



# Troubling Breath: Tuberculosis, care and subjectivity at the margins of Rajasthan.

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Troubling Breath: Tuberculosis, Care and Subjectivity at the Margins of Rajasthan

A dissertation presented

by

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to

The Department of Anthropology

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for the degree of

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Troubling Breath: Tuberculosis, Care and Subjectivity at the Margins of Rajasthan

Abstract

“Troubling Breath,” the product of fourteen months of fieldwork, examines the experience of tuberculosis sufferers in rural Rajasthan, India. In it, I engage the Indian national tuberculosis control program, local health institutions, informal biomedical providers, non-biomedical healers and sufferers to consider how global tuberculosis control initiatives interact with social life and subjectivity among the rural poor. I ask how tuberculosis affliction and healing builds and reveals the diversity and limit of relationships between state and citizen, individual and kin, body and social, global and local, and formal and informal healthcare.

Each chapter focuses on a particular aspect of these relationships. In the first, I consider one sufferer’s experience in a tuberculosis hospital to examine global health discourses of documentation and transparency as they inflect Indian TB and a biopolitics of partial information. From the hospital, I move toward “community” and caregiving, examining dialogical relationships between global health’s community-based interventions and social structures (family, caste, community.) To examine the forms community and community-based care take in the context of contemporary India and TB, this section engages

ideas about social life embedded in intervention design by asking how actors mediate the two. Chapter three considers informal biomedical healers – figures who treat TB with both cutting-edge and antiquated pharmaceuticals. Here I consider how knowledge flows between formal and informal biomedicine and the relationships forged between universal and particular ideas of body, market, and care.

The remaining chapters engage TB intervention through two theories of the subject. In chapter four, I take up Foucault's theory of subject formation to show that poverty, although an analytic category of the Indian state, is flexible in practice for gaining access to state resources by reworking social life. This suggests that though state categorization reworks the social, the social and the self are not wholly fixed by it. Finally, I borrow local understandings of breath to consider a relational theory of the subject embedded in South Asian philosophy. Here, I raise questions of stigma and care of the self by examining breath as a biomoral substance that is a seat of affliction and a site for building relationships across multiple ecologies.

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## Introduction.

### On locations: Ambawati, tuberculosis, representations and fields

This dissertation is about being in the middle. I situate it in the middle because it is in the middle. It is based in a place I call Ambawati sandwiched between a hilly forest and an agricultural plain where people feel encompassed by two linguistic zones and forms of social life. It is also in the middle of processes of development characterized at times by headlong rushes toward the new, and at other times by struggles to carry the old along. Its central focus is tuberculosis (TB)<sup>1</sup> in the middle of local responses and global health structures. It is also about disease and its experience as located between biology and social life.

I focus my research and analysis in the middle because the middle is also a margin (Kleinman 1995). TB was for a long time, and still is, at the margins of global health. Ambawati too is a margin, neither plain nor forest. The people who live there must manage at the margin, economically and socially. They are lowest caste farmers and petty shopkeepers, low-level bureaucrats, masons and laborers. As Ambedkar argued, they are hewers of wood and drawers of water (1945). The margin between developed and abject sits here, among these vibrant and intelligent people. Much of their story, as I tell it, is about cultivating life, well-being, and aspiration in this space cluttered with the detritus of caste, projected development, illness, political process and regress, ghosts and other shadows of death, love, frustration and work.

Other stories I aim to share are similarly mired in context. The narrative of TB that runs through this work is one of being in the middle of debates about care, cost and good governance. It sits between being a global problem and a national concern, somewhere

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<sup>1</sup> Though TB afflicts the body in many forms, the majority of cases are pulmonary. I have limited my scope to

between locally specific illness, a re-emerging global infectious disease and a disease only selectively repressed. At the same time, TB comes to be a double—local and national—concern. As such, TB is both a biosocial problem and a window through which to view social suffering. To transverse the middle and margins, I engage India's Revised National TB Control Program (RNTCP)—one of the institutions moving between local, national, and global—and put anchors in the global and the local.

TB in India is caught in the middle of development, rapid neoliberal reform, poverty, and disparity both between people and states. India's TB burden is the highest in the world, with about 2.2 million reported cases of TB in 2011 alone. According to the WHO, this was approximately a quarter of cases globally (WHO 2012). India also has the largest market for anti-TB drugs in the world and manufactures a lion's share of the drugs used on TB globally (Wells 2011). As such, the RNTCP and the many private clinicians treating TB in India have become both ruling experts and intermediaries between elected officials, the global TB community and the WHO (Mitchell 2002). Their expertise and bureaucratic power comes to construct Indian TB as something in between a pressing issue and a problem solved. As Tanya Li suggests, these experts build a narrative of a desire for development and TB eradication, but include in it roadblocks that make addressing TB difficult (Li 2007; Mitchell 2002). I work through this middle space delimited by experts and discursive processes that marginalize TB by situating it as both a political problem and untouched by politics (Ferguson 1990), both solved and out of control .

This is also an ethnography in the shadow of the state. I position the state as a partial collection of bureaucratic actors who create, implement and plan state actions (Fuller and Bénéï 2000; Tarlo 2003) even while bound by discursive practices of writing and archiving

(Cody 2009; Tarlo 2003) and their own needs to manage and access power as citizens (Bailey 1969; Das 2004). In doing so I show the blurring lines between state, policy and everyday practice. I look to other practices of the state like filling forms (Hull 2008; Hull 2012), statistics taking, statistic making and data collection (Gupta 2012) and e-governance (Mazzarella 2006) to consider the material and knowledge practices that make TB and poverty matter and not matter simultaneously.

The work as a whole is steeped in the subaltern school tradition in part because a facile reading of Ambawati would set all of its residents as subalterns (Guha and Spivak 1988) or political society (Chatterjee 2004) in the gaze of a bourgeois state. I see both RNTCP actors' and Ambawati residents' practices of making do as not just a struggle for voice in politics, but as moments of provincializing global health, living both dominant and alternate histories simultaneously (Chakrabarty 1997). As a whole, I hope this work gives us reason to reconsider easy categorizations—often drawn from western political experience—like subaltern, bureaucracy, backward, or even citizen. It may be more useful to look to the practice of each of these categories as assemblages of global forces that come together to privilege some forms of life as normal in relation to a strange which is felt but not necessarily put in words (Canguilhem 1991).

The global health apparatus understands TB, political or apolitical, as a disease of poverty. Like people in Ambawati, I work to acknowledge TB as a disease that results from, constitutes, and contests poverty. As a disease of poverty, TB is easily glossed a disease of the lower castes and those known as *Dalits*. Indeed, the majority of Ambawati residents would be considered *Dalit* by *Dalit* political activists. They experience regimes of violence and subjectivity that anthropologists have come to understand as part of creation of a *Dalit*

political subjectivity (Rao 2009). Yet very few people in Ambawati find this category useful. Instead, they have found other their own ways to manage caste and social exclusion (Khare 1984). The question of caste, history and politics is pressing (Dirks 1993; Dirks 2001; Gupta 2000; Gupta 2004; Gupta 2005; Jaffrelot 2000; Jaffrelot 2003), but caste politics in Ambawati are politics of dignity (Appadurai 2004). Politics of dignity are political and embodied. In Ambawati, aspirations for recognition and dignity come in two strategies. One set of politics of dignity foregrounds inhabiting the state and social categories for representation, rights, and care by evocation of government and socially determined marginal status categories.

Though many Meghwals in Ambawati argue that life before independence was not without connection to the seats of power—indeed Ambawati’s Meghwals, though part of a broader untouchable category, were called to work as labor in the local lord’s castle and interacted, though unequally, with surrounding communities as providers of leather goods, manual labor, and removers of dead farm animals—the community has developed intricate sets of caste politics in the post-independence period. The Meghwals, belong to what Rawat has called North India’s *Chamar complex*, (Rawat 2011) a of group of leatherworking and small-landholding agricultural castes in the midst of a long sanskritizing process across North India (Srinivas 1952). Though sanskritizing they hold simultaneously fast to Ambedkar, the untouchable writer of India’s constitution’s confidence in the universalizing liberal state’s ability to bring about development and social reform (Ambedkar 1945; Ambedkar and Anand 1990).

About forty years ago the Meghwals of Ambawati joined a caste uplift movement led by a very prominent Meghwal from Udaipur and several holy men. The fifty-two village collective in which Ambawati falls met and resolved to eschew practices like the consumption

of buffalo meat, eating the left overs of patrons feasts, leather tanning, and removal of carcasses. They also changed the community appellation from the derogatory Mehter to Meghwal, unearthing long hidden links to the Meghvansh of Rajputs and a long forgotten guru Megh Rishi (Tararam 2011). At the same time they tied themselves through kinship, shared experience, and politics to Ambedkar's depressed classes movement and the broader struggle against untouchability in North India. As part of this strategy young men began entering schools and slowly find employment in state schemes building new patronage relationships with the congress controlled state government. "We are congressi because they freed us, we were slaves before but the congress came to power and now we are free." Mangaba Meghwal explained.

Today this kind of Ambedkarite sanskritization has been shifted by a new genre of caste politics emerging in the Meghvansh movement, a politics beginning in Rajasthan to collect together the fragmented groups of ex-leather working castes and build a stronger vote block within the Indian National Congress Party (Sagar 2012). Meghwals in Ambawati consider themselves supporters of the congress and its caste-based reservation, uplift and universalization schemes. These caste politics and the forms of state sponsored dignity, uplift, and aspiration link to an increased confidence in state programs and the more modernist Congress Party.

Within the community as a caste, however, things are more complex than I have outlined here. Individual ways of understanding the relationship to the state and new Dalit politics have begun to enter newer forms of collective recognition around a unified "scheduled caste" identity. They have borrowed these terms from Ambedkar and the Indian constitution to make claims on the state in its own terms. Ambawati's Meghwals have done



particularly well through these forms of recognition. All men under-fifty are literate and many have found employment outside of agriculture (such moves were driven in a large part of their meager land holdings). Indeed the community prides itself as being the most educated Meghwal village collective in their fifty-two villages. They have found themselves integrated as a part of the democratic and liberal state doing their best to align themselves with its values.

That said the Meghwal community in Ambawati is not uniform, rather it has several layers of fission, linked to long-standing debates about contributions to collective social and ritual action. These two “parties,” as they are called locally, make collective decisions separately and come together and split over a range of topics. Additionally though they share a common ancestor seven and eight generations past, extended families consider themselves separate, recounting kinship through ancestors four or five generations distant they forge links of kinship come to matter in shared space, care and ritual with the caste at the village level. None-the-less they share a political ideology supporting the role of the state as organizer of social life and its potential to create an aspired for egalitarian society. As such a shared politics of dignity around state categories and shared strategies of making claims on the state exists and is important.

The other set of forms of aspiring to recognition come in rejecting state development through categorized backwardness. These politics respond to already filled quotas for rights and representation by subverting them through other structures of power and asserting a higher status in older hierarchies of power. In this case, it means asserting Rajput status instead of indigenous.

Ambawati’s numerically dominant caste, the Rawats, tend to opt for these forms of politics. As Ambawati’s Rawats represent themselves to others and internally, they recall an

important sociological shift from what they now call backward Meena status and life style to a more historically respectable Rawat one. Pre-figured by the mid-twentieth century “tribal movements” of Govindgiri and Motilal Tejawat who worked to Sanskritize adivasi life and agitate for greater self determination and land rights from the feudal state and its British colonial embrace, the Rawat Movement spread quickly in the area about thirty-five years ago (Hardiman 1987; Jain 1991; Singh 1995). Surprisingly change in caste and jati status was led by the erstwhile local lord who left the Congress party just after Indira Gandhi’s emergency (Ranawat 2009). In a move to build a new voting collective the lord played up whispers of a self-respect movement among his patrons to forge links between a then adivasi community and his own Rajput constituency. The name change and caste change links to a now fifty year old movement of marginal groups in Rajasthan to forge links with Rajputs by asserting shared historical link to both the Sisodia Rajputs of Udaipur and the Chauhan clan which ruled Ajmer and Delhi before the cities were Shahabuddin Gohri (Carstairs, 1983). Though not a part of the Chauhan clan, the lord challenged the Rawats to find a common ancestor by reading their bardic lineage texts together. After two days of reading these texts side by side a common link emerged and the lord gave those once called Meenas the right to call themselves Rawats and to append Singh to first names. This kind of indigenous aspiration for status is not uncommon in South Rajasthan but the links to party politics and vote blocks is generative as caste have often been observed re-inscribing caste difference instead of changing it (Unnithan 1997).

The newly minted Rawats moved to distance themselves from their once caste mate Meenas by adjusting language, dress and kinship norms. The move, however, was complicated. It severed links to an indigenous identity and the reservations and privileges that

accompany it. As Meena's the community had access to reservation and competed locally only among themselves for access to services, however Rawats are categorized by the Rajasthan state government as Other Backward Castes and now must compete with more powerful and educated middle castes for reservation and state uplift. Particularly surprising the Rawats are counted by census takers as OBC but their land records remain under adivasi status. As a result local government seats reserved based on population proportion got time and again to Other Backward Caste candidates though there are only about ten Other Backward Caste families in the area. As a result these families control local politics. In response and due to the local lord's departure from politics, Rawats have begun to distance themselves from politics and do not share vote block status like the Meghwals. Instead they are split between Rajasthan's major parties the Congress and the Bharatiya Janta Party. Alongside has come a kind of political theology, which highlights the Rawat's existing discourses of rugged individualism and detachment from state forms (Carstairs 1954; Jain 1991; Singh 1995). As we will see throughout, Rawat families tend to prefer the private sector and do not access (in part because they cannot) reservation.

This distance from the state can also be linked but not causally to a long history of distance from the state and even small rebellions. Ambawati's Rawats belong to a once highly mobile set of Meena indigenous people who tended to move when the state worked to interpolate them too strongly. Family histories are filled with peripatetic narratives in which the community moved in response to strengthening local government structures. Even Ambawati's settlement pattern suggests this, as Rawat families continue to move further into the forest carving out new fields and homes further and further from centers of government.

The literature of indigenous communities in Rajasthan suggest that such communities are “shy of contact and particularly backward” but this does not seem to be the case in Ambawati (Hooja 2004). Instead the community is working to integrate itself in historical realms of power by cultivating links to the Rajputs and asserting signs of respectability linked not to the state but to the local social structure. This too is not uncomplicated as the new generation is in the process of dialing back these strategies and working to build a new kind of identity, Rawat-Meena. In doing so they are working to access both the reservations available to them through Meena status and the locally contested self-respect movement their fathers carefully crafted.

Focusing on these politics of dignity shows people working between the poles of state and local, historical social hierarchy and populism, public and private medical care. Chapter one deals with a nation-wide concern with modernity and not being backward (McDowell 2012) that affects consumption of goods and healthcare as well as ways of discerning good and bad in Ambawati’s local moral world. Chapters two, three, and four develop Snodgrass’s argument about the complex relationship between caste, labor, history, narrative and power by looking at its effects on health and embodiment (Hocart 1950; Snodgrass 2006).

The study itself is a rural study and fits in a long history of village ethnographies in India. Ambawati is a rural community of about 1,500 people in Southeastern Rajasthan, about a half-day’s bus journey from the Lake City of Udaipur, “The Paris of India.” Though Rawat and Meghwal families make up the vast majority of residents, there are also two Bhat families, six houses of Salvi families and about fifteen families of Chaudharies or Kalals, each group with its own strategies of aspiration for status. There are none of Rajasthan’s famous Rajputs or any forts or high walls. Instead there are twelve clusters of mostly mud houses spaced

across roughly six square kilometers. There are two large ponds, two temples in the process of construction and numerous devras (small uncovered or covered platforms containing carved and uncarved images of local deities), a health center, a local government and land records office, an asphalt road running along the northern border, a school, and two state run crèches called Anganwadi centers. All families have a little land even if they have mortgaged it. Some have a half-acre while others have as many as five acres. Ambawati's farmers grow corn, wheat, soybeans, ajwain, psyllium, mustard, lentils, peanuts, and until recently sugarcane and poppies. Many farmers supplement agricultural income with wood and other forest products, and herds of cattle, goats and occasionally sheep.

I draw on important studies of Rajasthan and the work of G.M. Carstairs, one of the first medical anthropologists to work in India. Carstairs argues that questions of mediumship and conviction mattered for health and healing. He provides early nuanced ethnographic data on Mewar and the effects of transition from feudal colonialism to self-government (Carstairs 1955; Carstairs 1983; Carstairs and Mead 1957). Anne Gold's work to understand relations of power, caste, and the environment in Rajasthan flows through chapter five. My interest in mobility and aspiration for a good life, too, is tempered by work in Rajasthan that argues for a perspective on life which is more nuanced than bare life or social suffering (Gold 1990; Singh forthcoming; Unnithan 1997). I pay homage to this literature by working to understand Ambawati as a vibrant space with many forms of life and power though not wholly untouched by histories of marginalization and contemporary violence. Though the literature on Rajasthan is less comprehensive than for other areas in India such as Tamil Nadu, Uttar Pradesh, and West Bengal, a growing cohort of scholars is emerging.

I draw particularly from longitudinal studies of rural India (Carstairs 1983; Wadley 1994; Wiser and Wiser 1971) and in-depth descriptive ethnographies that take villages not as a microcosm but situate them in global flows (Gold 1990; Gold and Gujar 2002; Pinto 2008; Srinivas 1980). Other ethnographies of rural India work through change and politics, and they guide my thinking about development and change, a key preoccupation for this dissertation (Gupta 2012; Mines 2005; Sharma 2008; Skaria 1999).

Outside the rural context, Cohen's work to understand change and the intersection between western discourses of health and the body and South Asian ones is pivotal (Cohen 2000). I build on both his form and argument, and extend them to global health. Global health, as a discourse mediating western medical knowledge of the body and South Asian life, has taken a form completely unimagined during Cohen's fieldwork and a focus on global health allows us to look again at the kinds of interactions Cohen observed with new lenses.

One of the global forces at work in Ambawati, and India more generally is global health. Many global health assemblages—like the WHO and its technical advice, the Bill and Melinda Gates Foundation, the Clinton Health Initiative and other national and international funding agencies that finance interventions, the World Bank that sets the tone and form of what global health interventions look like, and a host of global NGOs—are present in India and together they congeal in an assemblage we can think of as Indian global health. Global health, for the purposes of this dissertation, is that constellation of actors and values clustering around a concern with managing and fostering health and well-being. It is undoubtedly centered on a real concern to make a positive change in the world and to alleviate suffering and inequality through recourse to the clinic, though at times other values come to unseat this as what really matters. The arguments I make here stem from the work of Paul Farmer and his

many colleagues who argue for a global health measured by quality of service provided rather than cost efficacy or suspicions of sustainability (Farmer, et al. 2013).

By examining the RNTCP and its effects on the ground, I am also situated in concerns for implementation science and evidence-based intervention (Ashraf, et al. 2007; Ashraf, et al. 2013; Frenk 2006a; Frenk 2006b; Ooms, et al. 2008). I am less intrigued by policies of TB intervention than the ways policies are implemented and practiced. I focus particularly on policy practices that affect intervention on the ground and lived experience as it interacts with and constructs sufferers. Chapters one and two consider how three of global health's assumed priorities—epidemiological statistics, transparency, and community—might come to be troubled, tussled and rearranged to think about what they hide, what they reveal, and what other structures they work within. Although this work is situated in implementation science, I have not settled with simply understanding what works and what does not, but try to understand what values are being implemented and what other and priorities they rely on. As such, I push implementation science to think more about what success or failure looks like, how to measure it, and at what costs that success was achieved.

In each of these middle spaces, the question of care is central. I will try to position the RNTCP and Ambawati in a middle space as well. Care is practiced between global health's selective rules and regulations, which set out the most basic requirements to diagnose, treat and return the body to working order and recommend everyday acts of caregiving. Global health rules are permeated with the need to protect the nation and globe from an infectious disease like TB and alleviate suffering. I call these basics, like the surveillance of people and bacteria as well as provision of pharmaceuticals, care-taking. However, in Ambawati and many other spaces, the rules of care-taking are being broken, adjusted or enforced in the name

of care giving. This dissertation is situated here between the laws of stewardship and national care-taking and the quotidian practices of care giving.

I am interested in both quotidian care giving and stewardship. The everyday physical and embodied practices of care giving, as Kleinman calls them, are front and center in *Ambawati* (Kleinman 2009; Kleinman and Van Der Geest 2009). They include giving massages, recommending dietary changes, fetching medicines, cycling sick people around on the backs of bicycles and motorcycles, and consulting deities. These kinds of caring are characterized by what Lauren Berlant calls love. Berlant writes of love, "...to love is to deal with what's here amid the noise of projected pasts, futures, and states. But 'dealing with' might point too much toward exchange and bargaining, the forging of false equivalences...I propose love to involve a rhythm of an ambition and an intention to stay in synch, which is a lower bar than staying attuned, but still hard and awkward enough"(Berlant 2011:683). I think this willingness to "deal with" gets quite close to care giving in *Ambawati*. It focuses, as Kleinman suggests, on a presence and a futurity, and helps us understand why care is not uniform across time and people. Berlant takes love out of the context of intimacy and romance (Berlant 2000) and helps us think through care giving as a willingness to engage with things and people as they are. In *Ambawati*, care as dealing with things as they are crosses gender and class. This kind of willingness to deal with a sick person includes practices of caring like those I outline above but also to keeping life moving, picking up the economic slack, searching for care, and keeping life from falling off the edge. This kind of care *giving* as dealing with immediate concerns stands in contrast to *care-taking* as stewardship. TB care I see as happening effectively when there is a combination of care giving and care-taking, and I engage it in chapter two.



Care-taking as state stewardship comes in many forms. Legal structures of reservation, poverty alleviation schemes, old age and disability pensions, and now free pharmaceuticals in public clinics and hospitals are all examples of the care-taking state. These structures of care-taking are important ways the state both fosters and structures life in Ambawati. Such forms of care-taking are not necessarily a taking of care by the state from citizens, rather they constitute a stewardship by which the state hopes to build and support a nation. It is caring for citizens in order to care for the state itself. The same is true for TB care-taking. Providing basic but necessary care for TB, as health economists with Disability Adjusted Life Years calculations argue (Murray 1994; Organization 1993), is a cost effective way to maximize productive lives and protect the once growing Indian economy. At the same time, treating TB is the best way to stop its spread (Jawahar 2004). As such, providing free treatment to those with active TB prevents transmission to the Indian population not already infected with the disease (Kochi 2001). Yet TB presents a contradiction here. The key problem for TB sufferers is not infection or latent TB, but the active, pernicious version of the disease, which affects about ten percent of the population with latent TB (Flynn and Chan 2001). Treating others cannot prevent the active infection of those with latent TB, but it can prevent the suffering of those who are exposed and quickly develop the active disease by limiting the time sufferers are infectious.

This biology-based complication, as well as a lack of important data about what activates TB, makes TB care as prevention complex. As such, TB care-taking comes to be prevention and a care for the nation as well as a way to foster lives and bodies for economic productivity—TB often affects men in their productive years. Most of the people I knew in Ambawati who had TB were men between twenty-five and fifty. They had children, homes

and families to support. Indeed, treating their disease did not just contribute to the networked economy, but sustained a future economy. Still, there is another complication. Subsistence farmers and laborers who stay in Ambawati contribute little to the Indian or global economy. With economic concerns for production bracketed, care-taking for TB is a matter of managing national image on a global stage and protecting the productive population from less productive people and their ills; taking care of TB is taking care of a post-colonial state interested in proving its ability to the world.

Outside the narrower purview of TB, studies concerning the quality of biomedical care are beginning to paint a harrowing picture of clinical practice in India. Jishnu Das and a team of economists and anthropologists have done significant work with simulated patients to understand patient experience and physicians' practices in the Indian clinic. They report an Indian medical community that orders few diagnostic tests, does limited exams, and spends an average of four minutes per patient (Das 2011; Das and Hammer 2004; Das and Hammer 2007). Their work also shows only a slight improvement in diagnostic success between untrained and trained biomedical practitioners and reveals that proper diagnosis, let alone care giving, is elusive in both informal, private, and public clinics (Das, et al. 2012). I take their studies as foundational and work to fill in a few of the ways patients and doctors experience these disheartening failures of recognition (Das 2010).

TB as a topic of inquiry in anthropology and medical anthropology is growing. My work is deeply rooted in Farmer's *Infections and Inequalities* (Farmer 2001). His strident critique and call to see infectious disease and inequity together guides my work, and his call to understand TB in the context of HIV was an impetus as I first began to ask questions about what TB care might look like where TB is not brought to attention by high rates of HIV. His

critical provocation to understand TB in global contexts of power structures this text and guides my thinking about provision of care and the eyes wide shut perspective on TB in India.

Farmer's engaged critique of social science and TB is an important corrective, and outlines a research trajectory I have tried to follow (1997). Farmer criticizes social sciences for making claims of cultural difference where economic marginality might better explain health behaviors around TB, compliance, and drug resistance. He argues that the social sciences are implicated in marginalizing TB sufferers and contribute to a denial of care by pointing to health beliefs and a lack of knowledge as roadblocks to diagnosis and patient compliance. He calls this a conflation of structural violence and cultural difference. At the same time, he draws important links between poverty and susceptibility to TB, implicating global economic systems rather than poverty in the propagation of sickness. I have tried to continue this work by focusing on his five main criticisms of social scientists: 1) they confuse structural violence for cultural difference, 2) minimize poverty, 3) exaggerate patient agency, 4) indulge in romanticism about "folk healing" and 5) continue practices which insulate the social sciences. Each concern runs through this text and in each case I have tried to understand TB in Ambawati by refusing to leave them unexamined.

Farmer was not the first anthropologist to address TB. Its history as an anthropological problem and a window into social and biological life is a long one. Ales Hrdilicka, an early physical anthropologist working at the turn of the twentieth century, wrote about differing rates of TB infection among Native American communities (Hrdlička 1909). His was a very early biosocial assessment of TB connecting the biology of TB with the lifeways of Native American people. Hrdlička stopped short of linking these forms of life to histories of oppression, disenfranchisement, racism and economic marginalization, but his

work is path breaking in its willingness to examine the biological and social outside a facile racio-biological categorization of certain groups as innately more prone to disease.

More recently, Erin Koch locates Directly Observed Therapy Short-course—the globally systematized treatment of TB—as a therapeutic paradigm that works in the sometimes violent connections between TB, citizenship and surveillance. Her work delicately positions TB in a space of marginalization and biocitizenship, tracing an prison economy of sputum asking what incarceration can mean for direct observation and points to a troubling agentive use of suffering (Koch 2006; Koch 2011). Her longer work focuses on DOTS as a governmentality in Post-Soviet Georgia and traces debates around DOTS as a global model as it supplanted older Soviet forms of caring for TB (Koch 2013). Finally, the work of Salmaan Keshavjee guides my critical perspective on global health and its internal logics of profit and economics (Keshavjee and Becerra 2000). His work to place TB science and intervention in a disheartening context of economics and scientific forgetfulness is an important corrective to overly optimistic perspectives on global health, the will to improve, and assumed commitments to solving the problem of TB (Keshavjee and Farmer 2012).

Most social science work concerning TB in India and globally focuses on compliance, highlighting a real concern for keeping people in treatment (Barnhoorn and Adriaanse 1992; Gopi, et al. 2007; Jaggarajamma, et al. 2007; Jaiswal, et al. 2003; Munro, et al. 2007; Rubel and Garro 1992). However, much of this literature places the onus of medicine taking on patients and rarely considers the factors that make not taking medicines an option and a reasonable choice. Other work looks to the rising tide of drug resistance in India and I engage

this literature in chapters one and three<sup>2</sup> (Atre and Mistry 2005; Balaji, et al. 2010; Khan, et al. 2009; Mittal and Gupta 2011; Pandit and Choudhary 2006; Udwadia 2001). Recent studies have begun to take a “patient pathways approach” to understand and assess questions of delayed treatment. They move the burden away from patients and reveal the long lists of misdiagnoses by the medical community (Kapoor, et al. 2012; Mishra, et al. 2014). My work sits in these literatures, asking questions of compliance, delay, resistance, and misunderstanding about TB, but it troubles the representation of poor patients as ignorant and uninterested in their own health. I also show an RNTCP interested in solving the problem of TB but bound by discourses that represent the poor as non-compliant and other commitments to national and global health.

Finally, I draw heavily from anthropology’s interest in the body and bodily processes. For me, TB is one way “*bodies remember*”. I see TB infected bodies as they come to memorialize, if only temporarily, policies, practices, and even social suffering. Many have written on how, when and why bodies remember (Connerton 1989; Fassin 2007; Kleinman and Kleinman 1994; Livingston 2005). This work and its focus on ways social life and practices get inside, mark, and are lived by the body is an important impetus to thinking of breath as an analytic and an ephemeral way bodies remember. Breath and its practice are a way bodies remember along with the people who live in them. Though I find a focus on the

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<sup>2</sup> This work has been catalyzed by a growing prevalence of drug resistant forms of the TB microbacillus in India. Indeed India has one of the largest drug resistance problems globally. Though drug resistance floats like a specter through this text, RNTCP policy and life on the ground in Ambawati leaves the question of resistance open. Most people in RNTCP treatment in Ambawati were diagnosed with drug susceptible forms of the disease regardless of their bacteria’s actual susceptibility. The “growing threat of drug resistance” is an impetuous of change in the RNTCP and global priorities around TB, but at the time of research the presence or absence of resistant forms in Ambawati was neither confirmed or much of a problem for the RNTCP. I do not mean to ignore the importance of resistant forms but such uncertainty prevents me from delving too far into questions of Multi-Drug Resistant or Totally-Drug Resistant forms of TB. The most I can say is that certain RNTCP policies have made the likelihood of resistance high across India.

body enticing, I hesitate to think of these bodies as material objects easily reworked or made docile by power (Dwyer 1995; Foucault 1978; Martin 1994; Rapp 1999). In my view, this perspective flattens lived personhood and social life, leaving just a shell of a body or corpse. Multiple bodies also give me pause. Bodies may be multiple, political, social, gendered and individual, and the meanings and values attached to them connect to this multiplicity (Mol 2001; Scheper-Hughes and Lock 1987), but bodies are also unitary. As lived, bodies are always and already marked by their multiple meanings and can experience many of these simultaneously.

I have tried to use an analytic in which the body remembers the meanings associated with its multiplicity. To do so I focus on care for the body and the self as inflected by meanings and practices that are at times visible, but even when invisible are present and lived or died (Das 1996; Das 2007). Correspondingly, although I have worked to understand how bodies remember, I have not forgotten to keep the people in them. I do this not by focusing on embodiment (Csordas 1994) but by focusing on the structures of power and moral life that matter for people and how they interact with bodies, minds, and souls.

The problems I address in this dissertation—rural TB and its care—speak to literatures in global health studies, South Asian studies, anthropology, and social life. They are driven by a simple set of research questions: what is the state of TB care in rural India? How do we understand TB care as a state and keenly local project? What is the role of social life in TB experience? What is to be done about this treatable disease that kills two or three or four Ambawati residents annually? The dissertation is driven by an even simpler empathic question: why do they die?

I came to these questions in part by accident, and initially asked them in a state of shock. One of the first people I knew in Ambawati was killed by TB just a few months after my first real field visit. This dissertation is driven by his memory and the memories of countless others, but I will take a moment to name, if only in pseudonym, those who I knew who died of TB as this research and dissertation was in infancy; Udai Singh Rawat, Tulsiram Dholi, Devi Singh Rawat, Hiralal Meghwal, Prem Singh Rawat, Shankar Singh Rawat, and Ganga Bhai Rawat. It is my hope that this work will help make sense both of their deaths and of the intense social suffering that their deaths caused. In mourning, this work is an attempt to think through what Farmer has called “stupid” deaths from a known and curable disease (Farmer 2010). It is not my goal to write from a place of righteous indignation, but rather to write with these deaths in mind. They, time and again, remind that these seemingly simple questions have incredibly complex answers. They are questions of life and death and matter immensely in this context of precarious rural life.

It is also important to explain how I came to Ambawati. Rarely does a young man from the farms of Iowa come to find himself living and working in the fields of Rajasthan. The path to Ambawati was a circuitous one. I first went to India as an intern at M.S. Swaminathan’s research foundation in Chennai. After a few months I realized I had a lot to learn about India and the people who live there. At college, I chose to study Hindi and then study abroad in Rajasthan. Part of the study abroad was another three-month internship, this time with a small NGO in Udaipur. The NGO asked me to study private physicians in rural areas. Over the three months, my Hindi skills underwent a trial by fire. I became fascinated by this part of Rajasthan and returned for two months the next summer. I had known folks in Ambawati during the earlier internship, and though the NGO shuttered its program there,

these friends helped facilitate my research. It was on that trip that I came to know about TB and have my first experience with the RNTCP and rural primary health in South Asia. My frustrating experience there and introduction to a Kailash, a man undergoing treatment, prompted me to begin asking questions that have taken over half a decade to begin answering.

After eight years, Ambawati has come to be as familiar to me as Cambridge. I know each of its paths, and have watched young men and women grow from eighth grade students to college graduates, finishing the same year I finish at Harvard. I have come to know almost everyone in Ambawati and in Sagwai, the large market town nearby. Over time, I watched mud houses be replaced by brick ones, bulls by rented tractors, bicycles by motorcycles, and kerosene lamps by electricity. I have gone from *angrez*<sup>3</sup> to Andy. This longitudinal acquaintance has been invaluable for the conversation I begin here, and, though it focuses most on a year of intense fieldwork, it is shaped by the many summers before and after.

While in the field, I had several advantages and several disadvantages. First, my foreignness was complicated. Not only could I ask questions with a seemingly common answer, but I did not fit within established hierarchies. This lack of fit changed both gender and caste norms related to an outsider and gave me access across a broader set of people in Ambawati. Though I was outside of local hierarchies, as a white American man I was simultaneously at the very top of global ones. In Ambawati, my powerful whiteness was manageable by living simply, washing my own cloths, sweeping my own walk, taking the bus, and cooking my own food. Yet in places of greater ambiguity, my positionality as clearly foreign and possibly connected to seats of global health power opened some doors and closed others. I was able to enter spaces like the hospital and was an asset for friends and neighbors

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<sup>3</sup> Foreigner



who thought bringing me with them to the doctor would garner better care. In other spaces, doors were summarily closed to me by fears of global connections, a possible orientalizing bent, or nationalism; the TB office in Jaipur is a prime example, though I am not sure an Indian would have fared any better there. The majority of people, even in the RNTCP network, were happy to talk to me after I showed genuine interest and competence, but others remained suspicious.

After a few summers I became a known entity but the intricacies of Ambawati's Mewari, Hindi, and Wagri mix were difficult. Not until a few months into fieldwork did I feel comfortable speaking in this hyper-local glot. The problem of language was compounded by problems of gender. While most men could speak Hindi, the majority of women often knew only the local ways of speaking in Ambawati or their natal homes, as brides came from Mewari- or Wagri-speaking areas. I had to learn both ways of speaking. My closest neighbors spoke a more Mewari version among themselves though several women knew Wagri and I was lucky to pick up their language through everyday conversation. By the end of my year, I could speak to men and women equally.

This was in part because of language, but also by virtue of becoming a neighbor. Women in the Meghwal neighborhood where I lived were comfortable with me as a known person. They watched me live a life in front of them, and winning the love of their children surely helped. Only after I achieved known status could I begin conversations, and through them become competent in their version of Rajasthani. In other parts of Ambawati, speaking to women was still difficult. Many Rawat households spoke a language more closely related to Wagri, and it took months to develop the proficiency to understand and be understood in this kind of code switching environment. Women talked to me, but it took more time and I

was not able to have the same kinds of conversations I could with neighbors or men. As such, there are fewer women's voices in this work. Nonetheless, the voices of close woman interlocutors like Siddharth's mother and aunts, Daulat Singh's wife and others play an integral role in this work. Rajasthani forms of purdah also made speaking with women difficult, though did not preclude them entirely. Many women will not speak openly in front of their husband or his elder male relatives, so often I was unable to speak with them. Shared work in the fields with women allowed me to have more open conversations.

Methodologically, my work was participant observation. Fieldwork included work in fields, trips to hospitals, nights and days in clinics, interviews with bureaucrats, dancing in weddings, sitting in mourning, waiting for busses, and waiting for god to come to the medium in all night rituals. I collected narratives and stories, carried water, helped build houses and joined in a weeklong motorcycle pilgrimage. Research was also deeply person-centered. I visited Siddharth nearly every other day and shared about 75 conversations of varying lengths with him. The village nurse and I met weekly during fieldwork and had nearly 80 hours of conversation. I also conducted archival research at the Rajasthan State Archives at Ajmer and Udaipur, and the Maharana Pratap Shod Sansthan's library. With the help of two local youths, I also conducted a 100-household survey asking questions about economics, expense, aspiration, exclusion and TB.

Most keenly, I learned that fieldwork is about living with people. Being present is our shared anthropological method, and in our case, more presence is better. Yet simply being present is not without location. Where we live matters and I learned this when my landlords came home for two weeks during vacation. While they re-occupied their house, I moved to a smaller one room house. I was woken several mornings by the sound of singing and what

sounded like an airplane taking off. I asked what that sound was and was told that it was Jamna's mother; she had a habit of grinding flour and singing bhajans at five in the morning. Shifting just four houses down the street and to one with a shingle—not cement—roof, I came to learn about the importance of positionality and presence. I did not know that anyone in Ambawati still ground wheat by hand even though I had lived there for nearly eight months. It was a good reminder that even while present, location allows some things to be seen and others to be missed. Being present during mornings, day times, evenings, and nights made clear the importance of living with the community. My work would have been very different had I lived in nearby towns or made occasional field visits from Delhi or Udaipur.

Last, I want to write briefly about ethics and morality in anthropological research. It is important to share what was at stake for me in the field. My work was difficult to bear at times. Watching people I had grown to care about, who were parents of children I cared about, wives and husbands, people I have known now for more than a quarter of my life, struggle with a curable illness was terrifying. Even more terrifying was sitting in mourning of those killed by the disease. Indeed, there were moments when I wanted to shake friends and drag them to the health center. Siddharth and Daulat Singh are examples of this. Yet this is not really an option with a disease like TB. It is one thing to be diagnosed and another to be in six months of treatment without support. I could only offer what became my perennial suggestions--“Maybe it is TB, how about we get you tested,” or “Just try the medicines for another week, maybe you will stop feeling nauseous”—only to be politely refused as people suggested we try just one more thing. Always trying one more thing threw the inadequacy of the RNTCP in sharp relief. For me, what really mattered was finding a way for the people I knew to be

suffering from TB to be diagnosed, start, and continue treatment. Indeed, finding better strategies to do this and elucidating its context are my key goals in the dissertation.

To remain “neutral” and watch people I cared about die may have assuaged some anxiety about anthropology’s scientific aspirations of objectivity, but would have been a life-long burden I am not willing to bear. I am first a human and then an anthropologist. I, however, advocated a system I did not have full confidence in. I too was torn by questions of economics. Should I have advocated RNTCP care I knew friends could afford and stave off total poverty, though I knew they would not receive care I would expect? I do not know, but I chose this path for two reasons. First, I had seen too many children pulled from schools to pay for private care and medicines, and too many families become destitute in private hospitals where they received marginally better care. Second, I was committed to public medicine and strengthening public provision of services, not subverting it. Today, I am not as certain of this particular politics but future work will help me examine the ethical questions involved in the private health market more thoroughly. For now, I can only say I advocated for the RNTCP and I still do because of these commitments, both political and practical, local and global.

### **On Chapters and Themes**

The dissertation traces a global program and problem, examining its effects on lived experience as well as the effects of lived and local experience on a global program. As such, the first three chapters concern care and the remaining subjectivity and experience. Though I parse them this way, care and subjectivity cannot be separated, and indeed each chapter deals with both in diverse forms.

The first chapter introduces the RNTCP and links some of its key values to global health discourse. I join a man from Ambawati, his wife, and his son on a visit to a TB hospital

in hopes of diagnosis and care. The chapter examines the events of two days at the hospital and locates them in the context of global health values like evidence, statistics, fears of corruption, transparency, and national health. It locates a few nodes of this discourse at a global TB conference in Paris and in the RNTCP state director's office in Jaipur. I trace these values' effects on the experience of TB and which kinds of suffering are recognized and treated.

Chapter two returns to Ambawati to begin again. I examine the roots of and argument for community-based TB care in a 1950s study in southern India. I outline its suggested components of community-based care and examine them in Ambawati. I work to understand what community is in the context of TB. I follow Siddharth as his family works to care for him and find him a cure. I examine their everyday and embodied care giving practices and eventually their interaction with the village public health nurse. Following Ambawati's nurses, we come to a few insights on public health staffing in rural India and, I hope, a more nuanced view of absenteeism. We also get a sense of why care giving matters and its connection to stigma around TB. The chapter concerns with mediums and mediators of care, RNTCP and otherwise.

The third chapter leaves the RNTCP and focuses on something adjacent to it: private practitioners. By understanding private and untrained practitioners, we see an example of the effects of the market on health care and forms of resistance: drug resistance, social resistance, political resistance, and even economic resistance. These forms of resistance beg the question: must one call it resistance to resist? We can see these practitioners slowly edge out the public sector as they build a supply chain, market, and discourse of the body through biosocial processes and treatment techniques. Understanding these private informal physicians gives us

an opportunity to better understand one aspect of multi-drug resistance as it occurs in Ambawati. The existence of these untrained practitioners cannot be decoupled from the trained formal sector, and seeing them as either anathema or as mimicry is not an option. Instead, I argue, we must see them as a part of the global health apparatus working within and without its norms.

The fourth chapter concerns poverty. It examines the way the state and its intervention mechanisms, like the public health system and public distribution system, come to both define poverty and ask subjects to perform poverty as a way to stabilize their economic precariousness. I shift my gaze from health bureaucrats to development bureaucrats who assess poverty through various forms and statistics collection methods. I also chart the ways people manage these metrics to answer questions raised by Duflo and Banerjee in *Poor Economics*, offering a corrective of their psychological arguments about the poor (Banerjee and Duflo 2011). In lieu of economic psychology I suggest more interesting avenues of interpretation may exist in consideration of aspiration and hope for certainty and stability, as well as what it means to live in poverty, together. I argue that it is not pride that makes people reluctant to ask for help or prevents them from using state resources, but rather other forms of marginalization and gate keeping. People will perform the kind of poverty needed to access resources, though they may not accept poverty wholly as a subjectivity. This gives us a first glance at the problem of too easily applying Foucault's theory of biopower in rural India (Foucault 1978). The subject is performative and malleable, but it also has a stickiness Foucault called freedom (Foucault 1978; Foucault, et al. 2003; Rabinow 1997).

The fifth chapter attends to breath in Ambawati and the RNTCP. I locate breath as one of the ways TB sufferers come to be blamed for their own suffering. I examine discussions of

breath in Ambawati and read these narratives for themes of wind, control, violence and values. I argue that examining breath is a window on relations to the body, the environment and power. Connections between wind, air, breath and individuals resemble classical Ayurveda and its perspectives on wind and breath. After showing these links, I suggest a few of the meanings of troubled breath and the effects of these meanings on global health in India and health in Ambawati. Taking breath as a sign of relationality, I am able to parse the marginalization of TB a different way and look to the connections made between TB and violence, structural and physical. In doing so, I make important claims about the difficulty of applying Foucault's concept of "care of the self" in rural India.

