

‘I feel like some kind of *namoona*’¹: Examining sterilisation in women’s abortion trajectories in India

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Abstract

Sterilisation in India (and globally) has a contentious and deeply politicised history. Despite this troubling legacy, India continues to rely on female sterilisation as the main form of contraception and family planning. Abortion, which has been legal under broad grounds since 1971, intersects with sterilisation at different points over women’s reproductive life course. Drawing on three case studies exploring women’s abortion trajectories in Karnataka, India (2017), this chapter examines sterilisation as a reproductive technology in women’s abortion narratives. These include experiences of failed sterilisation necessitating abortion, as well as narratives around pre- and post-abortion counselling with sterilisation conditionalities. Women report healthcare workers shaming or scolding them for not being sterilised after their last pregnancy- demonstrating the prominence of sterilisation as an enforced social norm using “health” frames. Using reproductive justice as a lens, I analyse how sterilisation interacts with abortion and the narratives of shame and stigma that surround the two technologies and make visible the ways in which it results in the denial and restriction of women’s reproductive freedoms.

Keywords: Abortion, Sterilisation, Intersectionality, India, Reproductive Justice, Reproductive Stigma, Reproductive Trajectories

Main Body:

‘I wasn’t angry- I was just upset that this happened to me. That it [sterilisation operation] failed for me. It felt like a prick in my heart and I was angry about that. I still don’t feel like it was fair or just for it to happen to me. [...] I couldn’t understand how this happened- I feel like some kind of namoona.’¹

At 27, Tasheen’s sterilisation is reflective of broader sterilisation patterns in India. Female sterilisation is the most prevalent form of modern contraception in India- among currently married women aged 15-49, 36% are sterilised, with 6% using male condoms and 4% using contraceptive pills. The median age at which women are sterilised is 25.7² (IIPS and ICF, 2015). Tasheen also experienced a failed procedure- unfortunately also not uncommon in India (Date et al., 2014)- necessitating her quest for abortion care.

Tasheen’s abortion trajectory is shaped by and intertwined with her failed sterilisation operation, reflecting the delays and reproductive stigmas she was required to navigate when attempting access to abortion care. Understanding her sterilisation and abortion experiences within her reproductive life course situates it within the broader socio-economic conditions that shape available options and pathways. It challenges the framing of abortion as a singular, disconnected reproductive experience, expanding- through Reproductive Justice (Ross et al.,

¹ *Namoona* [Hindi, Urdu], noun: a specimen to be examined (implied to be an oddity) [author’s translation].

² The median age at first birth among women aged 15-49 is 21 (IIPS and ICF, 2015).

2017)- understandings of the spectrum of women's reproductive desires and the interruptions they experience. In viewing these events alongside each other, it highlights the conditions of reproductive injustice and its cumulative nature (Davis, 2019).

In this chapter, I draw on three narratives to examine sterilisation as a reproductive "event" over the course of women's³ abortion trajectories. Exploring sterilisation and abortion as linked reproductive events offers deeper insights into how they interact and in which ways. Using the Reproductive Justice framework (RJ), I situate sterilisation and abortion within the matrixes of oppression (Ross et al., 2017) that govern reproduction in India, interrogating the narratives of stigma and shame that surround the two technologies and make visible the ways in which it can result in the limiting or denial of women's reproductive freedoms. As Ben Kasstan (this volume) argues, reproductive freedoms and choices are tied to such technologies (e.g., contraception, sterilisation, abortion) which carry opportunities and implications that require negotiating and navigating.

Reproductive Justice, sterilisation, and abortion

RJ, conceptualised by Black feminists in the USA, critically examines the structural and institutional mechanisms that control, limit, and shape women's reproductive lives and the conditions that they live in (Ross, 2017). Partly shaped by Black women's experiences of state-sponsored sterilisation abuse, RJ 'examines the meaning assigned to reproductive relations and externally imposed policies and practices' (Ross, 2017). Population policies- like those relating to sterilisation and abortion- can reproduce and exploit systemic inequalities that shape reproductive decision-making around childbearing and parenting, particularly affecting vulnerable women and girls. RJ, thus, champions (i) the right *to* have a child under conditions of one's own choosing; (ii) the right *not* to have children and (iii) the right *to parent* children & raise families in safe and healthy environments (Ross and Solinger, 2017).

