566.13422

Policy Briefs

Chadha, Neymat. (2022). Rising caesareans and obstetric violence in India: Exploring the question of dignity during childbirth. *SPRF India*, April 11, 2022.

Chadha, Neymat, & Bisht, Jitendra. (2021). Urban water supply in India: Policy paradigms and institutional priorities. *SPRF India*, May 18, 2020.

Chadha, Neymat. (2020). Street vendors: Outliers of India's urban landscape. *SPRF India*, October 23, 2020.

Chadha, Neymat. (2020). Domestic workers in India: An invisible workforce. *SPRF India*, July 3, 2020.

Chadha, Neymat. (2020). The outliers of the healthcare workforce: Recognising India's frontline workers. *SPRF India*, May 12, 2020.

Chadha, Neymat, & John, Jenny S. (2020). The Indian healthcare system and right to health. *SPRF India*, April 24, 2020.

Chadha, Neymat, & Gaur, Pallavi. (2020). The other side of illness. *SPRF India*, January 24, 2020.

Chadha, Neymat. (2020). Leprosy: A forgotten disease. *SPRF India*, January 24, 2020.

Chadha, Neymat. (2019). Constructing the female labouring body: A study of Beed district of Maharashtra. *SPRF India*, December 24, 2019.

News/Media Publications

Chadha, Neymat, & Bardhan, Sara. (2021). The challenges and unaddressed issues of child adoption practices in India. *The Wire*, September 16, 2021.

Chadha, Neymat. (2020). Why are so many working women getting hysterectomies in Beed? *Feminism In India*, April 2, 2020.

Podcasts

'Maid in India: Domestic Workers and the Informal Workforce', Hear Here. Spotify.

Professional/Editorial Services

Manuscript Reviewer, *PLOS Global Public Health*

Manuscript Reviewer, *Social Science & Medicine*

Manuscript Reviewer, *Anthropology and Aging*