I conclude with ghosts and the influence I think ghosts have on this work. Ghosts trouble and check in on my discussion here as they, too, search for modes of voice. Like the ghosts who bring the past into the future and destroy as they rebuild, I conclude by suggesting that this work has been deconstructive but not destructive. This is a project of incremental change. Rather than take a too cynical view of intervention as a form of coercive interpolation to global structures of western ideological, ethical, and bodily imperialism (Fassin and Pandolfi 2010; Fassin and Rechtman 2009; Pandolfi 2008; Redfield 2013), I recognize these tendencies in intervention and look for places where they can and are being subverted in hopes of building a more care-centered and inclusive global health. I suggest that a better understanding of the happenings between big structures, like the global and local, the WHO and the Ambawati health center or TB sufferer's cot, are important for implementation science and the work to build an evidence based global health with a focus on quality of care. And now, I begin again in the middle by focusing on TB and its care.





## Prologue to part one.

### State care and the RNTCP

The Indian state provides free TB care to places like Ambawati with a program called the Revised National TB Control Program (RNTCP). In the following chapters, I pass through the RNTCP's many layers, from the global to Ambawati and intermediary spaces between. As prologue, I sketch the RNTCP and outline the pathway a patient who receives ideal care might follow (Central TB Division 2005a; Central TB Division 2005b; Central TB Division 2010b; RNTCP 2003). Alongside what ought to happen, I follow some alternative routes that a patient might take if she does not start at a local level, is misdiagnosed or referred.

One encounters the RNTCP's most basic unit, *The DOTS Center*, at Ambawati's Health Sub-Center. The Health Sub-Center is the most basic outpost of the rural health apparatus and it provides short term and basic care. The DOTS center is not a room in the health center or any specific actor like a nurse or community health worker. Instead, it is a set of files, notebooks and posters; just one small aspect of the village nurse and health center's daily work. Ideally Ambawati's TB afflicted would first come to the sub-center. As a person with two weeks or more of cough he or she should be examined and referred for testing at the Primary Health Center six kilometers away in Sagwai. After two positive sputum tests at the Sagwai *Designated Microscopy Center*, an RNTCP provided microscope and slide set, a patient would start treatment at the Ambawati DOTS Center in a few days. However, it is more likely that nurses and physicians at the Primary Health Center refer a patient to the Community Health Center in Sadri, the sub-district's administrative center fifteen kilometers away. Here too patients can be tested and diagnosed in the hospital's laboratory.

If a patient is not diagnosed or tested at the Community Health Center, he or she is referred to the District TB Center in the District Hospital—about one hundred kilometers or three hours by bus away. Though there is another TB Unit in a large government hospital about sixty kilometers away, I do not know of anyone from Ambawati accessing it. At the District TB Center, a patient should be seen by an RNTCP contracted physician, typically the District TB Officer (DTO). DTOs are ideally pulmonary specialists. Regardless of specialization the RNTCP trains them to identify and manage TB, and organize district level RNTCP activities (Programme 2011). Accessing the District TB Center is common in other communities, but people in Ambawati typically choose the Bari TB Hospital in Udaipur. Slightly closer than the district hospital, the Bari TB Hospital is a public TB specialty hospital. Most major Rajasthani cities have a correspondingly large TB hospital as part of the public health system or a medical college. TB hospitals do not fit as neatly into the RNTCP's administrative trajectory from village to Delhi; hospitals are an exception in the RNTCP's community-based healthcare system.

Independent of where a patient starts RNTCP TB care, his or her local Health Sub-Center must requisition the necessary drugs from the nearest Primary Health Center or Community Health Center. The six-month course of drugs arrives a few days later in a square white box known locally as the *dibba* or box. The box contains the globally standardized TB treatment a six-month course of rifampicin, ethambutol, isoniazid, and pyrazinamide (RNTCP 2003). Initially patients must come every other day to receive medicines. Occasionally patients take their medicines in front of the nurse but more often they take them with food and bring an empty blister pack as proof they have consumed the previous days' medications. After a two-month initial phase, patients take home an entire week's supply of drugs and

return the blister pack on the same day each week. As before, the nurse monitors and records patients' treatment in a TB card. They are asked to get a sputum recheck once during treatment. All of this should be free.

Ambawati's Health Sub-Center lies on the paved road about a kilometer from the bus stand. TB patients walk an average of two kilometers to take their drugs. Those who live further, and this is not uncommon, may be administered DOTS by a neighbor, community health worker, or other person deemed "responsible" (Central TB Division 2005a).

The patient's biographical data and treatment is recorded at the DOTS center on a TB card, and the information from these cards is reported to the district level. From the district, data goes to Jaipur, the state capital and the State TB Control Cell. Further aggregated, the State TB Cell sends the data to Delhi. In Delhi statisticians compile data and top-level bureaucrats generate policies at Nirman Bhavan, India's bureaucratic hub. RNTCP leaders work closely with the World Health Organization (WHO) and technical consultants supported by the WHO to develop policy, conduct research and implement new TB science.

As records and the statistics derived from them move toward Delhi, administration, technical assistance, and pharmaceuticals to treat TB travel away. The State TB Cell oversees implementation practices in the districts through annual field visits by the state team of physicians, technical consultants, communications specialists, pharmacists, and HIV/AIDS liaisons (RNTCP 2003). Each expert biannual district visits, composing a letter to document and update the State TB Officer and the District TB Officer of progress. District TB officers and their counterparts, the Senior TB Treatment Specialists (STS) and Senior TB Laboratory Supervisors (STLS); visit community health centers and DOTS centers in turn. Their work is

supported by district and sub-district medical officers. The STS and STLS check to be sure patients are getting the correct form of “motivation,” monitor the documentation of treatment, and facilitate both laboratory and pharmaceutical supply chains (Central TB Division 2005b). Additionally they oversee testing and treatment of Multi-Drug Resistant Tuberculosis (MDR-TB) patients.

Each DTO ideally implements the RNTCP guidelines and liaises with the State TB Training Center in Ajmer with any technical questions or when a molecular test occurs. DTOs also interact with medical schools and specialty hospitals like the Bari TB hospital at Udaipur. DTOs interact with medical schools and hospitals like the one at Bari to facilitate RNTCP implementation and documentation so patients can, on discharge, move into the primary public health system for DOTS.

The RNTCP is a mammoth “diagonal program,” to borrow Julio Frenk’s term (Frenk 2006b; Frenk 2010; Frenk, et al. 2011). At the local level it is just a small part of the larger national rural health system, but as it moves to the district level and beyond it becomes a vertical program with its own administration, drug pipeline, policies and funds. As a diagonal program the RNTCP is also charged with strengthening the health system; and it supplies the state of Rajasthan with more than eight hundred microscopes.

Staff alone is an example of the RNTCP’s complexity. The RNTCP at an all India level includes 628 district TB officers (physician/administrators), 74,983 medical officers (physicians), 291,207 paramedical staff, and 693,628 DOTS providers. It aims to keep track of TB in a country of 1.2 billion and provide care for the highest number of TB sufferers in any single country (Central TB Division 2012).

The chapters that follow emerge from an ethnographic engagement with the RTNCP and the system it uses to diagnose, treat and monitor patients free of cost. I organize chapters around patient care and intersect patient experience with brief glimpses of the programs bureaucratic machinery. The first chapter works to locate hospital experience--the most common way Ambawati residents enter the RNTCP system. This engagement shows what diagnosis experience can teach us about TB in India, Indian modernity, and the discrepancies in care there. The second chapter focuses on RNTCP care in Ambawati and the local nurse as they treat TB patients, counsels them (with little success) to get tested for TB and provide care for those already part of the program. The chapters follow a pair of neighbors, Daulat Singh and Sidhharth, and three generations of a Meghwal family; septuagenarian Hamera Ba, his distant nephew Ambalal and Ambalal's son. In chapter two we work through problems of stigma and politics that already emerge in chapter one. The chapters serve as introductions to some of the ways people in Ambawati access TB care and how it shapes lived experience and social suffering.

A third chapter moves away from the RNTCP but maintains a focus on care and illness. In it I engage the large contingent of "Bengali doctors" who serve Ambawati and surrounding communities. I explore the ways Bengali doctors manage TB and other illness by examining who they are, how they come to know about biomedicine, particularly pharmaceuticals, and the ways they treat illness. I also look to the discourses of the body in which they fit, focusing on themes of relief and rotation. The thrust of the argument is to show how these informal providers both fill gaps in the state system of care for the poor and create a health market in which they are the best option. I examine these providers who bring advanced pharmaceuticals and dangerous treatment methods to understand what happens

when the state system both continues to aspire to cost effective therapy and is unable to offer care giving to the rural poor. Importantly these private and highly market savvy charlatans build an adjacent system of medicine in the spaces where state care is either stretched too thin or unwilling to operate. They provide a wholly different route to biomedical care that puts a price on care giving and accessibility but engages suffering and the need for relief.

## Chapter one.

### The Hospital: Global TB as practiced, accounted and reported and not

Kabir maya mohini, mohair jaa sujaam.

Bhagai hoo chhootai nahin, bhari bhari maari baan—Guru Kabir

Kabir says-‘the maya is a very strange type of allurement. It implicates all—be it good or bad, knowledgeable or illiterate—in some way or other. It shoots attachment like arrows in such a way that despite trying to run away one cannot survive—translation Lalchand Doodhan

#### **On the hospital: Day one an emergency case**

Daulat Singh and his wife Dholi Bhai came home angry. That morning they pawned a piece of Dholi Bhai’s heavy silver jewelry and told the neighbors they would go to Udaipur’s Bari TB hospital. At the crossroads they changed their minds and decided to try the community hospital in Sadri, the sub-district administrative headquarters. I met them slogging home on the waterlogged dirt road from the bus stand. Daulat Singh, too weak to manage the morass, was perched on the back of a bicycle. Waving a government hospital prescription and twelve capsules, he swore in frustration with the mud and the care he received in Sadri. Daulat Singh wanted serious engagement and medicine, and he asked if I would come with him to Udaipur’s Bari TB Hospital the next day. I agreed.

In the morning, it rained as I pumped water for a bath. As the soft rain continued, I made breakfast and skidded down the slippery clay dirt road to wait at the bus stand. Daulat Singh’s son Mukesh called near eight. He was worried. They were prepared to leave, but his father could not travel in the rain, and they could not arrange a motorcycle ride to the bus stand. We decided to postpone our visit to the hospital. My phone rang an hour later. Mukesh

told me that the rain had stopped and we should go by the eleven a.m. bus. I ate another bite and slid back to the bus stand.

I arrived to meet Daulat Singh, Dholi Bhai and Mukesh huddled under the smoky tea stand sunshade. “So you are coming!” Daulat Singh wheezed as I arrived. “Good.” We boarded the minibus and bumped over potholes to Sagwai. The travel quickly affected Daulat Singh. In Sagwai he had difficulty walking and stopped often to breathe and cough up the phlegm filling his lungs. We bypassed the primary health center and caught a bus to Udaipur. As the bus left Sagwai, Dholi Bhai pulled back her *ghungurt* (veil) and Daulat Singh curled across their seats to rest his head in her lap. He slept for the next three hours to Udaipur, waking occasionally to wheeze and cough out the window.

I ate peanuts with Mukesh as the greening landscape bumped past. I asked him if he had been to the TB hospital. He had accompanied his cousin’s wife a year earlier and “knew a little.” He brought 6,000 rupees with them (about 110 dollars) and hoped they would be enough. The travel to Udaipur cost the three of them two hundred sixty rupees and Mukesh estimated another hundred in auto fare to the hospital.

Indeed the auto rickshaw to the hospital cost Mukesh a hundred and fifty rupees. I tried to remember the route as we left Udaipur. The crowded auto circled the famous Fateh Sagar Lake and followed the road inland past a cove of pink water lilies, *kamal ke phul*. Eventually a tall white temple spire of eastern India emerged. I wondered if it was an ashram? The rickshaw pulled to a stop at the base of the crumbling white tower. The tower is a clock tower and gate, a faded memento of an older TB hospital built at the base of this once wooded



hill far from the city. The clock's faces, two in roman numerals and two in Hindi were all stopped at 3:18.

The hospital sprawled beyond the gate. Several rows of inpatient wards, low buildings, of standard government architecture and color sprawled on a side hill, and a slightly larger building with glass doors and a driveway near the clock tower was the "out patient ward." People, some with handkerchiefs and scarves tied across their mouth and nose, walked the green yards. Some set up teashops and others sold fruits and vegetables; still more were cooking and eating on the hospitals lawn. Some in the crowd were visibly sick, their bodies shrunken by TB. Others looked healthy but afraid. They had come with sick family members. Some walked with purpose, clearly they had been here a long time. Others walked as we did, slowly and unsure.

We sat on a sheet Dholi Bhai had sewn of used fertilizer sacks outside the out patient ward and intake building. Pointing it out, the auto rickshaw driver told us the doctors would arrive at four. Soon, a young man strode up confidently, "What are you doing here?" Mukesh explained that we were waiting for a doctor. The man shook his head vigorously. "Today is Sunday. No one will come back. The hospital closed at noon. You will have to wait until tomorrow or go to the emergency. It is over there." He pointed. "You could go to the doctor's house too. If he is home he can admit you, but he will take two hundred rupees to admit someone during off hours."

Forlorn, we walked to the emergency ward. What if they did not admit Daulat Singh? Where would we stay the night? We decided to try the emergency ward and tension grew as we waited for Daulat Singh to catch his breath and energy. At the emergency ward we found

a woman in a white polyester sari. She asked abruptly what we wanted. Mukesh said we needed to see a doctor to admit his father. She saw Daulat Singh and moved the end of her sari to cover her mouth. She asked how long he was coughing and if they kept their house clean. Mukesh answered and Dholi Bhai grumbled, hurt that her housekeeping had been questioned. The nurse left to find the doctor. She came back, sat down on the outside doorjamb, and told us the doctor was coming.

The young doctor was startled to see me. He asked about Daulat Singh's symptoms, appetite, persistent cough, weight loss and fevers. The doctor stayed a few paces from Daulat Singh but did not cover his mouth. He asked if Daulat Singh had been sick with TB before. Daulat Singh quickly said no. "You've never taken treatment before?" the doctor asked again. Daulat Singh replied again, "No, never." "Are you sure?" I knew this to be untrue and spoke as the doctor stood over us, "Doctor, a lot of people in his neighborhood have TB right now, several of them have started on medicines for second category and MDR-TB." I hoped this intervention might give the doctor an indication that he should think more about testing for drug resistance without exposing Daulat Singh's lie. He had started DOTS twice before.

The doctor asked a series of questions and Daulat Singh answered. "Name? Daulat Singh. Father's Name? Kartho Singh. Caste? Rawat. Age? About fifty. District? ----- . Block? Sadri. Village? Ambawati. Religion? Hindu. BPL? Yes. Ever treated for TB before? No." His questions answered, the doctor admitted Daulat Singh and told us he would have a bed back down the hill in Ward Three. Before starting treatment, Daulat Singh needed to get a sputum smear and chest x-ray the next day. Until then he could only give a prescription to relieve

pain. The doctor thrust three forms in Mukesh's hand and instructed Mukesh to show them to the ward nurse and the intake nurse in Ward One.

We found the ward languid. Sick men filled the beds and their attendants the floor. The nurse's office was empty; a patient's wife told us that he left on his motorcycle. We waited. Later, Mukesh and I set out back up the hill to Ward One and the intake nurse. Ward One was half moon shaped with partitions between each pair of patients. It was dark and smelled musty. A deathly sick man and his attendants occupied each bay. Ward One is for serious patients, yet we could not find the nurse. We circled the ward, passing each of the ninety full beds only to return where we started.

Finally we found an office with an open door and pulled curtain. A man was sleeping on top of the desk. Mukesh roused him and we learned that he was the ward-in-charge and hospital intake nurse. He took our papers, opened a pad of forms, and leafed through a large account book. He asked the same questions the emergency doctor had. Mukesh answered but a little differently. "Are you the patient? No my father is, he is waiting in Ward Three. His Name? Daulatraj. Father's name? Karthalal. Caste? Meena. Age? Maybe fifty. District, block, village, age, phone number." He handed us the now filled up form and told us that Daulatraj had been registered. We should report to the outpatient clinic promptly at nine am. The crowds would grow as the day wore on.

We descended the hill to Ward Three with his advice and hope that the nurse had arrived. He had not. Daulat Singh and Dholi Bhai were asleep so Mukesh and I waited in silence. We were afraid. Sitting on the ward's cement floor, the smell of floor cleaner filled our noses. Through the doorway the ward's whitewashed and pillared hall opened to reveal

three rows of beds. Windows covered the eastern wall. Their dusty windowpanes looking out on a now unused veranda and further to Fateh Sagar and Udaipur City. An hour later the ward nurse showed up to find the four of us on the floor. He attended to patients and settled into his office. To us, he said nothing. Exchanging sidelong glances and a *chalo*, Mukesh and I rose to knock on his door. Dholi Bhai and Daulat Singh waited outside.

Mukesh thrust the papers at the nurse. “We have been admitted” The nurse took the papers, opened a large slip pad, and began to ask the same questions. “Name? Daulat Singh. Father’s name? Kartho Singh. Age? Maybe fifty. Caste? Rawat. Phone number” and on. Form full, the ward nurse tore out the two sheets of paper and took the old ones. These were Daulat Singh’s treatment forms. “Go early tomorrow to the outpatient clinic to pay for the x-ray. This form is for the sputum and this one for the x-ray. Do not confuse them,” he ordered. He handed Mukesh a small glass bottle with Daulat Singh’s patient number written in permanent marker. He explained that we must collect Daulat Singh’s first sputum in this container. He told us to go and take the bed at the end of the ward, number forty-eight. He also handed Mukesh some medicines. There will be milk and sesame seed mush for Daulat Singh twice daily but nothing for Mukesh or Dholi Bhai, he explained. With a sixth grade education and good Hindi, Mukesh was anxious about the forms. They were in English.

We picked up Daulat Singh and Dholi Bhai’s large sack of things and walked past the sixty beds searching for Daulat Singh’s. Bed forty-eight had a gaping hole in the mattress, stained sheets and no blanket. This bed unsuitable, we took one nearby and got Daulat Singh settled in. He would have to manage. As Dholi Bhai arranged her things in the windowsill, the

ward nurse walked up briskly. He told Mukesh that we must return to get the emergency doctor's signature.

We went back up the hill. I asked Mukesh why he had not told the doctor about his father's previous treatment. "They would have yelled at us and sent us home. We came all this way. We needed to get father admitted. They would have told us to go back to our local clinic and get the treatment there or get a referral. But, we are here and he needs treatment here first, so we could not tell the doctor the truth." We returned to the emergency ward. With no sign of the nurse we searched this ward too. It was empty, aside from a dusty unused operating theater and an old x-ray machine. Rattling doors, we found the doctor. He had removed his white coat and was watching a movie on his laptop in a Pink Floyd t-shirt. "What happened? There is an emergency? Which ward?" "No, no emergency. You did not sign the form." Mukesh handed him the form and he signed it quickly.

With the doctor's signature we returned to Daulat Singh. He had been moved again. We found them in the middle of the ward where Dholi Bhai had already settled into a new windowsill. With no hope of seeing a doctor, Dholi Bhai and Mukesh readied for a night on the hospital floor near Daulat Singh's cot. We decided to meet the next day at seven. I passed the gate to the bus stand and three pharmaceutical shops. Catching the ramshackle mini-bus back to Udaipur, I rode with visitors and a woman who sold fruit to patients.

As I sat on the mini-bus going to a friend's home, my mind whirled through the day's activities. What structure had Daulat Singh, Dholi Bhai, Mukesh and I just entered? Why did the family and I feel we needed to deceive the doctor? Why did the doctor imply that he knew Daulat Singh was treated before but not adjust his diagnostic criteria? Where would all these

forms go? How are experiences like Daulat Singh's anxiety and our circulations around the hospital campus structured and mitigated by global health as practice and discourse? What are the lived implications of the policies, practices and political economy of this aspect of global health today?

### **On deceit: the RNTCP's three lies**

Daulat Singh lied about treatment history. Why did he lie and what insight might his lie tell about RNTCP in general? This section considers these questions and places them in the context of an RNTCP deceit: questionable case detection and cure rates. We will explore the two lies in the context of a not-really audit culture and RNTCP system that can simultaneously succeed and fail. We can see how the RNTCP allows to die as it fosters biopolitics and life.

Daulat Singh began TB treatment and stopped treatment early twice, both times to visit his sons who work in South India. After falling sick again he spent months and a lakh rupees (about 2,000 dollars) managing TB with a private physician in Sagwai. When that treatment failed he decided to go to Udaipur. Though Daulat Singh visited the community hospital the day before, he did not ask for a referral and no state physician suggested he visit the hospital or provide a sputum sample. In Udaipur he found a closed hospital and an institutional *chakkar* (runaround). He felt the lie was necessary to access care and to not be spun out of this run-around.

When the moment for the questions came, Daulat Singh was already accessing the hospital through channels he felt were unorthodox. With no referral, a closed hospital, stern

doctors and nurses, a visit to the emergency ward, he lied to access care. He had good reason to think would be denied care. It all seemed out of the ordinary and the door ready to close any time. He lied to keep the door open. His lie and others like it cripple the project's ability to find cases that should be tested for resistance and put his life in danger. They also limited Daulat Singh's to access a higher standard of care as a relapse case, and present a moment when Daulat Singh feels that as a re-treatment his chances of accessing adequate treatment decrease. Yet, lies like Daulat Singh's also seem required.

His feeling that he needed to lie is part of a larger trend in the way the RNTCP manages TB. It gestures to the important ways the RNTCP is partly built on obfuscation and gives a sense of the ways patients feel at risk of being marginalized by the RNTCP. It highlights exception as the norm and the way to keep sufferers out (Gupta 2012).

His misinformation hides RNTCP weaknesses and tendency to exclusion by inflating RNTCP's surveillance and treatment success numbers. Daulat Singh becomes a triple entry in new case data. Case number 12345, case number 24680 and 13579 all correspond to the same individual, Daulat Singh. New case detection success is the backbone of the RNTCP's self-styled achievement. Daulat Singh's deceit helps the RNTCP on a global stage. It helps the RNTCP continue a system in which patients must be very sick and access a distant specialty hospital before they are diagnosed or started on treatment and maintain high case finding and cure rates.

The severity of Daulat Singh and others at the TB hospital's illness exposes failings in the RNTCP's passive surveillance method. Daulat Singh and others know what TB is, but often do not enter the RNTCP system until they are too ill to move. Active case finding,

though not suggested by the RNTCP, might help find and council these patients before they are too sick to move. Active case finding could have found Daulat Singh and many of the people I interacted with in the TB hospital before their disease was serious enough that they needed to be admitted there. It will also uncover the alarming trends Daulat Singh's lie masks.

Though the RNTCP strengthens some aspects of the health system at a state level, priorities at a national level are statistical, namely, achieving seventy percent case detection and eighty-five percent cure rates. The targets are not idiosyncratic. The RNTCP borrows benchmarks from the UN's Millennium Development Goals 2015. Case detection and cure rate statistics, collected and exceeding global goals, make for success in the reflexive gaze of the state and its actors. They index India's self assessed success and modernity as a global player and developed country.

India first met the goal of detecting at least seventy percent of new smear positive cases in 2002 (Central TB Division 2003). In succeeding years, quarterly reports show case detection rates oscillating above and below the seventy percent mark (Central TB Division 2010a). The general trend surpassed seventy percent in 2008 (Central TB Division 2010a). Since then case finding rates remain near the seventy percent goal. Indeed, in 2012 India's case detection was seventy-one percent and cure rate eighty-seven percent (Central TB Division 2013). This stagnation is surprising: why have case findings stayed the same for four years? One might assume from the easy ramp up that an increase to seventy-five or even eighty percent detection would be possible. Statistical success and program stasis, despite missing thirty percent of cases, is a structuring contraction that deeply affects Daulat Singh's experience, his lie and the situation that evoked the lie.



What of this statistical success on the global stage? The Indian press frequently criticizes TB control and the RNTCP for poor management of drug resistant TB and warns the country of a looming threat of TB almost annually (Mahr 2013). Yet bureaucrats strike back each time non-RNTCP actors point to gaps in RNTCP care. They point to the Millennium Development Goals as indisputable proof of success and argue that scaling up will catch anyone missed.

I observed the RNTCP's aggressive focus on epidemiological success at the November 2013 Paris World Conference of the Union Against Tuberculosis and Lung Disease. When the Additional Secretary to the Ministry of Health and Family Welfare Chandra Kishore Mishra gave a plenary lecture on the conference's opening day, activists in the crowd booed and heckled him. In July 2013, during drug stock outs across India, the RNTCP's Delhi office organized a move of MDR-TB drugs from Rajasthan to Mumbai and Bihar. Shifting these supplies left Rajasthan unable to enroll new patients on MDR-TB treatment and did not help Mumbai or Bihar avoid interrupting many patients' MDR-TB treatment. Their actions received little global or Indian press, but to activists were criminal negligence and genocide.

When the crowd calmed, Mishra delivered his speech unaffected by accusations of genocide. He highlighted both the challenges and success of India's RNTCP. In fact his touchstone for the lecture was India's success beyond the millennium development goals. He focused on preconditions—the difficulties of India's vast diversity and striated development—to highlight the mammoth task of achieving these goals. Mishra said,

The Indian story is a reasonably good one, which needs to be taken forward. What is wrong must be accepted, what is good must be complimented upon. If there are issues, let us face them together. These are issues for humanity. If we cannot face them together that is the real shame.

Mishra's comments make clear that achieving the Millennium Development Goals is a sufficient indicator of success and suggests India's RNTCP as a model globally. He also makes India's relationship to the global TB apparatus clear. On one hand, there is, a self-congratulatory aspect of India's success. On the other a question of unity—only together can shortcomings be addressed—nostalgic for the era of Nehruvian unity. He harkens back to national propaganda of the early 1970s that suggests unity can solve all national problems. Mishra uses unity to highlight the problem of Indian diversity, simultaneously gathering diverse TB sufferers into the nation and RNTCP into the international fold. He does not suggest the individual rational economic actor contributes to RNTCP achievement; rather it is unity and cooperation, statistic over subject. Mishra also asks for international solidarity not help. The Indian team and its history of success should, he argues, be trusted to move the existing program forward. It is not change that he suggests. Instead he advocates continuing successful policies and accepting mistakes. He highlights statistical success despite programmatic shortcomings matters.

The next day I met two Indian WHO consultants who disagreed with Mishra's decision to continue the RNTCP as is. They leveled stronger critiques than genocide. Dr. Arslan and Dr. Rajeev raised pressing questions about statistical success. They argued that RNTCP epidemiological numbers are misleading, and their single-minded defense of the program prevents changes that might improve the program.

These two men from Uttar Pradesh—one of India’s most populous and highest TB burden states—argued the RNTCP focus on epidemiological success prevents better case surveillance and prevents changes that may contradict epidemiological success but find more TB sufferers.

This program started in 1993 and since then it has been built across India. It was replicated and replicated, and now it has been, what 20 years, no? And it is the same program it was in 1993. Things have changed. We have new technology and new drugs but the leaders they do not want to change. They say what we have is working, but it is not working. It is not that they are afraid; they just don’t see it as necessary. They want to address a changed problem with the old solutions.

The RNTCP, they argue, is blinded by a need to see success in the project.

You know, India has money now. They can pay for their own project and they want to say it works well, and it does. But before when there were external funders there was something different, there was checking. People who were looking to see a return on their money could point to problems and push the government to do better. Now that the government pays for the program they want to show they are doing well so they don’t do so much checking.

The WHO consultants gestured to connections between national respectability and seventy percent case detection and eighty-five percent treatment success. I asked a question I would never ask in India, “So, does this mean that the baseline incidence and prevalence (of TB in India) might be incorrect?” They did not hesitate, “Of course they are wrong. As consultants we cannot publish but we have had data for years that these numbers are way off. A study in Ahmedabad showed that they should be increased by nearly a hundred.” The men confirmed what emerging data only suggests; there is reason to doubt the statistics.

Not only do the two consultants or my rudimentary data from Ambawati cast doubt on incidence projection, the presence of TB chemotherapeutic drugs in the Indian market does as well. Wells et al have shown that 119 percent of the first line TB drugs are sold in the private Indian pharmaceutical market (Schwalbe, et al. 2008; Wells, et al. 2011). This alarming rate

of anti-TB drugs in the private market becomes even more alarming and devastating for the RNTCP if they argue that they are already treating seventy-one percent of TB cases with public drugs. Where do all these drugs go?

To calculate a percentage of TB cases detected, the RNTCP relies on an extrapolated number of annual TB cases. They come to an India specific number of cases expected in negotiation with the WHO and an expert panel. Today the WHO estimates, after negotiation with the RNTCP, the annual incidence of new TB cases in India is one hundred sixty-eight per hundred thousand people or about 1.98 million cases annually (Gopi, et al. 2005; RNTCP 2005). The consultants argue that the projected number of annual TB cases ought to be doubled.

Let's take a more conservative estimate and guess that the projected incidence is one hundred cases per hundred thousand too low and should be adjusted to two hundred sixty-eight. If this were the case, the RNTCP would need to find one hundred eighty-eight cases per hundred thousand instead of one hundred seventeen. More alarming, if this incidence rate is more representative, the RNTC's current identification of one hundred seventeen cases per hundred thousand a year is only forty-three percent of TB cases annually.

With an unrepresentatively low incidence rate, the RNTCP is forced to do a fascinating and dangerous set of maneuvers that prevent higher incidence rates from coming to light. Higher incidence rates might suggest a much larger TB problem and discredit the RNTCP's statistical success and efficiency as a health intervention and bureaucracy. As such the RNTCP cannot surpass the seventy percent case detection by too far. Passive case finding identifies just under half of all new cases and keeps incidence numbers stable while active

case finding and improved access to RNTCP services threaten to reveal TB as uncontrolled and growing problem. These anxieties about incidence help understand why Daulat Singh needs to lie and also why his lie is important. Such deceit masks the problem and maintains an acceptable level of sick people who, of their own volition or in fear of death, access the RNTCP. At the same time statistical blindness allows those who do to occasionally count twice. Change, as the two consultants suggest, threatens to expose a national statistical fiction.

Yet, why hold to this success and why create it statistically if not actually? What is it about the current moment in India that makes supporting a limping TB control program important? I argue that it has to do with an Indian modernity and an Indian effort to foster a globally comparable biopolitics. This biopolitics comes wrapped within guises of post-colonialism, anxious sovereignty, the disciplining gaze of the imagined international community and the WHO. To understand this particular constellation of biopolitics we must engage a bit of the literature in South Asian Studies, debates about neoliberalism and modernity (Mitchell 2000), and flirt with the waning Subaltern School.

The RNTCP processes of statistics taking, of acknowledging pre-existing conditions, and of regimented improvisation of the RNTCP gesture to what Sudipta Kaviraj calls an Indian modernity (Kaviraj 2000; Kaviraj 2005; Kaviraj 2010). Such processes gesture to the Indian state's post-colonial anxiety that Kaviraj suggests is a feeling of contestant improvisation and coming from behind (Kaviraj 2005). In Kaviraj's formula, the RNTCP is caught between a global standard of rationalized modernity and effective biopolitics, a disease discursively linked to unattained modernity, and an Indian modernity in which statistics are indices of power and efficient governance.

Biopolitics as a category of analysis draws on Foucault's iteration of the term (1978). He suggests that biopolitics are a function of a larger concept biopower, a form of governance Foucault connects with liberal states of the nineteenth and twentieth century that aims to exercise subtle power on vitalities like life itself. Biopolitics, then, are ways of exercising that power and managing groups of people as populations with similarities around differences in biological existence. This population management too comes with associated subjectivations (ways of interpolating a subject) and technologies of the self set up in relation to power. Recent work to describe these processes with precision has generated a set of new terms: biocitizenship (Petryna 2004), biosociality (Rabinow 1999), biocapital (Sunder Rajan 2006) and the politics of life itself (Rose 2007). Most of this work has problematized genetics and exposure to think more about how social forms have been built around vitalities, troubled vitality and potential vitality (Rabinow 2006).

Other work has looked to the power over life to strip life of its social meanings and abject a kind of emptied biological life from the social whole (Agamben and Heller-Roazen 1998). What may be more useful, however, is an attention to the ways existing social meanings and practices are pulled into contemporary biopolitics and how they play out as new forms of life are problematized or protected. TB intervention in this case seems to be a key way to look to biopolitics as wrapped up with other forms of political life, reckoning the social, international relations, and statecraft that have conflicting priorities and multiple vitalities and populations at stake.

RNTCP biopolitics then seem to have more than just TB sufferers at stake; rather modernities too seem to be in the balance. Kaviraj suggests that Indian modernity developed

through three processes. Attention to these processes, he argues helps develop a stronger concept of Indian modernity, its contours, its ethics, and its anxieties.

Thus, three processes were involved in the making of modern political India: a reasoned attention to the historical preconditions out of which modernity has to be created, the specific sequence of the processes, and in particular the idea that modernization was not a blind imitation of Western history or intuitions but a self-conscious process of reflexive construction of society that should rationally assess principles from all sources and improvise institutions suitable for particular societies. (Kaviraj 2000:154)

Kaviraj argues that modernity as practiced in India is not the technical, rational modernity of Europe and North America. He argues that in India, attention to preconditions, a willingness to improvise, and a self-reflexive assessment of suitable changes, characterize modernity and the process by which modernity is achieved and evaluated. As he outlines it a pre-modern haunts that modern, and the past seem both to structure the present and be often in a state of only tenuous repression. We see all three in Mishra's speech, self-assessment through statistics and improvisation or fear of it.

As Kaviraj predicts, the RNTCP self-consciously styles itself part of the neoliberal Indian modern by working against a common set of constraints and structures to find a place (reflexively and rationally) within that modernity and uphold it. I argue that the RNTCP tool for rational self-assessment is not totally indigenous but an intersubjective one. The RNTCP assesses itself not against the state, as Kaviraj suggests, but against global standards. In this case statistically comparing itself to the Millennium Development Goals for 2015.

Constant form filling and statistic taking has become a particularly Indian form of self-assessment. Statistics are both fungible and infallible signs of modernity. Statistics are tools to measure modern phenomena and also index modernity in their use (Gupta 2012).

Daulat Singh's treatment and previous ones were properly accounted, and though there was no way to track if he had been treated, he was of biopolitical statistical significance.

This particular RNTCP hail to statistical biopolitics is complex. It assumes the citizen's particular relationship to the state and biopolitics fostered by the RNTCP will be temporary and only once. Biopolitics in the case of TB is performative and temporary—suffering with TB and treating it through the RNTCP enacts citizenship and makes claims on the state at the same time as the state makes claim on the sufferer<sup>4</sup>. The state (theoretically) takes the responsibility for both patient care and patient compliance through the DOTS model. At the end of a course each patient ought to be cured, never to re-enter this form of sufferer and pastoral state relationship again. Yet Daulat Singh and others must be interpolated by the RNTCP again and again without being included in a permanent biopolitics. As a curable disease TB biopolitics cannot be permanent. Patients like Daulat Singh must lie and deny previous failed treatment to access this kind of biopolitics again. Subjects engage the bureaucracy to get treatment, to become a statistic and to finish treatment. To return again is to enter a new year's population as a new subject.

Daulat Singh's experience suggests that the RNTCP practice of modernity is consummately a post-colonial practice of counting that aims to foster the lives of its citizens. Gupta and Mazzarella both argue that statistical capability is the key self-reflexive processes by which the state assesses its capacity to govern (Gupta 2012; Mazzarella 2006). As such the

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<sup>4</sup> Petryna's formulation of biocitizenship(2000) does not quite work here as radiation exposure is a chronic and incurable disease while TB through DOTS is curable and thus has the potential to not be chronic. As such this is not a life long form of citizenship and does not entitle the bearer a whole life in particular relationship to the state. By focusing on a temporary disease the RNTCP builds a biocitizenship for just a few months, trains the citizen and allows for certain claims of sovereignty through biopolitical control, but it does not build a biocitizenship for the sufferer.



very existence of statistical reports, quarterly reports, published rules and procedures, and careful documentation come to be quantitative measures of a qualitative success, good governance and care taking.

Pointing to the RNTCP and doubly counted people like Daulat Singh, the state can show on an international stage some handle on the kind of unhygienic chaos so often linked to India globally. By succeeding with this intervention, the state shows its mastery of chaos and its ability to bring structure and health to even the most marginalized citizens. Yet Ambawati remains to show that this is not the case and something more precarious than a biopowerful state exists. Statistics and passive case finding mask this precarity by allowing some to die and others to count twice.

RNTCP delegates like Mishra and others in Paris were keenly concerned with presenting India as a global model and modern success. As a global model The RNTCP points to the Indian state's effective biopower and proves the biological and experiential sameness of Indian citizens. Changes in the program to find patients or even more closely tailor interventions to particular classes, states or ethnicities, are problematic and gesture to a dissimilarity in theoretically equal citizens and highlight aspects of India not consonant to its aspired global model status.

Aspiration for a statistically documented and bureaucratized reality might suggest we see the RNTCP as a kind of care and audit culture complex. Indeed like an audit culture it seems that the collection and creation of statistical data is a key priority for the RNTCP. Mishra and others saw this kind of audit culture as an example of correctly functioning bureaucracy and also effectively mobilized biopolitics. Yet this audit culture as Foucault

(1980) and Strathern (2000) have formulated it relies on the idea that what is being documented is truth, some existing empirical phenomena, some correct knowledge from which to build knowledge/power. Yet in our case we see that what is being audited is a fiction that does not match empirical reality. We can see more of this kind of esoteric audit culture at work and look for the ways the RNTCP construct its knowledge and truth. Daulat Singh's second day at the hospital brings a neoliberalized aspects of this esoteric audit culture comes closer into focus.

### **On the hospital: Day two and seeing the unseeable**

My phone rang at five-thirty the next morning. It was Mukesh. He asked when I would arrive and told me to come quickly. They needed their Below Poverty Line (BPL) card. Mukesh was worried someone would take it in the night and suggested I keep it. I rushed to Udaipur's Delhi Gate and waited for the bus to the hospital. It was six am and no bus came. Six thirty came and went. As I waited auto rickshaw drivers arrived to begin their day's work. One had outfitted his vehicle with an impressive speaker system and was helping us all start our day with *sufiana kalam*--islamicate mystical music common in Rajasthan and growing in popularity across India. As the second song finished I decided to spend the hundred rupees on the speakered auto.

We pulled away as Chotu Mian sang of the veiled nature of God. Listening, I reflected on the tasks Daulat Singh would need to achieve today. We would need to do several more laps of the hospital campus to get his sputum tested and chest x-rayed. We needed to find TB hidden in his body—something we were already convinced was there but needed to be made technologically transparent, something like Chotu Mian's veiled but present God.

I arrived and walked to Daulat Singh's ward. All three of my friends were visibly startled. Dholi Bhai was anxiously chattering about not knowing what to do and how three had gone in the night. She pointed to an empty bed with a large oxygen tank next to it. Mukesh paid her no attention and hurriedly told me to come with him. I pulled the BPL card from my bag and handed it to Mukesh as we crossed the ward. We found a middle-aged woman in the nurses' office. She looked up as Mukesh stammered, "See we have a BPL card, it means we do not have to pay for the medicines you gave him this morning." The woman found their BPL number and registered it in her book, telling Mukesh she would need a photocopy.

Next she turned to me. "Who are you?" I respond, "I am the friend Mukesh told you about, the one bringing the BPL card." "Friend? Oh you mean he works in your house?" "No" I replied, "I am his friend we are neighbors and he asked me to come with his family to the hospital. I am studying TB. From the USA." "Oh, fine." She turned back to him, "So now that you have this you should go early to the out patient ward to get the paper that tells you to get the x-ray. They will take seventeen rupees, but not from you. Show your BPL card. You do not need to pay it."

When we returned to Daulat Singh's bed Dholi Bhai had already repacked her things and Daulat Singh was sitting on the edge of the bed. We were more than an hour early but they were ready to go be first in line. At the outpatient ward Dholi Bhai spread the sheet and we all sat down. We were not the first to arrive. A few people were already waiting. A middle class family ate breakfast on the approach to the hospital. Two nurses on the stairs chatted about their evening meals. A young man stood near a pillar. He recognized our accents. The

young man, Muaz, was from a village just twenty kilometers from Sadri and he struck up a conversation. He had been an MDR-TB patient and needed to return today for a six-month sputum sample and chest x-ray.

As Mauz chatted about the hospital and its routine, a man arrived and removed the large lock connecting the chains across the glass doors. A nurse called out to him as he walked in, “Oh Kamal Singh, you’re right on time.” It was ten past nine. Maybe Kamal Singh was a doctor. As he and the nurses disappeared in the building, Mauz and Mukesh followed to be greeted with a yell, “Its not open yet, yaar, let me wash the floor once.” Finally by 9:30 Kamal Singh had washed the floor inside the building and out. The doctors arrived, one parking his car on the approach displacing the middle-class family. He went inside and pulled open the window for the cash desk. Mauz hurried to the front of the line. He gave the man at the cash window some money and got a receipt.

As the man cut the receipt he asked Mauz’s name. Mauz replied “Mauz.” “Last name,” the man asked. “Harijan,” replied Mauz. At hearing this Daulat Singh’s whole family was startled. They had just found out that this man was an untouchable and the affect of untouchability washed over them (Sarukkai 2009). Mukesh stepped a pace back, giving Mauz a wide berth as he hurried to his x-ray. They chatted no more.

Mukesh and I got Daulat Singh’s X-ray slip and we left the large dark waiting room. Again we climbed the hill again. A small sign said we should go past the emergency building and up a path to X-ray. As we followed the path, we took breaks for Daulat Singh to catch his breath. Finally we approached the x-ray and sputum test building. The X-ray technician had not yet arrived. As we waited Daulat Singh became violently ill. He coughed up large

volumes of phlegm. Wheezing he asked Mukesh to take him to a small bridge nearby. Racking his small frame he held the bridge railing and vomited into the stream below.

He finished and we waited as he caught his breath. The x-ray tech had arrived and a line formed. As we waited Dholi Bhai began again to tell her story of the night before.

Three, three died in the night. The one right next to our bed, he died. We were sleeping on the floor, so much coughing in the ward. I awoke and there were so many people by his bed. The doctors tried to help him but they could not. They brought all kinds of machines and tanks but nothing. They hooked the tank to his face. His wife she cried out and cried again but nothing. They could not save him. He vomited so much blood and then they all left. In the morning the Harijans took his body away. Two others they went too, in the night.

We fell into silent reflection. A few minutes after she finished, our hush was broken by the X-ray tech calling out. “You, you’re next, hurry up.” Daulat Singh walked into the large room with black painted walls. The x-ray tech told him to mount the stool behind the stand holding x-ray film. “Take off your shirt,” The tech ordered. With a cough Daulat Singh removed his shirt and handed it to Mukesh. “Don’t cough in here,” The tech barked, “First thing in the morning and they’re already coughing on me.” As Daulat Singh stood shirtless in front of the x-ray machine the tech gave another command, “take off those malas (necklaces made of sanctified materials) and look over here.” A religious man, Daulat Singh hesitated. Sheepishly he handed Mukesh the necklaces and draped his arms forward over the frame’s props as instructed. The tech stood behind the large conical x-ray machine and snapped the image. He told Daulat Singh to get down and put his shirt on. He took the form, wrote Daulat Singh’s patient number on the x-ray film and told us to come back after one that afternoon. Mukesh and Dholi Bhai were upset. “But if we do not have the x-ray how will the doctors

start treatment? They will not start, it will be another day here and no treatment.” Dholi Bhai mumbled.