Reproductive decision-making- to have a child, to not have one, to parent- are a series of connected events and experiences occurring over a woman's life course. The conditions under which abortion and sterilisation occur- the services available, the restrictions imposed, the delays experienced- shape the extent to which women exercise reproductive autonomy or experience injustice. Interventions- direct and indirect- on reproduction may be underpinned by judgements of whose reproduction is de/valued and deemed un/worthy (Roberts, D (2000) in Asian Communities for Reproductive Justice, 2005). While sterilisation is seen as reproductive empowerment for some, it can be experienced as reproductive coercion for others⁴ (Brunson, 2020), particularly where it is marked as ir/rational by providers, the State or a number of other actors (Mishtal, 2012). For example, women living with HIV have experienced forced and coerced sterilisation in El Salvador, Honduras, Mexico and Nicaragua; with healthcare providers claiming their HIV status 'annulled their right to children' (Kendall and Albert, 2015, p. 1). In many countries, trans persons are forced to undergo sterilisation to meet requirements for legal gender recognition (Lowik, 2018). It evidences how reproduction is experienced in stratified ways (Colen, 1995), tied to understandings of whose bodies and reproduction are valued (Saunders, 2020).

Where sterilisations are heavily encouraged, subsidised, incentivised, or linked to welfare programmes, they particularly target poor and vulnerable communities. In the UK, the two-child limit for those receiving welfare support limits full reproductive choice. By demanding

³ Trans and non-binary persons also experience reproductive injustice over their reproductive life courses. I use the term "women" as my sample population were women- all of whom identified as such. I focus on their subjective- heteronormative and cisgendered- experiences. I did not want to tokenise trans and non-binary persons' experiences and struggles by co-opting political terminology without substantive work underpinning it. I do, however, recognise the importance and relevance of utilising more inclusive & accurate language in reproduction studies.

⁴ I acknowledge that sterilisation, when accessed with full informed consent, can be reflective of reproductive autonomy. I also recognise that some may be prevented from accessing sterilisation due to medical professionals' fears of sterilisation regret if they are nulliparous women or based on their age (Hintz and Brown, 2019). I would contend, however, that these stigmas are similar to those underpinning judgements of whose reproduction is de/valued and under which conditions. It is beyond the scope of this chapter to explore this in greater depth.

that women ‘*think carefully about whether they can afford to support additional children*’, this policy forces them to choose between greater financial insecurity and hardship for their existing family and their reproductive desires (BPAS, 2020). This policy has largely affected Black and minority women in the UK, heightening existing reproductive and social vulnerabilities (Pearson, 2019). During the COVID-19 pandemic which exacerbated job and financial insecurities, women cited the policy and its impacts as part of their abortion decision-making (Butler, 2020). Smith-Oka (2009) details how indigenous women in Mexico, enrolled in a conditional cash transfer programme (*Oportunidades*) as part of “economic empowerment” initiatives, are made vulnerable to sterilisation through the scheme. Medical practitioners, who monitor indigenous women’s compliance with *Oportunidades* requirements, utilise their authority to compel them to accept sterilisation, constraining women’s reproductive autonomies.

In countries where efforts are underway to reduce population growth or meet other related population stabilisation goals, social norms around “ideal family size” may be utilised to encourage sterilisation (Brunson, 2020). Under some conditions, this can manifest as contraceptive coercion (Senderowicz, 2019) in structural forces and individual actions. Where a full range of contraception options may be unavailable or inaccessible, making sterilisation the only option to manage reproduction; it is a form of coercion and of structural violence (Nandagiri et al., 2020). Additionally, sterilisation procedures may fail, which have been linked to method and age of the woman; with one study finding that women over the age of 40 have the lowest failure rate (Joshi et al., 2015).

Analyses of sterilisation and abortion have been treated as separate and siloed events in women’s reproductive life course. Abortion stigma, constructed and reproduced locally, is a negative attribute ascribed to women who terminate a pregnancy, marking them (internally or externally) as inferior to ideals of womanhood (Kumar et al., 2009). “Womanhood”, while context-dependent, is underpinned by normative constructs (sexuality for procreation, motherhood as inevitable, and women as natural nurturers). By linking sexuality to procreation, abortion becomes a marker of illicit, non-procreative sex. (Kumar et al., 2009; Norris et al., 2011). Abortion stigma enables a hierarchy of “good” and “bad” abortions, underpinned by perceived “good” or “bad” reasons that are framed and assessed in relation to existing social norms and values (Norris et al., 2011).