Mukesh and I crossed the dark hall to a wide table in the sputum testing area. Blotched blue with iodine, the table held a collection of the small sputum-sample bottles. Mukesh and I put Daulat Singh’s two samples in the group on top of the form we were told was to go with the samples. The attendant told us that in the morning the doctors would have Daulat Singh’s results as they came for rounds.

The four of us, our work for the day complete, walked back down the hill. Daulat Singh’s ward came into view as we took a break on the road’s curb. Daulat Singh was not happy about the x-ray. “Why can’t the man do it faster? He only had a few and why would it take all day?” He grumbled. “They will never start treatment. All the nurses say they can do nothing until there is an x-ray. Now the x-ray man will not give it. He just wants money. He would give it faster if we paid him.” As we sat on the curb another woman who had been spinning in the same circles in the lab and x-ray came over. “You can get the x-ray now if you give him two hundred rupees.” “Thank you, but we’ll wait” Mukesh said. “Leave it lying there where he took it,” Daulat Singh snapped in frustration. We rose and went back to the ward. As we settled in Mukesh asked a young man about the x-ray. After a brief conversation Mukesh called out, “Bhaiya, let’s get the x-ray.”

We started up the hill and Mukesh began his doubts. “It’s supposed to be free with a BPL card but look. It took four hundred rupees (\$7.20) to get the head of the hospital to sign a form after you left last night. The nurse said I had to go to his house and get him to sign a form. He would not (sign) without a little extra money. And now look, here we go. Off to give

the x-ray man another two hundred so he will do his job.” “Well, we could just wait. Anyway they will not have the sputum test results back,” I said. “No, we need it now, maybe if they have the x-ray they will start my father on the drugs and he can start getting well. We need the x-ray.” Off we went to bribe the x-ray tech.

Before he went into the x-ray tech’s room I handed Mukesh two hundred rupees change. He could not give the man one of his five hundred rupee notes lest the x-ray tech take it all. I stood outside in the x-ray building’s waiting room. Waiting, I read the sign on the wall’s three languages, Sanskrit, Hindi, and English. It read:

न त्वह कामये राज्यं, न स्वर्ग न पुनर्भवम् । कामये दुःख तप्ताना, प्राणनिांङ आतनाशम्

अपने लयि न मैं राज्य चाहता हूँ न स्वर्ग की इच्छा करता हूँ मोक्ष भी नहीं चाहता। मैं तो केवल यह चाहता हूँ कटिःख से टेप हुवे प्राणयिां की पीडा कनिाश हो.

I do not want for myself kingdom, or heaven, or even freedom from rebirth. I desire to end the suffering of beings that are in anguish.

The lofty sentiments seemed ironic as Mukesh was behind that very wall paying a man to hand over the free x-ray. The tech gave him the still wet x-ray. We stood in the warm morning sun waiting for our film to dry. A pair of hefty men and another desperately thin couple waved their own expedited x-rays in the sun too. Soon the outlines of Daulat Singh’s rib cage emerged. A few minutes more and we could begin to see the cavities TB carved in his lungs. I hoped the dark spots in Daulat Singh’s x-ray and his symptoms would allow the doctors to start him on DOTS soon, if only to calm Dholi Bhai before night fell.

We walked the x-ray back to Daulat Singh's ward before rounds were finished. The doctors had started on one side of the ward. Mukesh walked to a nurse. He chose the one who did not have a handkerchief tied across her mouth. Handing her the x-ray, he told her that he had gotten it early. She slid it inside the chart near Daulat Singh's bed and went back to her work with other patients.

X-ray in the folder Mukesh was certain that his father would start treatment soon. Yet the sputum test did not come back by evening and Daulat Singh's treatment would not start until the next day. His sputum smear revealed what the x-ray already made clear: Daulat Singh had TB and a relatively high load of bacteria in his sputum. He would stay another four days in the hospital until he decided to return home and start DOTS there.

The Bari TB Hospital provides Numerous diagnostic scenes—the morning exchange of patient milk packets for boiled milk, the accidental theft of a cup and plate from the hospital provision shop, the three large and well stocked pharmaceutical shops just outside the front gate, the frustrated and probably drug resistant TB infected patients returning home on the bus, the home TB care advice given by the mini-bus ticket taker, and the amazing diversity of people who came for care or accompanied family members—help build a better picture of the TB hospital. Others like the BPL card, the way Daulat Singh and his family responded to untouchability, and stigmatization started by the clinical caregivers will all follow in different chapters. For now let us focus on x-rays, transparency and corruption.

**On Transparency: seeing form and secreting movement**



The x-ray as evidence but not proof enough of TB is a fascinating analogy for transparency discourse in India and the neoliberalized world. The x-ray revealed what the physicians already knew but was still not the whole and transparent sense of what happened in the body. It was a way of seeing the extent that the disease affected Daulat Singh. It could not, however, reveal how much bacteria was in his body or how contagious he was. In policy a positive chest x-ray is not enough to start a sufferer on DOTS (Central TB Division 2005b; Central TB Division 2010b; Programme 2011; RNTCP 2003). A sputum test, despite its lack of sensitivity and tendency toward false negatives, is. Similarly transparency and certainty come to be of value for the RNTCP though they only show certain aspects of the bureaucracy with varying sensitivity, outlining bones and cavities but not movement, bacterial load, or presence conditions of TB in Daulat Singh's body.

Political anthropologists have addressed transparency in the Indian context by heeding Jean and John Comaroff's call to examine the new shadows that the millennial transparency discourse casts across the landscape of life (2003). Sharma looks to the creation and use of right to information legislation (designed to make much of the state's inner workings available to citizens) and the effects of information availability on bureaucratic processes of inscription and orality (2013).

Similarly Mazzarella takes just one case of corruption accusation to suggest ways transparency in India has become a kind of technological optimism (2006). I place my own work adjacent to Mazzarella's because he successfully points to the places transparency hopes to shed light: accounting and action. He argues that the hope of ending corrupt and unsavory

accounting techniques is enacted by e-governance that replaces physical registers with excel spreadsheets that seem less fungible.

The RNTCP's transparency in this regard is fascinating as it aspires for transparency as an end to corruption. Yet, an examination of what is made transparent shows that in this new transparency come several assumptions that lend not to corruption per se but a kind of productive mis-information through which the RNTCP can fit into what Mazzarella called a modern form of "incorruptible government" and avoid examination or change. Transparency in my experience with the RNTCP at Jaipur is like the x-ray, an effective way of seeing the program outline or skeleton but unable to show the inner workings of the body of the bureaucracy. Transparency as a discourse seems to act analogously to Daulat Singh's x-ray. The x-ray's transparency made the lesions caused by TB visible but could not diagnose him with TB because it could not confirm the presence of bacteria in his body.

In the name of transparency, the RNTCP's website makes a surprising number of procedural and policy documents available. One can download all-India level annual and quarterly reports and each of the training modules used to train RNTCP actors. A few more clicks and one finds TB communication materials, policy papers written in Delhi, and an outline of the standards of Indian TB care. One can even access RNTCP financial norms to follow both the money and the practice.

This abundance of transparency, however, makes the RNTCP in Jaipur no less difficult to access. I wanted to understand the people who manage a huge statewide program. Initially RNTCP actors were willing to talk to me but things changed when I approached the State TB cell in Jaipur with hopes of an ethnographic engagement. The state TB czar, as I

began to think of him, he told me I would not understand the RNTCP from his office. The place to find the RNTCP was in the district hospitals. I persisted, insisting that their office, I thought, was the place that solved problems and managed tough cases. We chatted briefly and I was given a perfunctory tour.

I arrived the next morning to an angry czar. He wanted to know why I had come back and what I had learned from my two hours of observation. When I was not quick enough to answer the question he began to quiz me. “Do you know anything about our office? Have you read what is available on the website?” “Yes, sir I have read many of the policy papers and the training materials.” “Oh in that case, you’ll be able to tell me how the financial structure is organized, how funds are released to us from Delhi?” I stammered. I had avoided the financial documents, “Sir, I did not think it would be wise for me to come here and ask you first thing about money, it seemed rude and none of my business. Besides I am not so interested in the money.” The Czar responded, “Well, finances are released from Delhi in April...” and explained in mind dizzying detail how money arrived from Delhi.

When he finished I thanked him for teaching me about this important aspect of the RNTCP. My politeness did not seem to settle him, “So what is the catchment area of a TB center? How many people must it cover? And what about in hilly and deserted areas?” He asked. This time I was ahead of the czar. I knew that the district TB centers were set up in district hospitals of varying size and hilly and desert areas had been bisected so that although a large part of Rajasthan is covered by desert and hilly areas there are few districts in which

these areas are counted contiguously.<sup>5</sup> None-the-less, RNTCP policy requires one TB center for every 500,000 people and in hilly and desert areas one for 250,000 people. I said that each district hospital has a TB Center and most districts also have another auxiliary TB Center or two. I did not tell him the numbers, as I knew them to be fictions.

No this is not correct. There is one TB center for every 500,000 people and half that in desert or hilly areas. You clearly have not learned anything. You are not working systematically. All of this is available on our website. You must read all of this first and then only come back here. And, when you come back bring me papers saying who you are. I want to see an outline of your project, questions you want to ask, a letter of introduction from your university and from your guides. Your work is not systematic, how will you show what we are doing if you are not systematic. I have to be sure that you will do a good job so the things you write about us are true. We have nothing to hide but I must be assured that you will be systematic so you do not mistake us.

I asked him what else I could bring him, thinking that if I studied hard I could pass his next quiz and easily provide as much documentation as he wanted.

I studied a week in my room. I read and took notes on over four hundred pages of RNTCP policy. I emailed my advisor and got a few letters of introduction. I wrote a research plan tailored for his office, listed a hundred questions, and was ready for the quiz.

On the day I crossed the city to the State TB Cell in *Swasthya Bhavan*, the health building, near the State Secretariat. I found the offices empty. I went to the accountant's office. He was compiling the monthly reports from each district. I asked him about the Czar and five other men who occupy that office. "They've all gone to Delhi for a meeting. They will be back." I handed off the papers and asked him to see that the TB czar got them. I tried to chat with the accountant but he was not willing to risk his job on a conversation with an

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<sup>5</sup> Ambawati is an example, it is hilly and forested but due to the district lines its hilliness is off set by the large flat spaces of the district and sub district.

interloper. He was far too busy compiling reports and keeping all the bills. Earlier, I had seen him ferrying files of bills and reports between his small room at one end of the health building to be read and initialed by several men in the czar's office.

Two days later I went back. This time I met the media officer Kamal. I had a conversation with him and came back the next day. On the third try the TB czar looked briefly at the Harvard letterhead, did not read any of the research plan or begin to quiz me. Instead he pushed the papers back to me and said, "This is all fine but without approval from Delhi I cannot speak to you. We are transparent here and have nothing to hide. You can see all of our documents on the website." This kind of runaround is not unfamiliar to both Indians and ethnographers and even links to Daulat Singh's fear and his lie.

I went home and bemoaned my fate to my landlady. Well positioned in Rajasthan's government circles, she had sage advice,

You know this is to chase you off. He expects you to go to Delhi and get permission but if you get it, and I think you will, he will then ask you to go to the state Minister of Health. I can help you with the Minister but you should first go to Delhi. Besides don't waste your time with these babus they will never tell you anything.

After five months of unanswered emails, I went to Delhi. A journalist friend told me to show up at the Deputy Director General for TB's office and convince him. I did and he was convinced. He emailed the TB czar and others in the Rajasthan instructing them to allow four days of observation at the RNTCP offices in Jaipur. He suggested we work together to set the best dates for that observation. I returned from Delhi with a copy of the email and my ream of papers in hand. I handed the email to several acquaintances in the state TB office. All of them

read it and put the papers back on the desk. I asked when would be a good time. No one answered. All went about their own tasks. I asked again. An hour passed and then another and finally after four hours each bureaucrat had quietly left without saying a word. It was now four o'clock and my observation appointment would never be set. I decided to use the data I had. My landlady was right, I would not get access to the RNTCP at Jaipur in a meaningful way. The babus would never talk to me.

Though the door shut on me, I got a good sample of how the RNTCP at Jaipur works. I met the accountant and saw his piles of statistics to compile. I learned about the troubles with hierarchy and patriarchy in the bureaucracy and gotten a good sense of what a few people contributed to the program and the importance of political will. I cannot speak much to the subjectivities of bureaucrats and I surely cannot give a good sense of what might really matter to each but I realized that in my ousting an important value was revealed, transparency. The evocation of abundant transparency made it clear that they envisioned themselves as Weberian bureaucrats whose subjectivity did not matter and whose daily operations are revealed in the policy documents that outlined them (Weber 1946). In pointing me to the website and policy papers, they gave me all they thought I needed to systematically understand how the RNTCP worked.

Yet as Kaviraj (2010), Gupta (2012), Bailey (1969), and Sharma (2013) all suggest, these bureaucrats cannot be understood as routinized cogs in a wheel or men who have put an unstoppable biopolitical machine in motion. Transparency presents them as such and suggests a smooth running RNTCP. Yet its gaps and lapses should not necessarily be foisted on them or on their policies.

A conversation with Amit Bhardwaj the RNTCP's communication officer made this clear. We had a long conversation on my second attempt to submit the bundle of papers. He seemed excited to talk to me and was alone in the office. I asked him about his recent visit to the field in Banswara a district relatively near Ambawati. In this conversation the limits of this transparency became clear.

When I met Amit on my first visit he was planning a trip to Banswara in southern Rajasthan. He had not yet been to Banswara in capacity as communications officer. Mangnani sahib, my guide for the day, agreed to introduce him to the DTO for Banswara. He warned Amit that the DTO was a nice man but should be dealt with respectfully and intentionally. There were problems with health communication in Banswara but an order would not solve the problem. Instead more experience Mangnani Sahib suggested a gentle motivation.

Today Amit told me that Mangnani Sahib had warned him correctly. The personalities of each DTO matter greatly. Amit explained that some DTOs take an interest in health communication. Their districts do well with TB communication. Others who see little value in the posters and fliers Amit provides usually require a letter from the director demanding they distribute fliers publicly. Practices like TB communication are idiosyncratic. Policy is not blindly followed by DTOs. This is in part due to these men's incredible workloads; many serve in three or four different capacities. Some, Amit said, would put posters in their offices but not distribute fliers. Amit addressed these issues in a form letter composed after his review with suggestions and praise. He wrote letters he could not enforce much action as he visited only once or twice a year. The format of these assessments and letters of

commendation and recommendation for changes are transparent and available online yet the comments in these letter are private.

The problem Amit faced was not of policy but one in which each DTO's priorities and way of doing things mattered. None of this fills a bureaucratic transparency mold Fliers sent for distribution are tabulated and represented to the WHO, but transparency cannot discern whether they are distributed or thrown away. Amit's conversation with the DTO cannot be tabulated, but the number of letters he writes is document and their form clear.

Similarly, the RNTCP publishes working papers for all to see and but implementation is hidden in individual roles, personalities and state politics. Record keeping strategies are ubiquitous and transparent to patients and outside observers while the practices of crafting and managing those statistics is opaque.

DTOs alone do not affect implementation, divergences from policy also occur at the TB hospital. It is against RNTCP policy to give TB suspects a chest x-ray.<sup>6</sup> Yet there are multiple areas of TB training manuals and even treatment categories that assume the physician took a chest x-ray. This kind of doubling as we saw in Udaipur and in many aspects of the RNTCP leaks through the opacity of transparency when one knows where to look for it.

By arguing that the RNTCP was transparent, the czar insinuated that I was looking for corruption. Transparency for him could prove him innocent of high level embezzling. As Mazzarella predicts, transparency was proof of doing right. Indeed I have no indication of

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<sup>6</sup> This policy against chest x-rays is in my reading two fold, it aims to keep costs low for the RNTCP and it aims to keep from giving patients without active TB long and difficult courses of medication



financial corruption at the RNTCP and the low level kickbacks in Udaipur are meant to show places transparency cannot permeate not systemic corruption.

Transparency as the Comaroffs suggest throws down new shadows in which the unexpected can happen. The ways transparency makes a certain idea of a bureaucrat and allows for different modes of bureaucratic action fall outside the gaze of transparency. They are exceptions to neoliberalism and neoliberalism as exception (Ong 2006). Strong policy, transparency, and assumed rational bureaucratic actors provide a neoliberal aspect to a project, which looks ostensibly above the fray of neoliberalism. Exceptions to transparent policy abound, the x-ray, the kick back, keeping Mangnani sahib on long after his formal retirement are all examples of ways policy and transparency allow exceptions and play.

As such I hope to have argued here that transparency is an effective mode of secrecy, a way in which biopolitics can look clean and easy but hide important aspects of implementation. Second transparency has made some forms of corruption more difficult. Transparent practices of book keeping made the theft of pharmaceuticals more difficult and embezzling funds near impossible, but it is not a simple answer for everyday graft in a healthcare setting.

### **On conclusions**

These experiences with the hospital and Rajasthan level RNTCP administration gesture to an esoteric audit culture that is both audit and obfuscation, both care and allowing to die. This audit culture at once includes the RNTCP in a global web of TB control and builds in anxiety. Yet, practices of transparency and audit do not necessarily make

transparency or audit culture real. Gupta argues that collection of statistics, which may not represent an empirical reality, is common for Indian bureaucracy (2012). He does not, however, offer ideas of what work spurious data collection may do.

The TB program's care-taking provides treatment for the TB affected and safety for its citizens at large, while creating a temporary and aspirational biopolitics. By gathering itself tightly in the web of global health through transparency, audit, and rationalization, the RNTCP and these discourses serve as mirrors as much as a biopolitics. Audit and transparency help constitute a system in which only a certain percent of cases matter and those exceeding it become a threat. Sovereignty and modernity come to be wrapped in moments of nationwide care-taking and in flattening diversity. The government's control of TB indexes the state's ability to manage an infectious disease, that threatens the nation/population, but indexicality builds a relationship to, not a direct representation of reality.

We must remember that India is burdened with a quarter of the globe's TB sufferers, most of whom are understood as rural and poor (WHO 2012). These "backward" subjects seem particularly in of need integration with the idea of a cosmopolitan, modern Indian nation (Khilnani 1999) or to be denied, hidden so as to ignore TB as a symbol of underdevelopment. This double bind is an example of what Aihwa Ong has argued is neoliberalism in exception and exception to neoliberalism. Ong's data in Southeast Asia suggests that these countries organized around neoliberal ideologies have set up systems in which subjects are at times disciplined along neoliberal lines and in others exceptions are made (2006). These exceptions,

however, do not necessarily mean increased freedom or necessarily a return to modernist modes of government, they can, at times, mean exclusion and being ignored as well.<sup>7</sup>

I follow Ong to suggest that this closed eyed embrace of the poor and inequality is not an intention of the RNTCP leaders or functionaries. Rather it is a function of the RNTCP's co-emergence with new forms of capitalism and a particular Indian zeal and hesitation to engage neoliberalism. In these exceptions for and of neoliberalism, TB treatment is both imperative and ignorable. It is a kind of slippery biopolitics, one in which management of the problem is a point of respectability and embarrassment. It makes to control the disease to be a modern strong state, whereas to be unable to control it to be lumped in with states lacking capacity or finances. The presence of a "disease of poverty"—"eradicated" in most of the so called developed world—requires government intervention and control to better provide a strong labor pool, reduce poverty, and stimulate development. Yet at the same time to put too much effort forward is to recognize that India has not yet reached its own development goals.

Ong's lead suggests that we might look to the ways exceptions are framed and in doing so focus on production to understand who matters and who does not. Yet this is complicated by Gupta and Sharma's argument that Indian state interventions can be a window

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<sup>7</sup> To understand the Bare Hospital, the RNTCP and state provided TB care and its relationship to modernity, I suggest we locate these practices in their world historical milieu. The story of the RNTCP in India is one of co-emergence with neoliberalism. Neoclassical economics formally entered India with economic reforms in 1991, a year before the state heavily revised its National TB Control Program to incorporate DOTS and WHO standards of free care. At this same moment, 1991-2 "out breaks" in New York City, links to HIV-AIDS, and the fall of the Soviet Union helped "re-emerged" TB as a global infectious disease. As such the co-emergence of the RNTCP, neoclassical economic and neoliberal ideological and governing forms in India<sup>7</sup>, and TB as a global priority require an analysis of the RNTCP in a context of neoliberal sovereignty and discourse.

into an as yet fragmentary transition to neoliberalism (2006). Indeed the two frames I have chosen, modernist statistical bureaucratic care-taking and neoliberal governance through transparency examine this in-between-ness. The RNTCP is both set up as an organization designed to provide free and universal care by a parent state yet at the same time priorities for participation and self-motivation intersect this. Neoliberal ideology then comes to rework citizenship not through the state's relation to the citizen but rather the state's relations to productivity and an opening up of business. As such those who matter shift from the citizen writ large to those who are productive. Ambawati, a rather quiet backwater lacks this productivity and while those who are willing to engage a the market as productive labor and in a highly monetized economy at all costs get care while those uninterested in this kind of relationship to the state are left out. It is in this form of exceptionalism that some are left out of the requirements of neoliberalism at the same time as they are left out of a modernist state project of free care for all. As such the RNTCP, we can see, is a way of mediating exceptions and who matters by making care difficult and by at the same time creating a veneer of a strong, safe, and productive workforce for business.

I have examined the RNTCP and Daulat Singh's experience for contradictions and exceptions that allow the project to simultaneously succeed globally and fail locally. Our days at the Bari Hospital are examples of the ways patients are drawn in and frustrated by the RNTCP. In doing so I hope to have located discourses of sovereignty, responsibility, transparency, community, and the nation as they are worked and reworked as the state attempts to take care of TB patients like Daulat Singh.

Daulat Singh's exceptionalism and that exceptionalism's gesture toward cracks in India's self-reflexive terms of modernity led him to lie to the doctor in hopes of getting treatment and allow the RNTCP to both the present a protected biopolitical sovereignty and mislead the global health community about the magnitude of TB in India. This omission of truth means that Daulat Singh could be added to the rolls of the treated and cured twice. He lied because he knew that to access the RNTCP system he needed to present himself as a subject in need of assistance and as a subject willing to continue the narrative of RNTCP success. The truth would have cast doubt on both.

### **Coda.**

I have not argued that Daulat Singh received poor care at the TB hospital. The work of doctors and nurses at the Bari TB hospital saved Daulat Singh's life. I do, however, wish to complicate and understand the experience we had there. This chapter I hope has presented some of the policy and discursive practices which shaped Daulat Singh's experience in the hospital. To name a few: an emphasis on TB as a disease best managed in the community left the hospital understaffed and underfunded, discourses of statistical modernity have limited our knowledge of just how well the RNTCP is doing, transparency has helped us understand programs at a policy but not practice level and kept a close examination and aspiration for positive change at bay, and despite transparency everyday practices of corruption do affect patients who many argue are receiving free care.

The next chapter will engage the RNTCP in Ambawati and give a sense of local actors and the ways they, in my view, work against many of the criticisms I have outlined here to provide care in difficult circumstances.

## Chapter two.

### On care communities: Community-based care in a context of direct observation

*Jab lag marane se darain, tab lagi premi nahin,*

*Baree door hai prem ghar, samajh lehu man maanhee.* –Kabeerdas Bhajan, sung in Ambawati, Nov 2012

One cannot become a true lover so long as he has fear of death in his mind. The abode of love is too far; it is not easy to reach there. One may be blessed with love only after he overcomes fear of death. This should be very clear to everyone. –Translation of the saakhi by Lachand Doohan (2010; 123)

#### **On the beginnings: community-based care for TB, Madras 1956**

A research team in India made the first strong case for community-based TB care. In 1959, the Tuberculosis Chemotherapy Centre, Madras (now Chennai) published a ninety-two-page report in the Bulletin of the World Health Organization. The document is a careful comparison of domiciliary and sanatorium-based TB treatment. This comparison came in the context of staggering numbers of TB cases in India (2.5 million) and a dearth of sanatoria beds (Tuberculosis Chemotherapy Centre 1959). The report gestures toward the minimization of social suffering as a meaningful consideration when designing a standard of care.

The experiment to revolutionize TB treatment began three years earlier. The study organizers recruited 193 TB sufferers and divided them into two cohorts. They admitted one cohort to a sanatorium for one year, treating it with Isoniazid and PAS (para-aminobenzoic acid), and prescribing strict bed rest and a healthy diet. The other cohort received the same pharmaceutical treatment but was not admitted to the sanatorium. They were instead sent home, but asked to attend a TB center to refill their prescriptions every week. Patients at home were given a supply of powdered milk and occasional cash stipends if necessary. They were encouraged to stop work and to take bed rest, although few did. This cohort also received monthly home visits in order to monitor their progress.

The Madras study found that sanatoria patients had better food and better access to food, took more rest, and lived in less crowded conditions. Nevertheless, the patients at home did just as well as patients in the sanatoria. Bacteria responded to treatment similarly, toxicity was uniform, and although home treated patients were more likely miss doses, their treatment success rate was similar. Meanwhile, the study found that patients in sanatoria experienced noticeably more “sociological problems”: problems like being abandoned by a spouse or embroiled in accusations of infidelity. The study concluded:

The results of domiciliary chemotherapy, as carried out in the study, *approach sufficiently closely* the results of the sanatorium treatment to suggest that it is appropriate to treat *the majority of patients at home*. In formulating this conclusion, consideration has been given to the manifest advantages of sanatorium treatment—namely, rest, diet, nursing and supervised medicine taking—on the one hand, and the social disadvantages, as represented by the disruption to family life and the difficulty of persuading patients to remain in sanatorium, on the other. It is recognized that the standards of medical care during this study were very favorable, but is considered that comparable results should be obtainable from a domiciliary service, which is being operated from a tuberculosis clinic, provided that certain minimum requirements are met. (Tuberculosis Chemotherapy Centre 1959)

The Madras study’s remarkable findings heralded the global demise of sanatoria, and of institutional care for TB more broadly. The authors did, however, put caveats on the study’s success. They made it clear that home based care is effective provided that patients receive home visits, financial support, minimum nutritional support, free medicines, and frequent progress checks in the form of sputum smears and x-rays.

Today the “very favorable” standard of medical care necessary for success is overshadowed by the success of chemotherapeutic treatment without sanatoria. Domiciliary care in its DOTS avatar has been whittled away from the Madras protocol, to just the simple provision of free drugs and observation at the health center. DOTS, as outlined by RNTCP policy, is simple intermittent short-course chemotherapy. Intermittent therapy attends to the burden on clinics and patients by arguing that drug absorption rates and half-lives do not

require a daily dose (Jawahar 2004). Today a patient on intermittent therapy needs to take antibiotic drugs only every other day. As such, patients must visit the DOTS, Monday-Wednesday-Friday or Tuesday-Thursday-Saturday, depending on the DOTS center schedule. At the health center they are given a day's dose of medicines and, according to the policy, should be observed as they take the medicines in front of the care provider (RNTCP 2003).

This thrice-weekly intensive phase characterizes the first two months of treatment. After two months the treatment changes from intensive phase to the four-month continuous phase. During the continuous phase patients must come to the health center weekly to pick up a blister pack containing their medicine. This phase is not directly observed, but patients must return with their emptied blister pack to get the next week of drugs (RNTCP 2003).

The support provided to the Madras Study patients throws the bareness of DOTS' contemporary iteration into sharp relief. Attention to TB's experiential, financial and epidemiological effects on the family has completely eroded. Madras Study domiciliary care participants had regular home visits and counseling by physicians, nurses, and social workers. Though counseling is formally part of RNTCP DOTS, home visits have been removed and counseling is minimal. Madras Study participants also received small stipends to cover transportation costs and a second small stipend to provide the family minimal financial support. This was in addition to a modest nutritional supplement. Neither occurs today. The Madras group wrote of such support that:

[w]hen the study was planned it was regarded as essential, in order to undertake it at all, to have funds available to give financial assistance to especially needy families for their necessities of food, or for their rent. This was particularly so because it was evident that patients under study would, in the main, be drawn from lower income-groups or the unemployed...In addition it was thought that funds would be required to buy a number miscellaneous items, e.g. to pay fares for very ill patients to attend the Centre. (Tuberculosis Chemotherapy Centre 1959:115)



The experiment built minimal financial and nutritional supplements into study design and recognized their importance for patients at home and in the sanatorium. The Madras study also tested patients regularly for toxicity and took steps to deal with side effects. With DOTS there are no x-rays, and sputum smears to assess the effects of treatment only occur twice: once during and once after the course of drugs. In the Madras Study attention to financial needs, dietary and family support, and side effect management were all integral parts of successful domiciliary care. DOTS—as the provision of pharmaceuticals—is now a shadow of the domiciliary therapy that the Madras study showed to be effective.

Comparing contemporary DOTS to the Madras study and its recommendations raises numerous important questions about domiciliary care today. Does the Madras model work today? Did the fact that DOTS phased out support aspects of the Madras findings mean that they were not necessary? Do people get the forms of care the Madras Study suggests they need? Does the community filled gaps left by DOTS? Do other areas of the health system come to fill in these spaces? Is everyone able to find them in other ways? How do families fill the voids, especially with limited financial resources? What of people marginalized by the community or whose families cannot provide care? What is community for TB sufferers in Ambawati? How can we conceptualize community that is not bounded, nostalgic, pristine or wholly violent (Das 2007; Theidon 2012)?

This chapter works to unravel this knot of questions and think about mediators who move between knowledge of care and its practice.

### **On a first glimpse at DOTS in Ambawati, 2012**

It was evening. The monsoon had started that week and it rained today like the day before. I walked behind the talab (pond) jumping puddles and avoiding slick spots on the way

to Siddharth's house. Siddharth lives with his parents, wife, and three children in a cluster of houses on a triangle of land behind the dam. Siddharth's house is a small low-slung mud and stone structure with clay shingles. Siddharth and his father built it themselves. When I arrived, Siddharth's father, Sohan Singh, was sitting on the low half-wall near a vertical beam of the house's awning. I sat as well, teetering gingerly on the edge of the charpoy string cot where Siddharth lay, his fragile body curled under a heavy blanket.

Siddharth stirred as Sohan and I turned in unison to track the sound of a motorcycle passing down the low hill below. The rider came into view as he doubled back up the hill, taking the path to Siddharth's house. A visitor was not a surprise. Nearly one thousand people had come to visit Siddharth since his condition became grave, and Anarsi Bhai, Siddharth's mother, finished sixty kilogram of sugar making small cups of tea for each of the visitors. As the motorcycle slowed to a stop in front of the house, Sohan, Anarsi Bhai and I were startled to see that the rider was completely covered in mud.

The rider was Suresh. Suresh was not an unexpected sight, either, but covered in sludge, he seemed like lean swamp monster riding a dirt bike. Anarsi Bhai rushed inside to fetch a towel and sent her grandson to deliver it. "I wont stay long," Suresh said as he toweled off. "I slipped and fell between the asphalt road and Jageeri Phala. I just missed the ditch." When he finished with the towel, he reached into the small carrying pouch on his motorcycle's gas tank and pulled out a tiny vial, a clean needle, and a syringe. "How is Siddharth?" he asked. Siddharth moaned in response. Sohan Singh said he was about the same but had been able to drink a little tea and had eaten a few pieces of chapatti.

Now somewhat less muddy, Suresh flipped off his sandals and ducked below the veranda's low tile roof to reach Siddharth's bed. The syringe ready, he began injecting its contents in Siddharth's remaining soft tissue, a casual, and now routine, process.

The injection was streptomycin. Suresh was the General Nurse Male (GNM) deputed to Ambawati. TB specialists diagnosed Siddharth as a second category TB patient and as such his DOTS course included regular injections of streptomycin<sup>8</sup>. This must have been Suresh's fifteenth visit and as he finished the injection Sohan Singh asked, "Cha vanau? Shall I make tea?"

"No, no. I think I'll go home and get a bath before it's too dark" Suresh declined. "He's able to eat the medicines? They're not causing too much trouble?"

"No, not too much trouble any more" Sohan Singh responded, "He's eating a little and has begun to sleep in the nights, we all have." Sohan Singh spoke in a mix of Ambawati's Rawat sociolect and Suresh's childhood language Wagri.

"*Thik, kale ni aalunla praso dan averiyun.* —Ok, I won't come tomorrow. I'm coming the day after," Suresh said as he mounted his muddied motorcycle. He asked if I wanted a ride home, as dusk had fallen. I straddled the dirt-spattered seat, and we headed home.

"You think he'll be alright?" I asked as we rode.

"I don't know," said Suresh. "He doesn't seem to be getting much better. TB medicines usual work more quickly. I hope for Sohan-ba<sup>9</sup> and all of their sake that he starts to

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<sup>8</sup> The RNTCP adds Streptomycin, another bactericidal drug, to the regimen when patients have seemingly more complex cases or have been treated for TB once before. They do so in hopes of preventing rifampicin resistance.

<sup>9</sup> Appending "*ba*" to the end of men's names is the most common way of indicating or building kinship in Ambawati. One could translate it directly as father or as the common Hindi/English use of uncle. *Da* does similar work. When a postfix on a proper name it means brother.

get better soon. I'll keep going until he does," Suresh continued doggedly. Why did Suresh-- busy, muddled and disheveled as he was--make the effort to come to Siddharth's home?

It is clear that Suresh felt treating Siddharth at home was important. Indeed, it probably saved his life. Siddharth was lucky in that regard. Suresh was by no means required to visit him at home. Siddharth was both a fortunate patient and a fairly representative one. It was fortuitous for him that his DOTS provider, Suresh, was a devoted caregiver. Still, the extraordinary lengths that Siddharth's family and community went to in their care giving are representative.

TB care for Siddharth and others in Ambawati is not simply the provision of medicines. It is a whole complex of engagements with social care and support. Siddharth was cared for by his family, including his children; by extended family members; by deities, tantrics and traditional body workers; and even by Suresh. Situations like Siddharth's are not uncommon among the families in Ambawati. Some provide more care than others. Each follows a different path and has different priorities. But as we saw in Daulat Singh's case, family care is of great consequence in the context of a system of biomedicine in which even institutional settings provide the minimum of care.

In what follows, I examine the community-based form of TB care that Siddharth and others received, not just from Suresh, but from others as care builds and reshapes community, to think more about the ways people access the support that the Madras study argues is essential. Also, I will consider ways the community makes TB support more difficult. The community cares and does not care for the TB afflicted in a variety of ways. This care is often inflected by the RNTCP's official DOTS program, and how it is enacted.

I will show how the nurses, Suresh and Sajjana, who serve Ambawati today (alongside the ghosts of their predecessors), leave crucial traces in bodies and forms of care. In turn, their divergent ways of approaching care giving significantly influence the quality of care giving that patients receive from the community. I see them as mediators of DOTS and will introduce other mediators of care in Ambawati. These mediators, I will show, matter tremendously for outcomes and people's experience of treatment support.

### **On community care in Ambawati**

I bumped into Dal Singh on the first day of intensive fieldwork in Ambawati. He told me I must come meet Siddharth as soon as possible. "You will be surprised by your friend's condition. He has grown quite thin." I had a hard time imagining Siddharth Singh thin. During the five years I had known him, Siddharth was one of the strongest, most dynamic, young men in Ambawati. I remembered him carrying a wooden double door two kilometers home in the dark and throwing bricks with ease.

The next day I started off for Siddharth's house. I expected to find him dynamic and gregarious as usual. Nearly half-way there, I saw a frail man and an old woman walking toward me. I recognized them when they came quite close, but I could not believe my eyes. It was Anarsi Bhai and a thin and fragile Siddharth. They were going to Sagwai to see the Ayurvedic doctor. As Anarsi Bhai kissed the back of my hands as older women in Ambawati often do when they meet nephews, nieces, or grandchildren after a long time. Siddharth invited me along and asked why it took me so long to meet him. As we walked towards the bus stand, he told me the story of his falling sick.

The preceding winter Siddharth's youngest son Shyam was playing with friends and fell in a dry well. Shyam's friends ran to find a neighbor. This neighbor, Shantilal, along with

Dhal Singh, Siddharth, and Sohan Singh, pulled Shyam from the well. He was hurt badly, and they rushed him to the primary health center at Hollarheda.<sup>10</sup> Shyam was admitted, and Siddharth, his wife, and their other two children stayed at the primary health center for four days to care for him. Siddharth said

I did not bathe for four days. I did not even realize how dirty I was. I was so distraught about Shyam. On the fourth day I knew he would be all right, then I realized that I was disgusting. I had worn the same clothes and slept on the hospital floor all these nights. I needed to take a bath so I went behind the hospital. There was a tank of water there. It was very, very cold but I did not care, I needed to take a bath. I bathed there out in the open with the cold water. The cold from the water must have settled into my body because since then I have been coughing.

The cough “settled in” (*be gi* [Raj], *baith gayi* [Hindi]) as Siddharth put it, and he tried various therapies for two months before he started DOTS. Indeed the account of the cough *settling in* raises two tropes common to cough narratives in Ambawati.

The first trope is a stressful social event. Most coughers in Ambawati link the beginning of their cough to some stressor: a stressor like a child in a well; a long and difficult pilgrimage; too much to drink at a wedding or ritual; a beating by a parent; or the loss of a family member. Whether or not these emotional stressors could be linked to the biological processes involved in activation of latent TB is debatable, but emerging work gestures toward this possibility, as do much older studies (Lerner 1996). Regardless, it is important to note that the beginning of illness is linked with moments of deep moral unsettlement and existential uncertainty. These moments of liminality, tension, and moral and social uncertainty come to matter, because they become the fulcrum on which intense stories of care giving and in some cases social abandonment come to rest (Biehl 2013). They also gesture to the importance of social support.

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<sup>10</sup> Hollarheda is between Sagwai and Sadri.

In many narratives, this kind of stressful event is followed by an exposure to cold temperatures: the second important theme. Sleeping outside in wintertime, being drenched in the rain, or a particularly frigid bath are common in cough narratives. Linking the onset of cough to cold and stress fit a diagnostic paradigm that makes sense to someone who conceives of the body as deeply affected by balances of heat and cold. Cough in Ambawati is understood as an excess of cold or a deficit of heat. Even the TB medication rifampicin fits into this paradigm – its red color indicating for many that it will heat up the body.

Families like Siddharth's manage cold in the body through the diet. Siddharth started his treatment by cutting out cooling foods like milk and buttermilk. When that did not help he began eating eggs. The incubating warmth from the hen is transferred and stored up in the egg. Meat too, we will see, began entering Siddharth's diet along with other hot foods like garlic and unrefined sugar. These basic but costly dietary changes are the first and most basic parts of care given to TB patients.<sup>11</sup> These new dietary practices held steady until Siddharth was well, and Anarsi Bhai and Siddharth's wife made sure to adjust their cooking.

Siddharth took DOTS treatment for three months before he got in a fight with Smita, the nurse in Ambawati at the time. He refused to take any more medication. "I gave it to her in writing, I did not want that medicine any more. I did not have TB and it was terrible. It made me so nauseous and I was not coughing any longer." After a few months, he fell sick again and began losing more weight. He decided to get treatment in Sagwai from the Ayurvedic doctor there; that's where he was headed the day we met on the road.

I had met this particular ayurvedic doctor once a few years before. He was an eminent man. He had once chaired the medical board for the area, and his family had served as the

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<sup>11</sup> Meat, eggs and unrefined sugar are expensive while buttermilk is free and milk tends to be available at home.

private Vaid (physicians) to the lords at Sagwai and Sadri. People agreed he was a good doctor. When we got there, a young man greeted us in his clinic. The Vaid died shortly after I met him, and his grandson, Gaurav, had taken up his practice. Gaurav trained in Udaipur as an Ayurvedic compounder, and practiced there until his grandfather's death.

Gaurav asked Siddharth if he felt any better. Siddharth reported that he was feeling weak but better. "Are you still coughing?" "Yes," "And still having fevers?" "The fever stopped but now this morning it has come back." "What about your appetite, is it returning?" The young Vaid asked as he felt Siddharth's hand, took his pulse, and confirmed the fever. "Yes it has gotten better. I do feel better doctor," "Good have you taken the Ayurvedic medicine I gave you, the one with jungle honey?" the doctor asked. "No we could not get any honey but I have take the other medicines." "Ok well I'll give you some more medicines," Gaurav advocated as he filled a syringe. "And try your best to get a hold of some honey, it will help."

Siddharth lay down on the table and offered his arm for the injection. The young Ayurved swiftly injected him with two syringes of antibiotics. As he was making an Ayurvedic compound, I asked Gaurav what was wrong with Siddharth. He replied that Siddharth had asthma as a result of his lung damage from TB. He could be treated in a few weeks, but if Siddharth's condition did not improve by the next visit Gaurav would have to suggest he try another doctor.

The next day Sohan Singh surveyed Ambawati for honey or someone to collect it from the nearby jungle. No one came forward. Finally he found a man in his wife's village who collected honey, but the man was arrested after a fight. Eventually, Sohan Singh bought honey



in the Sagwai market. Yet even with the honey, Ayurvedic medicine, and injections, Siddharth did not improve. They did not go back to the Ayurvedic clinic.

Next, Sohan Singh started visiting the spirit medium at Chor Kheda, near Sagwai. The spirit of a Muslim saint or warrior called a *pir* possessed the medium on Fridays and Mondays. After consultation with Sohan Singh, the *pir* agreed to take responsibility for Siddharth. The *pir* forbade alcohol in their house, provided Siddharth with ash from his offering fire, tied a strip of green cloth around Siddharth's bicep, gave Siddharth a half lime to keep at all times, and required at least one family member to be present at his shrine every Friday. After four weeks Siddharth felt significantly better. His father had been to the shrine diligently, and though I frequently suggested he get another TB test, Siddharth was certain he did not have TB. He was committed to following this treatment through. Could this ghostly *pir* heal Siddharth?

Siddharth, his mother, father, wife, and I gathered at the *pir*'s shrine on a hot Friday afternoon when the medium beckoned the *pir* for worship and healing. The devotees had amassed a large pile of frankincense incense, coconuts, rice, corn and wheat, ghee, cigarettes and perfume. Sohan Singh and I added our offerings to the pile. A crowd gathered by the time the medium arrived. Sohan explained that the medium was a distant relative: the medium's mother was a distant cousin and grew up in Ambawati. The medium had come to visit Siddharth at home a few weeks before.

Braisers burned with piles of incense, and smoke swirled around the *pir*'s tomb, rising past green cloth tide to posts and the branches of a massive Birbal tree. Assistants smashed coconuts, emptying their juice on the braisiers and cutting small pieces to distribute with *vibhuti* (sanctified ash). With a green cloth on his shoulders, the medium knelt facing the

shrine, his hands open as if readying for *namaz*. Soon he began to belch. After a few minutes of labored breathing, belches, and a shout, he slumped forward. Now calmly rocking back and forth he addressed the crowd. “Salaam Alekum!” The all Hindu crowd chorused back: “Salaam Alekum!” Then the conversation between *pir* and devotees began.

Anarsi Bhai and Siddharth’s wife were among the crowd of women sitting before the *pir*. The men filled in along side. Siddharth, Sohan Singh, and I balanced on a pile of rocks near the shrine with other men. The *pir* first addressed the children, “bring those sitting in laps first” Next he called those who had come from far away. Siddharth, Sohan Singh and I shifted a bit closer as Siddharth’s turn came. A scarf wrapped over his ears, Siddharth labored to tell the *pir* that he had been sick and had kept the family’s promise to the *pir* but he was not feeling better. The *pir* touched Siddharth and told him that he would be ok. He passed Siddharth a lime-half and re-tied the green strip of cloth at his bicep. Siddharth protested, “I’m not feeling any better, sahib what is the problem? My father has been here every week for seven weeks. That was your requirement.” The *pir* was unfazed. “I told you I would make you better, so don’t worry. I will do it. I am powerful. Now come back next week, you’ll be better.” Siddharth’s mother spoke up from the crowd of women, “Do something. He is not getting better, we are all worried.” Her final intercession unanswered, we all left. Siddharth’s wife, mother and I caught the bus back to Ambawati and Siddharth rode on the back of Sohan’s bicycle so as not to come into contact with any alcohol on the bus.

For two weeks Siddharth showed considerable improvement. He was still able to walk a little and found relief from his fluctuating body temperature under a ceiling fan his cousin bought in Sagwai. He could not bathe himself, but every day his wife or mother washed him. They heated water on the wood cooking fire so the cold water would not shock his system. I

was amazed by the attentive care Anarsi Bhai gave him. She scrubbed him fiercely every day, spending extra time on his back in an attempt to dislodge the phlegm that filled his lungs.

After a few weeks of feeling better his condition began to deteriorate. The *pir* and Siddharth had a falling out. Siddharth lost faith (*vishwas*) in the *pir*'s ability to help him. "Tell me Andy, have you ever heard a *pir* say he could not fix someone? They always say, 'yes, just pray to me and I'll fix you.' They lie and say that can do it, even if it is a problem bigger than their ability." Having left the *pir*'s care, Siddharth again perched on the back of Sohan's cycle, scarf tied over his head, spine heavily bent (his back muscles were no longer strong enough to hold him in his once proud posture). The two went off to consult a goddess who resided a kilometer outside of Hollarheda. The goddess turned them away. She said she had no problem with Siddharth, but he ought to consult Bheru Baoji (Bhairav, South Rajasthan's ubiquitous and terrifying avatar of Shiva). Obediently, Siddharth went with Ramesh, a neighbor and once his DOTS advocate, to Hangariya Bheruji. The very powerful iteration of Bheru, at a village called Hangariya, told Siddharth that he had a problem, but he ought not be too concerned.

Before going home, Ramesh and Siddharth met another mystic in Hangariya. The mystic gave Siddharth a pendant but told him that it would not help much. He instructed Siddharth to see a doctor instead. Siddharth did not want to go. The day after the mystic's instruction I asked Siddharth why he would not go. "If I had TB I would be sicker. You know coughing up blood and all. TB is not like this, I'm not sick enough to have TB. Besides I tried a TB test someone told me. If you put sputum in water and it floats only then do you have TB. I did it, mine sunk." I relented, again, "Well, I think you should have the test and see".

Soon after, a tantric began visiting Siddharth. Sohan Singh had called other tantrics before. Tantrics are common in Ambawati and south Rajasthan. They heal through incantations and evocations of a divine healing power. The tantric did his best to counteract any negative magic worked on Siddharth, but shortly afterwards Siddharth became much worse. His face became gaunt and his ribs visible from his chest and his back. In his desperation to get better he went to an expert in a technique called *daam*. *Daam* practitioners apply red-hot pottery shards to *nass* or veins through which *peep* or puss flow. In times of sickness these flows become blocked and cause pain or drying out. Siddharth and Sohan Singh went to the practitioner and got two *daams* placed on Siddharth's back in hopes of unblocking flows to his liver and calming his breathing. Later, at home, Siddharth put three burns on his sternum for the same purpose, but the blockages were not dislodged.

Finally, there seemed to be no other option. After many sleepless nights for the whole family, and extreme pain for Siddharth like a total lack of appetite, a near inability to speak and uncontrollable coughing, Sohan and Anarsi Bhai decided to take Siddharth to the Bari Hospital, where I would go a few weeks later with Daulat Singh and his family. They left on cycles at three am, Sohan pedaling one cycle with Siddharth and Ganpat, Siddharth's cousin, pedaling another with Anarsi Bhai. The foursome wanted to catch the four am bus at Sagwai before the heat of the day began to trouble Siddharth. Ganpat got them settled on the bus and brought the cycles back home. Then he fell into bed with a fever until his father, Dhal Singh, took him to the Sagwai Primary Health Center the next day for treatment.

Siddharth, Sohan Singh, and Anarsi Bhai returned a week later from the Bari Hospital. Siddharth began DOTS from the Ambawati health center that week. He was identified as a second category case of TB. This meant that along with the rifampicin, ethambutal,

phyrazinimide, and isoniazid, Siddharth Singh would need to go to the health center three times weekly to be injected with streptomycin. But Siddharth was not strong enough to travel to the clinic. And so, breaking with protocol, Suresh the nurse came to him during his free time: every second day for two months. It was during this task that we met that muddy evening.

Suresh' sodden heroics were no mean feat. Even after a week in the hospital and treatment, Siddharth was unable to speak. Word went around the village twice that Siddharth had died. But Suresh kept visiting. Once, he came with a large specimen tube with a red lid. Suresh had arranged for a drug sensitivity test for Siddharth's bacteria. He filled out all the paper work and carefully explained to Sohan, Siddharth, and Anarsi Bhai that first thing in the morning Suresh should spit his sputum into the tube and that Sohan Singh should take it in the district hospital. But Sohan Singh cannot read and was worried about going to the District TB Center alone. He asked if I would go with him in the morning if he could not find a ride. I told him I would, but Sohan Singh was lucky: another of Ambawati's TB sufferers was having a similar test. Bhagwanba, whom we will meet in the next chapter, had also been cleared for a drug sensitivity test and Sohan Singh was able to join Bhagwanba's son on a motorcycle to the District TB Center. There he met Dr. Arora the District TB Officer. Dr. Arora helped Sohan submit the paperwork and explained that the test would go to Ahmadabad for analysis. A month later the test came back. It showed that Bhagwanba's TB was rifampicin resistant, but Siddharth's was susceptible. Suresh and I could not understand why he was not improving.

A few nights after submitting the sputum sample for culture, Siddharth came down with a very high fever. At two a.m. Sohan Singh decided to take him to the community hospital at Sadri for emergency care. Anarsi Bhai recounted the events at the hospital. "The

fever would come on strong and he would sweat through the blankets. We put on new wet ones but he was still feeling like there was fire. I went crazy and I decided we had to go right then to Sadri.” At Sadri they found no one at the hospital. Finally they located a doctor, but he did not do anything. ‘They just stood round rubbing their eyes,’ Anarsi Bhai observed.

In frustration Sohan Singh called the local legislator. The MLA, as they are called in Rajasthan, grew up in Ambawati and knew Sohan Singh. The MLA called the doctor who was also the Block Medical Officer and insisted that he do his best to relieve Siddharth's pain. At three am with Sohan, Anarsi Bhai and Siddharth's wife covering Siddharth with wet blankets, the Block Medical Officer worked to reduce his fever. Eventually the fever subsided and by mid-day Siddharth was back on the cot in the shadow of his small home's porch. That was the second time word went around that Siddharth died. His sister showed up in tears only to cry even harder when she saw Siddharth silent and shrunken but alive.

As word spread through the region that Siddharth was extremely ill and not seeming to get better, men and women from his extended family began to arrive in large numbers. Daulat Singh's elderly mother spent extra time at Siddharth's house and the midwife, an aunt, dropped by often. Once, when I was visiting, a group of four women came and sat down near his bed. They sucked air in over their teeth and clucked at his state but said little. Eventually one spoke loudly, “*Siddharthiyo, muhe orke?*” “Siddharth do you recognize me?” “Aunty.” He responded. She was satisfied and began to talk to Anarsi Bhai about Siddharth's state as the other women shared hushed whispers about how sick he had become. Two days later Siddharth's father-in-law came with a rooster, to bury just in case an angry ghost was troubling Siddharth.

Men who visited often asked which ward Siddharth had stayed in at the hospital. Some even asked which doctor he saw, describing several of the physicians at the hospital both physically and based on their care. The conversations revealed a real familiarity among Siddharth's extended community with the Bari Hospital. They knew where it was, how to get there and which ward was for which kind of patient. Many had been before and several had been admitted.

With extra the expense of finding Siddharth treatment and hosting guests, Siddharth's family went to work as day laborers. His mother and father worked double shifts in poppy fields doing the backbreaking work of harvesting raw opium as it oozed daily from the poppies. They sold a large portion of their goat herd and during the summer months the whole family went to the forest to collect tendu leaves that they packed and sold to middlemen. These leaves, which would eventually be rolled into bidis, helped supplement their income during the lean summer months. Sohan Singh, Anarsi Bhai, and Siddharth's wife all worked tremendously hard to support the family financially and pay for Siddharth's treatments.

Because Siddharth had high fevers that made him feel like his body was on fire, his eldest son stopped going to school to fan and massage him. He massaged Siddharth's head and back, and pressed his feet. The massages, Siddharth said later, helped keep blood moving round his body. They were a crucial part of his home care. Anarsi Bhai even borrowed a liter of kerosene from the midwife and used it to massage Siddharth, in hopes that its heat would counteract the lack of heat in his body and stop the fevers. But after one massage, Siddharth's skin was so dried they discontinued the kerosene, but kept massaging in hopes of keeping the body's rotation moving, keeping blood pumping, and getting phlegm out of the lungs.

Siddharth did not respond quickly to DOTS. It was two months before anyone saw noticeable improvement. Sohan Singh felt that there were too many side effects—nausea, anorexia, discolored urine, headaches—and little improvement. He told Suresh he would bring any medicine Suresh saw fit. Suresh stayed the course but looked closely at the medicine the RNTCP sent for Siddharth. Examining the streptomycin injections, he noticed they were near expiration. He asked Sohan Singh to bring a new vial from the medical store in Sagwai and looked for a change in his condition.

Suresh's explanation of the expired streptomycin confused Sohan a bit and the whole family did not know if they ought to trust the strength of the RNTCP medicines. Suresh told them the medicine was old and not as strong as it should be. For a few days Sohan and Anarsi considered changing medicines, but Siddharth began to get better slowly. He started to talk again. Eventually the guests coming to say their final good byes slowed to those coming to see how Siddharth was doing. Sohan Singh was, however, not convinced that biomedical care was the only best option. It was working too slowly and the side effects were serious. Sohan Singh kept looking for another form of care, or another medium to solicit supernatural support.

Eventually, Sohan Singh joined the crowd at Nathubaoji's devra. Nathubaoji is an ancestor spirit and a deified ancestor/thief. Like many deified ancestors, Nathu was killed in violence. He was from a small village of just a few houses deep in the forest about ten kilometers from Siddharth's home. One day, long ago, Nathu stole a small herd of cattle. He drove the cattle through the forest to what is now Madhya Pradesh to sell. By all accounts thievery was common in Rawat households at that time. As he drove the cattle east the cattle's owners tracked and attacked Nathu. Though he put up a valiant effort to protect himself they killed him bloodily. The powerful Rajputs who live near Sagwai killed this adivasi thief. As



he was killed in violence, his soul has remained on earth and he has become a healing and magnanimous force for the marginalized in Ambawati and the surrounding areas. He mediates the relationship between his now living kin and other intercessors and the deities whose power might trouble or heal them.

Sohan Singh felt that Nathubaoji located the source of Siddharth's distress from the side effects not the illness. Nathubaoji agreed to mediate a dispute between Siddharth's family and their *khul deva*, White Bheruji. White Bheruji was angry with Siddharth and Sohan Singh--they had failed in worshiping him properly. They had worshiped him enough and at the right time, but they had not followed the correct order. Sohan Singh agreed to fix the mistake as soon as Siddharth was well. He would complete the assigned task and an offering to Nathuba. The bargain struck, Sohan Singh visited Nathubaoji's devra for months following Siddharth's illness. Siddharth continued to get better and the drugs' side effects diminished. Eventually Siddharth was well enough to sit on a motorcycle by himself without risk of falling off, and a neighbor drove him to Nathubaoji's devra.

Siddharth, Sohan, Anarsi Bhai, and to some extent Suresh agreed that Nathuba had helped manage the night sweats, the burning sensation, and the nausea associated with Siddharth's TB and treatment. Nathuba was an important support during Siddharth's DOTS treatment. Sohan Singh traveled to the devra each week to sustain Nathubaoji's goodwill and advocacy. At the same time Sohan made sure he also went three times a week to fetch Siddharth's medicines from the health center or the non-RNTCP streptomycin Suresh

suggested. He sought care for Siddharth where he could; not choosing either Nathuba as a spiritual mediator or medicine and Suresh but both.<sup>12</sup>

We see an experimental approach in the search for care and the ways Siddharth's family cares for him. Their approach is not chauvinistic in its preference of one over the other. They access spiritual, medical, and family care: much of it at the same time. It also is not superstitious. Instead it is a form of trial and error that drives them. They do not necessarily believe in any one system over another, one *pir* or *baba*, without proof. Siddharth's doubt of the *pir*, and his comment that no *pir* had ever said it could not cure someone, is indicative of a kind of hermeneutics of suspicion rather than a course of action based on belief in on particular system.

Byron Good, in his seminal work on belief and rationality, has pointed to this kind of willingness to experiment as a way of traversing the binary space between belief and "rationality" (Good 1994). Siddharth, Anarsi Bhai, and Sohan Singh's were ready to try new forms of care and providers of mediators of care. The conversations they had with neighbors and others who knew about sickness and remedy was never so exclusionary as to argue that a form of care would not work. They did not need to believe or not believe in a particular mode or style of healing. What they needed was something that worked and a mediator of healing they could rely on. Indeed their willingness to try and later jettison something that did not work is clear. When a kerosene massage did more harm than good they were happy to burn the kerosene as lamp oil. When the *pir* did not succeed in healing or brokering Siddharth's

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<sup>12</sup> I choose the word mediator because, just like the multiple levels of mediums and mediators that work between afflicted person and deity, Suresh and others mediate between DOTS and the patient. Just as mediators can choose what to reveal and what to keep secret about their negotiations with deities mediators of medicine can do the same. Further more it is often the case that if spiritual or biomedical health fails the failure is blamed on the mediator's charlatanism rather than the divine or biomedical. As such mediator sits in the space both of communication but also between cause and effect, between theory and practice, semiotics and phenomenology.

healing, they were ready to try something new. They stayed with Suresh as a mediator of biomedicine and Nathuba as a mediator of spiritual care because these two sources were reliably present when needed, gave support and provided results.

Even their slow recourse to the hospital in Udaipur came only when other systems proved that they were not working and they saw signs and signals (extremely serious illness and a near death state) that unquestionably pointed to TB. When the doctor at the Sadri clinic that night was unwilling to treat Siddharth they appealed to another higher power mediator, the MLA. It is clear that they were willing to search for care, but they were not ready to use a form of care with an absent mediator that did not seem to attend to Siddharth's well being. Their approach was neither about belief or rationality but was instead utilitarian, choosing what for them made the most sense at the time. If a system worked and its mediator was accessible physically and affectively, then they "believed" in it.

Siddharth's point that no mediator says they cannot heal him was clear. Every system and mediator was willing to take a chance and so were Siddharth and his family.<sup>13</sup> When DOTS was not working, they were ready to abandon it. Indeed what we've seen here is not a case of belief limiting care, instead we see a rather experimental and evidence based approach in a setting of great care giving diversity. What was constant, however, was a requirement that sources of care be present and deal with Siddharth as he was. The gods could make claims on Siddharth and DOTS could require his subjectivation to state rules, but not without showing results and not without a supportive mediator. Support, reliability, and attention matter.

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<sup>13</sup> The goddess might stand a good counterfactual but the case of the goddess actually proves this point. The goddess and her medium were willing to engage Siddharth but once the goddess determined that she was not the problem she told him another place to look. The same is true for the mystic at Hangaria.

### **On local politics and local care: Nursing the system and nurses in the system**

Even when the streptomycin and intensive phase was complete, Suresh kept visiting until the day he announced to Sohan that he had been transferred. Over the first three months of Siddharth's DOTS treatment, Suresh and Sohan developed a close relationship. I had seen tears in Sohan Singh's eyes several times as he talked with Suresh about Siddharth's condition. Suresh had come to care quite deeply for Sohan Singh and had watched the elderly man run himself ragged trying to care for his son and keep his family together. Sohan Singh was upset when Suresh told him that he would be transferred the next day back the Brahmin village he was originally assigned. "Our caste, our nurse, finally a good man and he is sent off to serve the Brahmins."

Before and after his transfer I spent considerable time with Suresh. I even lived for a few weeks at the health center with him. Over the years of engagement with Ambawati, I had met two other nurses who served and left Ambawati, and heard stories of the one who came before them. The collective experience of these four nurses will give, I hope, a sense of both the lived experience of providing primary care and help us understand the absenteeism and low quality care characteristic of Indian primary healthcare (Banerjee and Duflo 2006; Banerjee, et al. 2008; Chaudhury, et al. 2006; Deussom 2012).

Smita, Asha, and Ramgani all preceded Suresh and pre-figured both the challenges and successes he experienced. Ramgani is remembered as a formidable nurse, and an advocate for women. She served Ambawati for seven years. It is whispered that she left after being harassed by four local men, all of whom have since met untimely ends. Asha and her informal provider husband replaced Ramgani. I met the pair on my first visit to Ambawati. They served the community out of a rented room for four years before being transferred for

absenteeism and profiteering. Asha was an auxiliary nurse-midwife who worked with a Loharni Dai. She was known for her habit of giving multiple injections to mothers after delivery for strength.

Smita followed Asha. She and her (also out of work) husband unlocked the previously unused health center and worked hard to provide somewhat reliable care to residents. Smita was a diligent field worker and made a significant impact on TB prevalence and other disease. She diagnosed and treated a case of leprosy, helped build a birthing room at the Ambawati health center and was the first nurse to live in the quarters attached to the isolated health center. Sujjana joined her a year before my extended fieldwork as a fieldworker and midwife. She and Smita managed the clinic together, Sujjana in the field and Smita in the dispensary.<sup>14</sup> Suresh was deputed to Ambawati soon after Smita left. Suresh and Smita both had run-ins with local governance structures and part of this chapter examines the strained relationship between village nurses and local government as it affects TB care here significantly.

Some nurses, like Suresh, work to make a difference with care, presence, and competence. Suresh's swamp monster-like appearance that evening and his care giving for Siddharth does not allow us to wholly write off primary healthcare nurses as uncaring absentees or simple representatives of a care-taking state. His care giving points to the few nurses, lab techs, doctors, and others in the public health system who are willing to deal with the difficulties of becoming part of a community. Located between the state and the community, a delicate relationship forms between these primary health workers and the community they serve. They are people who can be both care giving mediators of

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<sup>14</sup> After the *sir panch* (elected village leader) showed up at the health center drunk and accused Smita of not doing her job, she used political connections to leave Ambawati a month before my long-term fieldwork.

biomedicine as members of the community and care-taking state actors in public medicine.

With that double membership comes the difficulty of community politics and rural social life and the pressures of being a state actor.

By comparing Suresh and Sujjana we get a glimpse of the ways differences between care giving and community integration mediates DOTS. We can also see how stigmatizing care-taking practices of a local nurse affects social care among families. This is not to say that histories of development, caste, and forms of aspiration do not affect social care giving and stigma. They do.

The evening of his transfer Suresh and I chatted. He was very upset by the way he had been treated.

It's the *sir panch* (local government leader). He does not like me. I refuse to suck up to him. I tried when I first came here but he does not treat others well. I was polite but he came and screamed at me and tells everyone I do not do my job. It started because I went to his house to vaccinate his child. It was time for the child's first vaccinations and his wife told me that the child was not well and it was not a good day. I said 'fine, I will come back next week.' The next week she refused again. I said, 'ok bring her to the health center and I will give the vaccination there.' I had been to his home twice. I can't go time and time again. Eventually he has to be treated like everyone else, he must bring the child here. Anyway he is supposed to be an example. He will not even have his own child vaccinated and he is part of the government. A week later he came to the hospital and told me to come to his house and vaccinate the child. I was alone there and could not close the hospital so I asked him to bring the child. He refused and later that day he came back drunk and screaming at me. He told me I was no one and he would have me transferred. That I did no work and that he had the power to ruin my life. Just like he did with Smitaji before she asked to be transferred. I was calm and knew he could not do anything. But now that he has changed parties he has a little power and he has joined with the MLA and the pradhan to have me transferred. He even lied to do it. He said I came to his house drunk and screamed at him. Have you ever seen me drunk Andy? Ever? No, you have not. He took his own behavior and told everyone that it was I who acted in that way. It's ridiculous. He is sixth grade educated and thinks I should call him sir. I will call him sir if he acts like, it but not if he is a fool. I'm going tomorrow. I am happy to go. I will be away from that buffoon. Even if he says what he wants I know I did a good job. Siddharth would have died if I had not gone every day to give his injections. This is more than is necessary and I did it from my heart and now look what this fool has done. I'm happy to go."

The next day Suresh started to commute between his room behind the Ambawati health center and the village health post he would now serve. Though he was living at the Ambawati health center, the health center's door was locked. Suresh had to turn people away. "I cannot see patients there. It is not in my charge. I cannot give away the government medicine or use the registers even if I want. It is illegal. I can treat people only from my own supply which I do, a little" Suresh abdicated his role as a state actor but did not stop visiting Siddharth or treating people who he lived near. As part of the community this role remained even after his official capacity changed. He continued to maintain ties of care giving though he was no longer the official caretaker.

After that, the situation in Ambawati went from a poorly staffed health center to a locked one. The first three days after his transfer, the TB patients waited outside the health center for their directly observed therapy. "The first day there were seven of us all waiting there for medicines. No one arrived. We waited for hours and then eventually when it was after the health center should have closed we all left. Remember we met at the bus stand and I told you I was looking for Suresh." Daulat Singh told me later. "It was that day; there were seven of us all waiting. Sohan, Bhagwanba, two girls from Dhuli Kheda and others all waiting under the tree, No one came." Suresh's transfer left the health center post vacant except for Sujjana who was often in the field and unqualified to run the clinic alone. Smita, who was asked to return, flatly refused. In the interim, residents, Sohan Singh and Daulat Singh among them, began to slowly work for Suresh's return. They met with the *sir panch* and the *pradhan* and threatened to call the MLA if something was not done. After a week and a half Smita too negotiated and Suresh was transferred back to Ambawati. She told me, "I said it to the block

medical officer simply. If he sent me back to Ambawati I would quit my job. He could send me to any place but not there.”

Local politics, rural government structures, and personalities affect care and the way it is practiced. They, in Suresh’s case put up significant barriers to his job performance, but were not such insurmountable hurdles that he was unable either to connect with people in Ambawati or keep him from being willing to be in synch and deal with Ambawati. They did, however, stop him from viewing himself as simply as part of state governance structures. Other nurses were not willing to provide care in this setting and saw trouble with local governance as a challenge to their place as a state caretaker. A willingness to engage and to be with those in need of care were to be a characteristic of Suresh’ effective DOTS practice but for Sujjana when her state actor status is shaken, fear and uncertainty become unbearable.

The difficulties with local government are compounded by uncertainty. Suresh, Smita and Sujjana were, like other National Rural Health Mission (NRHM) nurses, deeply concerned about their status as short-term contractual employees. They felt that this impermanence prevented them from enjoying their work. Suresh anticipated that with permanent employee status, he could negotiate with leaders to bring his wife to Ambawati or find a way to move closer to his family. Sujjana agreed. Permanency would help her move home. They hoped as permanent employees they would be able to unionize, strike, stand for promotion, stand up against people like the *sir panch*, have more say in postings, and be paid on time.

After years of stress, in 2013 the government of India announced it would both extend the NRHM and make existing NRHM staff like Suresh, Sujjana and Smita permanent state employees. That summer, a flurry of action began in the Ambawati health center. Files needed



to be prepared and interviews given, competitive exams scores had to be unearthed and relationships in the bureaucracy had to be cultivated. The nurses would be re-ranked and reshuffled.

The ranking process included an interview. Suresh and Sujjana hoped that good interviews might help them move closer to home. Smita coached Suresh for his interview. She had been transferred back to Ambawati but was not particularly unhappy, as she did not have to work here alone. She asked him all kinds of questions but none seemed to reveal a sense of what the interviewers might be looking for. They called a friend who had already given the interview and asked.

The friends said it was a farce. The interviews, he said, were only a false show of interest by men who would just assign people wherever they wished or were paid to. Suresh wondered aloud, how much would be the appropriate incentive, ten thousand, twenty thousand rupees? He made a few calls and decided that fifteen thousand would be enough to have he or his wife's new permanent posting near his home. On the day of the interview the three locked the door to the health center and went to the district headquarters for their interviews.

Each felt that it went well, but after nearly a year all three still served at the Ambawati health center. Though they have been made permanent employees, they have experienced none of the benefits they imagined permanent employment would bring. Suresh and Smita set new goals, to work extra hard at fulfilling their targets. Their target is clear, meet or fulfill their quarterly quota of family planning cases.

The most pressure (zor) is on family planning cases, it feels like they don't much care if we do no other work. We must bring family planning cases for sterilization. Smita and I are going to roam all over Ambawati; we'll leave no hamlet uncovered to find our quota. If we can show success there then maybe we'll get our work done. In Rajasthan family planning is the

most important thing, and if we do not reach the goals the doctors really scream. They are concerned about vaccination and all, but we have to get the sterilization cases or the rest does not matter. It is difficult though, we have to stake our reputations on this and we have to try very hard to convince people. We could use our time on other things but this is what they want. So we will have good merit and be able to get good transfers.

Though the slow moving bureaucracy and unfulfilled promise of transfers have motivated Smita and Suresh to better fulfill the NRHM's goals, the disappointment seemed to strike Sujjana hardest. She was already the most marginal part of the Ambawati team and now became more prone than most to missing work or embellishing documentation. After the failed transfer project, Sujjana takes a few days leave and is gone for several additional days at holidays, as Banerjee and Duflo's work shows is common among rural health nurses.

Though absenteeism was not totally anathema to Suresh or Smita, they worked to coordinate their absences in order to keep the hospital open – a priority in part because of the DOTS patients. Though Suresh and Smita's homes were comparatively nearby, Sujjana's family lived a two days' trip away in Bikaner, Northwest Rajasthan. With limited family support, Sujjana had a difficult time managing her job and her six-year-old daughter. She missed work when her daughter needed her or when she traveled the long distance home. She was often gone for weeks at a time near the major holidays. Suresh did not mind this, as he knew that he would be there to open the hospital. Instead he pestered Sujjana about the way she dealt with people. He found her gruff, authoritative and downright bossy. Many in Ambawati did too.

Unlike Suresh and Smita, Sajjana did not have conflicts with the *sir panch*. Conversely, she was often in trouble with her supervisor the Medical Officer at the Primary Health Center in Sagwai. Suresh and Smita covered for her as best they could but the doctor scolded her for doing poor work and being lazy. Suresh and Smita were concerned by her

poor treatment of patients. She was short tempered and spent little time with patients who came to her in the clinic. She preferred to give them paracetamol and send patients away. Suresh and Smita were not stalwarts of in-depth medical history taking but they did seem to show a care for their patients that Sajjana lacked. All three were under stress, and each reacted to the political and emotional difficulties of their jobs differently. Suresh held to his role as part of the community. Smita felt obligated to be present as a caregiver and mediator of medicine. Sajjana was disillusioned and further alienated when the local community and state bureaucracy failed to live up to its promises.

### **On Stigma or why DOTS mediators matter**

Sajjana is an Auxiliary Nurse and Midwife and unlike Suresh and Smita who completed three-year Bachelor of Science in nursing courses, Sajjana's ANM training is a yearlong practical course. She has a basic knowledge of public health, vaccination, family planning, and midwifery. She does not have more than a basic training in pharmacology and disease etiology, but her experience provides basic knowledge and she can manage simple cases on her own. Her role, on paper, was that of a fieldworker, vaccinator and program implementer. But her in-between position and role as an implementer of state projects has important effects on some people's TB care in Ambawati.

During a vaccination campaign Sajjana and Suresh stopped by my house in Ambawati's Meghwal neighborhood. Suresh needed a place to rest. Thirsty, he drank nearly half of my water pot. But Sajjana would not have any. I was a little offended that she thought my house or water vessel too dirty to use. With coaxing, she took a small sip. After a while Sajjana said to me, "You should leave. This is not a safe place." I was surprised. I was used to casteist remarks about living with Meghwals but Sajjana was a Meghwal. "Why? I find it

quite nice, people are friendly and the house is sturdy,” I responded unsure of what danger she might think I was in. “No its not safe. You will get sick.” “Sick?” “Yes there’s so much TB around here; in every house, Hameraba across the street, and that Ambalal and others. Who knows how many? Probably the whole neighborhood is infected.” I was shocked by her comments.

Sajjana was not telling me anything I did not know about the fact that TB was endemic. What surprised me was her conviction that I should move. She went on, “Even the water. Who knows if it is safe, all the people coughing?” So this is why she would not drink the water, I thought. Frustrated by her calling the neighbors who cared for me as their own dangerous, I hoped she would leave soon. Indeed Suresh, sensing my growing unease, suggested they check the neighborhood for expectant mothers. Suresh, it should be highlighted, was willing to visit Siddharth often and though he tended not to stay for tea he politely drank water instead. He never covered his face. He confided in me later that Siddharth’s home was a little dirty but that did not stop him from giving care nor did he say this openly to Sohan Singh or others.

As we left my house, Hameraba, a septuagenarian with a close-cropped white hair, crossed the road with three teacups. “Sister,” the common term of address to women nurses “I made tea.” He said stooping deferentially. “No, we cannot have tea. We have to go,” Sajjana flatly refused. Suresh looked incredibly embarrassed. Rejecting tea, I had come to know after days of ten separate cups of tea, was tantamount to cutting social ties. Hameraba, the eldest in his community and not quick to invite visitors for a cup of tea, was offering Sajjana hospitality because he saw her as a woman who saved his life.

He asked again and Sajjana refused again. In hopes of ending the situation as soon as possible, Suresh and I gulped down our tea and split the contents of Sajjana's cup. As we tried to limit the awkwardness, Sajjana tied a large cotton scarf over her mouth and began walking around asking if there were any expecting mothers. After she and Suresh left, the women in my neighborhood began to ask who this stranger was. "That woman is your friend? Where did she come from? Who is she?" Their questions surprised me as much as Sajjana's comments. Though Sajjana had been in charge of health fieldwork in Ambawati for over a year my neighbors did not know her. She had avoided this unsafe tubercular zone.

For months I watched Hameraba take his old cycle down the path toward the health center every Wednesday to get his weekly dose of TB medications. I joined him a couple of times. When Sajjana was on duty Hameraba would wait in the vestibule outside the health center. Sajjana did this with all the TB patients. She made them wait in the open air before she could cover her face regardless of how many months they had been on chemotherapy. That day when she saw him waiting, she searched for a cotton scarf and wrapped it around her face and mouth. Properly covered, she called him in. With Hameraba stranding near the door Sajjana walked to the stack of white boxes on the shelf across from her desk. She ruffled through Hameraba's box of pills, picking out a new packet of a week's worth of RNTCP DOTS intermittent therapy. She took Hameraba's empty blister pack and put it back in the box. After handing over the blister pack of medicines she sent Hameraba on his way. Hameraba bowed a little and left.

It went like this for the six months of Hameraba's DOTS treatment. Sajjana covered her face and spoke little. Though this is not the community-based care either the Madras Study designers or the RNTCP has in mind, it is common. Care-taking stigma from RNTCP

and NRHM professionals is the norm. On my first extended visit to Ambawati, a distant uncle of Siddharth's was dying of TB and unable to travel to the clinic or hospital. Asha--the nurse at the time--refused to act. I worked with a doctor at Sadri to order a sputum test, and had the sputum cups delivered to the sick man. I got the samples from his wife at the bus stand and rushed them to Sadri. The lab tech was angry when I reached the lab. He asked why I brought such filth and told me he would not prepare the slides. He sent me in the hall with a small wooden wand to spread the sputum on the slide. I completed the task and gingerly brought the two slides back to the lab. He told me to leave them in the windowsill and return in an hour. The same occurred with the X-ray technician and the nurses who covered their faces at Bari hospital. Stigma began in the clinic.<sup>15</sup>

Like the lab tech, Sajjana stigmatized patients in the clinic and refused to provide services to areas where she felt TB was in high prevalence. Just as the lab tech's refusal to prepare the slide was a barrier to diagnosis, Sajjana's actions had a critical impact on the people she stigmatized: the Meghwal neighborhood.

Meghwal families are no strangers to stigma. Rajasthan's Meghwals were, and at times are still, considered untouchable. Before independence they were heavily stigmatized. Elderly Mangaba and Hameraba recall a time when Meghwals were not allowed to use a single stone in building their houses a memory the thick mud walls in the old homes their neighborhood confirm. Mangaba said they were not allowed to wear turbans or shoes, or to upturn their mustaches. Women had to wear certain clothes and Meghwals were allowed only to sing certain songs and play the drum. They were also at times required to perform unpaid

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<sup>15</sup> There is good reason for physicians to be concerned. 42 members of the Mumbai Sewri TB hospital staff were killed by the disease between 2005 and 2013. <http://www.dnaindia.com/health/report-in-death-mumbai-doctor-spreads-tb-awareness-1857553>

labor for the Rajput lord. Men like Hameraba also served as bonded debt laborers to neighbors and larger farmers.

Though such institutionalized disadvantage was abolished at independence, subtler forms of exclusion still exist. Meghwal owned and operated shops are less frequented than those owned by other caste proprietors. Derogatory phrases pepper the language and many people deliberately walk around the Meghwal neighborhood rather than taking the paved road through it. It is then, I think, an extension of old stigma to argue that the Meghwal neighborhood has more TB. Indeed several other area hamlets had higher numbers of cases and the Rawat families, who lived in the same hamlet as the Meghwals, had more members with TB and more TB deaths. Nonetheless, the question of stigma was pressed on to the Meghwals in part by Sajjana who believed that they were something like TB carriers. TB stigma, I think, comes both from healthcare professionals as care-taking state actors and their fears as well as existing ideas about who or what can be stigmatized. TB and Meghwal stigma seems to group together and what becomes even more alarming is the tendency to stigmatize within the Meghwal community.

Family care in the context of stigma becomes much more complicated as fear and contract enter the paradigm. Fear of TB patients is built into the discourses of hygiene, surveillance, suspects, observation, and compliance as part of DOTS. As it enters the realm of family care through mediators like the lab tech, the x-ray tech and nurses that fear become more complicated and more dangerous. It seems to ripple down existing fault lines and hit those in precarious positions hardest.

How did Sajjana and others' opinion of the TB situation affect family care in their neighborhood? The first real sign of stigma I observed was not to a TB sufferer but rather his

son. Manish was four years old the year I lived in Ambawati. He took an immense liking to me and I him. His distant cousin and best friend Bhavesh was the same age and a bit quieter; ‘businesslike’ his family said. They were fast friends, but Manish was afraid to go Bhavesh’s home was next door. I learned why when Bhavesh’s grandmother chased Manish away one day. Adults often tease little children, but she was not teasing this time. “Go home and stay there. You’ll get us all sick.” She saw my surprise and turned to me. “His father had TB, it’s in their home. The little fellow comes over and coughs on Bhavesh. He’ll give him sickness for sure.” “I thought Ambalal (Manish’s father) finished his treatment,” I responded. “Sure he finished but who knows if it is really gone, it never is. We have to be careful,” she reasoned.

Ambalal was also a young man, about Siddharth, Suresh and my age. He completed DOTS just a few weeks after I arrived in Ambawati. Unlike Siddharth he had a meager support network before falling sick. He was also charismatic and eager to join in any community project, but his father died about ten years before. On the death of his father, his family began to disintegrate. His mother was somewhat reclusive and not one of the leading women in the extended family. She and her sons became isolated. Eventually both his brothers left Ambawati for work and though two of his neighbors were cousins they were both almost twenty years older than Ambalal.

Jealousy might also have added to Manish’s grandmother’s readiness to stigmatize. Manish and Bhavesh are the same age. Manish was much sharper than Bhavesh, though from a financially struggling and marginalized family. He never treated Bhavesh badly, but he was more talkative, more engaging of his parents and others, and certainly seemed smarter. Bhavesh’s mother might have reacted rather differently if she had confidence in Bhavesh.



Bhavesh's grandmother and Sajjana seemed to share a common and related problem. They knew both enough and too little about TB. They know what public health schemes had taught them: they have sufficient information to be afraid of TB's infectious etiology, to know it spreads by close contact and most often among people living in the same home, and to take steps to prevent their own infection by monitoring exposure to the breath of sick people. However, they seemed to be aware of only the most alarming aspects of TB. Neither Sajjana nor Bhavesh's grandmother know how quickly proper treatment stops the spread of TB. They do not know the ways TB can be spread and they do not know about the intricacies between exposure and active TB. These are just a few examples.

Their stigmatization is in some ways part of a partial biomedical knowledge. This is of course not to say that a more in-depth knowledge of TB or a complete ignorance will limit stigma. Rather I want to show here too that stigmatizing practices in the community are linked to local histories, disease physiology and the contours of public health intervention. Just as Good has convincingly argued that belief and rationality are not binary opposites but rather deeply imbricated in co-construction, stigma could also be understood as a construct not outside biomedical science, but rather a part of, and created in part by, scientific knowledge (1994).

### **On stigma and other "Sociological Problems."**

What the Madras Study writers called "sociological problems" associated with TB compounded Ambalal's already marginal position. Just before falling ill, Ambalal built a new house. The house was simple, a two-meter by two-meter room with an awning off the front. He borrowed money from brothers, cousins and local shopkeepers, but after falling ill was unable to work as an electrician. He and his wife and their young son came back to Ambawati

as he healed. But the inability to pay debts caused a strain between Ambalal and his brother. The two stopped talking. Debts unpaid and treatment slow, rumors began to circulate that Ambalal's wife had been seeing another man. Ambalal's mother and other elder woman caught his wife with the other man and gave her a swift warning and beating, not an uncommon occurrence in Ambawati. Ambalal's wife left for two months and he was cared for on-and-off by his mother and his cousin's family across the street. The other families did not pay him much notice. Many thought he should leave his wife, while others blamed his sickness for her straying.

For months after things got back to normal, Ambalal was an even more marginal part of the community and this marginalization was due to TB. People were unwilling to come to his house and spend much time with him. Lonely and impoverished, he chose to temporarily migrate to Gujarat and work as a laborer building apartment buildings there. His wife and Manish stayed home, living quietly alongside neighbors who avoided them because of TB and its effects on their lives.

Hameraba too was marginalized but he had a different strategy. Hameraba kept the name of his illness quiet, though his neighbors all knew. When people asked he told them he had chest pain. Even when he called Sajjana over for tea he simply said that she had been giving him treatment. She had taught him to avoid the name of the disease just as she and other public health campaigns had taught others in the community to avoid Ambalal. He was marginalized. Although he was the oldest male member of the community, his son died nearly ten years before. He quarreled with his daughter-in-law and granddaughter but was lucky to have been diagnosed with TB quickly. They stayed far away from the sick man.

When he completed DOTS, he held a large community event in fulfillment of a vow like the one Siddharth made to Nathuba. At the event he chose to adopt an heir for his modest landholding. Without telling any of his neighbors in advance he tied his turban on his nephew Vajeram (who we will meet in another chapter)'s eldest son. Tying his turban on the young man made him an adopted son and transferred both land rights and responsibility of care. Vajeram had been influential in helping Hameraba get treatment. Hameraba's widowed daughter-in-law contested his decision and made her views clear at the event. She hurled insults across the village all week. Hameraba and his wife Bamvari Bhai insulted their daughter-in-law right back. For weeks the neighborhood was regaled with every kind of Rajasthani curse and insult as well as all the family's dirty laundry. There was much at stake in Hameraba's management of stigma and his decision to reward those who had given him support.

Ambalal was marginalized for a long time after his treatment, and Hameraba never let anyone know his disease's name but still experienced tension along existing fractures. Though everyone knew he had TB, Siddharth, on the other hand, joined his extended family at their Navratri celebration only a few weeks after starting to feel better. He did not feel strong enough to sing his repertoire of possession songs; but he was quick to take back up the possession drum.

Suresh's willingness to take part in Siddharth's care and his engagement with Sohan Singh was an important support. It helped limit Siddharth's experience of stigma. His reliable provision of drugs and support gave reason not to fear. He did more than observe the short course of therapy. He participated and presented an example of someone unafraid of TB. His presence at the home facilitated family support like that his cousin gift of a ceiling fan, his

family's massages and baths, and the presence of hundreds of people. Suresh's support not only helped to convince Sohan, Siddharth and others to continue DOTS as Siddharth's condition improved, but it maintained the social fabric that Siddharth relied on.

Support and stigma have mattered in both of these cases. I do not mean to blame Sajjana for stigma, but those people who began DOTS treatment before Suresh's arrival and those who began after had markedly different community care experiences. His non-stigmatizing mediation of DOTS combined with family support helped Sohan and Siddharth manage the stress of illness. Sajjana's unmediated application of DOTS was unable to protect Ambalal and Hameraba from the suspicion of contagion built in the observation of therapy.

Indeed, a kind of pharmaceutical perspective would lead us to think that the RNTCP's provision of pharmaceuticals and occasional side effect management is sufficient for treating TB in the home. Rather, it is clear that this method contributes to both non-compliance and stigma. More importantly, without support from family and caregivers DOTS moves the focus away from care and onto compliance, and its requirement of observation might do as much to spread stigma as it stops the disease (Koch 2006; Koch 2011).

Stigma, we can see, comes with DOTS, not in spite of it. DOTS, as it is currently formulated, is much closer to the care Sajjana provided than what Suresh did. In the context of existing stigma, we can see that DOTS narratives of surveillance, separation, suspicion and contagion come to be important. They resonate with existing difference, and, as Yang and colleagues have pointed out, as socially experienced stigma (2007). They write of anthropological approaches to stigma that

Building on other theorists' notion of stigma as a social, interpretive, or cultural process, anthropologists have pushed us to conceive of stigma as a fundamentally moral issue in which stigmatized conditions threaten what really matters for sufferers. In turn, responses arise out of what matters to those observing, giving care, or stigmatizing; here, what matters

to these social interlocutors can allay or compound conditions. In addition to compounding the experience of illness, stigma can intensify the sense that life is uncertain, dangerous and even hazardous. (Yang et al, 1528)

The dialogical relationship they outline is between stigmatizer and the stigmatized. Being stigmatized and stigmatizing, they argue, contribute to a perspective on the world that highlights uncertainty and danger. It limits the willingness to be with others and to give care. In the same breath stigma legitimizes its own presence. Ambalal and Hameraba's loss of moral personhood and the social debacles they experienced help confirm a fear of TB as loss of self, status, and life itself. Even though Ambalal and Hameraba both got well more quickly than Siddharth, their loss of social status and inability to return to a wholly normal social life highlighted the danger associated with TB and its contagious moral threat. As Irving Goffman argued in the context of 1950's Euro-American life, stigma is a mark that permeated other aspects of their personhoods and futures. Even after the disease is suppressed the mark of TB remains (Goffman 1963). We can see here a further spoiling of an identity the Meghwals in Ambawati have worked hard to recover. It also becomes clear that stigma did not stop people from getting treatment, it was the unsupported treatment itself that deepened the experience of stigma (Castro and Farmer 2005; Farmer 1992).

Sajjana and Bhavesh's grandmother do not, I think, mean ill, but for them the local moral world, history and social memory, TB biology and epidemiology, and the RNTCP/global DOTS discourse have all come together to make it dangerous, but not impossible, to provide support necessary for care. Without support from well-trained and reliable DOTS mediators the moral effects of stigma become dire.