Reproduction is also deeply stratified, with some peoples’ reproduction encouraged and valued while others are discouraged and devalued (Colen, 1995), Policies and programmes (e.g., family planning and sterilisation) embedded with these norms, give rise to the idea of “responsible” reproductive management: the proper spacing, timing and number of children (Sasser, 2018). Deviating from these standards marks individuals as “irresponsible” with their fertility, justifying interventions to discipline them (Nandagiri, 2021).

Sterilisation and abortion are linked through the production of reproductive stigmas which function as mechanisms of social control, legitimising modes of social and structural inequalities. Like sterilisation is tied to stigma surrounding “high fertility” or the reproduction of “unworthy” persons, abortion is also linked- through social and structural processes of abortion stigma (Millar, 2020) to understandings of “good” and “bad” forms of reproduction. In some cases, abortion can act as a marker for women’s *lack of sterilisation*- a reflection of their “irrational” reproduction and a marker of their non-procreative sexuality, requiring intervention (Nandagiri, 2019a). Access to abortion may also be made conditional, requiring post-abortion sterilisation (Open Society Foundations, 2011).

Examining sterilisation in relation to women’s abortion trajectories can reveal how reproductive stigmas interact and manifest across different dimensions, at different points in the trajectory (i.e., before abortion, post abortion), compounding social and structural inequalities and injustices.

Sterilisation and Abortion in India: targets, incentives, & injustice

Sterilisation and abortion in India need to be contextualised within the larger structures of oppression that mediate these experiences. These include state-sponsored mechanisms like target-driven sterilisation provision in low-income, rural communities; coupled with poor

financing and infrastructure to meet a range of contraceptive or abortion needs. These indirect forms of “structural violence” (Galtung, 1969) in reproductive healthcare give rise to more direct forms of interpersonal violence like coercive sterilisation or abortion conditionalities (Nandagiri et al., 2020). These forms of reproductive violence are stratified. Dalit⁵, Adivasi⁶ and Muslim women whose fertilities are framed- socially and politically- as “high” are particular targets (Singh, 2020; Wilson, 2015); legitimising their bodies as particular sites for reproductive violence through these mechanisms (Jena and Biswal, 2015).

Sterilisation in India

In India, access to a full range of contraception options remains unfulfilled, with the current contraception method mix dominated by female sterilisation (Pradhan and Dwivedi, 2019). Female sterilisation endures as one of the main fertility control and regulation options available in the country, with 36% of married/in union women between 15-49 being sterilised. The vast majority of sterilisations (82%) were conducted in public health facilities (Vinod Joseph et al., 2020).

Sterilisation in India has a contentious and deeply politicised history, especially during the Emergency period⁷ where incentives and coercion were widely used to meet set targets in order to achieve population stabilisation. These were particularly borne out by poor men in rural India⁸, but was also filtered through gender, religion, class and caste identities (Scott, 2017; Williams, 2014). Despite this legacy, India continues to rely on female sterilisation as the main form of contraception and family planning. In 2012 and 2014, multiple women- largely Dalit and Adivasi women- died at sterilisation camps held in Jharkhand and Chhattisgarh (Pulla, 2014) and in 2016, the Supreme Court directed the central government to ensure that sterilisation camps were discontinued by state governments within three years (Supreme Court of India, 2016). The Supreme Court also observed that sterilisations infringe on the ‘reproductive freedoms of the most vulnerable groups of society whose economic and social conditions make them easy targets to coercion’ (Supreme Court of India, 2016).

Yet, even with these directives and prescriptions in place, sterilisation camps remain prominent forms of fertility control in rural India. Recent cases reflect how coercion and poor quality of care remain rife, risking the health and lives of women (Bhonsle, 2020). Sterilisation also remains socially and politically sanctioned, tied to decades-long policy to implement a two-child family norm and meet national development goals through a programme of population control (Wilson, 2018). These goals have been reframed under India’s commitments to the Family Planning 2020 initiative, but fundamentally stay the same (Wilson, 2018). Sterilisations remain incentivised, targeting people as well as service providers. For example, the Ministry of Health and Family Welfare (MOHFW) offers accredited private and NGO providers in so-called “high fertility” states like Bihar and Uttar Pradesh a “financial package” to provide sterilisations. The cost incentives are differentiated by tubectomies and vasectomies (Table 1) (MOHFW, 2016).