**Conclusion: Global community care**

This chapter showed that non-pharmaceutical support is still necessary and comes in part from the community and occasionally from the RNTCP. It also showed that community support is deeply affected by people who act as mediators between DOTS and sufferers. Community care has worked hard to provide dietary and social support, spiritual counseling and even financial aid, but the efficacy of these community supports rely heavily on the provision of DOTS support. As we saw, TB sufferers look to reliability and efficacy from those people who mediate between healing power and themselves. Suresh was a particularly effective mediator of DOTS and Nathuba, doubly mediated by a living medium's body and his role as intercessor with deities, mediated spiritual aid. Their work shows the continuing need for support in our contemporary context of DOTS. Sajjana and the *pir*'s mediatorship had different effects. Though Sajjana acted as mediator between DOTS and sufferers, she provided minimal support. She did not engage with sufferers and the stigma and fear embedded in DOTS went unmediated. To add to these fears came the unreliability of Sajjana's presence. The group of TB patients gathered at the health center after Suresh's transfer made this clear. Though the *pir* was constant in his presence and confidence as a mediator, he was unable to give lasting results. The *pir* was confident in *Allah*'s ability to heal Siddharth, but without results the family were forced to look for other mediators and other powers of healing. In both cases doubt and frustration overshadowed support and healing.

With doubt came stigma and for those with limited community support that support began to unravel. Hameraba and Ambalal were stigmatized, and community for them became less of a support than a liability. Their very place as moral members of the community took on the fear that unmediated TB and DOTS care brings in community. Suresh too felt an ambivalent relationship to community and the state. Community politics, as local government,

made his work as a mediator of state biomedicine difficult, but he was sustained by village links and a commitment as a mediator of medicine though not the state.

Community-based care is not simple and one should not necessarily assume that a community-based model alone is sufficient. We also cannot see care giving as an overly gendered act (Grant 2004; Horowitz 1985; Traustadottir 1991). By attending too much to gendered elements of care we miss out on the importance care giving represented by Sohan Singh's many trips to Sagwai for medicines or the dizzying circles in which he turned trying to get Siddharth care that would work. We would also miss the whole family's effort to get by financially and to maintain some sense of a normal life. Though women's work in care is important, men and especially male children are also important care givers.

A focus on DOTS also hides the myriad forms of care that TB patients receive and the multiple aspects of care, which may or may not help keep TB patients on their long course of medications. What has become clear however is the importance of mediators, nurses, deities, and families modulate and intercede upon the powerful systems of care at work. The mediators have come to unevenly provide the support that the Madras Study suggested. However, when one or more of these mediating and supporting forms is weak the importance of support not necessarily for healing but for wellness becomes clear.

Community-based care, we must come to understand, is not bounded or uniform. Rather community, policy, nurses, history, economics, pathology, and epidemiology all inflect it. In short, it is like all other community, neither bounded nor uniform, neither whole nor totally fragmentary, with both memory and amnesia. The task of anthropology in this case is to understand these relationships and re-think what "community-based" TB care and

healthcare more generally might be as a social form and as lived experience when community and family can be as sustaining and harmful, as Das has shown (Das 2007).



### Chapter three.

#### Relief, rotation and resistance: Ersatz practitioners, pharmacopeias and patient care in rural Rajasthan's storefront clinics

The body—real or imagined, living or dead, present or hypothetical—can mobilize scientific communities in equal measure around quests for profit, knowledge, justice, or simply the will to live. —Biehl, Good and Kleinman, 9.

Paan spitting, tea drinking, a little over-weight and occasionally puffing a cigarette or yelling in to his mobile phone in Bengali, Mohit Sharma is Ambawati's *Bengali Doctor*. He was one of the first people I met so many years ago and each time I return he grows a bit wealthier and a bit chubbier. After twenty years in Ambawati, he still speaks Hindi with a rather strange accent but neighbors often comment that other than his accent, everything has changed.

In an attempt to keep my notebook and cell phone safe from the monsoon, I bought a bag made from a recycled plastic cement sack. It was often a topic of conversation. The bag was a sign of my studenthood and stinginess. Many would see it when talking about healthcare, and begin a story about Mohit.

When the Bengali first came here he was as skinny as you and he walked everywhere like you. He even carried a three rupees cement bag like you. He walked everywhere, and sometimes people would let him treat them. He had a hard time you know. He could not understand our local language, like you when you first came too. He would always say, "what are you saying" and turn to someone nearby and ask what the patient had said. But now look at him, riding fast everywhere on his shiny red motorcycle and is growing fat. He now has that nice black shoulder bag for carrying medicines. You should get one like that. He has brought his wife and child here and he eats meat everyday. He has done well over the years, eating our money.

Their characterization of Mohit rings true. When I first met him, he had a small motorcycle, but replaced it with a fancy Pulsar with a red cross on the fender. Over time he moved his family from his brother's rented room to a separate house and began to build a house in Ambawati. His clinic has not changed much. He still has the same hard, wooden bench covered with a bed sheet I sat on when I first began to gingerly ask questions about his

practice six years ago, the same small wooden desk, old mini-refrigerator and two mostly empty shelves for boxes of medicines and IV bags. Time has added a ceiling fan and his prices have gone but his clinic has changed little.

Very friendly, he always scared me. I was cautious not because of any indemnity, but because of his heavy influence among people in Ambawati and simultaneous lack of connection in the community. Others had families and land here. They were grounded and knew that their community would hold them responsible but Mohit did not. In fact for many years this ability to pack and leave overnight made his practice possible. He and other Bengali Doctors were commonly talked of as men who could, at any sign of trouble, be gone without a trace before morning. “What is their responsibility? They cannot be held accountable. If something happens they will just run away,” Leela Bhai refrained.

In fact this happened to Ambawati’s other Bengali Doctor. The Barber, as he was called, once treated a patient in nearby Pilipura and shortly after administering an IV, the patient died. Whether there was a reaction, problem with the medication or manner in which The Barber treated the patient, or if he was called too late and unable to save a dying man is unclear. It is clear, however, that The Barber and the man’s family believed he was at fault. The Barber, fearing for his life, probably not without good reason, hastily left Pilipura. He cleared out his rented room in the night, and departed before sunrise. He has never returned to Ambawati. Some said he moved about fifty kilometers away and re-opened his clinic there. Many were quite happy with this turn of events. Though they mourned a neighbor and brother, the flight of the The Barber released many from debts, some of which had been accruing for years.

Despite their lack of rootedness in the community, Bengali Doctors most often work on a credit basis. Once when I was with Mohit he asked after a substantial debt. Mohit asked an elderly woman when she would repay the 4,000 rupees (\$75) she owed him. She replied, “Soon, we will pay you soon. Look, the soy beans are flowering.” The old woman’s comment meant: *look to our crops, they are good this year. We will have cash soon.* Corn and soybean crops are the first income many farmers have after the cash lean months of monsoon and growing season when their money is invested in seed, fertilizer and agricultural labor. It is also this time when most people get sick and decide to access health services. Bengalis tend to do their best business then, and their patients accrue several thousands of rupees in debt to be paid when the crops come in. The same day we met the woman who suggested that Mohit be comforted by the purple soybean flowers as proof that his money would be repaid, he pulled four crumpled hundred rupee notes from his trouser pocket.

Look Andy, today I’ve done about 5,000 rupees (\$100) of treatment but look in my pocket now. I will come home today from a full day of work with just four hundred rupees. If everyone paid me what I am owed tomorrow, I would be a lakhpati (a millionaire) but no, I treat everyone and slowly, slowly they pay me back. Many even tell me that I charge too much and do not give me all I ask. How can they just not give me one hundred rupees because they think I ask for too much?

Indeed credit and flexibility are major contributors to Mohit’s popularity in Ambawati, but they are by no means the determining factors in his success or the success of the four Bengalis in Sagwai and three others in nearby villages. The popularity of Bengali Doctors in Ambawati prompts all kinds of questions about care and TB. What is different about Bengali care and why--if it is similar to biomedical care--is it startlingly more popular than other forms of biomedical care? What are Bengali Doctors’ relationships to pharmaceuticals? What informs Bengali TB care? How do they treat TB?

Alongside these large and largely descriptive questions come a set of more detailed questions which might help us better understand not just what Bengali Doctors are but also how we might make sense of their popularity and footprint within the local biology of Ambawati and TB more generally. What ideas of the body and wellness play out between Bengali Doctors and their patients? What is the nature of the healing encounter between Bengali Doctors and patients? Do these Bengali Doctors allow for divergent sets of practices and techniques for care of the self that state biomedicines do not? What effect does their treatment have on both disease and bodies of Ambawati residents? Might they give new insights into old debates about biomedical dominance and hegemony, pharmaceutical care and drug resistance, care and the market?

What follows is first an introduction to a few Bengali Doctors, particularly their techniques, personalities and roles in Ambawati. I move from there to a discussion of pharmaceuticals and their role in a chain of both materials and knowledge linking folks in Ambawati to global discourses of care and pharmaceutical *biocapital* (Sunder Rajan 2006). I give a sense of what medicines these men use and how they use them, not only to help understand why their medicine works, but also to understand the ways these medicines fulfill local expectations of medicine and the functioning body. Finally, I focus on Bhagwan Singh, a man who accessed Bengali Doctors' care for six years to treat his chronic TB and chronic pain. I want not just to foreground the use of antibiotics as a local contribution to global problems of antibiotic resistance but to show how the local biology of TB in Ambawati is deeply inflected by Bengali Doctors (Lock 1993; Lock and Nguyen 2011).

Through the remaining pages, there are crucial points to keep in mind about the importance of Bengali Doctors and ersatz pharmaceutical use in India. First, antibiotic

resistance is of increasing concern in India where cases of totally drug resistant TB have been reported, and resistant strains of pneumonia, e. coli, and STIs are no longer uncommon (Udwadia 2001; Udwadia, et al. 2012). Second, private doctors are the first points of access for 86% of TB sufferers, a number my own and other ethnographic studies report (Uplekar and Shepard 1991). This preference, coupled with Das et al's finding that 66% of rural biomedical practitioners had no formal training, alerts us to how common the Bengali Doctor phenomenon might be across India (2012). Third, and importantly, the private sector sells enough first line drugs to treat each of the statistically predicted TB patients in India and an additional seventeen percent. This, coupled with the claim that at least half of Indian TB patients are treated by RTNCP-provided medications, shows an alarming oversupply of TB drugs that points to a massive misuse of pharmaceuticals. Moreover, the same private suppliers sell 62% of the globe's MDRTB drugs in India, though India only shares 36% of the burden (Wells, et al. 2011). A massive problem of antibiotic resistance both in the context of TB and more generally is perhaps unsurprising. Bengali Doctors are at the front line of both TB care and drug resistance. Understanding the discourse and treatment methods they tap into can help us better understand both TB at a local level and get a better sense of global resistance and imperatives to treat.

### **On inside and outside: ethical positioning and complicity in care**

As collecting data on this aspect of life in Ambawati was unsettling, this chapter deserves its own note of ethical and methodological reflection. My own discomfort kept me from engaging Mohit and other Bengali Doctors as I might have other healers. In fact, after a few days of accompanying Mohit on his "circle," my nerves were so frayed I had to stop. Mohit's "circle" included eight villages around Ambawati and his brother provided care in

another slightly larger village and about as many nearby villages. Mohit's eight-village circle meant that he provided care for about five thousand people. Circling through most of these villages each day, he checked on people who he had treated the previous days or was flagged down by new patients. Mohit seemed to like having me along. Indeed, as Pinto suggests, a connection to the non-local comes to be a key mark of medical authority in rural India (Pinto 2004), and by spending too much time with Mohit I risked augmenting the already heavy weight of Mohit's expertise. A foreigner accompanying him might lend prestige to the medicine he positioned as cosmopolitan and contribute to Mohit's hope to represent his care as being both world class and globally accepted.

At nearly every place we stopped I knew the patient or some member of the patient's family and had some kind of rapport. However, each time Mohit began to treat the patient my blood pressure rose. I was terrified that something might go wrong. Though Mohit has many years of experience, his actual training and knowledge of the drugs he uses is limited. Each time he began an IV drip I would be afraid for his patient and the possibility not just of contamination but also of a drug reaction and its life-threatening effects. The prospect of not knowing what to do in this event, which drugs he used, and stories of Bengalis and tantrics being beaten after failed healing, were sources of anxiety. Unlike Mohit, I was not willing to submit my own body as guarantee of his treatment and knowledge.

This bodily fear was suppressible, but I could not reconcile my own implicit support of a system that endangers the lives of people I cared about. Indeed, Mohit's tendency to ask me to confirm his diagnoses or treatment practices made me very uncomfortable. Jhalam Singh's treatment is one example. Jhalam Singh is an older man, maybe sixty; with several sons and a small house about two kilometers from Ambawati. After Mohit began an antibiotic

and B complex drip, he sat down to chat with the family. Mohit commented to me, “I have treated Jhalam Singh for thirteen years; his treatment is fixed. He always needs three IVs to get better. Even if he feels fine, we know he needs to finish his course. It is important to finish any course of medicine, isn’t it Andy?” This kind of comment, frequent with Mohit, made me uncomfortable. In part he was right, one should finish a course of antibiotics. Yet what is the correct answer when “the course” is two to three times the safe dosage, as is often the case in Bengali care, at an unfair and predatory mark-up, and administered by an untrained practitioner? Grudgingly, I agreed with Mohit, not because I thought he was right but mostly because in Ambawati the discourse about completing courses of medicines is fragile and necessary to keep TB patients from defaulting on their six-month DOTS course. However, I also agreed to keep Mohit talking to me, not to embarrass him, and to keep Jhalam Singh and his family from feeling that I thought their decision to access Mohit’s care was an unsafe one. After all they had just told me that Mohit had treated their ailments for a decade.

Despite the distance I tried to maintain, Bengali Doctors were quite open with me about their lives, their training, and their choices of medicine and forms of care. Indeed, the Bengali Doctors were not much concerned about the legality or illegality of what they were doing and were in many cases more open than those physicians trained and certified by the Indian state. Mohit and others highlighted their relationship to trained physicians and the practices of representation that grow from it. Many painted red crosses on their store fronts and consciously carried a stethoscope not to dupe their clients into believing they are trained physicians, but to access the symbolic authority of doctors.

Complicity was not mine alone. The local formal biomedical system, too, is rather complicit in Bengali Doctor forms of care. Lines between the formal and Bengali Doctor

informal are not firm. This chapter shows not just that biomedical practitioners work with and against Bengali Doctors, but that Bengali Doctors have been able to set the tone of biomedical care in Ambawati. Trained physicians have to contend with Bengali Doctors' treatment paradigms and many adjust to fit Bengali paradigms. At the same time, for Bengali medicine to be effective, it must be connected into pharmaceutical knowledge and distribution systems. They access the signs of authority used by physicians and make these signs a part of their practice. The red cross, the stethoscope and the injection are all invoked freely by Bengalis. In thus appropriating, Bengalis shed light on the formal system's lack of hegemonic control over signs and practices and make clear that biomedicine in rural India too has a precarious kind of dominance without hegemony. Biomedicine's signs and techniques are dominant and highly meaningful, but trained physicians do not seem to have a complete hegemonic control of their use.

This complicity in forms of care I would not choose for myself to better understand and document them seems ethically dubious. Yet as anthropologists we are called to spend time with and understand people with whom we disagree on a daily basis. Understanding Mohit and getting a sense of his treatment can and does help us understand why men like him exist in Ambawati. Though I do not agree with his treatment strategies or his prices, he is an integral part of the health landscape in Ambawati. To ignore his contribution to questions of both poverty and resistance is not an option, but it is just as futile to ignore that he is providing care for people who otherwise would not get it. He is fulfilling an imperative to treat where others are not. It is neither in my power or my place to choose to allow him to stay or go; my neighbors in Ambawati had made that decision themselves. It is my role to understand why they did so and what effects it had.



### **On Sanjay Roy: Who are Bengali Doctors?**

In a survey of the area's Bengali Doctors and other private physicians, I had a chance to get a better sense of who Bengali Doctors are and how they like to represent themselves. A friend and I met with all but one of the untrained practitioners in Sagwai.<sup>16</sup> The other three Bengali Doctors came to Sagwai after working nearby, and all had been practicing in Sagwai for at least 8 years. Some came here after living for a few years in Uttar Pradesh while others came from West Bengal directly to Rajasthan. The youngest Bengali Doctor in the area but not in Sagwai was about twenty-seven while the eldest was near fifty-five. All were married, though none lived in Sagwai itself. Instead they lived in smaller villages nearby or an adjacent town. Most tended to speak Hindi but would speak Mewari when necessary. All gave credit and all paid house calls.

During the interviews I met Sanjay Roy and came to know him quite well in the months following our interview. Like Mohit, my acquaintance with Sanjay gave me a better sense of the social and market forces that brought Bengali Doctors to Sagwai and Ambawati. The market in private health care that they both create and take part in is imbued with aspiration, a sense of service, profit and expertise. Bengali Doctors and their work in Sagwai are deeply

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<sup>16</sup> I learned that despite his title as a "Bengali Doctor" the man who refused to be interviewed was not of Bengali descent. A local Rajasthani man, he fits the patterns we might draw for Bengalis and their treatment techniques. As such, Bengali Doctors need not be Bengali; instead, Bengaliness identifies their lack of local ties and a historical point of origin for their medical practices. "Bengali," according to KS Singh, was in colonial North India used at times for any foreigner rather than exclusively Bengalis, much as *Angrez* is today.

connected to markets of pharmaceuticals, trained medicine, agricultural production as well as social factors like caste and biomedical uncertainty. A brief encounter with Sanjay will give a sense of the networks of family and knowledge of which Bengali Doctors are part as well as the notions of work and capital that they and their patients invoke.

Sanjay and Mohit make clear that Bengali Doctors across North India cultivate familial ties. His wife helps extensively in his practice, maintaining the stock of medicines and running a clinic at their home in a village on the road between Ambawati and Sagwai. When he cannot be there she also manages his clinic in Sagwai. I saw Sanjay ask his wife several times which medicines he should order and it seemed that theirs is a joint endeavor. His son, now fourteen, wants to be a doctor and Sanjay has resolved to send him to university in Udaipur for training when he is old enough.

When I asked him about his family Sanjay told me of his brothers, “I have three brothers. Two are here in Rajasthan and one is home in Kolkata. Well, do you know Howrah? He is there with my parents. The other two are nearby. One, my oldest brother, is like me. He sees patients in Nimbahera. And the other [sees patients] near Nimbahera in a smaller village. My big brother came here first and then we came.”

“How did you learn, from your brother?” I asked,

“No, my uncle does this work in Bengal; we learned from him. Now we learn by doing and we keep up with the new pharmaceuticals and with what works. My brother is very good. He has made quite a bit of money, and earlier, before I came here, I lived near Nimbahera.”

“How did you come here? Why Sagwai?” I inquired.

“Some people from Sagwai came (to me) and I found out that there was a need here. There were so few services here so I set up my small shop and moved to Jhuni,” Sanjay concluded his arrival narrative.

When I asked him about Bengal and why it was that this kind of medicine seemed to be dominated by Bengalis, he remembered his home and his eyes sparkled. He placed his life in this profession at a crossroads between social hierarchy, expertise, and prestige, both highlighting and rejecting the authority of biomedical knowledge and the high caste members he saw as monopolizing it.

See, Bengal is very different from Rajasthan, we do not have so much difference between high and low, but you see, we still have a little. See, the high castes, they have all the doctors’ posts. We in the middle classes, smaller Brahmins like others and me; we have to take the places they leave. So we take this profession. We do not have the opportunity to become doctors, so we do this work. We do not know as much, but we do know some things. For example, there is a man in Nimbahera; he is an expert at treating shingles. There are crowds and crowds who go to see him. Even the government and private doctors send patients to him. See, many people have specialties. I am good with common colds and pneumonia. I have all the medicines to treat these problems well, but this man in Nimbahera; he is an expert at shingles.

His continued talking about the ethical ambiguity of his work as he added economics and caste to his narrative about Bengali Doctors’ medicine. He narrates a neoliberal market for healthcare, one which foregrounds debt, credit and authority to require payment in the context of power.

And where do most of your patients come from? I asked.

Most of my patients come from the villages near the road to Udaipur, some patidars and Brahmins, but these folks are so stingy, they never pay, no matter how many times I tell them. I like to treat the Rawats, Meghwals, and other lower castes. They are less stingy and always pay. Still, most of my patients are Patidars and Brahmins from the Brahmin villages there. I don’t go to many other villages, but people from all over come here to Sagwai during the day. See I go out in the villages in the mornings and sometimes the evenings, everyone is available in the mornings and there is no reason to be here in Sagwai to open the shop before ten. I come here at ten and leave around seven. Sometimes I close if I am called to the villages but usually I am always here. My times are fixed here and people know they can find me.

I have introduced Sanjay and Mohit, as they seem to be rather generalizable examples of the Bengali Doctors I know. Their timings, training and temperaments are similar. After knowing these two for several years it is now clear that worldliness and an ability to gesture to an outside-of-India world of empirics, science, and technology was important for their assertion of medical authority. This kind of globalness affected not only their perspective on the world outside of Sagwai, but also their perspective on health economy, their treatment strategies, and the medicines they used. I observed both Mohit and Sanjay treat TB patients and TB suspects and I can be quite certain that they are, for the majority of Ambawati's residents, the first source for biomedical care. Evocation of market economy and inversion of caste power is salient, and the same market forces and high caste control of resources which brought Bengali medicine to Sagwai are active in keeping them there, and in business, among the rural poor. Indeed, without poverty in Ambawati, men like Sanjay and Mohit would have much thinner wallets. But at the same time, they are part of the social system that keeps the poor poor. Still, these market forces seem to be unsatisfactory answers to why people are willing to access care they know is risky. One answer seems to be its efficacy and this efficacy lies in pharmaceuticals and Bengali Doctors' integration within networks of pharmaceutical knowledge.

### **On Bengali medical education: evaluating pharmacy and seeing bodies**

Eventually I asked Sanjay where he bought medicines and he named the shop in Sadri where he and “most Bengalis and other private doctors get their medicines.” The next time I went to Sadri, I asked after the shop and found it just a hundred meters from the front gate to the government hospital. As I went to introduce myself, I noticed Sanjay sitting with the

owner. He introduced me to Saeed, the shop owner, and asked me to sit down with them behind the counter amongst the small white boxes of medicine. Over tea, Saeed explained that he owned this shop, one of the two wholesale medical shops in Sadri. He was trained as a pharmacist and a GNM or general nurse (male) and at times saw patients as well. What was most striking about the encounter, however, were the boxes and boxes of injectable cephalosporin. Cephalosporin and other antibiotics, particularly in injectable forms, are the preferred drug for most Bengali Doctors. They made up the bulk of the stock, but he had a wide selection of other drugs and he supplied the biggest private hospital and surgery in town.

Saeed's shop, I soon learned, is a meeting place for Bengali Doctors and other private practitioners, trained and untrained. Some sit for hours discussing treatments with Saeed and others come to collect large cardboard boxes of medicines. Saeed carefully recorded sales in small notepads with each doctor's name or location written across the book's spine. These accounts, he said, were usually left running. Among the stack were the names of each of Sagwai's Bengali Doctors and Mohit's as well. The lines between formal and informal blur here, where medicines are available at the cheapest and for credit, and as men trained in biomedicine and homeopathy sit with men who are untrained and discussed new medicines and ways to better manage patients.

On another visit to Saeed's shop, I asked him how Bengalis learned about new drugs. He rehearsed the same narrative of Bengalis learning from family members or while working as helpers in hospitals and shops. I listened and then asked the question I really wanted him to answer. "Yes, of course, but how do they learn about new drugs and dosing and all after they have started practicing? How do they learn about all these new drugs?" I read his face in that moment as a little sheepish and he seemed to know that I was asking about him. Softly he said,

“Well I have to tell them, don’t I. The drugs, they start coming when the doctors in the hospitals order them, but I need to sell more and Bengalis ask me what is good.” Saeed’s shop becomes an intermediary space between formal pharmaceutical knowledge and the ersatz.

I asked Saeed how he kept up on the new medicines and he explained that pharmaceutical representatives from nearby cities like Banswara and Udaipur come down his lane with their brief cases and suitcases of samples to tell him about new medicines. Indeed, a few days later I met a pair of these salesmen in Saeed’s shop. Like others they, too, sit down in Saeed’s shop and have tea. They discuss treatment strategies and drug delivery and give a sense of what symptoms their drug might manage. Saeed listens quietly, asks the price and the expected sales from the drug. Others, a few Bengali Doctors, are also listening to this transfer of medical knowledge. They wonder how quickly the drugs will work and if they can expect the drug to cause any “unsettledness” in their patients.<sup>17</sup> This time, the rep walked away unsuccessful. When he was out of earshot, a discussion of the drug’s power and the need for a stronger drug than this one that works fast and gives energy began. There was a need to find the newest and fastest drug. I recalled Suresh the village nurse’s comments: “Bengalis usually try medicines which are the newest on the market and ones too strong to have in government supply. They give two or three times what we give and before we start to use it.”

The need to stay ahead of new drugs on the market seems to be a key consideration for Bengali Doctors. Even though Suresh, Mohit, and Sanjay had rather similar knowledge about the drugs on the market and what they might be used for, Mohit and Sanjay seemed much more adamant about using the newest, and Sanjay had a very well developed knowledge of which medicines were new and which were becoming a little tired. He seemed to develop this

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<sup>17</sup> Unsettledness was a kind of keyword that gestured not just to nausea but other negative side effects as well.

knowledge both through practice but also from his friendship with Saeed and family contacts. Suresh, the government nurse, had a stronger knowledge of chemistry and drug safety, and this led him to pursue what seems in comparison to Bengali Doctors a conservative treatment protocol.

Another time at Saeed's shop I met Ganesh, a homeopathic compounder who practices in the villages north of Sadri. I asked him about practicing homeopathy and allopathy, and he began to outline the difference between biomedical seeing and the seeing practiced by Bengali Doctors (Good, 1991). For him, a key difference between the relationships Bengali Doctors and trained biomedical actors have to pharmacy was linked practices of seeing the body and thinking about pharmaceuticals and the body in time.

So, if you do a homeopathy course they must tell you a bit of allopathy?

*“Well the practice of it, meaning the practice of homeopathy and the ones who have MBBS, the bachelors that they (allopathic physicians) have, that is the practice of allopathy, that is different. The rest like physiology and all, that's the same...”*

So you have some really useful training.

*No, it's not like that. Trained and untrained physicians are cleaning up in the market. I mean really, man, what's the difference?*

True, but a little training is good, no?

*Yes, of course.*

Well, theirs too is training. Experience is a kind of training.

*I mean, their methods are a little different, after being trained a man becomes a little...*

What do you mean?

*I mean the theory and all, you know. Theory, well from it, it's a little like, you know, we get support. Like we, we are seeing a patient, like we are studying that patient, so if you want to understand a patient deeply, you know, if we want to*

*study him we get support from theory. On the other hand, the man with no training or anything he will just go by practice. Meaning, just that he thinks, it could be this, it could be that, or it could be that. So that means he will kind of remain in confusion. See, its like they can see the clothes but not the underwear.*

So do you ever feel like the medicine you give and the medicines that someone else who is untrained gives, between them there is a difference?

*Yes of course, look there are some things that. See, these people use a lot of steroids, meaning yes, they kind of use these steroids a little too much. Meaning, they think that the patient should get relief fast, you know, for them they need to make money but for me I need to make a life. Like, see I am local and know my area, fully, if I work there my whole life and I start using steroids now then in later times what will I do.*

The Bengali Doctor clinical gaze does not come to be more and more molecular and internal as Good suggests among medical students. Instead it is at a symptom level, and focused on solving the phenomenological problem of illness rather than biological disease. In the Bengali system the body is source of pain and disability that needs to be both relieved of its pain and put back in a productive system. The clothes, as Ganesh calls them, are symptoms, and the underwear, disease. Drugs, then, are understood for what symptoms they address. If they limit pain, if they reduce fevers, if they cool an over-heated body, then they should be used for such problems. The drive to see inside the body, and concomitantly to think of drugs as having isolatable and system-related effects, falls away. Drugs instead treat symptoms. One is good for patients with chills and another is good to reduce fever, still another to help increase appetite. As learned in places like Saeed's shop, prescription patterns tend to follow this jig. Patients with all three symptoms would then receive medication for all three symptoms. Bengali medicine, by virtue of treatment patterns and the drive to stay current with the newest drugs, helps these physicians outperform other medical practitioners. Their methods tend to make people feel better more quickly and get people back to work sooner, if not treat the disease.



So we can see in Ganesh's opinion and a visit to Saeed's shop a concern for the efficacy of drugs. Ganesh, however, does not share this concern in the same way as the Bengali Doctors. His preference to give fewer steroids and possibly smaller doses because of a long-term concern about how drugs might work locally over time is key to our understanding of Bengali Doctors as resistant and Bengali Doctors as fostering microbial resistance. Bengali doctors do not look to a local biology of drug utility. Rather they take a global view, putting their confidence in the pharmaceutical industry to replace drugs that no longer work and come up with faster and better medicines for unchanging symptoms. The question of pharmaceutical treatment and resistance in Ambawati both to TB drugs and antibiotics in general is fascinating and made even more threatening by the uncontrolled supply of drugs in tablet and injectable form in rural India. These drugs, starting with drug reps, moving through shops like Saeed's and passing to private physicians, eventually come to be held, at least in small amounts, by petty shopkeepers. Along the way the discourse of drug reps and efficacy is barely changed or mediated. Bengali Doctors and their patients embrace the pharmaceutical drive for new and faster drugs, more effective physiological and economic substances that Sundar Rajan traces in the global pharmaceutical industry. Drugs work not to cure but to relieve, and relief is the measure of efficacy. Ambawati and its informal doctors, though changing this biocapitalist discourse slightly, are happy to engage in a fantasy of unbridled pharmaceutical progress.

### **On An ersatz pharmacopeia**

Though not the first to stop using a medicine with growing antibiotic resistance, Bengali Doctors pick up the newest drugs first. Their short-term, high dose treatment strategies attend to a discourse of speed and efficacy in bringing symptom relief that moves

from drug reps and Bengali Doctors to patients and their families. There is a kind of joy in staying ahead of biomedicine and one that comes with appropriating it. Though used dangerously and without the theoretical and pharmaceutical knowledge to follow best practices or understand drug interactions, Bengali Doctors bring biomedicine and some of the newest, most powerful drugs to this corner of Rajasthan.

A visit Shantilal and I paid to a Bengali Doctor in Sagwai elucidated the particular relationship Bengali Doctors and their patients have to pharmaceuticals. Shantilal went to the doctor with a persistent cough and occasional fever, though Shantilal was certain it was not TB. “I did not drink alcohol or smoke,” he reasoned. The Bengali Doctor asked Shantilal his symptoms and how much he was willing to spend. Shantilal told him that he had a cough he could not get rid of and wanted a few days of medicine, about thirty rupees worth (\$0.55). The Bengali gave Shantilal twelve pills, six of amoxicillin and six of norfloxacin, and told him to take one of each twice a day. The Bengali Doctor told him he would get better, and for quite some time he did.

We see a combination of cutting edge and outdated antibiotics common among Bengali Doctors. A trusted older antibiotic, Amoxicillin has its own share of resistant bacteria (most from the staphylococcus family). It is, however, effective and suggested for the treatment of simple cases of pneumonia due to other bacteria. The second drug, norfloxacin, is less common outside of India and, according to Merck, its producer, norfloxacin is a kind of catch-all antibiotic effective against bacteria resistant to more common drugs like amoxicillin, penicillin, cephalosporin and sulfonamides (2013). Its continued efficacy makes norfloxacin a drug of last resort for resistant bacteria, and as a chemotherapeutic antibiotic it is somewhat effective against TB. However, Norfloxacin is recommended and approved for just three uses:

urinary tract infections, prostatitis, and sexually transmitted diseases. Along with ciprofloxacin it can be picked up in most any drug store in India and has come to be an idiosyncratic treatment for most everything. This Bengali Doctor seemed to agree, hoping it would end Shantilal's cough regardless of its cause. As he had no access to bacterial culture or sputum smear, he could never know the actual cause.

Shantilal's respiratory infection--which may have been TB--comes as an example of Bengali Doctors' use of cutting edge antibiotics alongside everyday medications and a reminder that a wide spectrum of antibiotics circulate in Rajasthan as symptom suppressants, routes to relief. Bengali Doctors' strategies make new drugs available and give people the sense of getting a quality of care not available in government clinics that stock free drugs, though at times in unreliable supply. The speed of Bengali Doctors' medicine, its dose, and the way it is administered, (most often in injectable form) are all aimed at making patients feel better fast (I hesitate to say cure here as steroids and one time high doses of antibiotics may repress rather than cure). These and the Bengali Doctors' presentation of self all give people the sense that they are getting care that is, in their own words, "high-fi" or cutting edge. Bengali Doctors' care popularizes pharmaceuticals but not necessarily the knowledge attendant to them. Instead Bengali Doctors' care continues a discourse of quick cure, miracle drugs that state medicine is either unable to provide or unwilling to give to the poor.

For a long time I thought that the adjective high-fi simply suggested that people felt the drugs Bengali Doctors use are better or more effective at doing standard work better than state medicine and gesturing to the fact that Bengali Doctors access the newest drugs. Yet high-fi might suggest more than this. High-fi is an abbreviation of high fidelity, meaning a copy extremely similar to the characteristics of the original. Indeed Pinto has argued that ersatz

forms of medical care in North India have a kind of mimetic quality. They both mimic and appropriate state structures of medicine as a way to access and destabilize the power of the state (Pinto 2004). Though I think this is true the Bengali Doctors seem to do something slightly different. What they seem to mimic or be a high-fidelity copy of is private medical care of urban and semi-urban India. Though these too can be thought of as a mimesis of the state system and western medicines, what is important here is that the institution being mimicked is the private healthcare market, its strategies, and its forms of relations to finance, power and health. Relations to pharmaceuticals come to be re-interpreted through this imagined high fidelity to cosmopolitan care. Price of course inflects the quality of the copy of private medicine and at the same time the fee for service suggests that the quality of care and speed of medicine will be superior to state services. As such the high-fi of Bengali Doctors' medicine comes to be an echo of a whole constellation of ideas and fantasies about institutions like the state and the market as well as what a doctors is and how medicine ought to work.

But what drugs are the Bengali Doctors actually using? After months with Mohit and Sanjay I finally asked Mohit to show me the vials he emptied in an IV drip. He laughed as I slowly read the drug names for my recorder and corrected my pronunciation. First comes cephalexin, recommended to treat pneumonia and a slough of other bacterial infections. Mohit administered it to every patient receiving an IV or injection. He and others suggested that it was effective for “cutting” fever quickly and, as he claimed, is the best drug available now. With cephalexin in intravenous solutions, Mohit tended to combine vitamin B12 and metimazole, an antipyretic and anti-inflammatory commonly used outside the US as a pain reliever, fever reducer and treatment for asthma or other chronic airway problems. He adds a

fourth drug, theophylline, most commonly used for chronic COPD, asthma, and other respiratory distress like bronchitis. Finally he tops the mixture off with injectable ranitidine, commonly known by its US trade name Zantac. Though most conventionally used for its anti-gastric acid properties, in India it is commonly mixed with Bismuth, which has antibiotic properties. In the Bengali Doctors' case, it is used primarily for the antibiotic properties of its stabilizer and to quiet an upset stomach.

This IV mixture and corollaries in injectable form tended to be the totality of Mohit's treatment. He would additionally give patients a few tablets of paracetamol, a common over-the-counter painkiller, and four or six capsules of leofloxin<sup>18</sup>, another antibiotic. It is

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<sup>18</sup> In fact his tablet of choice, leofloxacin, is a part of the RNTCP's second line TB regimen. Levofloxacin, on the market for thirteen years and one of the first second line drugs available, circulates in Ambawati. Saeed related its popularity: "Everyone uses levofloxacin. It is in tablet form and people can just give it to patients." Bengalis buy it from you? "Yes, everyone buys it and uses it." The district TB officer, upon hearing that I was engaging Bengalis and investigating their treatment practices, asked me to keep a special focus on Levofloxacin due to its second line status. He suggested I have conversations about limiting its use in order to preserve it as an anti-TB drug. Oddly, Levofloxacin's use for TB is apropos for a chapter about the counter-indicated or off-label use of pharmaceuticals, because though it has been integrated in India's second line of drugs, using it as chemotherapeutic TB treatment is not one of its indications. Ironically, it is indicated as a broader spectrum antibiotic, and in a strange turn of events we see Bengalis using the drug as indicated, whereas the RNTCP is not.

important to note that Mohit gave this cocktail to all of the patients I observed him treat with IV fluids. Few of his patients, however, had respiratory distress. Most had pain and fever. His anti-inflammatory and antibiotic cocktail seems to reduce pain and inflammations associated with fever, and boost lung capacity, causing strong regular breathing. The short-term high dose of antibiotics would strongly affect patients' system for a few days.

Engaging Bengali Doctors' treatment paradigms brings two key points to light. First, there is a tendency to focus on antibiotics indicated for use in managing pneumonia and asthma as well as TB, regardless of the patient's symptoms. These drugs are used for their wider antibiotic activity and for their tendency to ease troubled breathing during fevers and colds. They speed recovery by focusing on strengthening patients' lungs in order to maximize breath, making a real difference in limiting the experience of uneasiness and unbalanced breath. These drugs, as Mohit explained, help create a body that is visibly in stronger rotation as breath goes in and out. Just as Mohit suggested a definition of wellness that focuses on a rotating body, as we will see below, his medicines help him set the rhythm of that rotation, giving the experience of wellness and strength through steady breathing. We can also see that the combination of drugs Mohit uses are often contraindicated and designed at times to use the drug's side effects rather than indicated effects. Using Zantac for its Bismuth stabilizer as an antibiotic is a good example. Finally the combination of drugs Mohit, Sanjay and others use is also a mix of cutting edge and decades old pharmaceuticals. First marketed in 1922,

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This is another example of an engagement between trained biomedical practitioners and Bengalis, but this time we see a concern about their practices in fear of drug resistance.

metamizol has mostly left the western drug stage and been relegated to veterinary medicine<sup>19</sup>. Theophylline is another example. First used in 1902, with a chemical structure similar to caffeine, it increases blood flow and heart rate. Combined with Levofloxacin and Keflex, two of the newest drugs, Bengali Doctors mix old and new anti-pyretics, anti-inflammatories and stimulants with antibiotics. This combination of new drugs and quite old ones, drugs highly controlled and those available over the counter in quantities unheard of outside his own and other informal practitioner's practice, is Mohit's own alchemical symptom control. It also gestures to what Emily Martin has called the "black box" of pharmaceuticals suggesting that there is much mystery in pharmaceuticals and there is much to know about them outside of what they purport to do in the body (Martin 2006).

The kind of joy and anxiety Bengali Doctors and their patients experience as they chase the next antibiotic or stronger steroid leads to a kind of unhitching of medical knowledge and pharmaceutical knowledge and a shifting gaze at the body, that does not look to the increasingly microscopic and even genetic cause but to the molar and the bodily (Good 1994). As Ganesh said, Bengali Doctors are interested in the clothes not the underwear, symptom not disease, relief and not cure. To look deep for a root is not necessary when both doctor and patient are keenly concerned about symptom control rather than cure. Resistance in this case comes with re-distribution and a kind of Robin Hood act of making drugs, at a cost, available to all. Though not high quality care, certainly these Bengali Doctors have included themselves in a discourse of high technology healthcare for all and see themselves as going about providing it. Patients too have come to demand not just speed, but also advanced drugs and home care explained in terms of rotation and relief, idioms of the body they understand, and

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<sup>19</sup> In fact in 2013 Analgin was removed from the Indian market as well.

they are willing to pay. The state's lack of care has opened a space in which the market has created not just a robust and predatory health economy, but trained patients about healthcare and the body in new ways. In this sense, the Bengali Doctors may make a mockery of professional care, but they facilitate family and self care. The remaining sections of this chapter examine the discourses of relief and rotation, through which we partially see why Mohit's focus on controlling breathing and pain are important and can examine local idioms as part of a dialogical embodiment.

So as we have seen Bengali Doctors' care though more dangerous and aimed primarily at symptoms has real effects in the body. Indeed the relationship it builds between healthcare markets and the body is both fascinating and alarming. As Birla suggests a kind of bifurcation is happening between who and what kinds of bodies can and ought to access the market (2009). Ironically Bengali Doctors are actively creating this bifurcation through both an embodied component and a discursive one. The two work together to build both a health market and one that Bengali Doctors can come to control. Notions of high-fi and pharmaceutical superiority accompanying Bengali Doctors' treatment strategies and presentations of self link the care they provide with globally top quality medicine and attentive care. At the same time the medicines they use and over use create locally specific bacteria and bodies, which become resistant to state medicine. The market they have built discursively then comes to have a biological component. This is not to say that there was no market for health care in Ambawati or other parts of South Rajasthan but it is important to point out that Bengali Doctors and their medicines actually come to be both discursively and biologically more effective, outcompeting state care and building a kind of self fulfilling demand not seen since the birth of the clinic itself.



## **Mohit treats Roop Singh**

After a few months of fieldwork, but while I was still joining Mohit on his circle, I was sitting with the bicycle repairman, Kalu Singh, a witty TB survivor and genius with bicycles. He flagged Mohit over. They spoke about Roop Singh and his illness. Roop Singh's son had asked Kalu Singh, a cousin, for a small loan and to call Mohit. Mohit asked Kalu what he should give Roop Singh, an IV or just injections. Kalu Singh said, "Only some injections and some medicines, I will pay when you come back." So Mohit and I set out on his motorcycle down the dirt road that led toward the forest and Roop Singh's house.

We arrived to find a very sick man sleeping on a rickety string bed in the cattle pen. Mohit woke him and searched for a relative. Women working in the field and a few nephews gathered. Mohit began to ask the short-of-breath Roop Singh what was wrong. "I am so nauseous. I cannot breathe," Roop Singh responded. "Do you get fever?" Mohit asked. "Yes in morning and evening, I get a fever." "How long have you been like this?" Mohit seemed as startled as I by Roop Singh's condition. Roop Singh's face was gaunt. He was having trouble talking and each of his ribs could be seen just under his skin. "It has gotten like this slowly. Sometimes bad and then getting better, it's like this. Maybe it has been six months, I have been here on this cot." Mohit asked, "Can you eat?" "Just a little, porridge and tea. I'm not hungry. I cannot eat and I cannot breathe" Roop Singh replied. "Why have you not gotten treatment before? Do you not want to get better?" Mohit chided.

I can make you better. I can make you run in a few days but it will take time. I have a good medicine but it will not be cheap. You will have to have a course of medicines and you cannot say, 'I have money today but not have any tomorrow.' If you want to run and be well tell me.

If you do not, just say and we will let it go on like this now. You will have to stop drinking. Alcohol is so bad for you.

As he filled the vial of his glass injection syringe with antibiotics and B vitamins, he continued to lecture Roop Singh about the danger of alcohol and how if he ever wanted to get better he would have to leave alcohol completely behind. After discarding the medicine vials near Roop Singh's bed, Mohit sat with his patient as he recovered from the three. Before making a move to leave, the doctor stopped to talk to the gathered neighbors. He knew the entire small crowd by name. After asking after each person's children, spouse, or brother away in Gujarat, we left. On the way back, he said, "You saw that I asked him for only 550 rupees (\$10), it was a reasonable price, just above my cost. I took fifty rupees to go to his house and see him. That is reasonable you know. Who else comes to your house? No one, not so cheaply for sure."

By noon he was back at his shop at Ambawati's bus stand. After a cup of tea and a cigarette or two he settled in refilling his black medicine satchel with injectable drugs and an IV bottle. Now fully prepared, he wound his way through the bus stand chatting with Mangilal the liquor shop owner and Kalu Singh the bicycle repairman. I went home disturbed by Roop Singh's life threatening illness. Mohit and I seemed to diagnose Roop Singh so differently. Mohit's comment that he would get a man who could not sit up in his bed to run in a few days seemed a bit exaggerated, and I began to wonder if and how he thought this was possible.

The next day I decided to go and see Mohit again, this time I realized I would be well served to ask him what he thought was wrong with Roop Singh, as no discussion about a possible diagnosis had occurred. I sat on the stone stoop in front of Mohit's shop and asked

him, “Mohit sahib, what do you think is wrong with Roop Singh, he looked so sick. Can you help him?”

Mohit thought for a minute, “Yes I can help him, but it will not be easy. See, he drinks. I have seen him drinking. It has gone to his liver. He has destroyed his liver.”

“But do you think that is his problem?” I asked.

“Yes, that is the problem, see, his liver has gone bad so he cannot breathe. It has dried up, it cannot take in breath.” And you can make him better from that, “Yes I can make him well if he wants to but he cannot drink or his liver will be totally destroyed.”

“I do not understand. How can his liver affect his breathing, how does it work?”

Mohit explained, “See, if his liver has dried up, his body, its ‘rotation<sup>20</sup>’ is not working properly, so breath cannot come in and out properly.”

“What will the drugs you gave him do,” I questioned.

“They will make him strong again? They will give him energy and help put his body back in rotation. His liver will be ok if his body starts rotating again.”

“Mohit, you don’t think he might have TB?” I pressed.

“No, he drinks. This is not a problem with his lungs but with his liver.”

Already we have seen a theme of rotation in Bengali Doctors’ way of seeing and understanding patients’ bodies and the pharmaceuticals they use. Mohit calls this practice of visiting patients his circle and he understands the body as being in motion. Rotation, as Mohit understands it, is the goal of a healthy body and his medical care; pharmaceuticals are aimed at restoring that rotation. Being in or out of rotation is a common idiom for talking about the body ridden with a physiological problem rather than a spiritual one. Rotation is responsible

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<sup>20</sup> Here Mohit, like others in Ambawati, borrowed the English word.

for hunger and the need to evacuate, managing heat and coolness as well as breathing and getting rest. Maintaining rotation requires people care for their bodies, in part by eating on time but also by attending to sleep, work, hygiene and proper diet. When Premji<sup>21</sup> Mohanlal's wife fell ill with chills and intense pain, her illness was attributed to a "jam" in her rotation caused by drinking cold water while working in the field. The cold water shocked her warm body and caused a jam in its rotation. I thought of it almost like a small tornado in the body as warm fronts and cold fronts collided to counteract the body's own rotation.

In proper rotation, a body can manage changes in temperature. Its blood circulates with a strong and steady pulse. It can work an appropriate amount. But for people in Ambawati, this rotational body is a rather fragile thing: missing a meal or not getting enough sleep or doing something to mismanage the body's temperature can disrupt it. Rotation of the circulatory and digestive systems are crucial for good health, and troubled breath has become an index of an improperly rotating body. Bengali Doctors' medicine, as we saw above, is designed to reactivate, if only synthetically, the bodily processes that signify rotation, which suggest a healthy rotating body, strong breath and appetite, and unhindered sleep and mobility.

Building a genealogy of rotation would be too difficult, as one can find roots or similarities in concepts as far away in space and time as ancient Greece and China (Kuriyama 1999), in Ayurveda and in local folk healing called *Dam Lagano*. Yet rotation seems to be a structuring trope of embodied experience and a way of knowing the world outside the body.

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<sup>21</sup> Like Ba and Da, Ji when postfixed to women's names is not the formal ji of Hindi but rather a familial ji meaning is sister. It is a shortening of the Mewari term for sister, jiji or jiya. Premji was a cousin to most men of the men in the Meghwal neighborhood. Her father's sisters had married several men here and several of the men's aunts married her father's brothers in Sagrapura her natal home. As such she is relatively freer in her movements as blood kinship precludes the need to keep veiled. Though she keeps her head covered, she covers her face and whispered in front of only two of the twenty-four men in her neighborhood. Additionally this earned her the name Premji though her name is formally Premi.

Seasons and rains, too, are in rotation, and a stagnation of that rotation causes crop failures. Night and day rotate, as do the fullness and emptiness of wells. Breath comes in and goes out. When the busses are in proper rotation they come on time, and dutiful young brides move back and forth between their natal and marital homes. Rotation is a social good, and stagnation foreboding.

I asked eighty-year-old Mangna Ram about being sick. He said, “Look, it’s all a question of the veins. If they are moving properly, everything is ok. They are flowing up and down and moving as they should. But, when they stop, [when] they get some knot or blockage, then there is pain or sickness and the rotation cannot happen. The rotation does not happen and the *nuss* (vein) is blocked and all kinds of poison builds up.” Manga Ram understands the rotating body as one with a certain number of flows and blockages that need to keep moving in order to sustain a healthy life. His flows here make a gesture to Ayurveda and Chinese medicine and a body with a *qi*-like life force moving around in veins with blood or lymph. This fluidic understanding of a rotational body was common among people of his age group, but among younger people rotation had become something slight less hydraulic.

For people in their thirties and forties, a rotating body is much like any machine that rotates. Shanti Devi, the village’s best seamstress, explained the rotating body with the metaphor of her sewing machine. When she commented about wellness and rotation, I asked her to be more precise about what she meant. She responded,

The body is like this: Look at the sewing machine. If everything is working it turns with the slightest of effort. If it has oil and the belt is tight, then it turns easily; I hardly have to press. But if I do not care for it, I do not give it clean oil or clean the gears, they will get stuck and turn hard. If the needle is bent, it will not go up and down, and if I use it too long it will wear out. Or look, if I try to make it go too fast, something will go wrong and it will get a jam, and until I stop and fix the jam it is worthless.

For Shanti Devi, the body needed care to work well and be productive. Her mechanical metaphor reminds of the high modernist perspectives on the body as a machine. Indeed, I commonly got the sense that a body is a set of gears, like those in a clock, which needed to rotate, some fast and some slowly, in order to make the whole machine go.

Another example comes from Sidhharth. A few years younger than Shanti Devi, and suffering from TB, he explained that his body too was out of rotation. When I asked him what he meant by rotation he pointed to his motorcycle, now nearly a year out of use.

It is like that (the motorcycle). It takes a lot to keep it going, no? Petrol and oil, but also it needs air. If I do not clean its filter, it cannot get bad air out, and even if it has everything it needs it will not turn on and rotate. Once I drove it too much and did not look at the filter and it stopped working. I took it all apart and spread pieces everywhere, but I could not find the problem. Then someone said look in the air filter. I did and it was so full of dust. I cleaned it and the motorcycle would start again. Its like that: all of the parts must be rotating and in good order. See, the filter is like the lungs: if it is not working or has some problem, the whole body does not work properly. Look at me. I have a problem with my lungs and my body has no appetite, I cannot manage heat and cold—all of this from a problem in my lungs. It is not that just the motor will not rotate. If the motor will not rotate then the wheels will not rotate. Some jerk put sand in the gas tank while I was ill. Just like that, if we do not eat good food, our body cannot rotate. We will be stuck like this motorcycle, stuck at home on this bed, like me. Sometimes we have to do things to make the body rotate again, eating well, sleeping well and taking medicines. These can all help get the body back in rotation. We have to take care just like we take care of the motorcycle.

In each case we see a rotating body, one that is precarious but has interlinking parts. Though Mangaba did not understand it mechanically like the younger two, he saw a connection between this precariously rotating body and the world. All three saw the body as a precariously rotating and interconnected system, ready to grind to a halt at any moment. For the younger two, the body is a mechanical, productive body; one that, like a motorcycle, can produce movement, or like a sewing machine can produce a seam. When it is not in rotation, it is not just in pain, but it is unproductive.

This way of thinking has been of much interest to anthropologists and other theorists, who see it as a kind of capitalist-incited abstraction of the body in which individuality is removed and replaced by a mechanized object useful for labor (Belmonte 1979; Manning and Fabrega 1973). Others might see this kind of embodiment, one in which the body is both a machine and capable of being possessed by a ghost inside the machine, as Aiwā Ong does, as a kind of resistance to simple and coercive capitalist expansion (1987). I, however, suggest we see it as a kind of capitalist, pharmaceutical overlay on local, upanishadic, and Ayurvedic views of the body (Holdrege 1998). In this case, a bricolage has been made with parts of the biomedical and mechanical theory of the body and an Ayurvedic theory of the body's flows and differing subtle substances (Marriott and Inden 1977). The emphasis is not placed on the body as a set of gears and cranks, but rather on the body's movement, motion, precarity, and balance. It is interesting that in each case the focus is placed on what it takes to keep the body rotating and not on a particular gear or organ that rotates. There is no central pump or crank. Rather, rotation is a natural phenomenon that can be disrupted.

Though still reminiscent of the blockages and flows of Mangna Ram, rotation for the younger two is much more about productive capacity. The rotating body can join things together, and when in good working order, it can go anywhere. It requires oil, which for Shanti Devi was food and water, and also rest and occasional maintenance. When any of these things were lacking, the body, like the sewing machine, would either function more slowly and require more effort or stop functioning altogether. The rotation within the body, like the rotating hand crank of the sewing machine, moved the rest of the parts and made it capable of production. Indeed Shanti Devi and Sidhartha point to air, food, sleep, water, hygiene, and something to turn the crank, but rotation was for her not just the turning hand-crank. It was

also the turn of the string off the spool, the raising and lowering of the needle and the cloth being pulled forward by the machine. For her, each rotation was important and each could equally cause a slowing or stopping of work. So here too we see a concern with producing modernity by contributing to a global productive system and its impetuous to foreground more cosmological ideas of the body and its hydraulic flows. Indeed bodies are good to think with (Hertz 1973).

This kind of tension between biomedicine and Ayurveda seems to suit Bengali doctors quite well. Rotation focuses, not on some particular thing wrong, but rather a set of symptoms to be dealt with to return the body to working order. It does not require practices of naming, but rather it requires observing a body out of rotation and working to return it to its properly rotating state. Mohit's pharmaceutical cocktail seems to do just this. As we saw with Roop Singh, Mohit had a diagnosis for his problem, a damaged liver due to excessive alcohol consumption. A problem in the liver caused what he observed as a "mistake" in rotation. The presence of morning and evening fevers, the difficulty breathing, and the loss of appetite, looked to me like TB but looked to Mohit like a mis-rotating body, something his medicine could manage. As we saw, the pharmacopeia he uses includes drugs, which strengthen bodily indices of rotation like breathing and appetite. This view of a rotating body allows side effects of a drug to be as indicative of relief as the intended effects of the drugs. Rotation, then, seems to be a key way in which a changing world, one spinning ever faster in an age of partial neoliberal reform; globalization's centripetal force too, pulls the body into productive rotation. Seen this way, the mechanized rotating body is just one way of appreciating embodiment, and indeed just one of many ways of understanding the body in Ambawati. Important for this



chapter, however, is its strength as the metaphor through which the body is understood by Bengali doctors and their patients.

### **On Mohit's visit to Kashi Ramji Mastersahib's house**

Urban Indians posit a lack of knowledge as guiding people to Bengali Doctors. They ask important questions like: Is Bengali Doctors care only accessed by people who cannot read a diploma or do not value the trappings of modernity associated with government biomedicine? If not a kind of mystification or trickery of a marginalized and uneducated proletariat, then what could be the draws of Bengali care? It would be too quick to understand patients who receive care from Bengali Doctors as victims duped into substandard treatment by hucksters. For a more nuanced view we must return to Ambawati's Meghwal *mohalla*. Kashi Ram and Kesari Bhai Meghwal might be good examples of resistant bodies and modern minds. Kashi Ram and Kesari are some of the richest people in Ambawati. Kashi Ram has been a government primary school teacher in a nearby village for twenty years, and with annual raises has come to earn a comfortable salary. Before completing teacher training, he and Kesari Bhai lived in Ahmadabad as laborers and shared all kind of urbane experiences. Today, back in Ambawati, they have all the material trappings of modernity, including a TV and educated children. The daily paper comes to their house and Kashiram and the children read it with great interest. Kesari wears saris and occasionally gold jewelry. She writes her own name and enjoys listening as Kashiram reads the newspaper aloud. Their family aspires to and has attained most of the marks of modernity in Ambawati: a motorcycle, a stone house, higher education, nice clothes, and command of standard Hindi. Yet, Kashiram, Kesari, and their children trust and prefer Bengali doctors.

Their son, Rahul, a nursing student, is an example of Kashiram and Kesari's perspective on medicine. He fell sick while studying in Udaipur and went to the hospital connected to his nursing school. After four days there, his cold and headache did not subside and Rahul felt he needed to come home to Ambawati. He and his parents decided that he would not feel better until he saw a Bengali doctor for a "high dose" of medication. On the evening Rahul was scheduled to arrive, Kesari explained to me over tea, "I can only take 'high dose' medication. The smaller dose does not work for me. I need a high dose of strong medicine to cut my fever. Government medicine does not give me relief. The Bengali comes here and gives a high dose. For years now pills have not worked for me. I need injections because when I get sick my pain is so strong and pills they do not cut it anymore." Rahul arrived that evening and the next morning Mohit came to treat Rahul's cold. He gave Rahul two injections and sat down with Kashiram. Kashiram and Mohit had a long conversation over several glasses of tea. They spoke of current events, ways of understanding the body, national politics and local events. He asked Rahul if he was well. Rahul felt better and Mohit went on his way.

After Mohit left, I stayed behind with Rahul, Kashiram, and Kesari. Kesari was the first to comment. "He is a good man, he even has tea with us. He knows we keep our house clean. The government sister never had tea here except once a long time back. She would have tea but nothing else. Mohit has tea and relaxes here, even though he is Brahmin. He came here and treated my father-in-law whenever we needed him." Rahul soon piped up from his cot, "Papa, we did not get an excuse from Mohit for college, we will have to call him back and ask him to write me a pass or they will scold me." My face wore a perplexed and astounded expression; I wondered what Rahul's nursing professors would say about a note written by Mohit on old notebook paper. Kashiram must have thought the same. "What will you do with

Mohit's paper? Nursing college will not accept an excuse from a Bengali doctor." "But papa, what will I do? I must have an excuse" Rahul looked surprised. Kashiram instructed, "Go tomorrow to the hospital in Sadri. Get a check up and a note. You will be well by then anyway." The next day Rahul did just that. He got a few days of medication from the government hospital and a note for his college. Kashiram, Kesari, and I had all observed the increasing failure of state treatment paradigms to work for people in Ambawati. State care seemed unable to keep up with the bacteria in Ambawati and its residents' bodies.

Though Rahul's case is an example of how biomedicine's slow and steady approach to treating illness fails Ambawati's bodies and residents, it also shows that access to untrained practitioners is not a question of education or simple resistance to state power. Kashiram is a teacher, and Rahul a second year nursing student. Rahul's elder brother holds multiple degrees and aspires to be a government teacher. Still, they chose a Bengali. For them, government care, or even care provided by private trained physicians, was too far behind the curve of evolving bacteria, emerging pharmacology and Bengali Doctors' practices of democratizing pharmaceuticals. Rahul, Kesari, Kashiram and others are examples of people who have received the benefits of these practices and experienced the real danger they pose. Kesari first gives us a few clues not only to understanding pharmaceutical resistance but also to frame a sense of what "being well" could be here. She uses a key word drawn from English: "relief." Kesari is not concerned with a cure for a sickness or infection, but rather relief for a body in pain or dysfunction.

Relief draws focus to the pain of illness experience, and the weakness and unsettled feelings it causes. Kashi Ram attributed Kesari's pain and desire for relief to the years and years of labor they did as the young couple struggled in pre-liberalization India. Kesari

worked as day labor in fields near Ambawati and on construction sites in Ahmadabad. Even now that the family is in a more comfortable financial state, her daily routine includes carrying loads of firewood from the forest five kilometers away on her head, transporting gallons of water from the hand pump daily, and washing endless heaps of laundry by hand. Whether the pain she experienced is different from that of a Delhi-ite, or from the exhaustion I felt after months in the heat during which I lived on a slightly imbalanced diet and endured demanding experiences of riding rural busses and carrying water, I cannot say. I can, however, argue that Kesari and other people's trope of *relief* might give a sense of the commonality of bodies out of joint.

What do we make of relief? What does it mean that the pharmaceuticals and dosages that I outlined are understood as a powerful because of the relief if not wellness they bring? Many neighbors in Ambawati complain about pharmaceuticals' strong side effects and attendant negative effects on the body, but at the same time they overlook that, citing pharmaceuticals as the best way to get quick relief. Relief is a dominant discourse in Ambawati and seems to operate as *kamzori* or weakness did in Lawrence Cohen's Nagwa (2000). Relief, like *kamzori*, indexes an experiential node or nexus of body, development, caste and gender. Cohen points to *kamzori* or weakness as a structuring principle of low caste experience. He writes, "In noting the centrality of *kamzori* in the perception and negotiation of social difference and political relations in Nagwa, I want to suggest how hegemonic constructions such as the naturalization of hierarchy as organic difference—pollution—simultaneously determine the position and experience of bodies and are fundamentally reworked by them" (Cohen 2000:232). For Cohen, *kamzori* is a social fact, an aspect of marginalized experience, and a critique that not only inverts the moral order of caste but also

re-appropriates the labor expenditure that produced the weakness in the first place. For me, relief does something similar but does less to invert caste hierarchy. Indeed, fifteen years later and in a location of more uniform low-casteness, weakness as comparison to the strong neighbor is less common and an upper caste fall from strength is of less emancipatory value.

Relief, however, points to a condition of low-level mal-ease, a not-quite-right-ness, as the norm, and this carries through socially, experientially, and subjectively as I have written elsewhere about official discourses of *backwardness* along caste, social and economic lines and the not quite rightness which these discourse elicit (McDowell 2012), but relief brings embodied aspects of marginalization to the fore. Relief then indexes a kind of distress, which comes from structures of caste and capital that continue to center on bodily pain, fatigue and long-term frustrations of desire. It is this constellation of factors which come to center not just on an occasional need for relief from bodily pain but from the social and economic structures which maintain it as the norm. Bengali medicine gives a momentary release from this everyday malease. This relief comes in the form of pharmaceuticals and the momentary fitness they bring, not from the messianic development discourses, which initially began the discourse of relief.

In a not so ironic twist, the respite from everyday pain comes from another significant financial outlay and relations of credit. Bengali Doctors' high dose and high cost medicines give a few days of relief from this everyday malease, but to what end? In Ambawati, where life hangs in the balance of a few days work, the overwhelming response was to get back to work, to put the body back in productive rotation. *Kamzori* for Cohen's friends was unavoidable and increased with age, whereas for my friends in Ambawati, relief was a way out of everyday experience. To get relief, and here it is significant that they borrowed the

English word, was to bracket and remake the everyday. As older studies of illness suggest (Victor 1967), relief and healing with it in mind reset experience on a footing of greater productivity and better chances for the future in hopes of moving past everyday weakness. Relief tends to be fleeting. Bengali Doctors and their medicine allow for a set of shifting possibilities in both social and phenomenological terms that does not accept everyday pain and malease as permanent or create a moral restructuring of hierarchy, instead it presents a pharmaceutical path out.

Over a two and a half day period I wrote down each bodily complaint I heard. I did not include people whose health I asked about. I collected only comments made in passing. What follows is a list of complaints made in open conversation with others or me in Ambawati. The number of comments about pain that gesture to an embodied condition as labor and lack becomes immediately clear. Two neighbors complained of stomach pain, three of headaches, three of pain in the hands and feet, two of back aches, one each of pain in the arms, sternum and foot, another of general weakness, and one each of nausea, diarrhea, and shortness of breath. An outlier occurred when a coyote attacked a young woman working in the fields. The coyote's victim sought immediate public medical care, but the rest managed their pain without medication.

Bodies, it seems, are commonly in pain or attended to in ways that make pain a key aspect of embodied experience. As we look across this list something startling comes to the fore, I look to the list and see people complaining of what others would call fever. In Ambawati, the most common idiom for fever is pain in the hands and feet. Just as fever indexes larger bodily imbalances for many, here pain in the hands and feet and headaches are such signifiers at the same time as they register a complaint about exhaustion, poverty, and

marginalization in an economic system. Yet, this difference in symptomology has deep effects. When pain, which is always there, becomes unbearable, it becomes a first sign of illness and the key to illness experience. Moreover, when pain becomes unbearable, the Bengali is the first resort. As such, the quest for rapid relief to bring the body back into rotation, to return to myriad and everyday forms of pain not augmented by illness, becomes rather sensible. Relief points to wellbeing as a faraway goal and instead a Bengali doctors' care tends to, as we saw, rely on pharmaceuticals which reduce pain or pain sensation and, though dangerous, make quick steps to relieve suffering. Bengali medical discourse does not promise to make patients "better" or "well." Instead, it promises relief and a return to everyday dysfunction and a productive mobile body.

Others have argued that such bodily complaint and experience are ways in which bodies remember. Relief then, one could say, is a strategy of bodily forgetting, just as the everyday malaise is a kind of bodily memorialization of experience and inherited pasts (Connerton 1989; Das 2007). However, in forgetting or momentarily relieving malaise, the bacteria in and around Ambawati become stronger, making them in turn harder to manage. Relief becomes a receding target. Relief, as Rahul experienced it, has become a pharmaceutical problem and one for which Bengali Doctors have diverted both biology and discourse away from the public sector and into their market.

### **Bhagwanba and making MDR-TB**

So what of TB in this context, in which pharmaceuticals are salvific and relief and rotation are embodied experiences to which the state cannot tend? Bhagwan Singh's synthesizes the aspects of Bengali medical care I've highlighted above. It presents one

outcome of relief-based treatment and shows how rotating bodies and patients in contexts of pharmaceutical care can bring about drug resistance.

Although I want to focus briefly on the effects of Bengali Doctors' care giving techniques in the context of rapidly increasing drug resistance in India, I do not wish to suggest that resistance is the natural outcome of Bengali care. Resistance is a problem, but Bengali Doctors are not completely to blame. Indeed, during fieldwork a hospital in Mumbai published on the first case of totally drug resistant TB (Udwadia, 2012). As we have seen, RNTCP policy and a host of other problems also contribute to India's emerging resistance problem. None-the-less, I want to focus on one case of resistance that seems to be connected to Bengali care.

Meeting Bhagwanba is always a pleasure and a walk. Bhagwanba lives in the last house on the western edge of an already sprawling village. It is a forty-five minute walk from my house, and as the walk progresses, fields give way to grass patches and scrub. After crossing a gully and ascending a hill, the Banyan tree that shades Bhagwanba's cattle comes into view. His house is a small clay shingled mud and stone structure on the top of a ridge. It is the kind ethnographers of south Rajasthan's adivasis like to write about (Carstairs 1954; Roche 2000). From the shaded space where Bhagwan Singh often rested one can see the five kilometers to Sagwai and also the beginning of the forest. His nearest neighbor is not in sight.

Bhagwanba and his father cleared and claimed this land, cutting the dense forest and selling the trees as lumber. They are part of long family and caste history of moving closer to the forest and re-starting new hamlets there. I asked him many times if he was afraid of living alone so far away from his brothers and cousins. He preferred it that way. As we chatted, a



few white chickens scratched the ground; Bhagwan Singh had eaten their eggs for months in an effort for the eggs' heat to heal his cough.

About six years ago, a bull gored Bhagwan Singh in the side. He had been in severe pain and saw several doctors. All of the doctors were Bengali Doctors, and he augmented the Bengali Doctors' medicine with a regimen of poultices and home remedies. The wound healed, but the pain and trouble breathing did not go away. Bhagwan Singh's wife supported him by pawning her jewelry and kept the farm running while he and his sons traveled across Southern Rajasthan in hopes of alleviating his pain and helping him breathe easily. Slowly, they began to take loans, giving more and more fields as collateral. Eventually, they had no more fields or pasturelands to borrow against, and became sharecroppers on their own land.

In the process, Bhagwan Singh traveled to Banswara, Sagwara, several hospitals in Udaipur, and beyond to towns with "doctors" known for their ability to manage trouble breathing. These private doctors treated Bhagwan Singh with all kinds of tablets and injections. Their prescriptions littered the rafters of his home. He recalled being called to a small town on the Gujarat border, a day's travel away, five times for a course of IV fluids. "I would get better for a time and then the pain would come back and so would the cough and trouble breathing." "So did you ever cough up blood?" I asked Bhagwan Singh.

No, I never coughed any blood. Well, maybe once. I was taking medicine all the time, you know, meaning I was always going somewhere and feeling well enough to travel. There were times when I could not, but usually I felt ok, but not well. I kept coughing all the time, six years I mean. I saw so many doctors, all over. So many doctors, I would touch their feet and hope to get better. Some had big hospitals and some had storefront rooms. Many made me better for a while, until they would give up on treating me or more often I would give up on seeing them. And when the clouds came out I was in a lot of pain so I stayed home during the day. We would always try to start out in the evenings or mornings when I could go.

It went on like that for six years and each time Bhagwan Singh left for treatments he passed by Ambawati's health center stocked with the supplies necessary to test and treat his disease. Bhagwan Singh recalled that they did not go to a single government doctor, but instead went only to private physicians. Over the years, he estimates they spent nearly 300,000 rupees (\$5,450) but he could not find relief. When nothing else worked and money was gone, they went to the government clinic in Udaipur. Bhagwanba began RNTCP treatment for TB. By then Bhagwan Singh's TB had become resistant to the regular directly observed therapy short-course. He traveled to Chittaurgarh with a sputum sample for MDR-TB testing and learned that his bacteria had become resistant to two of the first line drugs. We do not know how resistant his bacteria is to second line drugs, but common use of ciprofloxacin, norfloxacin, levofloxacin, amoxicillin, and streptomycin by Bengali Doctors led Suresh and I to wonder how effective even the second line could be. Still, Bhagwan Singh began and completed the year of treatment, and though his cough is not yet completely gone, he no longer tests positive for active TB.

In conversation, Bhagwan Singh made it clear that his major complaint was pain and trouble breathing. He found his body to be out of rotation and as such he went to Bengali Doctors. He occasionally had morning and evening fevers, but his biggest problem was his body's inability to cope with changes in temperature. For him, Bengali Doctors provided fast care that helped him get well after treatment. However, his experience showed that their medicines were effective in doing just that: providing temporary relief in his case. They did not provide a long-term solution. Instead, they helped the body's immune system and, with occasional treatment by first and second line drugs, slowed the disease down. It is, however, clear that they created a situation in which his TB became resistant. His body was out of

rotation and relief was only temporary, but the Bengali's did make his pain bearable for six years as he sought treatment for symptoms that Bhagwan Singh even now links to the mishap with the bull. Open questions remain. Why didn't Bhagwan Singh access the RNTCP's free care for six years? Why was he not referred to Udaipur sooner or why didn't he go? Additionally one must ask why the RNTCP does not prioritize case findings that would have helped recruit Bhagwan Singh?

It becomes clear that the market has brought TB drugs to Ambawati and people there are willing and able to access and pay for care. Though Suresh is diligent in treating the patients who come to him, he is not allowed to find cases, and it would make little sense for him to do so. Bhagwanba makes it clear that the state's forms of care are not the answer for many. The imperative to treat is fulfilled by Bengalis and the imperative to seek treatment is accepted by Bhagwan Singh and his family. The state is a last resort, and even then, Bhagwan Singh faces stigmatization by several of the local nurses and a thrice-weekly two-kilometer walk to the health center. These seem like rather little to ask of a man willing to crisscross the state for medical care, but even now Bhagwan Singh's relationship to the state is a complex one. I will return to his relationship to state care later, but for now we must note that Bhagwan Singh feels that the state is spending "several lakh rupees on my treatment. Now my only work is to be sure, by resting, that that money is not wasted. It is my only job right now to sit here in the shade and look at the forest, because if I do not get well all of that money the government is giving will be wasted." Indeed even in Bhagwanba's narrative the state is not a provider of care but rather a financier. For Bhagwanba, the state with its "lakh rupees of treatment" at stake could suffer significant loss if he does not get well is, in Bhagwan Singh's terms, paying him to be unproductive. The RNTCP, in its very late arrival on the scene of care, has come to

provide relief through rest and treatment, giving Bhagwan Singh a way to transform rest into production. What it has not done is produce relief or rotation through its medicine.

## **Conclusion**

So let's come back to Roopaba, Bhagwanba and think about how the story of his doctor-patient encounter is emblematic of many theoretical layers of the notion of resistance. Bodies and bacteria become accustomed to Bengali Doctors' treatment paradigms and pharmaceuticals. This is indeed alarming as I saw Bengali Doctors providing at least three second line TB drugs to patients I thought had TB, Ciprofloxacin and Levofloxacin as well as Norfloxacin which has anti-TB properties. We also saw Bengali Doctors set up an alternative system in which the poor too can access high-fi name brand private care. Last we saw that Bengali Doctors resist the hegemonic control of biomedical care by usurping forms of care like IVs and injections but also by connecting to the very knowledge channels physicians use to learn about pharmaceuticals. Last we saw a resistance to notions of restraint and lack of resources as Bengali Doctors work to find "the best" drugs and provide them. Access to the world of biomedicine here is not so much mimetic as it is reorganization of symbols of authority, ways of knowing the body, and pharmaceuticals. So the question I want to leave for us today is one of resistance. Must resistance be a reflexive act? Does it require a kind of consciousness, political or otherwise? Is Roopaba accessing Mohit because of a decision to resist state forms or would it be better thought of as a mapping of other strategies, meanings, and circumstances, which come to form resistance? Is breaking into global medicine through a back door resistance? Mohit too see himself not as a resistant actor or catalyst of biological resistance but as a man filling a gap, muddling through with the knowledge and resources he

has. And state forms too build this resistance; TB control program practices may be just as responsible for drug and other forms of resistance as Mohit or Roopaba.

Our time with Ambawati's Bengali Doctors has shown several things about TB and markets, treatment and resistance. We have begun to understand in part how antibiotic resistance can be built alongside economic and cultural resistance to and engagement with change. We have seen the market working in ways in which the RNTCP cannot. A focus on the intersection between pharmacy and ideas of the body have helped outline a kind of embodiment which engages ideas of the body, historical and economic forces and the spread of pharmaceuticals. I have worked to show the embodied intersection of global pharmaceutical discourse and the ways that discourse, the problematization of symptoms, and ways of seeing and caring for the body adjust existing ideas of the body and care. We have traced forms of knowledge building a tenuous understanding of the knowledge, lack and market which make Bengali Doctors common actors in Ambawati and helps us better understand their own response to and imperative to address suffering. I hope a kind of local embodiment and another lay of local biology may have been parsed, and in this layer the market, pharmaceuticals, ideas of the body, the semiotics of biomedicine, rotational bodies, and the TB bacillus itself interplay.

## Epilogue to part one. On caste and care

A reader familiar with India and caste naming conventions may have already picked up a thread woven through the first section. Differences, it seems, emerge between the two main castes in Ambawati, particularly in the context of care and the choices people make when they are faced with an illness that requires expert care. It also seems to affect not just whom they see but when and how they see them. Thinking back on these three chapters questions of quality of state care emerge with Meghwals while question of access with Rawats. People from the Meghwal caste play less of a role in the chapters that deal with searches for care, while they arise when stigma and the RNTCP is involved. Indeed Meghwals tended to access the public health system more quickly than Rawats. Though they did at times access spiritual care and guidance, when they decided they might enter biomedicine it tended to be both sooner—as we saw with Hameraba and Ambalal—and in the public sector. This preference for the public sector and willingness to access free state provided care taking might be linked to the kinds of politics of dignity I suggested in the introduction. Indeed ideas about the roll of the state, the provision of care, and the quality of services the state might provide seemed to fall along caste lines and further stabilized in lived health practice.

Moreover, these differences seem to be further enfolded in the politics of dignity and ideas of care and the moral self. Importantly the ways care is accessed and provided comes to be a moment in which we can see the politics of caste aspiration and the tense aspirational biopolitics of TB interact. The preference for forms of claims making not based on universalizing developmental citizenship, but through the market as already equal citizens seemed to characterize Rawats. This also suggests that public health knowledge campaigns

have been less successful among these communities less willing to enter patronage relationships with the state. As such Rawats tend to access the private sector healers, both trained and untrained, and at the same time provide better family care. The private sector then might become a site of aspiration for both self and community and help continue a politics of dignity tied to now deeply historical ideas about self determination, self reliance, and disengagement with the state.

This is not necessarily to argue that the two castes experience or embody TB as a disease differently, but I do wish to suggest that caste matters in the experience of care giving and social suffering. As such caste plays a role and in part shapes the experience of disease as well as the forms the bacterial and social might take. The ways politics of dignity interact with biopolitics are dense sites of ambiguity. These politics of dignity are moments in which the subject and what matters as a community and caste connect with the nation and the politics of life itself. Historical relationships to power and social life as well as the roles people play in social life are re-inscribed in stigma, preference for Bengali Doctors and healthcare markets.

Further the forms of aspired subjectivity have important effects on the body and its care. Caste then can be one of the analytics to think more about care and family, community and markets, aspiration and consumption, but I have not given it primacy here. Instead I have worked to look at the linkages to power and subjectivity people are asked to forge in the context of care as well as the context of caste. In the process caste has emerged as a category rather than been part of the lens I use to analyze practices. Though this is unsurprising, it does suggest that there are important ways one can both examine and think about caste, or rather subcaste, without beginning with castes and caste difference in mind. Caste and the

contemporary politics of subcaste have lived echoes in aspired futures, present disease  
remembered pasts and the bodies that span all three.



## Prologue to part two.

### Subjectivity, relationality and South Asia

The writers in this book treat subjectivity as both an empirical reality and an analytic category: the agonistic and practical activity of engaging identity and fate, patterned and felt in historically contingent settings and mediated by institutional processes and culture forms. (Beihl, Good and Kleinman 2007; 5)

The preceding three chapters deal with biomedicine, care and a globalized diagonal program, the RNTCP. What keeps them together is an interest in care, biomedically managing the body—even if informally—and the effects of social life on and in TB treatment. The chapters are concerned with ways global ideas like transparency, community, resistance and the market inflect and are inflected by practices of care and healing. Overall they make an argument against the unreflexive use of globalized tropes to understand particular processes, and show that care in the context of TB is both complex and cacophonous.

The chapters that come, on poverty and breath, grow from these three chapters. They keep one eye on TB—as a disease of poverty and troubler of breath—and move out of the space of health and illness toward a few moments in everyday life. They share an interest in self and subjectivity that is highly inflected by social hierarchy and the kinds of structural violence that increase the risk of TB in Ambawati. Each chapter lays out a somewhat different notion of the self and a correspondingly different conceptualization of subjectivity.

The first chapter applies a notion of self drawn from continental and post-colonial social theory that is confessional, cultivated and intersubjective as well as a subject of and for regimes of power. It considers subjectivity from a Foucauldian perspective and looks to the disciplining structures power uses to identify and create poor populations and better manage care of citizens. I understand the forms filled up by the poor, with their calculus of poverty by which the state to categorize citizens, as confessional technologies. I trouble a facile analysis of poverty alleviation schemes and the “free” RTCP care that perceives them either as overly

effective attempts by the state to craft and discipline legible citizens or a charity people are unwilling to access as it requires a confession of poverty. By tracing the practices people employ when faced with a task of accounting or confessing poverty, the subject in Ambawati emerges as both a subject of and a subject for power, yet capable of understanding the rules for categorizing and managing a poor population in their own work to escape the very category they are being interpolated into. Subjectivity, then, is a response to power through inhabitation or subversion of power's structures in moments of contingency opened by power and the self—with its own indeterminacies, sediment experiences, and intersubjectivities. Yet subjectivity's consummate concern with the individual is interesting here. The Indian state and social life contain manifold de-individualizing processes of collectivization, disciplining populations according to social/caste categories, economic categories, gender and language. Tracing confessional processes, however, reveals that the very fabric of social life is re-woven if only temporarily in the gaze of the state, showing that people are not so bound by social and political structures that they cannot use them strategically. This chapter then is an attempt to understand subjectivities and social life as shaped by and overflowing categories of care-taking. It raises questions about the analytic utility of a confessional and narrativised self, wholly marked by subject position and capitalist market logics in South Asia.

The second chapter, building on the lacunae produced by an overly westernized bourgeois notion of the self, takes seriously a South Asian conceptualization of the self. In South Asian analysis, the self is a relational self (Marriott 1989; Marriott 1991) one which is crafted in relationships, highly contextual, and at the same time less intersubjective and seemingly less mutable. I take the highly relational self Dumont formulates seriously, but try to find a place for the individual and deeply personal meanings and experiences. I follow this

notion of the self with a different tack, thinking about subjectivity and taking up questions of the body and one of its processes, breath. It continues a move away from a theory of the self that understands the self as a product of subject position and relations to state power. The chapter works to understand how the relational self might be understood through breath as connection. Breath, I will show, gestures to relations to place, the body, ecology, community, morality and social hierarchy. Yet, in breath, and the relations it indexes, come connections and subjection to power and hierarchy. With that in mind I examine the ways people manage the connections fostered by breath as modes of engaging the self, both reflexively and relationally. I examine this much more subtle form of subjection by considering the ways social hierarchy and economic marginalization come to be lived as part of the body and the dangers they bring to the relational self. Further I look to ways the non-relational self is fostered and protected from such dangers through breath and techniques of the body.

Finally it is important to note that the relational self has been often trafficked in anthropology and I do not use it here lightly. Nandy's suggestion, drawing from Fanon (1966) that the relational self ought best be understood as a strategy of critique in the colonial era is an important one (Nandy 1983). He argues that the more spiritually oriented relational self arose as men worked through their relations to power as well as the similarities and differences in presentation of self by Indians and the British in India. He argues that the relational self ought not be seen as a kind of natural or deeply historical phenomena but instead as a work of the self deeply scared by colonial relations of difference and a need to present a divided self with spaces protected from western control. In chapter five I argue for an attention to the relational self and draw links to Hindu philosophy to do so. None-the-less I do not intend to argue that a self in South Asia is entirely relational nor historically grounded.

Instead I follow Parry's passing comments in his study of death and death ritual in Baneras to argue that the self can be both relational and grounded, play roles and be caught up in habit (Parry 1994). In short I hope to argue that selves in South Asia can be simultaneously relational and more-or-less unitary and unchanged by context.

Together these chapters give a sense of the subtle and multiplex forms of subjectivity TB and TB care and their connections to broader discourses make visible. They can tell us not just how to re-think subjectivity in India but point to ways of examining self, subject, and subjectivity across different forms of power, effects of power and selves. My central claim is about theories of the self and the importance we must give them when considering multiple notions of the self working simultaneously.

## Chapter four.

### Authentic forms of poverty: Subjectivity, assessment, experience and suffering in the context of state care

“TB is a disease of poverty. It is widely recognized that the poorer the community, the greater the likelihood of being infected with the TB germ and developing clinical disease. A lack of basic health services, poor nutrition and inadequate living conditions all contribute to the spread of TB and its impact upon the community.”—Stop TB Partnership, (2002)

“What is really shocking is not that the official poverty line is abysmally low, but that even with that abysmal benchmark, so many people are below it. The belated discovery that it is impossible to have a dignified life on the official poverty line draws our attention to the appalling living conditions of the Indian poor.”--Jean Dreze, (2012)

Roshan and I waited for the eleven am bus. The bus is a ramshackle old thing that plies the bumpy roads of the Udaipur district’s hilly region and Chittorgarh’s Bari Sadri Tehsil. Its circuitous route and propensity to stop at every hamlet, riverbed and big tree earns this bus the name *Mongra Mail*, the Jungle Mail<sup>22</sup>. It was a wet monsoon morning, and we used fallen banyan tree leaves to wipe the stone platform dry before we sat. The chill cutting through my polyester shirt, I asked Roshan why he was off to the Tehsil headquarters. He waved a form at me, “I have to go get the tehsildar’s signature so I can apply to be BPL.”

I was a little surprised. Roshan worked as a computer operator in Chittorgarh before leaving that job to build a new house in Ambawati. We talked often of his search for work and he stayed in contact while in Alwar, North Rajasthan, working in a Japanese-owned ball bearing factory. He might have known I doubted his fitness as Below Poverty Line, a surprisingly rare government category of poverty. His father and older brother had low-paying

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<sup>22</sup> The word *mongra* or jungle does not simply mean jungle. For most people it also means regressive, dangerous and backward. As such a better translation might be “The Backwards Express.”

government jobs with steady incomes, a kind of security uncommon in Ambawati. I asked him about the form he planned to submit. He looked at the folded form and said, “they ask about land and caste you know, about how much money is made and that sort of thing.” “Can we look at it together?” I questioned. He opened the white double-sided sheet filled with questions printed in red-inked Hindi.

The form’s first question is about land. It asks how much land the family has. “This is important. Land is most important. If you have little land you have little income and little food,” Roshan said in a sure, clear voice. The next question is about housing. Roshan glanced over it with no comment. I wondered why, but assumed it was because he had recently built a two-story brick house on his father’s plot. Such a sturdy home would limit his chance at BPL status. Next is a set of questions of caste and religion. Roshan did not comment on these either. They seemed odd to me. I asked him later why we did not talk about caste or religion that day and Roshan explained that caste is a good indicator of poverty. “Some castes are poor and some castes are rich. It is a good question. We are from a poor caste. How many Meghwal shop owners or money lenders do you know?”

Roshan turned the paper over. He seemed more interested in discussing these questions. They were the material possessions survey. The first question is about the family’s clothing. Roshan felt this was a foolish question.

Look at these questions, they count what we have and then add it together. If we have too much they say we are not poor. Everyone has clothing, which woman does not have several sets? Even the very poor will have something to wear it is not like they will go without clothing. Women will have several saris and men several shirts. It does not mean they are not poor. It is not a good question.

Becoming a little upset, he moved on to the next few questions. Roshan doubted them too. The questions asked if the person had a motorcycle, a radio, a mobile phone and several

other items. He did not disagree that owning a motorcycle might index lower middle class status, but questions about smaller items as indicators of wealth were not good questions. “Anyone will have a few small things, even if he is poor. He will be able to bring together enough money to buy something worth a few thousand rupees like a radio or a mobile phone or a few pots and pans. They may not have a motorcycle but they will have small things, nowadays no one is so poor not to have these things. How can they think we do not? Even poor men have a motorcycle now,” He trailed off as someone walked up to talk to us. Soon the bus arrived and Roshan left to take his form to the Tehsildar and submit it for consideration.

What is the nature of this form administered to assess poverty? Why had Roshan reacted in this way, accepting some of the most intimate questions but rejecting questions about pressure-cookers and radios? What forms of poverty are recognized by the state? Are they different from the forms experienced in Ambawati? What kind of subjectivity emerges in this space between state-assessed poverty and poverty as experienced here? Are forms and manners of claiming poverty remaking poverty or are they asking the already poor to re-form their poverty? What are the local meanings of these forms of poverty and how do they enact relations of care provided by the state?