Table 1: MOHFW’s financial incentives for private facilities and NGOs. All in Indian Rupees (INR) (1 INR = 0.014 USD) (MOHFW, 2016).

| | Tubectomy (Interval and Post abortion) | Post-partum sterilisation | Vasectomy |
|--|---|----------------------------------|------------------|
|--|---|----------------------------------|------------------|

⁵ Dalit, meaning oppressed, describes those classified within the Hindu caste system as the “lowest” caste. The term was adopted by Dalit activists and scholars to identify the structural, social and cultural mechanisms that create and maintain conditions of oppression, rejecting the *savarna* [upper caste] frames and gaze of terms like “Harijan” or “Untouchable”. The legal terminology within the Constitution is [broadly] “scheduled castes”.

⁶ “Adivasi” is a collective term for the indigenous communities of India. The legal terminology within the Constitution is “scheduled tribes”.

⁷ Over a 21-month period in 1975-1977, the Indira Gandhi-led government imposed a state of Emergency. They suspended civil and political liberties, enforced press censorship, imprisoned political opponents, and carried out a mass, state-sponsored forced sterilisation programme.

⁸ The forced vasectomies experienced under Emergency saw an immense and sustained anti-vasectomy backlash that continues to present day. It resulted in a singular focus on women’s fertilities and its control (Connelly, 2006; Sarojini et al., 2015).

| | Existing | New | Existing | New | Existing | New |
|-----------------|----------|------|----------|------|----------|------|
| Facility | 2000 | 2500 | 2000 | 3000 | 2000 | 2500 |
| Client | 1000 | 1000 | 1000 | 1000 | 1000 | 1000 |
| Total | 3000 | 3500 | 3000 | 4000 | 3000 | 3500 |

Despite officially disavowing a target-driven approach to sterilisation (and other family planning programmes), these continue in practice and in broader reporting structures (e.g., “expected levels of achievement”) (Wilson, 2017). The MOHFW’s Annual Report (2018-2019), for example, still reports “state wise performance” for sterilisation uptake (MOHFW, 2019). These target-driven approaches are tied to incentives for lay community health intermediaries (CHIs) like Accredited Social Health Activists (ASHAs) and medical personnel to “motivate” sterilisation and other family planning uptake. Reports of linking sterilisation to service provision- abortion or as routine post-partum maternal health care- abound and are also borne out in the data. “Acceptors” of sterilisation are offered financial incentives or promised other “in-kind” incentives, which may not always be fulfilled. Adivasi women from the protected *Baiga* tribe, for example, report not receiving the promised cash incentives or being given rice and eggs instead (Bharadwaj, 2014). Since 2013, the National Family Planning Indemnity Scheme compensates acceptors or their family members in case of death, failure, or complications (MoHFW, 2018).

An estimated 7% of women experience sterilisation regret (Bansal and Dwivedi, 2020; Singh, 2018). Poor quality services, which reflect gendered and structural injustices, are linked to sterilisation regret (Bansal and Dwivedi, 2020). National Family Health Survey (NFHS) rounds 3 (2005-2006) and 4 (2015-2016) data show that one in three women were not informed sterilisation was a permanent method, and two in three women did not receive information on its side effects (Singh et al., 2021).

Abortion in India

In contrast to state infrastructure around sterilisation, abortion is under-resourced. Legally available in India under a broad range of grounds (contraception failure, socio-economic conditions, rape/incest, foetal health, or risk to mental and/or physical health) under the Medical Termination of Pregnancy Act (1971), abortion services can only be provided by trained and registered doctors and registered or authorised clinics. In 2020, new amendments extended abortion access to 24 weeks, requiring approval of one service provider up to 20 weeks’ gestation and two providers’ approval between 20-24 weeks’ gestation (GoI, 2021). Women over the age of 18 do not legally require spousal or parental consent but evidence show that providers condition parental or spousal consent before abortion provision (Sri and Ravindran, 2012).

Yet, despite the broadly liberal laws, access to abortion remains difficult. In 2015, of 15.6 million abortions; 73% (12 million) were medical abortions (MA)⁹ conducted outside health facilities (Singh et al., 2018). Evidence on women’s abortion pathways shows a lack of accurate information, reproductive stigmas, and poor availability of services (Stillman et al., 2014). Unlike sterilisation and family planning efforts, abortion services are not associated with strong financing or infrastructure. The shortage of trained providers- particularly in rural areas- dramatically affects abortion care provision through formal health settings.