One local definition of poverty is a sense of shared poverty, a shared experience of difficulty, rather than an impoverished subject of destitution and indignity. Not locally understood as a social suffering (Kleinman 1999; Kleinman, et al. 1997) or a kind of structural violence (Farmer 1996; Farmer 2003), poverty is something to muddle through, to manage and to use in order to escape its grinding frustrative force. What we will see below are the ways of being poor together, of sociality and intersubjectivity. The kinds of sociality

and subjectivities that poverty and state forms bring about in this particular place at this particular time bring to light the moral experience of those called poor. As Kleinman writes in his Tanner lectures, "...it is clear that suffering itself is intersubjective. In that intersubjective space, suffering is taken up in engagement with what matters most. Indeed, what is most at stake may be suffering itself and responses to it (1999:390)." It is my goal to look to poverty and state assessment of and intervention on poverty, as these are a few moments in which subjectivity, morals, experience, and aspiration come to view. Arthur Kleinman writes, "For the ethnographer like the social historian, in order to specify a local world and its transformations, it is crucial to understand how moral experience changes under the interactions between *cultural representations*, *collective processes*, and *subjectivity*, interactions that are in turn shaped by large-scale changes in political economy, politics, and culture (1999:373)." This charge, to understand subjectivity, sociality and care in intersubjective spaces where poverty becomes a question and suffering assessed is a main goal of this chapter.

This sociality of poverty is a precarious and ad hoc one, one in which the *gareeb* or poor are a precarious subject. As Indira Gandhi's slogan *Gareebi Hatao* (Get rid of poverty) perhaps suggests, the poor are both subjects the state wishes excise, as well as subjects of care. Just as their poverty is not created in assessments, the poor are not created by rhetorical strategies or in the aesthetics of development paperwork, as Riles would argue (2000). Poverty is a relative but very real and grinding aspect of existence, one which overdetermines parts of life in Ambawati. Its definition, topology and authentication, at least in the context of those who receives state care, are at work in poverty assessment forms and the subjects who complete them. These assessments and lenses, I argue, are projects of purification; as ways of



standardizing the local and situational forms of poverty to find an authentic poverty. Yet, as Latour notes, these projects of purification nearly always fail (1993). They are already hybrids of the authentic and the constructed themselves. Their own hybrid nature prevents a real purification, instead leaving traces of their processes and creating new forms of hybrids, in this case new ways of being both poor and middle class at the same time (Latour 1993).

These subjectivities of the precariously poor are at times due to real lack, and other times due to being not poor enough to access services. I will show that they later are also inseparable from the biosocialities of TB. Rabinow has described biosociality as a form of sociality thrown up around shared illness or shared risk of illness. He delicately traces the ways biosocialities and other forms of sociality interact, gesturing to the ways sociality nudges biosociality, setting the terms of possible biosocialities (Rabinow 1999). In the following chapters, I pursue a similar project, picking up strands of precarious *gareeb* sociality and subjectivity to think through the ways TB, caste, and aspiration come to create a local biology of breath here in Ambawati.

Here however, we must attend to poverty, sociality, and subjectivity outside the context of biosociality. I argue that in Ambawati there are multiplex and precarious forms of lived poverty. The state forms and interventions work to categorize these precarious and varying forms of life as authentically poor or unpoor. I will first engage the form, the BPL assessment, to help understand how the state determines the poor should look like. I will then briefly engage precariousness as a concept for anthropology before introducing and analyzing the ways people engage or disengage with forms to try and authenticate (in the state's terms or their own) their experience of low-caste rural Indian life. Then I will shift focus to the state actors charged with assessing and authenticating the claims of poverty people in Ambawati

make through these forms. Juxtaposing these groups I hope to help think more about worksheets and forms not just as tools of governing both in a pastoral and violent manner but also as ways the poor govern the state. Next I will try to work through the ethical ambiguity that precariousness and poverty discourses engender. Finally I will present two stories of men who seem to represent the kinds of subject and sociality I saw most often among the poor in Ambawati. These events and narratives along with introductions to state officials, I hope, will serve as a sample of what poverty in Ambawati might look like and help us better understand what types of analytical work both aspiration and precariousness might do as we try to think about notions of the state, the subject, and sociality.

This chapter will set up the state, poverty, and subjectivity with an eye to the local that will allow us to better understand the local biology of TB and the local moral worlds in which it plays a role. Thinking more deeply about poverty as experienced in Ambawati is necessary for a discussion of TB as the disease is often discussed as a “disease of poverty” that both disproportionately affects the poor and contributes to poverty. Substandard housing, poor nutrition, work exposures and lack of money for medicine are linked by public health practitioners to higher rates of TB. In turn extra expenditure coupled with an average of two to three months of lost work due to sickness exacerbate already difficult conditions. This trope is not wholly incorrect. TB’s tendency toward latency in the body allows it to wait for a bump in the road, a minor illness, a missed meal or two, or a good rain soaking to activate, and the poor in Ambawati are at higher risk for all of these. Yet by highlighting the precariousness of poverty I want to shed light not on how poverty contributes to TB but rather how precariousness can help us understand TB sufferers and poverty better. With precariousness we can see the high stakes of oscillation between poverty and stability and better understand

how poverty in Ambawati affects both the epidemiology and experience of TB, as well as relationships to state care and subjectivity.

### **On forms and identifying poverty**

The BPL form is a simple sheet of paper, front and back filled with questions asking each member of the household's name, education level and occupation. It asks about the family's monthly income and access to land, the distance they reside from drinking water, their caste category and if they migrate for labor. On the back of the page, the form becomes more complex. First, it asks the manner in which the family<sup>23</sup> accesses land, then the type of house they live in, and the average number of meals they consume each day. The next question asks about the "average available *normal style* clothing per person." It gives possible answers, as two or fewer, two to three, four to five, six to nine, and ten and above. This is one of the questions Roshan seemed to take issue with. He felt that having five or six shirts did not mean he was not poor. The next question asks where the family went to empty their bowels. Directly following comes the assessment of the family's material possessions. The form considers a TV, an electric fan, crockery, a radio, a computer, a telephone, a color TV, electrical kitchen appliances, expensive furniture, a car, a tractor, a motorcycle, a power tiller, and a threshing machine possessions of note. After this inventory of material goods, the form asks about the family's most educated member and its labor power situation. There are boxes labeled: no laborers, woman and child laborers, single adult woman, single adult man, and other. More questions follow. They ask about the number of children between five and

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<sup>23</sup> The social unit of poverty assessment is the nuclear family and we will soon see that the porous boundaries of family and the ability to re-draw familial lines become a flexibility, which people adjust to fit within the limits of authentic poverty.

fourteen, the manner in which the family accesses credit, the family's main source of income, and the sources of state aid the family avails.

The family's answers are entered in a calculus of poverty based in part on where they empty their bowels and if they own a telephone, but also on how many family members earn an income or food security. With a low enough score, a family is declared below the poverty level or BPL but as Roshan seemed acutely aware, being poor does not mean one is below the poverty level. Roshan's understanding of *gareeb* or "poor" was not the Dickensian destitution of rags and gruel this BCL worksheet was looking to identify. Instead, for him, poor means having only few things and being able to gather only a few rupees at a time. Last administered in 2002, the forms re-circulated through the village during my fieldwork. A district-level initiative to find those overlooked by the previous BPL list coincided with the revision of ration cards, which changed bounds of family and economic unit in the eyes of the state. This fortunate timing allowed for all kinds of new claims of poverty to be made on the state.

Roshan, like the others Marilyn Strathern writes of, "come to see themselves both through and beyond the eyes of the auditor. Yet it is not just how they see which is interesting, but how they *describe* themselves (2000:283)." His encounter with the BPL form as a state technology is a moment of reflection in which he measures himself against the standard of the state and sees beyond it. He sees beyond the poverty in the assessment form to a kind of poverty which is real lack but outside this kind of audit. It is this seeing with and beyond forms designed to assess poverty that I will look at here. I will look at the ways people use these forms both to describe and not describe themselves to the state and to themselves.

As Michael Fischer points out that our emergent future is one in which we come to see ourselves not just through the gaze and rubric of the empowered other, or the state, as

Foucault argues, but also through technologies of observation and mechanical reproduction (2003; 2007). These assessments and forms, I argue, are technologies of observation and reproduction. Forms are the state requiring each individual to submit the same assessment and watching as the individual and assessment change. This repetition engenders new ethics and a new subject, as Foucault argues, but also reworks sociality, reshaping and reframing relationships between others and the self. Kleinman writes again in the Tanner Lectures of how we might look to these assessments as transformative in multiple ways: “Ethical discourse can play a potentially useful role of reflexive awareness of how an institution and its members come to understand the way societal values and professional commitments influence their functioning. But it is equally crucial to focus on moral processes so that we can come to see how the subjects of institutional practices (as well as the practitioners) are caught up in the very transpersonal processes of social experience that create, sustain, and appropriate suffering (Kleinman 1999:396).”

The poverty assessments people in Ambawati encounter are undoubtedly biopolitical, but they do more than just state-work or give guidelines for disciplining the self. They rework categories of the social. In this case they have created a social form called BPL, an authenticated subdivision of everyday poverty. These assessments also bring other forms of subjectivity to the fore. They serve as moments to search everyday life for moral experience and aspiration as well as the signature of power. Finally, a fine-grained analysis of the mechanisms for assessment brings to light an aspect of the subject which readers of Foucault often forget: freedom (2003; 1997). The subject, like the state, is free enough to discipline herself but also to dupe the state, to play up poverty or play down poverty and it is in this context that the subject of care—both medical and economic--comes into focus.

With each election Ambawati has been electrified, the last few lines of cable stretched just before the 2010 elections. Like other parts of India, it has been counted and recounted, issued identity cards of all stripes, assessed for poverty, ground water quality and level, child mortality, family planning, rates of literacy, type and quality of housing, and much more. These assessments have become so common that “to survey” has been borrowed wholesale from English. Fitting itself into the local Rajasthani dialect, to survey has become a near fulltime job for one of the village’s primary school teachers.

For other authentications--particularly like Roshan’s BPL status, income and caste membership certificates--the government requires citizens have their answers certified by any number of government officials: the headmaster of the local school, the local panchayat bureaucrat, the panchayat head, and the land revenue officer are just a few examples. These forms and assessments, structures for normalizing, moralizing, authenticating, and monitoring the poor, help make legible those who are poor enough for state care. They are, for the state and civil society, the ways of deciding who is and who is not poor. These are biopolitics set up for all Indians but most importantly the poor who must access these worksheets as their key engagement with the state (Chatterjee 2004).

Identifying the poor is a difficult task, one recently the source of intense debate. In March of 2012 the poverty line in India was moved down. Despite what some at the time called rampant inflation, the state decreased daily expenditure figures for those who could be deemed BPL. In Rajasthan, where the income indicative of a rural person below the poverty line is higher than in many states, 24.8% or nearly one-quarter of the population is identified as below poverty line at the old guide line of 755 rupees per capita per month (Tendulkar 2010). The decrease in maximum income recognized as poverty started a fury in Delhi where

opposition parties and intellectuals alike accused the state of abdicating its responsibility to the poor by making it harder and harder for people to access services they desperately needed. The debate raged around the validity of economic criteria as a tool to identify a population. However, as we have already seen, these are not the only criteria to identify the BPL or poor in India. Defining the poor, particularly for interventions like TB care, moves beyond simply the economic and becomes local dramas of subjectivity and governance. The local definition of poverty allows for dignity at the same time as it rejects many politicized aspects of poverty which might lead to a kind of politicization of the rural poor just as Gupta saw nearly 20 years ago in Uttar Pradesh (Gupta 1998).

Yet the stakes are high. Having a BPL card guarantees an extra few hundred rupees a month and access to free health care. Though TB treatment is free through the RNTCP, BPL families have their fees waived at state run TB hospitals. There, all medicines not part of DOTS are administered at a fee, and without a BPL card the bills can add up fast. The BPL card cushions the blow of going to the TB hospital some hundred kilometers away. The access to housing schemes in which the government pays the majority of the costs to build a new stone or brick home, too, is a boon for the poor and particularly TB at risk. Finally, BPL families will have access to natural gas for cooking in hopes of significantly reducing the exhausting work of collecting firewoods and reducing exposure to excess smoke in the home. That all said, it helps reduce precarity felt about the future and present. New studies have shown that stress and precarity might be a large part of TB activation among new immigrants to the US. Precarity and stability might have more to do with the poor's susceptibility to TB than the material factors of lack.

## **On subjectivization and inhabiting forms**

The Public Distribution System, one of India's largest and most controversial public welfare schemes designed for the authenticated poor, provides a "ration" to each Indian family. Most families in Rajasthan still maintain their ration card, which, until recently, entitled all to various dry goods as well as kerosene. Though the scheme has been noticeably scaled back in the post-permit Raj of the mid-1990s and discussions about whether to completely scrap the project continue, kerosene is still available to all through public distribution or the black market. The contemporary state mobilizes the public distribution system through *Uchit Mulya Dukans* or Appropriately Priced Shops, to distribute kerosene as well as food grains, sugar, and occasionally other supplies like salt and tea leaves, at reduced rates to families designated as BPL. It is the biggest and most often criticized as mismanaged state program for the poor.

In September 2012, wheat reached 15 rupees per kilogram, a high on the local open market, and the BPL families in the Meghwal *mohala* where I lived accessed (what most agreed was inferior) wheat from the local Appropriately Priced Shop at two rupees per kilogram. Some sold the wheat directly back to the shopkeeper for a slightly discounted market rate without a single grain changing hands. Others brought it home and waited until a merchant from Sagwai came pedaling through the village on his bicycle. With empty 100 kilogram jute grain bags called *boaries* strapped to the back of his cycle, he bantered through the *mohala* calling out to all of the neighbors and me by name. He stopped at each house that had access to these subsidized grains and asked if they had wheat to sell. Those who did brought their sacks of wheat to their thresholds. Most had kept PDS wheat near the door, separate from their own stocks, just for this purpose. The preceding winter's wheat crop had



been good and the rains had watered the corn well this summer. Even those with very little land had no need for their PDS grain. Their own higher quality homegrown wheat still filled the metal or mud boxes in which they stored it. Each household dragged out the thirty-five kilograms they had been allotted that month and the merchant weighed it, dumping it from their smaller *dageenas* made of re-used cement bags into his larger jute *boary*, and counted out their cash.

Once after the merchant left Sanjay's mother's house I walked past as she was counting out her cash. "How about you share some of that money with me," I joked. "Ooo Andy. Come here and help me count this." I asked her what was happening as we counted through to notes the merchant had given her. "See, I get 35 kilos of grain from Kanyalal's shop at two rupees a kilogram and the merchant comes here and buys it from me at just below market rate. Today he is giving 14 rupees, which is very good. The Choudharies are giving 15 rupees for quality grain," she said with her dimples growing to reveal a few-toothed smile. I counted out her cash and told her that he had given her 420 rupees. "That is what I counted too," She exclaimed. "How much is that a kilo? It's too little to be 14, no?" We both sat running the numbers over in our heads until we calculated 12 rupees per kilogram. "Oh that is not enough. I should go fight with him for more money, no?" She chuckled. About fifty-five years old, Sanjay's mother was known as a good talker and a strong woman. She could win most arguments. "If he told you 14 and has given you 12 then you should fight," I replied. With that she hopped up off the string cot and pulled her wrap to a comfortable place on her head as she rushed out to the street looking for the merchant. A few minutes later I saw her standing with the merchant at the threshold of a neighbor's home, haggling for her two rupees

more per kilogram of wheat. I passed by as the merchant said, “We are all here counting after a few grains of wheat, when the whole world is turning around us.”

To appreciate this story, one must know that, even though a widow, Sanjay’s mother is still considered among one of the well-off. She and her son control about ten bighas, or two and a half acres of land, more than any of the other Meghwal families, and her son works outside the village in one of the government physicians’ home-based clinics. Finally her daughter-in-law, with a bachelor of education, is the best educated woman in the village and is studying for state service exams at Sadri in private tuitions. Nonetheless, Sanjay’s mother is categorized as a *antyodaya scheme* family and receives subsidized grain among other things. To receive supplies through the *antyodaya scheme* she has been designated both as the poorest of the poor and particularly backward. She does not seem to mind this designation much. In fact she, like others, has been working to access a greater share of the state’s tightening resources, embracing her poverty in this *Daulati ri daniya*<sup>24</sup>, world of wealth.

The merchant’s comment, though both flippant and philosophical, gives a good sense of the economics of life here. In Ambawati, we are all counting out each grain of wheat as the whole world turns around us. We fight with the bus conductor when he raises the rate for an eight-rupee bus ride to ten rupees. Life here is counting grains, watching paisa. It is attending to these small things as ways to guard against the precariousness of life. Others have described this precarious life of the poor, describing tipping points (Gladwell 2006), charting s-shaped curves and poverty traps (Banerjee and Duflo 2011), talking of the spiraling from meager success to poverty (Singh forthcoming), or even life within limits (Jackson 2011). But

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<sup>24</sup> This telling phrase is it lifted directly from Khabeeri bhajans sung commonly in Ambawati. It highlights an ambiguous relationship to capital and the world, which has never not been structured by capital and exchange but should not be held to too tightly.

the counting out of each grain, the maximization of value in each grain, and the ethic of hard work is an account of something which may be more pressing in Ambawati; the precarious nature of the greater human condition, the fine balance of life.

For lives in Ambawati, just a few grains might make a difference between the poor and the rich poor. A few troubled breaths might be the difference between a body suppressing TB and a body in which TB can grow. Precariousness is highlighted when each grain of wheat counts and is counted in the already fine balance, yet both grain and precariousness is also recounted and remeasured on state worksheets on which families tip the scales in their favor by a hiding practices of muddling through and making dire poverty clear. The state makes a fine-grain distinction between the poor and the BPL, asking the poor to draw precariousness to the fore.

One rainy day, Mohanlal, a neighbor of mine who manages Ambawati's public distribution system (PDS), was home sick with malaria. It was his fourth day off work and it had been raining for days. He and I and the rest of the neighborhood were restless, tired of being cooped up in our houses. This restlessness drove me to visit Mohanlal. Shaking the drops of monsoon rain off my umbrella, I sat down in the small sundry shop he and his family run out of one room in their house. He, on a plastic chair, and I, atop a 100-kilogram bag of wheat, chatted about his sons and their schooling when his phone rang. It was Kanyalal the owner of the PDS shop where Mohanlalji works. "Yes sir we have 48 BPL families and 32 state BPL families in our area. Yes, I am beginning to feel better sir." He hung up the phone and told me that the *malik* had called. I asked, "Do you think people are ashamed of being BPL here?" "No," he responded, "They want to be BPL, they get ready for the day when people will come to see if they are BPL. They practice. They want to be BPL so they can get

benefits. There are many benefits of being BPL. Children can stay in school hostels, very cheap grain, all kinds of other benefits. They are not ashamed.” Mohanlal, at times managing three of the region’s PDS shops, knows almost every BPL family in a 5 kilometer radius of Ambawati. Himself once on the list of BPL families, Mohanlal explained how there are people he felt should not be on the list of BPL, while others who should.

Look at the Choudharies. There are three or four families who have BPL cards. Lokesh has a BPL card, a new house, a liquor store, a tractor, and a truck. Kumar has a BPL card, 20 bighas of land and a sundry shop on the main bus stand. And Vinod has a BPL card and a minivan. How can these families be BPL? They have connections and they knew what to write on the forms. When the observers came by they gave them a little money and got the card. The same with your friend Narayan. He owns so much land and has no children, yet he is BPL. Yet look around our neighborhood. How many people who you know are poor have BPL cards? Hanuman Singh, look how poor he is. He does not have a BPL card. He did not know to fill up the form properly or appeal when he was overlooked. He was honest about what he has and now is not BPL. Or look at Khem Singh. He has two brothers and both of his brothers who have the same amount of land are BPL, but he his not. He has more mouths to feed, but he is somehow APL.

Mohanlal’s cynicism of the BPL scheme’s fairness was shared, and the willingness to do what was necessary to become BPL abounded. Substantial resources lied in the balance between living in poverty and living in destitution. Performed destitution was the goal when assessed by these forms. Those who could do this became BPL. What really mattered was not how poor one was but rather how one lived in poverty. If one lived frugally, hiding money and being willing to occasionally shake off dignity, one reaped the rewards of being BPL. If one aspired toward mainstream or middle class existence, the resources for the “authentic” poor might be foreclosed and the state might leave those families to manage on their own, to face the precariousness of impoverished life alone.

This new attempt at becoming authenticated poor was in part catalyzed by a change in state rules. A recent scheme to provide all poor families with a subsidized natural gas tank and a connection for cooking required a wholesale change in the management of the PDS. This

change shook the previously documented and fixed government-recognized social forms and opened a space in which they might be altered. The move to give away gas cylinders was initiated by activists, energy interests, and politicians in Jaipur for both health and environmental reasons. They hoped to reduce the number of respiratory diseases caused by cooking fire smoke and the extremely high rural dependence on forest-cut wood for cooking. They could not have intended the strategic space their revision of the ration card system would open. Coinciding with the new program, the state worked to revamp the PDS system first by requiring that everyone who holds an Appropriately Priced Shop contract to have passed the twelfth grade and to know how to use a computer.

Computerization, presented as a way to prevent sale of these gas tanks on the black market (Mazzarella 2006), also required that ration cards be digitized, starting a new round of applications for ration cards. Each family, or unit who wished to apply as a unit, needed to apply for a new card. This meant that they had to go to the village government center with their old ration card, a set of passport-sized photos, photocopied documents, and a new form enumerating their family, filled out and signed. This round of giving accounts of an economic self opened a whole set of other forms to be filled. Applications for widows' pensions, applications to be added to the list of BPL families and applications for other schemes flooded the village.

Why the run on forms now? Mathew Hull's work in Pakistan seems to help answer this question. He argues,

But, more commonly, the effort to use categories and measuring techniques to create bureaucratic objects—actual houses to be expropriated, displaced persons to be compensated—is a much more complicated task than planners envision, one mediated by elaborate documentary practices. Complications arise not only from the infiltration of the formal by the informal but also, as Harold Garfinkel (1967) emphasized, from the formal

procedures themselves, especially from the translation of the official categories into the operational realm of documentary artifacts (2008:508).

The new ration cards, as Hull's argument suggests, create an important opportunity for changes in family size, reorganization of land holding, and reporting of income within the inscriptive processes of the state if not in actuality.

His work suggests that new ration cards as forms and the agents using them rework documents and categories to bring about change, in official and unofficial life. Newly married sons and their wives who were part of the family on old ration cards applied for new separate cards and widowed mothers applied for their own cards in hopes of parcelling shared assets and showing how little each individual had. Daughters long moved to their husband's village returned on paper to claim a portion of their father's fields, and houses once family-owned were apportioned room by room. I view these maneuvers as attempts to be more transparently poor to state programs. Attempts ranged from fabrications--like the improbability of actually allowing a married daughter to possess family land--to ways of better representing the lack people experienced—like imagining shared space separately to show a lack of adequate space and housing.

The records in this case, ration cards and BPL forms, as Hull argues, allow for some agency and in fact do work in the world. First they enact a change of state and citizen relationship, initiated by citizens' accounts of themselves and the state's request for such self-reflection. The changes are sometimes in favor of the citizen but in most cases are opportunities to make claims, even if unheard, on the state. Second, they impose state categories of life and relationship on forms of life that are much more ad hoc. Cohn argues that the colonial census concepts like family, adult, caste and village had to be worked out and defined by the colonial state before they could be used as census categories (Cohn 1987). The

same work happens here, except we see the poor are reworking family as well, sometimes identifying a nuclear unit as a family and others an extended group or neighborhood with ties spanning generations. We must understand these forms as moment in which poverty can be performed with flourish or secrecy to access resources and as an opportunity to reflect on where social boundaries lie.

So what can these maneuvers in the context of precariousness tell us about lives of the poor and the state in rural India? Moreover, what can they tell us about health, suffering, and TB? Are these acts of aspiration, resistance, self-making and subjectivity cheating or muddling through? What do they tell us about the precariousness of life and self generally? The state has grain enough to let rot in PDS stockpiles (Bajaj 2012), and yet this accounting of each grain and each paisa occurs so often. Foucault's biopolitics and the techniques of biopower bring this shared precariousness to the fore. Managing the precarious populations, counting, quarantining, and disciplining those more precarious than the rest might be a way to make sense of biopower, as we know it today. The state, conscious of its own precarity, aims to be certain of poverty by counting each food grain and grain of socioeconomic distinction in Ambawati.

Such fine-grain assessment requires management from both the state and the citizen. Erica James writes of this kind of precariousness, particularly for the poor in Haiti post-conflict and post-regime change (2010). She observes the dark precariousness permeating her work as one that leads to both the commoditization and monetization of narratives, particularly ones of suffering and healing. For her, it is in acute recognition of the precariousness of poverty that her informants strategically use narratives of pain and loss to access resources. It is another strategy of stabilizing in uncertainty. However, I wonder, as

Derrida opines, if instead we must not think of this precariousness just in dark times of post-conflict or in poverty as a whole, but rather as a shared human experience constitutive of moral modes of being. His outlook is more in line with Kleinman's perspective on a world in which we strive to understand what really matters. Derrida argues that it is this precarious relationship in the contradiction between ethical code and everyday values where the subject is at work and also where the moral fortitude to live exists (Derrida and Dufourmantelle 2000). This then leads to a serious anthropological question, one I find myself grappling with throughout this text, of how to represent a world of poverty and precarious which is not always dark, which has humor, love and hope as much as death, lack and discouragement? These state forms do not seem to accomplish this either. Instead they search out only the desperate to identify as poor. My neighbors seem to answer this question of how to represent lack in their negotiations with poverty and the state. However, such self-representation does not preclude other ethical and economic pursuits, and certainly though poverty overdetermines economic and other forms of possibility, this is by no means a culture of poverty. Indeed the interpellation within the greater mass of "the poor" is incomplete, as we will soon see that poor *gareeb* is a definition open to change over time as development progresses. Like the increasingly popular Dalit identity, *gareeb* has long been an idiom of India with close ties to ideas of squalor and famine. From British administrators and missionaries who wrote of Indian poverty, gesturing toward it both to legitimize the colonial project and laud Christian prosperity, to films like *Slumdog Millionaire* or *Born into Brothels*, or to Indira Gandhi managing famine by playing both sides of the Cold War, India's overwhelmingly common international reputation has, until recently, been one of poverty. Yet, is there a poor here, a *gareeb* as a category in India? Even after 60 years of active Marxist



political parties, still fighting and loosing elections in South Rajasthan, the category of poor as a central identity category around which a self might be built has not gathered much strength here.

### **On searching for the right answers**

This kind of agentive form filling and reorganization of social life we saw earlier is, however, not the only or even the most common strategy to engage with these forms. Instead the most common strategy is to pass the form to someone else to fill. As the deadlines for each form crept nearer, small groups of men and women gathered around those who knew more about such forms than they did. In the Meghwal *mohalla* Sanjay's Kaki was advised by her son and a neighbor named Kamla. Having passed the tenth grade, thirty-year-old Kamla was the neighborhood women's trusted advisor in dealing with assessment forms. As we sat in the shade of her mud house's veranda, I watched her help adjust and estimate ages so as to fit state definitions of those who qualify for old age pensions but still agree approximately with existing documents. Filling each woman's form herself, she carefully checked for mistakes or neglected questions, and ensured the form's subject had the proper supporting documents. Her knowledge of what the state was looking for and her ability to read and write was enough to land her in the position to fill up the forms for neighbors. It became in part her responsibility that the form pass inspection by the panchayat bureaucrats. Its completion would indicate its possible authenticity (Gupta 2013). Like Kamla, there were several other knowledgeable people who helped others fill in their forms. Unexpectedly, I soon learned some of those were the bureaucrats themselves.

My neighbor Kalayani is one of Ambawati's daughters. She had a bit of land her father left her mother and her when Kalayani and her three children ran away from her marital village. Now a widow, she was also one of Ambawati's most thrifty. Known for her short temper, she is among those whom people went to for large sums of cash when in need of agricultural capital.

Once, as I left home for the government health center, Kalayani called out asking where I was going. I told her I was off to the government hospital and she told me to wait a moment for her. We began walking toward the health center and other local government offices. We chatted as we walked. I inquired about her mother's fluctuating health and when she expected her buffalo to deliver its calf. Eventually, I asked her what she needed to do at the panchayat building. She waved a form at me and said she was applying to be BPL. I asked her what she needed to do. She said she would give the form to the local man at the panchayat building and he would take care of the signatures, "If he will not do it, I will give it to a Choudhary boy with good connections. He will do this work for me." I asked her what was on the form and she responded, "It asks about how much land I have and how many things like TVs and shirts we have." "Well you don't have a TV, but you have plenty of land and clothes." I said. Kalyani replied, "Yes, I will give the form to be filled up anyway. Then when the government is ready to do the checking, the man at the panchayat will let us know before so we can get ready." "What will they look for?" "They will just come to our house and look at it, sometimes they come inside, and sometimes they do not. It all depends on who comes to look and if they are crooked or straight." We continued on like this.

The whole time I wondered how Kalyani would make the ranks of BPL. She has land, livestock, a spacious brick house, and the state provided Kalyani and her mother with a

widow's pension. How would she be accounted for her relative prosperity? I was excited to see how her interaction with the man at the panchayat building would go. I knew him to be cranky at times and familiar with Kalayani's considerable property. We approached the building and there was the babu—a tall, thin man a few years my senior, maybe twenty-eight—starting his motorcycle headed toward his own village two kilometers away. She called out for him to wait as she had come with her form. We rushed up and she handed him the form. He leafed through it. The form was empty but for the last line where Kalayani had carefully and unsteadily signed her name. She had not answered any of the questions. I had forgotten, she could not read them. She would let the babu fill the form. A few days later I met him and asked about the empty form. He said "I know everyone and what they have." With a knowing look I laughed as I left his office, "you know what they should have to be BPL."

Kalyani's response to a request that she account for herself is common. Giving an unfilled form to someone more knowledgeable about what the poor subject is supposed to look like is not simply a strategy to access knowledge and maximize the chances of accessing state resources. It also recognizes the lack of self-accounting with which Ambawati residents approach these accountings of poverty. Is this a rejection of the terms? Maybe, Kalyani certainly refuses to give an account of herself and answer questions that define the state's moral relationship with her.

Is Kalyani resisting or is she co-opting these terms as self-defining? She rejects the state's static form of poverty and its assessment form, but she allows the babu to fill the form as he sees fit. She, unlike Roshan and Kamla, does not engage the form as a disciplining practice, even if half-falsified, or allow it to make her poverty more legible. Instead she takes

a chance on a personal relationship, knowing that the babu knew her well and would be in the best position to help. However, Kalayani highlights that this self-assessment form is not the only part of the BPL identification process. She would still have to pass the observation, like many others who left answering the form to the babu or a local Choudhary man, with political aspirations and good connections. She left the form to the bureaucrat to fill and left him to make decisions about her poverty, but she was ready to embody poverty if it came to that. She would show anyone who came to observe how poor she was, but when it came to an impersonal assessment and its calculus, she left it up to someone who knew the right answers.

Impoverished citizenship is at work in the intense calculus of poverty and care. It is a state function here; it keeps state actors busy signing forms and checking records but it also overwhelms them. The very bottom rung of the bureaucracy is often local, the babu who filled Kalayani's form is a great example. Those whose job is to check the veracity of claims to poverty tend to be low-level officials like the *sacheev* and *patwari* whom both tend to be subject to the whims of the local *sir panch* and local *praDaulat*. These men are transferred frequently and often forced to fill two or three posts while being paid for one. The *sacheev*, a panchayat-level bureaucrat in charge of development and facilitating state schemes, was transferred during my fieldwork. Some say he was transferred for taking bribes, others say for not attending his post, and still others say for not allowing the *sir panch* to take bribes. Regardless, the void he left was filled by another *sacheev*, officially posted about fifteen kilometers away but a resident of Sagwai. He came to Ambawati on his way home from the tehsil headquarters and occasionally on Tuesdays. Everyone knew who he was but no one could ever find him when they needed his signature. They longed for the days when the *sacheev* was a local man from an agricultural caste a few kilometers away. "He did his work

because he was scared. He was a Dangi and afraid of us Rawats, so he signed our forms and came to work on time,” Narayan Singh once told me.

Tarlo’s work on the 1975-77 emergency might indicate that Kalyani’s is an effective strategy. Tarlo showed how bureaucrats, faced with the prospect of losing their livelihoods if they don’t gather enough sterilization cases, were in many ways done similar violence by the state as the poor were (2003). The bureaucrats, like the *sacheev* and *patwari*, here are similarly under pressure to meet state targets, to find an appropriate number of BPL citizens in their area. As Kalyani pointed out, so much depends on the *babus* and if they need to find people to be BPL or want to decrease the BPL roles. The state’s projections of how many poor people should live in a particular area put pressure on the bureaucrats can be as effective in making poor into BPL as people’s performing an “authentic” poverty<sup>25</sup>. It is men like these, and their signatures, who attest to the claims made on the forms. They can certify or authenticate poverty. Yet, as Gupta has also observed (2012), bureaucrats are too busy to check all the records. Instead they tend to look for small errors in forms so as to void them, or accept what residents have written in order to fill quotas or clear their desk.

So what of these forms, audits, and reports of income after they leave the hands of the poor? These assessments, after being signed and co-signed by various local officials, many of whom give residents the runaround and ask for kickbacks while others offer help, cross the desk of the local *tehsildar*. A mid-level bureaucrat in charge of managing state-led development in the *tehsil* or development block, the *tehsildar* for Ambawati was a young man of about 30. He had gone to JNU and taken an MA in sociology there. Himself a member of

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<sup>25</sup> I use authenticity ironically here. Early anthropology searched for an authentic culture or purely traditional way of being (Steady, Fischer, Soulula). My use of the word authentic in this chapter is in hopes of highlighting “the authentic” as the distillation of global processes in a form of life which has been authorized by power/knowledge.

the lowest castes in India and hailing from a nearby city, he was keenly interested in empowerment and social justice. During one of our usually light-hearted discussions he became rather serious and asked me if I believed in astrology. I revealed that I knew my stars and was concerned that they were not ideal, but I had not chosen any of the remedies available to me. He replied that while he at JNU he became very interested in astrology. He studied hard, but "One day I realized one man can be affected by Saturn and be poor or have misfortune, or be under the influence of Neptune. But in India we have whole castes of people who are poor, how can they all have an influence of Saturn or Neptune. How can all the Meghwals be affected by Saturn or all of the Rawats? Yet they are all going to these temples to placate these gods. This cannot be, it is caste which has cursed these people and made them poor not Saturn."

Tehsildar Chauhan's observation seems to recognize the multiple strategies people use to deal with poverty. I wonder if his comment was, in his mind, a stronger critique of the poor accessing mystical and ineffective remedies, or of the structural violence, that keeps whole groups of people poor, leaving only religious options as routes out of poverty. He and the other bureaucrats and babus I knew were well aware of multiple manners of dealing with the state and poverty. Chauhan recognized these as aspirations as an uphill climb for fiscal solvency and social mobility in a context in which structures work to prevent it.

The man who signed off on the forms claiming poverty was, unlike the gatekeepers to his office, no sleeping bureaucrat. His office did not believe in a limit on resources. He was willing to extend the definition of poor, he was willing to add people in need to the lists of the poor, and he was acutely aware of social and historical factors related to poverty. Yet what is the nature of the poor subject being produced by these forms, that cross his desk and require

his signature? In the case of Ambawati, the “state” to whom the poor must represent themselves is a Dalit bureaucrat, Tehsildar Chauhan. An educated man sensitive to structural and caste violence and poverty, he is a supporter of the poor and is constantly—I saw on more than one occasion—working to make the state wheels turn more smoothly for Dalits who cross his path. Yet his power is limited. The many gatekeepers, chaprasis, agents and men adept at filling forms stand between the tehsildar and the poor. Tehsildar Chauhan knows the answers people ought to give and is willing to use his position of power to help the poor. Yet his power to authenticate and assess is, at times subtly and at others tightly, bound by habit, structure and materiality. He can only act within those structures; he is bound but not indifferent (Herzfeld 1992).

### **On truth telling and poverty**

As Kalyani shows us, knowing the answers the bureaucracy needs to enter in its calculus of poverty is a key anxiety for families applying to be BPL. They think of themselves as poor but do not know just how poor they ought to be. The form of poverty accepted by these forms was one which people were willing and able to assume if they could. However there is another experience of poverty in play here, one which allows for a moral experience of poverty but also for a living in poverty with others.

Properties of *gareebi* that earn particular care are invoked not just by the state, but are extended and even more commonly invoked by the poor citizen herself as she thinks through her own or others’ sleight of hand and economic opportunism. "He took an extra 50 rupees from me, but he is poor, so I did not complain," is a common refrain sung by even the poorest of Ambawati's residents. The exemption from honesty and from taking what one has

earned, key ethical sound posts, is made possible by poverty and becomes a way to work through ones relation to that other. Does an ethics of form filling show a kind of local moral world, or the work of self-making, or a technique of the self as Foucault has called it and Mahmood (2005) and Pandian (2009) have extended?

In part, yes. These bureaucratic forms and formats are only sometimes filled up reflectively, earnestly, and with aims at agency as Mahmood and Pandian suggest. Yet this partiality of the subject stays closer to Foucault's initial theory of the subject. The forms create positions in regards to the state, which are embodied but not fully comprehended. These subjectivities gesture toward an understanding of ethics, self and other, care receiver and care giver, so commonly found in Hindu ethics (Monius 2004; Monius 2005). This is not to get to the bottom of such responses or subjectivities. Rather I hope to gesture toward an ethics of precariousness which people use to make a path through the world and live in a sociality of which poverty is part.

Hindu<sup>26</sup> ethical texts, including those whose whispers were only heard in Ambawati until after independence, resound with exceptions to and personalizations of the ethical code (Oldenberg 1964; Olivelle 2004). The codes of ethical behavior prescribing ethical life for upper castes and by extension lower castes rely on life stage, gender, caste, and situation. The Ramayan, a text steeped in the kind of precarious ethical action and uncertainty of the future I have tried to shed light on here, is filled with different exemplary codes for different

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<sup>26</sup> Here I am hesitant to use the word Hindu. Though "Hindu ethical texts" indexes a greater body of Sanskrit literature about aesthetics of the self and world, I have carefully chosen examples which people in Ambawati know and evoke. Additionally, my choice of the word Hindu here is not to destabilize the presence of Muslim, secular, low caste, or adivasi forms of ethics. Instead I want to mark their presence as well, particularly by integrating the importance of Baba Ramdev, a minor Hindu diety but a major syncretic force for low castes in Rajasthan. In devotion to him we might see traces of various ethical positioning. Nonetheless, people in Ambawati hold fast to their Hindu status and are in conversation with Hindu ethical practices of a good life and a good self, and as such I have called them Hindu.



exemplary heroes (Lutgendorf 1991; Narayan 2006). The dharma of Lakshman the younger brother is different than that of his older brother Ram, despite their shared life stage, gender, and caste. Sita's gender and mythical role affects the ethics of her life and the life of women on the subcontinent (Uberoi 1990). Hanuman's ethical position despite his animalian figure is one of bhakti and service to his guide, an ethical idea picked up by many of the young men in Ambawati. These shifting ethics are not the guide posts of light in the Ramayan's dark uncertain journey, instead they are presented as options which good people ought to choose as they act in the world.

To engage an ethical code a bit nearer to Ambawati and its residents, we might look to Baba Ramdev, not the anti-corruption yogi of today but the 17th century Rajput lord of Western Rajasthan and incarnation of Krishna beloved by many in Southern Rajasthan. Most Ambawati residents have traveled to Baba Ramdev's shrine about 800 kilometers away in deserted western Rajasthan. Even those who have not completed the pilgrimage are familiar with his life and his works. Like other deities, devotees know multiple stories of Baba Ramdev's life called *Katha*. These stories serve as important ethical texts and gesture toward ways of being good even today. The story of the Laakhi Banjara, a merchant selling sugar, is a common ethical tale of Ramdev's life.

There was a wandering merchant, Laakhi Banjara, who crossed into Ramdev's territory. He was stopped by the lord and asked to pay the tax on his goods. The crafty merchant left his load covered and responded that he was carrying salt, a cheap and untaxed good. Ramdev accepted this as truth and allowed the merchant to pass into the city. When the merchant stopped for lunch and began to uncover his load, he discovered that his costly sugar had indeed, turned into what he claimed it was: salt. He fell to tears and returned to Ramdev

wailing that he had been deceitful and had actually had sugar for sale. Asking Ramdev to change the salt back to sugar, Ramdev agreed and turned the salt back into sugar and took his tax (Bishnoi 1989).

So here too we see a shifting set of expectations. The merchant lies but Ramdev does not confront him. Instead he subtly shifts from valiant king to demigod and magically rights the merchant's wrong by aligning the cargo with the speech act. When the merchant comes to correct his wrong, he is honestly contrite but also suffering a huge economic loss. The now poor man had become poor by his own misbehavior but he was not condemned to remain poor. Admitting his mistake and righting his wrong return his economic prosperity. The poor man who takes too much money for distributing the pension form, or the lineman who pockets 2000 rupees to fix the village electrical transformer, are like the merchant. Allowed to take too much money and deceive others, they pay the price by being poor. The ethical response to and expectation of these people differs across space and time. Even those less poor than others are expected to address their poverty to the state. The poverty of one does not reduce or increase the poverty of the other, nor does it set up a one-sided ethical relationship in which the less poor are responsible to the more poor. Instead ethics of poverty suggest that one must count grains to prevent precariousness but at the same time one cannot be afraid to allow a few grains of wheat to go to others who are poor. Ethics of saving and giving come into focus here as the seemingly unified category of the poor, and their economics becomes one of scales and slippages in which bigger ethical codes like charity and hard work come to both undergird and undercut everyday moral intersubjectivity. To deceive the poor is wrong, but to be deceptive due to poverty is accepted. To accept someone else's need as pressing, the

reason the other swindled you, does not make your own need any less pressing. Instead, it makes the act of losing a few of your hard earned rupees a little more livable.

A thief, many of Ambawati's residents argue, is easily managed. Bhagwati Singh, an MDRTB patient who lives at the very edge of the forest, seems to characterize this perspective. When I asked him if he was afraid of thieves he explained that he had nothing to fear. "If a thief ever comes to my house I remember that he is a poor man who had just walked many kilometers through the jungle. He is probably hungry and thirsty, so I will give him freely that which he can steal from me. I will give him a meal and water and when he is full he will go away, and he will go away as my friend. He will not steal from me. What do I have to fear from him?" It is this ethics of being with the other which characterizes the poor's interaction with other poor. To give to those in need is protective. To openly give what otherwise would be taken by force is both to preserve resources and to act ethically. The contrary is also true: to support a thief is also not an unethical behavior because the thief is more than a thief—he is hungry and poor.

With this kind of situatedness and perspective on the poor other, we might make sense of ethical representations Ambawati residents make of themselves to the state. It is in this case a kind of ethical trickster position, not weapons of the weak but rather strategies of precariousness, which encourage questioning concepts like authenticity, durability, and the category of the poor itself. One might argue that it is also in this space of poetics, as Herzfeld has called them, which allow for a making of the self (1988). Yet still this does not help us think about the durability of the self, the ways in which the self is pinned down both by these categories as well as its own properties. How can we help to understand subjects who are both caught and free?