Women report sterilisation conditionalities tied to abortion provision (Ramachandar and Pelto, 2002; Sri and Ravindran, 2012). Sterilisation, particularly post-abortion, is also linked to (not) meeting ideal sex composition of children (Edmeades et al., 2012), with providers drawing on persistent son-preference norms to insist on or refuse services (Calhoun et al., 2013). CHIs, who play key roles as enablers or barriers to care in women’s abortion trajectories, use sterilisation as a counterpoint to abortion. They may shame women for not undergoing sterilisation and thus needing an abortion, or they may encourage continuation of pregnancy followed by sterilisation instead of an abortion (Nandagiri, 2019b).

⁹ Oral pharmacological drugs like mifepristone and misoprostol or misoprostol alone to induce abortion.

Study Context

Data were collected in two rural districts (Belgaum and Bagalkot) in north-west Karnataka in 2016-2017. I collected data at the level of the Primary Health Centre (PHC)- the frontline of the Indian public health system.

In Karnataka, sterilisations are incentivised for public and private facilities. CHIs like ASHAs and other health personnel are incentivised to “motivate” sterilisation or other family planning uptake. Between April 2016-March 2017, the state’s Family Planning Indemnity Scheme paid claims for complications (7), death (11), and failure (175) (Health and Family Welfare Service, 2017). The following year April 2017-March 2018, claims were paid out for complications (5), deaths (6), and failure (127) (Health and Family Welfare Service, 2018). These data are likely to be incomplete as the scheme is not well known and the claims process is lengthy and cumbersome (Masih et al., 2018). Other injustices also shape women’s reproductive experiences– Xavier et al. (2017) for example, detail forced hysterectomies of Dalit women, while other data show that disadvantaged women received poorer ante natal care than their more privileged counterparts (Rani et al., 2007).

To situate my evidence and the world it operates in, I present additional state and district level data on sterilisations (vasectomies and tubectomies) and abortions in 2017-2018 (Table 2).

Table 2: Data on vasectomies, tubectomies and abortions in Karnataka (2017-2018)¹⁰

| | Vasectomies (Public + Private) (%) | Tubectomies (Public + Private) (%) | Induced Abortions (Public)¹¹ |
|-------------------|---|---|--|
| Karnataka | 672 (0.3%) | 232,288 (99.7%) | 11,361 |
| - Belgaum | 105 (0.5%) | 19,463 (99.5%) | 480 |
| - Bagalkot | 7(0.1%) | 13,730 (99.9%) | 12 |

Karnataka- and the two districts my study is located in- follows India-wide patterns on sterilisations, with women bearing the brunt of the procedure. 19% of all tubectomies were conducted postpartum and a reported 1.4% of sterilisations were performed post-abortion. Yet, as Guttmacher modelling demonstrates (Singh et al., 2018), the induced abortion data in public facilities are likely to be underreported; affecting the reported post-abortion sterilisation rates. Additionally, there are inconsistencies in data entry (Dehury and Chatterjee, 2018). During data collection in my study sites, Auxiliary Nurse Midwives (ANMs)- who are tasked with entering data into the Health Management Information System- described sometimes underreporting abortion data under instructions from medical officers or other senior PHC staff.

These data demonstrate the near-ubiquitousness of sterilisation, the skewed emphasis on tubectomies, and the consistent underreporting of abortion data. It highlights how government priorities tied to notions of development function through the mechanisms of dis/incentives – financial and social, and barriers to knowledge, access, or quality care- to govern sterilisation and abortion in women’s lives.

I locate my study and findings in this context of poor method mix, incentivisation of certain services and tasks, and strong reproductive stigmas around so-called “high fertility” and abortion. This allows a deeper examination of how sterilisation and abortion interact in women’s reproductive lives and over the course of their abortion trajectories, making visible their experiences of and encounters with reproductive injustice.

Methods

¹⁰ Department of Health and Family Welfare, Karnataka (2018). Performance of Key HMIS Indicators (up to district level) for Family Planning (April-December). https://nrhm-mis.nic.in/hmisreports/frmstandard_reports.aspx (Retrieved 25/11/2020). I am unable to use data for 2016-2017, when I conducted my study, as government data are incomplete.

¹¹ Data on induced abortions conducted in private facilities are unavailable.

Data on women's experiences with abortion and sterilisation were collected over eleven months (2016-2017), as part of a larger project investigating women's abortion trajectories (Nandagiri, 2019a). Ethics approval was granted by the London School of Economics and Political Science in the UK [REC ref # 000493], and by the KLE Academy of Higher Education and Research in India [Ref: KLEU/EC/2017-18/D-4287].

Supported by a research assistant (GM), I conducted one-off semi-structured interviews with women (n=31) within three weeks of their abortion. Potential respondents meeting study criteria were first identified and contacted by local ASHA workers to gauge interest in participation. ASHAs were already trained as part of other programmes in informed consent and privacy maintenance but were given additional training on confidentiality, consent, and non-judgement as part of the study protocols. Once potential participants agreed to a conversation, the ASHA worker organised a meeting with the study team. Meetings were arranged at a time and place of the participant's choice— whether a private room in the PHC, a local Anganwadi centre, or in their homes. For some participants, where sites like the PHC are imbued with power (Elwood and Martin, 2000), these can be rather unsafe environments. Spaces like their own homes, even when surrounded by others, can offer privacy within a shared or public space—as participants explained, it would be *more* suspicious to request privacy than to have a seemingly innocuous conversation in plain view. If asked, we explained our presence as part of a general study on women's health (Nandagiri, 2020).

All participants provided written consent, including for audio recordings. Interviews were conducted in Kannada or Hindi by me and GM. The recorded interviews were transcribed and translated for analysis. Transcripts were anonymised and participants were assigned pseudonyms. I used hybrid thematic analysis (Fereday and Muir-Cochrane, 2006) to analyse the data.

Gender and caste are immensely powerful forces in India, shaping my research design, approach to data collection and analyses, and requiring an interrogation of how my specific locations as an Indian, *savarna* woman shape and influence these interactions and the study. While my Indian identity and local language skills marked me as an “insider”, my accent and other signifiers often marked me as an “outsider”. This led to participants and interlocutors questioning me about my life and destabilising the idea of an interview as a unidirectional encounter. Discussing abortion in a space shaped by this sense of trust challenges the idea of abortion as “taboo” and “sensitive”, instead allowing it to be understood through the prism of sharing and keeping secrets, and holding confidences (Nandagiri, 2020). This “insider-outsider” dichotomy, as well as my caste and class locations, underscore that my data and the secrets shared with me are all partial. I only observed, heard, and experienced what I was allowed to, and these data are refracted through my own interpretations, requiring an engagement in the ‘reflexivity of discomfort’ (Pillow, 2003, p. 192). I offer a more in-depth and reflexive account of my positionality and its impact on my research and analyses elsewhere (Nandagiri, 2020, 2019a, 2017).

Sterilisation narratives in abortion trajectories

I explore three narratives (Tasheen, Janani and Rajalakshmi), interrogating how and where sterilisation and abortion interact, and the ways in which reproductive stigmas shape care seeking experiences. Sterilisation is present at different points in women's abortion trajectories, shaping how women seek care, experience care-seeking, and the quality of care that is ultimately provided.

Tasheen was a 27-year-old married Muslim woman with three children— her youngest was 18 months old. She was sterilised when her child was three months old. She says:

I thought ‘Okay, this is how it is, and anyway operation [sterilisation] has been done, and after some years it will happen [a regular menstrual period]’. This is what I was thinking, and with this idea I didn't do anything or bother overly much about it.

Tasheen's post-sterilisation experience was painful, but she attempted to cope. She checked with the PHC (where her sterilisation was performed) about her irregular menstrual period and

was assured that it would stabilise. She was not given any additional information about her procedure nor were any concerns raised about a failed sterilisation.

We went to the PHC here- when we went there, and I explained my issues and they were like, 'You are pregnant'. We said, 'Okay, sir, but I have had an operation [sterilisation]. How can this be? What should I do now?' And they said, 'No...what can you do then? You can have the child.'

The failed sterilisation led to a delay in confirming her pregnancy, impacting the options available to her and her next steps. In addition to the reactions of PHC staff to an unsupported pregnancy (Macleod, 2019), she received little information or help. Due to her failed sterilisation, she required an ultrasound confirmation of gestational age before she could access an abortion. Tasheen had to travel to the district capital for an ultrasound- which took nearly a week of navigating bureaucracies before she turned to the private sector at a much higher cost. She was ten weeks pregnant at the time of the ultrasound, just over the legal limit for a medical abortion (nine weeks). She then had to identify a surgical provider, once again forced to opt for the private sector after further delays in the public health system.

The failed sterilisation shaped Tasheen's abortion trajectory: delays in confirmation, her subsequent pathways to abortion care, and the kind and quality of care she received. It affected not just the timing of her abortion but the method and cost of care. It also impacted her post-abortion experiences- increased pain and worry, loss of wages, and concerns about an requiring an additional sterilisation.

For Rajalakshmi, on the other hand, sterilisation was present in her interactions with health workers as she attempted to access an abortion. Rajalakshmi was 23 years old, Lingayat¹², married at 16 and had two children. She considered sterilisation after her second child but decided against it.

[Doctor] told me that I should get operated. In January, even my mother told me that. I thought I would get it done a bit. In March, I thought, I will get it done. Within that, this [pregnancy] happened...

Rajalakshmi attempted to access an abortion through four different public facility providers over the course of her trajectory. Her interactions with providers were marked with shame and judgement for being "careless" with her fertility (i.e., lack of sterilisation or effective contraception use).

They said things like, 'the operation should have been done earlier, when you delivered. After all this has happened, why are you coming now? [...] Why are you asking for [abortion] pills now?

In one of the facilities, Rajalakshmi was asked to consent to post-abortion sterilisation as a condition of accessing abortion care. Distressed, and concerned about the delays, she travelled to her natal village to self-manage her abortion with support from her mother and sister.

Like Tasheen, Rajalakshmi's trajectory was shaped by sterilisation- except, in this case, it was the failure to be sterilised. Her abortion was a marker of her lack of sterilisation and her transgression of the established sterilisation norm; locating her body as "unruly" (Love, 2021) and requiring disciplining through the health system in order to meet set goals and priorities.

Sterilisation, abortion & reproductive stigmas

¹² There is some dispute on classification within the caste system (particularly amongst Dalit movements who highlight the Lingayats' caste privilege). The Lingayat community is legally categorised as a "scheduled caste".

In the narratives on their abortion trajectories, the intertwined nature of sterilisation and abortion stigmas is evident. The structural processes manifest as a mechanism (Millar, 2020) to individualise blame- for an “irrational” pregnancy, marking the lack of sterilisation **and** the desire for an abortion as transgressions of fertility norms. This individualisation not only marks specific behaviours as irrational but is then applied to individual women to frame them as irrational actors (De Zordo, 2012). These are also tied to Tasheen, Rajalakshmi and Janani’s social positions across class, caste, and religion, which further mark them as requiring disciplining. The linked forms of reproductive stigma, then, manifest in shame and judgement, reproducing conditions of reproductive injustice (Davis, 2019) in which Tasheen, Rajalakshmi and Janani attempt to realise their reproductive desires.

Tasheen narrates:

When I was pregnant with my third child, I was dizzy and fainted in the PHC. They shouted at me and said, ‘Why haven’t you had the operation [sterilisation]?’ And now I’ve done it- they’re the ones who now speak badly [judgementally]. And they’re also the ones that ask, “how is it possible?” [to be pregnant].

In contrasting the judgement and shame she has experienced over her reproductive life course: her third pregnancy, her failed sterilisation and her abortion care-seeking; she identifies the multiple binds that surround reproduction. Tasheen, as a Muslim woman, is understood within the rhetoric of “high fertility”- her pregnancy, her failed sterilisation, and her need for an abortion are all proof of her innate, hyper fertile biology (Singh, 2020). It blames Tasheen for being a “*namoona*”, her body defying efforts to control hyperfertility; absolving the state of its failure of responsibility to provide a range of quality services and cater to women’s needs. Tasheen, too, grapples with this individualised sense of responsibility- her body, a *namoona* that failed her in attempting to realise her reproductive desires, at the same time as feeling the failures of the state in an embodied way.

Rajalakshmi’s experiences also reflect the presence of reproductive stigmas that frame her as norm-breaking, requiring disciplining. She is shamed and scolded for not being sterilised after her last pregnancy, demonstrating the prominence of sterilisation as an enforced social norm using “health” frames and mechanisms. She is able to navigate around this by turning to abortion self-management, removing herself from spaces of state intervention.

Janani (married, approximately 40 years old, three children, and was Dalit, part of the Madiga caste) circumvented the health system entirely— she did not approach any facilities or clinics, completely self-managing her abortion. She explained her decision to self-manage as partly motivated by shame—a pregnancy at her “advanced” age— and a desire for secrecy. She discussed the social stigma of having “too many children”, and her lack of sterilisation as shaping provider and public attitudes towards her pregnancy and her subsequent abortion decision-making.

It’s disgusting, they will say. As after so many years of marriage, I got pregnant again [...] they’ll ask, “Can’t she control herself?”. At my age, to get pregnant again <shakes head, long pause>. They will speak badly. [...] “She’s so old now, why does she need children?”

Janani identifies multiple reproductive stigmas: age and sexuality-relates stigmas in addition to sterilisation and abortion stigmas. By linking sexuality to procreation, abortion becomes a marker of illicit, non-procreative sex. Similarly, considering or choosing abortion acts as a sign of an unwanted pregnancy (Norris et al., 2011). Believed to be past “appropriate” child bearing years, Janani’s abortion is a display of her sexuality and perceived as a result of ‘too much sexual desire’ (Anandhi, 2007).

Tasheen, Rajalakshmi and Janani’s narratives also reveal their resistance to the imposition of these frames. Their persistence in seeking and finding abortion care in spite of being continuously faced with interpersonal, institutional and structural barriers reveals how

women's agencies confront the state in micro-level interactions, attempting to procure services under conditions of their own choosing. Janani and Rajalakshmi's circumvention of the health system- one that did not serve them or their needs- in favour of self-management is also a reflection of their agency and refusal of the state's interference in their lives. Tasheen's persistence- despite facing numerous barriers- is also reflective of a claiming of reproductive freedom.

Conclusion

In this chapter, I aimed to examine sterilisation and abortion as linked reproductive events in women's abortion trajectories, demonstrating how stigma and shame can limit and deny full reproductive freedom. By analysing them as linked events instead of as separate and siloed incidents, I offer an extension of RJ literature; focusing on the right *not* to have a child, under conditions of one's own choosing. Examining sterilisation as a reproductive event in women's abortion trajectories demonstrates how reproductive autonomy and coercion are claimed, experienced, and felt at different points. It also highlights the *conditions* under which autonomy and coercion flourish or are constrained.

Rather than *namoonas*, Tasheen, Rajalakshmi, and Janani's narratives are reflective of abortion and reproduction in India. Their abortion care-seeking efforts makes them and their fertilities visible to the state, marking their bodies as sites for intervention. Reproductive stigmas surrounding fertility, sterilisation, abortion, and sexuality are evident in these interventions. These stigmas act as a mechanism of social control, championing the small family norm at the same time as shaming any alternate behaviours or constructions as deviations or transgressions. Their abortion narratives demonstrate the pervasiveness of reproductive stigmas, particularly around the control of their fertilities and how it manifests at different points over their reproductive life course. These findings contribute to literature on abortion stigma (Kumar, 2018; Kumar et al., 2009), and specifically literature on abortion stigma as a social and structural process (Millar, 2020) linked to reproductive governance (De Zordo, 2012; Mishtal, 2019).

Reproductive experiences are not shaped just by particular reproductive histories, but the conditions under which their reproductive lives and decision-making occur: the state-set priorities of fertility control through the mechanism of the health system, in a context of poorly resourced reproductive health services. These narratives make visible the matrix of oppressions- and structural violence – that reproduction in India operates under, giving rise to a series of injustices carried out by the state and borne out on women's bodies and lives (Nandagiri et al., 2020). Stratified across different axes: age, religion, caste and class, it penalises poor Dalit and Muslim women; placing responsibility and blame on individual behaviours and acts (Jena and Biswal, 2015; Wilson et al., 2018). This shifting of responsibility absolves the state of its responsibilities and duties but continues to enable it to “discipline” wayward bodies through specific interventions like targeted sterilisation programmes.

This chapter complements this collection's interdisciplinary work through an examination of the conditions that surround reproduction and the technologies, timings and trajectories that intersect with them. Linking reproductive events to examine them at the individual level and locating it in larger (trans)national contexts, speaks to RJ's tenet to centre women's lived realities in the interrogation of power, making visible the mechanisms of injustice and the potential for activism in the pursuit of reproductive freedom.

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