Khem Singh recounted this story twice during our year together. It was an important account of his craftiness and luckiness, but also a way to explain how he was bound and not so bound to the politics of his caste. "When my son Dal Singh was in 6th grade, I wanted to send him to the hostel at Sagwai. I had most of the forms we needed to get him in the hostel but I did not have a *Jati Praman Patra* or caste identification certification for him. I had to go to the Tehsildar and have him sign the filled-up form. As I walked in the door, I noticed his name posted above it. It said something or other, I forget the first name, Meena. It was a new Tehsildar and he was our caste. I thought to myself, 'oh good, this man will help me, he is from our caste but he writes "Meena." I will use "Meena" too.' So I went to the babu and I told him all he needed to know and wrote Dalu's name—Dal Chand Meena—and I wrote my own name—Khem Raj Meena. And with that I went to the tehsildar. He smiled at me and signed the form. I took all the papers to Sagwai, to the hostel, but there was a woman there and she looked at all the papers and said 'Khem Singh you have a big problem. I cannot accept these. You have signed all of your papers with one name, but this one you have signed with a different name. On your ration card you have signed Khem Singh, on your son's school papers you have signed Khem Singh, but here on your caste certificate you have signed a different name.' I said that I did not know and that I would re-sign the caste certificate. She said 'no you cannot do this. The tehsildar has signed. You cannot change this. It is a punishable offense.' I became afraid. She knew that I had used a different name and now I could not change the form." What did you do Khemaba? I asked. "I had to go back to the tehsildar and get a new form. He again smiled at me and signed the new form, but this time I had to write my name was Khem Singh Rawat. The tehsildar knew all along what would happen and that I had changed my name, but again he smiled and signed my form as I brought

it by his desk. Maybe it was because of his caste, I don't know." This time the state is a smiling figure, looking on knowingly as it is being manipulated by and foils Khem Singhji. The tehsildar as the state smiles and watches Khem Singh cut circles in hopes of accessing his share of benefits, and smiles again as Khem Singh fixes his mistake.

Though allowing for slippages in identity and multiple ways of giving an account of the self, the state smiling all along. The tehsildar smiles, gesturing both to pitfalls and loopholes, which the poor might use to access resources or miss out. Like Khem Singh's precarious identity, one which can neither be proven or disproven outside the modern state, the precarious state is as care giving, with its form-filling babus and its smiling tehsildars, as it is care-withholding, with its formal assessments of poverty and its rule enforcing paper trail. The poor and the bureaucrats are left to make a way through.

Khem Singh's nephew Siddharth Singh, a man I followed closely through his yearlong search for healing and care, told a final story. His story highlights the importance of the poor's aspiration for a working state and their willingness to demand services. He shows how people might understand that the smiling state occasionally requires more desperate measures. In these moments the poor must make claims on state services to makes claims on the state.

I had asked him if the merchant who came through my neighborhood buying grain came past his house as well. "Yes but we do not sell to him, we take our grain or we sell it back to Kanyalal." "Do you think the PDS is fair" I asked. "Well there are a lot of problems. Like sometimes they do not bring us wheat at all and Kanyalal buying back the wheat and selling it on the market is really illegal. Once we caught one of Kanyalal's trucks. Did you hear the story?" "No," I replied, "what happened?"

Well it was a few years ago and Kanyalal had told us that there would be no shipment of wheat for that month. We thought, 'this cannot be true, all the other stores have had grain,'

and one of my friends who lives near his shop said the truck had already come. So, we decided to catch Kanyalal and teach him a lesson. That evening we found out that he was loading the grain on a truck bound for the market at Neemach. We decided to stop the truck but we had a problem. There are three roads leaving the Ambawati bus stand to go to Neemach. We had to gather many men and guard each, so we quickly gathered about 20 men. That evening as the sun was going down, small groups went to each of the roads. One group went to the bridge near Kardevla. One group waited at the turn in Chand Kheda. The last went to the valley near Devi Dungari. We all waited until the truck left. We had left one man to wait at the bus stand and let us know which way the truck went. Just as it was getting dark, the truck left Kanyalal's shop going toward Chand Kheda. I was in the group at Chand Kheda, and when we heard the truck coming we crossed the road blocking it. We turned on our flashlights and all stood fast. We were right at the turn where the road narrows and there are houses on either side. We stood behind the truck too, and told the driver he had two options. He could go back and tell Kanyalal to distribute the grain as he should, or we could call the Sagwai police to file a court case. That time we were successful. We stopped the truck and Kanyalal distributed the grain. After that, Kanyalal has distributed the grain as he should and we have not had to stop any more trucks. He still sells some illegally. He knows that we are poor people but we are not powerless. We will get up if we have to. He can be a little crook but not a big one.

Siddharth Singh and his group stopping the illegal sale of PDS grain intended for them seems a bit like an heroic episode of resistance that foggy evening, a story he tells himself to feel like the deified righteous thief ancestors. Siddharth Singh's is very much a heroic episode, but it is much more. It shows the poor themselves, those we have seen throughout this chapter working to get state care, policing the representatives of the state. Their collective action becomes a kind of governance, not in a democratic way or one in which they sneer back at the state. Instead it is a more aggressive manner of doing what we have seen happening all along. It is a story of gathering little resources and a knowledge of space to work through situational ethics and make a claim of eligibility on the state, one in which the poor are not powerless or without dignity and bargaining power, but instead in which it is possible to aspire both for a better life and for state help at once. We can see in this precarious conceptualization of poverty a new way of viewing care and the aspiration of care.

## **On the aspiring poor**

The diverse forms of poverty, the state attempts to identify authentic poverty, and the multiform responses individuals gave while being assessed for poverty and state care, have helped us see forms of precarious subjectivity in which both state and subject aspiration come to the fore. Ethical life and self-making have come to be part of these subjective processes, but so have state actors and luck. We have seen how subjects, in hopes of stability, can and do make themselves into the form the state interpolates in them. We have also seen that these processes are far more pliant than others have shown. Allowing for desire and aspiration within these forms, along with the precariously powerful state, helps us see that the poor subject is by no means a simple one, nor is it one that easily fits within a model of pastoral care. It cannot be categorized simply as a suffering subject or the effects of several biopolitical forces. Instead, we must remember that the subject transcends a single categorization, just as the people here fill, unfill, and overflow these forms of poverty. They require us to look to the local moral world and the ethical. We can look to the ways the state polices poverty, but as we've seen above, the state works in a haphazard way which leaves ample room for subjects to create themselves, describe themselves, and observe themselves in their own and the state's terms. These techniques require that we look past authenticity and look instead to aspiration. The aspiring subject must be further conceptualized and we must move past the argument that the poor do not aspire to be political (Appadurai 2004); the poor both aspire and act politically.

What aspiration does, however, is to make poverty as an analytic category difficult. Roshan would not reconcile himself and his aspiration to material goods with what the state required of him to be poor. Kalyani aspired to look poor but did not know the best route, and

instead mobilized personal relationships with those who knew the correct answers. Mohanlal looked to the state and saw its only occasional ability to find the authentic poor as examples of its inability, while the tehsildar rejected fated notions of poverty and instead looked to structures and deep historical sources of poverty. Khem Singh and his nephew both worked to fit themselves into the structures of the state, but at the same time felt that they must demand the care they want.

These forms of interacting with the state in a context of poverty resonate in the ways people interacted with each other, allowing for slights and failings based on the other's poverty, but also for their own misdeeds in this world of money. The performance of poverty has in many ways been prefigured by sociality, but we have also seen it refiguring sociality as families adjust their size, their rules of succession, and their land. Aspiration helps us see precariousness as it is mobilized not only to aspire to state aid but also in the failed interactions with a smiling state.

The same pastoral, bumbling state provides care for TB patients, and this complex and fluid relationship with the state, made clear in these forms of poverty, plays out in the realm of the body. It is a part of the local biology of TB here. Poverty enmeshes with subjectivity, the state, and the body, and for this reason a chapter devoted to poverty not as suffering, abjection, or bare life is an appropriate form of representing poverty and precarious life in Ambawati. It allows for a subject of power, a subject asked to account for herself, at the same time as the subject overfills the form or underfills it making the power a tool of its own. This analysis of poverty is of key import not because of the darkness and risk it makes clear in Ambawati, but rather because of the stifling position of uncertainty in the precarious place between danger and security, though both are imaginary. Precarious life, highlighted by



poverty as we have seen, is neither livable nor unlivable; it is something that lives with all of us and in this precarious place between breath in and breath out.

## Chapter five.

### Waiting to Exhale: Breath, ecology, violence and care of the self

Durbal ko na sataiye, jakee mote hay,  
Mari khal ki sans se, lohe bhasam hvai jay.—Guru Kabir

Do not oppress the poor and weak, and think them helpless not.  
Remember the breath of the lifeless blower, can burn iron to ashes.—Translation G.N. Das  
(Das 1999)

#### **On breath and control**

It was a dry summer afternoon at Naukchand Meghwal's house. A sadhu had come a week earlier to visit Naukchand and decided to stay through the month of Shravan to lead the nightly worship songs. The sadhu, Bansi Maharaj, was enjoying tea and shivprasad as I walked by. Naukchand invited me home and introduced me. We chatted briefly and Bansi Maharaj asked what I did in Ambawati. I explained that researched social life and TB, how people managed illness, what they did when they got sick, and that I spent time with various healers. He offered any help he could. Not wanting to reveal that I had no idea how a sadhu would help me, I told him I had a philosophical question. He agreed to answer as best he could. I asked him the question that perplexed me that week. "What is the relationship between the body and the soul? *Sharir aur atma ka kaisa rishta hai?* Does sickness affect the soul?" I asked. He was ready, not with an answer, but with a story.

He sat up straight and the small group of men and women started to listen intently.

There was once a farmer who, deep in the forest, caught a ghost. He put it in a bag and went to sell it in the bazaar. To each buyer he said: "Be careful if you buy this ghost. You must always keep him busy or he will eat you up." This warning frightened each buyer and each said, "No, no, I cannot buy such a dangerous thing." The farmer eventually found a merchant who bought the ghost from him. As he sold him the ghost, the farmer warned the merchant, "Listen, you must always keep this ghost doing some type of work or it will gobble you up." The merchant remained unaffected. He said, "I have enough work to keep me running ragged so I should have no problem keeping the ghost busy." With that, he bought the ghost and set it

to work. However, the ghost—being a ghost—was able to work much faster than any human could. He did all of the work in a flash. He could travel six kos (13.5 mi) in an instant and soon the merchant became very rich. The ghost did all his work, even the accounting, and the merchant began to stay at home, relaxing in the fortune the ghost had brought him. However, one day the merchant began to run out of work for the ghost. Everything was tidy, all of the accounts were done, and the storage rooms were fully stocked. He began to worry. That morning, becoming very depressed, he sat down in front of his house. A passing sadhu saw him weeping. He asked the merchant why he was so upset. The merchant said, “Guru, I am very worried. You see, I bought a ghost to do my work. I have to keep him busy or he will eat me. I am sad because I cannot think of more work for the ghost to do and soon he will eat me.” The Sadhu understood his predicament and said, “Go tell the ghost to find a tall bamboo tree and cut it. When he brings it to you, tell him to plant it in the soil nearby so that it is upright. When you have nothing else to do, tell him to climb up and down the pole. That way he will be doing something and will be unable to eat you.” So the merchant did just that and lived a long and happy life with his family and his shop.

By now everyone was captivated by the ghostly tale. We were relieved that the merchant averted his untimely death and commiserated with the farmer’s desperate poverty, but no one knew how this ghost story helped us make sense of the body or soul. A professional storyteller, Bansi Maharaj recognized our sustained confusion and explained the metaphor.

Now, that farmer is the body and the *atma* (soul/self) is the merchant. The ghost is the *man* (heart/mind/psyche) and the sadhu is the guru. The body brings the *man* to the *atma*. The *man* is useful and dangerous. The guru is the one who tells us that when we have nothing else for the *man* to fixate on, we should fix it on that bamboo pole. That bamboo pole is our esophagus, and we can make the *man* concentrate on going up and down, breathing in and out. Om, som. Our guru taught us this so that we will not be destroyed by idle thoughts but always have something to occupy our *man* and keep it from eating us.

Bansi Maharaj’s narrative presented both a subtle and alarming narrative of the body and soul. He complicated the relationship between the two by adding danger and indications of the coarse and subtle substances of the Ayurvedic body. The danger to the soul is the desire brought by the body with its own set of karmic debts and proclivities brought by the genetic contribution of parents (Holdrege 1998). The body and *atma* come together to create the *man*,

a force of great productivity and of danger to the soul. The tool to manage that relationship comes also from the combination of soul and body, breath. In Bansi Maharaj's narrative, controlling breath was a way to mediate the relationship between body, soul and self as well as the desire brought by the body and the world to the transcendental soul. Breath, Bansi Maharaj suggests, is a biomoral substance.<sup>27</sup>

Yet his discussion was haunted by specters of slavery and violence. These specters are not mere side effects of aspiration for care and control of the self. They are important modes of constructing a discourse of breath that includes subjectivation, structural violence and relationality. Talk of violence, both physical and structural, comes out in discussions of uneasy breath. Conversation about breath and disordered breath are narratives of weaknesses, physical, social, and spiritual. As such they become partly about hegemony and the ways global power structures inhabit the lived experience of something as everyday as breath. Talk and interest in breath acknowledges the experience of marginality, movement, and structural violence brought to the body. Retributive violence for moral failings or signs of the bumps and bruises of everyday life on the edge are overlain on discussions of breath in this chapter. Breath makes clear, one last time, how themes I have developed thus far, health, suffering, meaning, social life and a globalized diagonal program come together in experience. Moreover, it is an embodiment of social hierarchy and memento of marginalization that is not preformed, but instead is part and parcel of bodily experience and its interpretation.

Breath is a bodily process with side effects and properties that can sometimes be seen, measured and quantified; but can breath itself be spoken or written of? It is the arbiter of life

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<sup>27</sup> By identifying breath as a substance I fit in a pattern of South Asian thought which does not require physicality to generate a materiality and substance. Indeed Eck's work on darshan (looking at and being seen by a deity) very fruitfully lays the groundwork for a theory of materiality in which tangibility need not exist.

and death, being and not being, but does it also have other more nuanced meanings? These questions unanswered, one might easily assume breath to be a universally shared experience of the human condition. It remains as Nile Green puts it, “widely accepted as an ideologically neutral sphere of human activity...In short, breath has seemed neither to require nor reflect a context (Green 2008:284).” Taking Green’s provocation seriously we can see breath as both a shared experience and a consummately individual process. I examine breath and breathing in *Ambawati* as a way to situate it as a process not untouched by meaning and social life, and point to the effects of the already mediated material body and its processes on meaning.

TB in many cases troubles breath. In advanced stages it makes each breath laborious. TB’s troubled breathing is not as noticeable as cough or weight loss—both are permeated with meaning and anxiety in *Ambawati*—but raises important questions about care of the self, relationality, power and subjectivity. It becomes another middle space. Breath is a process we are in the middle of from birth. It moves between body and world, giving one way to think about how bodily processes remember—by both letting in, letting out, and holding onto—and connecting ecologies.

This chapter will work to contextualize breath in Indian history and philosophy and give a better sense of what it may mean for *Ambawati* and the human condition. I include a section on Ayurveda both to set up philosophical links for breath as connector and introduce the importance of wind in the relationship between the body and the world. I also include Ayurveda to show that it too can fold questions of blame and self-inflicted affliction on TB. Much contemporary discourse on TB, in and out of clinics, in media and scholarship, has a

similarly<sup>28</sup> inbuilt discourse of blame on the sufferer for his or her condition, compliance, or drug resistance (Balasubramanian, et al. 2000; Barnhoorn and Adriaanse 1992; Rajeswari, et al. 2002; Santha, et al. 2002; Shetty, et al. 2006; Thomas, et al. 2005).

I follow a set of narratives about breath to trace the relations created by breath to several ecologies—moral, bodily, and climatic—and examine these narratives’ simultaneous gestures to a marginallity that intensifies effects of life sustaining and dangerous ecological connections. These ecologies and discourses link a poor and marginal sufferer who is blamed for her own suffering to locations and aesthetics that come to both affect and share that suffering. I examine the ways these three ecologies interact through breath as a metaphor and directly. Breath comes to be a connector and frame of relationality in the world. I follow breath out of the philosophical frame of these three ecologies to examine tantra and the ways breath might also work cosmologically as a source of power and control. Next, I consider a lack of concern for breath as both opening a space for stigma and a rejection of relationality between TB sufferers and the RNTCP. Last, I argue that breath is a biomoral substance that suggests we look to movement and relationality as a way to push past the structuralist paradigm of self and other and understand something about breath as care of the self outside Foucauldian frames of subjectivity (Foucault 1988).

Breath is biomoral, and as a biomoral process it can build relationships as well as signify a troubling link between TB, self and world. Biomoral has become a key analytic in the study of South Asian societies (Marriott 1968; 1976; 1990). One can trace its genealogy from McKim Marriott’s work on substance and personhood in South Asia and his

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<sup>28</sup> I use the word similar to suggest that the question of blame is in Ayurveda and other medical discourse but not to suggest that it comes from Ayurveda. I do not mean to argue that stigma, self blame, or suspicion of some internal flaw in TB patients comes from classical Ayurveda. I simply want to show that this is shared by classical Ayurveda and the contemporary biomedical discourse of TB.

collaboration with Ronald Inden on caste and substance (Marriott and Inden 1977). The pair link ethnographic observation of caste with a textual foundation in Upanishads and Ayurveda to argue that biological substances in South Asia can and do take on moral meanings. Importantly, for Marriott and Inden the bio in biomoral is not a Foucauldian bio as it has been used of late. Instead they draw from Schneider an emphasis on substance. Schneider suggests that blood is a substance through which kinship is made meaningful and organized. His discussion highlights that blood is a bodily substance imbued with meaning beyond its physical properties and as such does work in social and moral space through questions of kinship (1980). I use of biomoral here to build on this way of thinking about bodily substance and embodiment on Ambawati's own terms in lieu of a Foucauldian conception of "bio" as a tabula rasa on which politics are written and populations managed.

Marriott and Inden's work has been used fruitfully to talk about meaning and bodily substances like blood (Copeman 2009; Copeman 2011; Copeman 2013), the placenta (Pinto 2008) and semen (Alter 1996; Alter 1997; Alter 2000), as well as objects like food (Appadurai 1981; Appadurai 1988) and systems of knowledge like Ayurveda itself (Berger 2013). I want apply their idea of moral meanings attached to the body by considering breath and wind.

Breath as a biomoral substance takes on a semblance of its bodily process. Breath moves inside and outside the body connecting the bodily processes to natural ones. The effects of the environment's movement in the body are highlighted but so are relations to others. Breath is not contagion while in the body or village. Yet on leaving the body or going from village to hospital breath is inflected a contagion paradigm. Its meanings and

contagiousness are contingent bodily and spatially and a change of space is concurrently a change of state.

Contagion and contagiousness are complicated concepts in South Asia. Contagion is at the same time a western biomedical discourse with a historic utility for managing colonized subjects and deceptively similar to the befouling substances against which practices of caste hierarchy are meant to protect against. This family resemblance allows conversations of contagion to slip in to re-iterations of caste discourses of purity and pollution and vice versa by hiding subtle differences in both logics. Contagion, I argue, is an important way of re-iterating caste hierarchy in a contemporary medical guise, but it only works in certain places and with certain biological processes. Breath can give us an example of ways contagion, ecology, morality, and hierarchy can be read on existing anxieties about TB and a small section about the absence of breath in RNTCP discourse examines these shifting discourses.

The problem of troubled breath in Ambawati, however, is not its contagiousness but the biomoral mal-ease it highlights. As Bansi Maharaj told his audience, breath is also a way to control desire and protect the self, and there is a power in this control as well as an effect of lacking power. Labored breath is first linked to a problem in the body related to injury and carelessness and second to the difficulties of the Rajasthani wind. With troubled breath, relations between the body, mind and soul are in jeopardy or already jeopardized. In this way breath is doubly “bio,” it is biological in the sense that it becomes at times a part of the body biological and in other contexts is biological as a part of the larger atmosphere in the environment. Its control then becomes moral and a way to manage the relationship between the body, environment, soul and the self. The soul, I argue, comes to be particularly important because *pran* and *jeev* in Ambawati go with the soul after death and carry some of its karmic



baggage. The rest of this chapter works through the ways that breath is biomoral and considers how that biomorality matters for breath as a way of caring for the self, as a tripartite combination of soul, body and *man* (Holdrege 1998).

**On the breath in the text: Ayurveda *vayu and vata***

Breath out is in the world is air. Wind and air in the body and leaving it is breath. Air and environment for the Ayurvedic thinkers (Caraka 1907; Suśruta, et al. 2007), the German romanticists (Herder and Forster 2002; Koller 1937), and Kuriyama's ancient Chinese clinicians (Kuriyama 1999) is wind. For many wind was a metaphor for the conditions of the environment and its people. For Herder and Kuriyama's Chinese and Greek thinkers, good winds came to stand for pleasant places and people. Bad winds prefigure unsuitable places and difficult forms of life. This perspective is shared in Ambawati to some extent and becomes clear when from people from Sadri and Sagwai's economic and brahminical classes warned me to not let the Ambawati wind touch my nice things, particularly my laptop or a Reebok messenger bag I brought back from a trip to Delhi.

Not letting Ambawati's wind touch these things meant several things. First it suggests by keeping these things out of Ambawati's wind they would not become degraded by an assumed dirty and degenerative place that turns all nice things into rubbish. Second it gestured to an assumed climate of thievery. The Ambawati wind was a code for the thieves many thought to be endemic to Ambawati. The wind touching something would take it away. Finally, reference to wind may have been to the magic floating on Ambawati's wind. By seeing these nice things in the open air jealous tantrics might try to harm me or them.

Indeed my laptop failed the day after the Meghwal Mohalla and I watched a DVD about Baba Ramdev in an open space to celebrate his birthday. The common explanation was

that the wind had affected it. The wind might have meant dust or even that nightly dew sneaking in its wires, or it might have meant that a tantric had afflicted it. The wind in Ambawati then is dialogically coded, indexing the environment's effects on people and people on the physical environment.

Links between wind, the environment, and forms of life are key concerns in both Ambawati and in classical Ayurveda. Though connections should not be drawn too tightly between the two, family resemblances appear. It is not my intent to argue that there is a direct link between people in Ambawati and classical Ayurveda, or to argue that they use Ayurveda to think or respond to illness. Instead I hope to show a set of parallels in ways of understanding wind and air as bodily phenomena in Ambawati and classical Ayurveda.

Not a single resident in Ambawati comes from the twice born castes for which the *Vedas* were historically available. Until independence the lords at Sagwai were not cruel rulers, but they did allow Brahmins to prevent people like Ambawati's Meghwals and Rawats from entering their temples.<sup>29</sup> They also kept knowledge like the *Vedas* out of earshot from lower castes.

I examine classical Ayurveda rather than the wealth of theorization, both practical and anthropological, on contemporary Ayurveda for two reasons. First classical Ayurveda emphasizes wind and breath, and analyzes each in a manner that helps me think about the concepts in Ambawati better than contemporary Ayurveda. Second, though contemporary Ayurveda exists in Sagwai and Sadri conversations with these practitioners revealed what Langford has argued is on the more biomedical side of Ayurveda (Langford 2002; Naraindas

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<sup>29</sup> Though Ambawati never had Brahman inhabitants several women who married into the families at Ambawati recall being excluded from temples and I know of at least two neighboring villages who still do not allow Meghwals or Rawats in their temples, evoking a lack of historical participation and patronage as grounds for exclusion.

2006). They tended not to focus on Ayurvedic concepts like wind and breath concerning themselves instead with digestion and hot/cold paradigms.

Nevertheless, key ideas in Charaka and Sushruta's treatises on Ayurveda, like a focus on digestion and a concern for heating and cooling substance are lived not as *Ayurvedic knowledge* but everyday knowledge of the body. My sense is that classical Ayurveda gives one way to interpret the experience of basic bodily processes and TB so that moral relationships to breath and TB matter. Ayurvedic logics are part of the moral discourse of the body and shape embodied experience but are neither unmitigated nor wholly reflected upon. As such, I want to frame classical Ayurveda in this discussion not as authorizing discourse or an essential source of practices and ideas in Ambawati but a part of bodily discourse and practice that could also be parsed by analytics like nationalism (Alter 1996; Alter 2000), global health, other systems of medicine (Chishty 2009), yoga (Alter 2004) and Victorian era bodily control discourses (Green 2008; Nandy 1983; Sinha 1995).

In the classical Ayurvedas, both Charaka and Sushruta's texts set wind in the body—*vata*—as the primary humor. Yet they theorize *vata* in part by looking to wind outside the body, highlighting both physical and metaphorical connections between wind and breath. Outside the body, Charaka generates an exhaustive list of the worldly wind's cosmological functions,

*Normal Cosmic Functions:* Of the one (wind) which is in its natural state, the functions, when it circulates in the world, are, in truth, the following, i.e. the support of the earth, the flaming up of the fire, the regulation of the continuous course of the sun, of the moon and of the totality of the stars and planets, the formation of the clouds, the emission of waters, the putting into movement of the course of water, the production of flowers and fruits, the piercing of that which pierces, the division of the seasons, of the elements, the determination of the quality and the aspect of elements, the elaboration of grain, the growth of cereals, the dryness and the secondary drying up and the transformation that which is not transformed. (Filliozat 1964:200)

Wind in the world, the sages write, is a support. It moves water and forms clouds. When properly functioning it brings forth life and growth. It is also a foil for things constant, *able to transform that, which cannot be transformed*. The winds are both winds of change and winds of growth. Wind when disturbed in the world is a force of great destruction and also regulation. Charaka explains,

Of the one that is excited, the function, when it circulates in the worlds, are, in sooth, the following, i.e., the leveling up of the summits of the mountains, the uprooting of trees, the overflowing of the oceans, the rising of the lakes, the pushing back of the courses of water, the trembling of the earth, the swelling of the clouds, the production of mist, of thunder, of dust, of sand, of fish, of frogs, of serpents, of caustics, of seasons, the clearing of cereals, the calamities for beings, the complete destruction of existences, the production of clouds, of sun, of fire and of wind which bring to an end of the for *yugas* of the world.(Filliozat 1964:200-1)

Charaka works to contrast the productive and life-giving force of the wind with its potential to destroy. Wind is destructive not simply by its sheer excited persistence but by what it can bring: frogs, serpents, and caustics. He ends his discourse with wind's paradoxically ephemeral potential to destroy crops and the world. Wind, the bringer of life, is, when agitated, able to bring down mountains and destroy the whole world in part by drying out or pushing back the courses of water and rising lakes.

Fascinatingly, clouds and weather come to matter in both normal and pathological winds. Clouds, we will see in Ambawati, have an incredible potential to harm and nourish the body. Regeneration and desiccation of the landscape are signs of positive and destructive wind. Indeed while wind comes to matter less, clouds come to be signs both of the wind and weather that carries them and potential harm, connection and regeneration. Clouds, too, are a moral force indicative of the wind and weather that brought them.

The wind in the body acts analogously to the climatic wind. Charaka and Susruta enumerate five breaths in the body (*Prana, apana, samana, udana, and vyana*) (*Susrtua*;

*Bhishagratna 1911:4*). They call the body's winds *pran* or breath, while the humor itself is *vata* or wind. Each of these five bodily winds is a *pran* and as a group they are also called *pran*, breaths are parts of a whole that is also called breath. The proper function of wind/breath in the body is required for nearly all aspects of embodied life. Of breath Charaka writes and Filliozat compiles,

The wind is the support of that which retains the chain, it consist of the breath of front, of the upward breath, of concentrated breath, of diffused breath, and of low breath. *Physiological Functions*: It promotes movements of all types, it puts brakes on the wind and also guides it, this puts in action all the faculties, it is the conveyor of objects of all the faculties, the distributor of all the elements of the organism, which brings about the coherence of the body, it is the promoter of speech, it is the matter of contact and of sound, the basis of power of hearing and of touch, the source of joy and of liveliness, the kindler of fire, the freer of the elements of trouble, the expulser of impurities, the border of thick and fine canals, the maker of embryos (Filliozat 1964:199).

Wind, outside the body, and breath, its iteration inside the body, is busy, and Charaka argues that it is the chief humor. Wind in the body as breath is connective, keeping diverse parts of the body together. It is a kindler of fire, a source of joy and liveliness, a purifier and a facilitator of speech. Breath is a regulator of wind on the inside and wind on the outside. Breath on the move is a body on the move; breath too must go in and out as well as move through the body to keep balance. Too little will create disconnection.

Unlike Aristotle's formation in *De Anima* and *On Breath* (Aristotle, et al. 1964; Aristotle and Hicks 1965), breath is not the sustainer of the human fire. Instead its movement in, out, and around the body is key, not because the internal fire will go out but because congested wind will dry the mobility and flexibility of the body's substances. It is a connection.

The connection is both inside the body and out. Charaka relies on this connection to observe a breath as it leaves the body and *actually observe* it. Though *vayu* (wind) "is

described as having a tactile sensation which is, neither hot nor cool, *vata* of the body is described as having a cool tactile sensation. This is based on an actual observation,” Charaka writes (1907:69). Though it has the capability of desiccating body parts, wind in the body is essentially cool. An excess of it can be addressed with warming substances. “*Vata* occupies the most prominent place among the pathogenetic factors in the body...*Vata* is also gives rise to eighty types of disease, *pitta* forty types and *kapha* only twenty types (Caraka 1907:65).”

Any one of the five breaths can become agitated and cause various problems in the body, from paralysis to mental illness to digestive trouble. Indeed if wind cannot flow freely in the body, it becomes pernicious. Breath/*vata* agitated by blockage of its flow quickly dries out the area of the body in which it becomes concentrated. This desiccation harkens back to the dry Rajasthani wind in Ambawati, which in the summer quickly dries whatever it touches.

Wind, or breath, depending on its place in or out of the body, is necessary for life. Charaka writes again, “It becomes the determining cause of the prolongation of life when it is not excited (Filliozat 1964).” The problem then becomes keeping breath excited but not agitated, moving and not bound. Ayurveda allows for all kinds of movement of wind/breath in the body and observes its characteristics outside the body, but presents no theorization of its moving in and out. Charaka and Susruta have breath but no breathing. Breathing comes later in tantra and yoga but the Ayurvedas seem to be uninterested in breathing as a verb. At the same time there is little note in the Ayurvedic texts of contagion either through breath or other forms, though smell, poison, work, and emotion have external effects on the body.

One of the few moments when breath becomes important as a source of disease in the Ayurveda is in the context of *Rajkshaya*. *Rajkshaya*, King Consumption or the King’s

Consumption, is a complex imbalance of all three *doshas*—*vata*, *pitha* and *kapha*. From today’s perspective *Rajkshaya* looks like TB, particularly as it is experienced in Ambawati.

Indeed, most people in Ambawati call TB either *TB* or *Kshaya*.

Charaka sites a breathly source of *Rajkshaya* in the human world. Anthony Cerulli translates and recounts Charaka’s retelling of the upanishadic tale.

It was the King Moon and the vice of sexual indulgence. King Moon did not take care of his body, for he was completely addicted to the constellation Rohini. His semen wasted away, and his body shrunk. [Because of his dalliances with Rohini] King Moon did not have sexual relations with the remaining daughters of the Lord of Creatures, Prajapati. Because of this Prajapati heaved an angry sigh, and the anger streaming from his mouth assumed a bodily form *Rajkshaya*. . . His (King Moon’s) excess passion [for Rohini] and subsequent ineffectualness [in the presence of his other wives] caused disease to settle in King Moon.

With the gods and divine sages, King Moon went to Prajapati for relief. . . King Moon was treated by the divine physicians, the Ashwins, and freed from the grasp [of the disease], he shone brilliantly. The disease the Ashwins treated [in the heavens] then descended to the world of humankind. It is said that humans catch this disease on account of four causes: performing actions beyond one’s abilities, suppression of natural urges, drying up [of the bodily fluids], and irregular diet. (Cerulli 2012:107-8)

The sigh that Prajapati emitted in anger (other sources translate it as expectorated) became the source of the disease that effected King Moon’s sex-worn body. This embodied anger at impertinence, lack of self-control and unfulfilled responsibilities becomes a disease, *Rajkshaya*. Cerulli traces embodied *Rajkshaya* to a later tantric text in which *Rajkshaya* is married to Darkness, the daughter of death. Cerulli translates the *Kalika Purana*’s description of *Rajkshaya*. “His mouth has dreadful teeth, black like charcoal. He is very tall, with very few hairs on his head. He is emaciated, with veins all over his body. After resting a while, with a stick in his hand and his face hanging down, he casts his eyes downward, coughing, and longing for sexual pleasure with young maidens. . . (Cerulli 2012:113)”

*Rajkshaya*—the disease incited by the moon’s sexual impropriety, caused Prajapati the creator’s anger and brought upon the world by the celestial physicians’ work to heal the

moon—in classical Ayurveda and the human world is caused not just with sexual impropriety but also suppression of natural urges, drying up, and improper diet. Not doing what one ought and when one ought. Charaka outlines numerous other causes of *Rajkshaya* but the main cause is a too much sex and a lack of semen causing kapha to block the flow of the body's breaths. Other sources of breaths' blockage include injury and lesion to the chest, over exertion, not heeding the body's need to defecate or urinate, being stricken by grief, old age or travel (Mādhavakara and Meulenbeld 1974:336-9).

Aside from the four most common causes of *Rajkshaya*, Madhavakara recounts Charaka's list of others. Some structure TB narratives in Ambawati. He says,

In someone is extremely exerting himself with the bow, lifting up heavy loads, fighting with strong[er] men, falling from a rugged [or] high [place], [trying to catch and] check a bull or horse that is running away and should be tamed or another [animal]. [trying to] kill enemies by hurling rocks, pieces of wood, stones or missiles, or reading with an extremely loud voice, covering a long distance by running, crossing great rivers, or running with horses, making long jumps in an inconsidering way, or dancing with quick motions, or vehemently injured by formidable actions, a lesion of the chest having developed, a powerful illness is stirred up, as well as in someone who is extremely attached to women, or who eats dry [articles of food], a slight amount [of food] or a restricted amount (Mādhavakara and Meulenbeld 1974:341).

Daulat Singh connects his bodily trouble to exhaustion from a life of hard work and a fight with a stronger man (his father). Bhagwan Singh links his sickness in trying to check a bull and being gored in the chest. The hurling of rocks too is not uncommon in the cultural memory of people in Ambawati as it is linked with thieves and protecting one's self from thievery and a source of bodily strain in times of self and social preservation. Eating too little or out of timely order is also a key concern for folks in Ambawati. Though they do not seem to make links between TB like illness and an excess of sexual activity, they draw strong linkages to other forms of excess and carelessness like these and add over consumption of alcohol.



Blockages of the wind produce other blockages of other humors and body organs, These blockages cause the eleven symptoms of *Rajkshaya*, Meulenbeld translates

Madhavakara's commentary on Charaka's symptomology as,

1) Cough, 2) glowing heat of the scapular region, 3) an altered state of the voice, 4) fever, 5) a painful condition of the sides and 6) head, 7) vomiting of blood and 8) phlegm, 9) shortness of breath, 10) seizing of the excremental matter and 11) an inability to eat, these eleven symptoms (occur) in consumption (Mādhavakara and Meulenbeld 1974:334-5).

Most people suffering from TB in Ambawati indeed experienced similar symptoms. Though I hesitate to call *Rajkshaya* tuberculosis, one cannot miss *Rajkshaya*'s correlation with the suffering experienced by Siddharth (all of these except vomiting blood), Daulat Singh (1, 2, 3, 4, 8,9, 11), Hameraba (1, 2, 4, 5,6, 8, 9) and Bhagwan Singh (1, 2, 9, 11).

Again, it is not my intent to say that the Ayurvedic compilers were writing about TB or that folks in Ambawati think through their illness with the idiom of *Rajkshaya*. Instead I want to point out that the relationships between an illness with a set of symptoms like those of TB suggests for Ayurveda a lack of moral fortitude. The contemporary experience of TB and trouble breathing in Ambawati suggests we look at the effects of the ideas presented in these texts on the meaning of TB and breath and they ways they might inflect contemporary views of TB patients both in Ambawati and across India.

Wind as a connectivity between place and body serves to both bring place into the body and recognize the effects of people on places. The wind in Ambawati and its use as a metaphor for the people who live there might be linked if not traced to these ways of thinking about wind, breath, and *Rajkshaya*. Control of the self and its desires comes to matter as a way to think about illness and sets one aspect of the frame in which poor TB patients come to be marginalized and represented as living in degraded or adulterated spaces. Wind and breath

are connective of the body and its environment. At the same time such connections allow for the idea that illness creates a sick environment and vice versa. Hygiene and morality come to move on the wind and the idea of TB patients' unhygienic state is reinforced by easy connections to the environment. Sajjana's suggestion that I move out of my neighborhood finds force in this discourse where wind and air can be dangerous not as spreaders of disease on droplets moving in the air, but by the very connections it can make to people, their moral personhood, and their ways of caring for themselves .

### **Wind in Ambawati and its relationship to breath**

In April 2012, Shankar Singh died. He had been lying on a cot for the summer months staring down at the pond as it slowly dried up. The nurse had come to visit and council Shankar Singh about TB several times; the Bengali also stopped by. Burns from treatment to clean his liver marked Shankar Singh's chest. His neck, ankles, and wrists were tied with colorful strings—telltale signs of tantric intervention. When he died, like most everyone else in Ambawati, his body was carried away to the cremation ground. The hundred men who usually walk barefoot behind biers did not follow his. Shankar Singh was a thief and a troublesome man. His neighbors pointed out that his sons could hardly finding enough people to even carry his body the two kilometers to the cremation ground. Though men carried away his body, clouds carried away his life.

I asked Pyaar Singh, Shankar Singh's distant cousin, about the clouds (vadra) and Shankar Singh.

“The clouds come out and because of that, if somewhere someone has been injured, blood builds up and the clouds pull it up. It starts to throb.” He responded.

A man sitting with us interjected, “When clouds come out they give heat. Then from heat what happens is that blood cannot rotate.”

Pyaar Singh continued, “Blood gets blocked and throbs, and then someone says, ‘my back hurts, my chest hurts, my head hurts, my arm hurts’ (wherever he was injured). The bad clouds have come out and it hurts. It hurts, meaning the blood has stopped and is throbbing. That’s it.”

“What about those whose *dham sale* (Breaths are moving)? How is that connected to clouds?” I asked.

“Don’t we have a *dhaman* (lung/chest) inside? That *dhaman* suddenly moves quickly, because of the clouds. So he says *dham sale, has sale*. There must be an injury in the *dhaman* so it moved fast (throbs) because of the clouds, because of the heat.” Pyaar Singh explained.

“From the heat,” I asked. Pyaar Singh considered. “The *Gavadiyo* are about when the wind is hot. The lungs, they begin to spasm all the sudden, (hupak hapak ekdam kare). Because of that, because of some problem, like when our head pounds, there must be some “mistake” in that too. Because of that (mistake) the *dham sale*. If he were a right man (*sahi admi*) it will not happen.”

I asked him more directly about the effects of the *gavadiyo* on life, “Pyaaraba people say that the clouds took Shankar Singh away. How is that?” He laughed.

“He took a lot of beatings.” Pyaar Singh reflected. “Yes, because he stole.”<sup>30</sup>

The other man intervened, “Yes, he was a thief.”

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<sup>30</sup> Pyaar Singh has a fascinating way of speaking, almost as if he is telling a tale in verse. His response was almost comical in its composition and syntax, a mix Wagri and Hindi. “Mar ghani kha di us ne. Ha, vo chori karta.”

“Yes, people really beat him. That’s why his breath, it moved, *dham chalta tha*.”

Pyaar Singh responded. “His breath swelled and that’s why. His *dham chalta* from being beaten.”

Interested, the stranger did the interviewing for me. He asked, “Why Pyaraara, Shankar was a thief and fought and because of that his *dham chalta*.”

“Yes, from that he got in this situation.” Pyaar Singh said. “But what about Daulat Singh who lives near the pond” The stranger asked. “Yes he must have been beaten for something but he is a good man. Maybe he drank too much alcohol,” Pyaar Singh decided.

Other neighbors told me that Shankar Singh was often caught stealing and beaten. It was rumored that once in a fight, deep in the forest, he had been hit in the back with an axe. Many such beatings happened in the forest where he tried to steal goats or women’s jewelry. Others occurred in Ambawati when he tricked his cousins or made dishonest business decisions. It was because of his thievery and the punishments he received that Shankar Singh was neither a right man morally or physically, correspondingly his breath moved more than most.

The beatings, many argued, caused Shankar Singh’s injured body to build up knots and thickenings. The clouds agitate these thickenings and caused Shankar Singh’s *dham*, his breath, to move (*salña* Raj/ *Chalna* Hindi) in ways that did not happen to uninjured people even though the *gavada* cloud’s upward pressure has an effect on everyone’s breath.

Shankar Singh’s malady, as neighbors put it, was *dham salña*, moving breath aggravated by a drying up of the body (*sharir sukh gaya*) or persistent weightless, fever and cough. He had shortness of breath as we might say in the US. Shankar Singh, many posited was killed by the clouds and their upward pull (*uthav*) that made his *dham sal* or breath move

uncontrollably. Wispy yellow tinted clouds (we might call them cirrus in English; they are called *gavada* or *gavadiya* here) have an especially negative effect on bodies—particularly those injured and susceptible to *dham chalna*.

Shankar died when the clouds “carried him away.” Though I understood his death to be from TB, it seems clouds aggravated his breath and his injury riddled body so much that they caused blockages of the air in the body that killed Shankar Singh. He suffocated while his countable ribs moved up and down in quick succession as his lungs struggled for the air they could neither process. The clouds carried his breath away by stopping it up in the body.

What cannot be glossed over here though is an important oscillation in Pyaar Singh’s discourse. I caught it only later, but Pyaar Singh conjugates verbs differently around the word *dham*. Sometimes *dham* is pluralized and sometimes it is singular.<sup>31</sup> At times it is breath that moves and at other times breaths move. We can see an ambiguity built into the conversation around breath(s). By keeping breath both singular and plural Pyaar Singh was gesturing to the multiple ecologies of breath and its ability to be a fractal--a smaller part of a whole but always having all the characteristics of the whole.

In each case, plural and singular, we see (a) breath as a connection between moral ecology or local moral world and ecologies of air (Choy 2011). In the climactic ecology we see breath as a connection that sustains a metaphorical relationship between climate ecology and bodily ecology. Breath(s) acts as both a link and a symptom of the relationship between

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<sup>31</sup> Pluralization of nouns that are the subject of Hindi, Mewari, and Wagri sentences are also reflected in verb conjugation. *Dham* and *pran* are masculine nouns ending in consonants and as such show their plurality in the adjectives use to describe them and the verbs describing their action (except past tense sentences with transitive verbs in which case verb declension follows the number and gender of the object.) With this we can see that *dham sale/dam chalte hain* means breaths move and *dham chalta hai* means breath moves. *Pran* too follows the same pluralization ambiguity; some times *pran nikal gaya* and others *pran nikal gaye*, breath went out and breaths went out respectively.

body and climate. Climate is in relationship with the body as the effects of the climate affect the body differently based on its moral state. At the same time a moral ecology of breath comes to be mapped onto the body. Breath trouble is an index of moral failures like thievery, carelessness and insubordination.<sup>32</sup> Yet this too is dialogical as these three moral behaviors can and do overlay onto breath cause troubled breaths or a failure to breath can create a failed moral life in which the *man* makes mischief or is indolent. The three ecologies of breath then point to three separate and interrelated aspects of breath in Ambawati: climatic, bodily, and moral. In each, breath is the conduit of relations between each ecology and is of primary importance as we move forward with these three philosophical engagements with breath. A fourth ecology, that of power and strength, will emerge later as we engage a cosmological not philosophical perspective on breath.

Pyaar Singh too received his own share of beatings. He had been hospitalized following a land dispute with a local tantric and neighbor. He was cared for in the hospital by his Meghwal neighbors and Kamla Devi sometimes mused about how she and her mother-in-law went to care for Pyaar Singh in the hospital when he was severely beaten and without a wife. Yet for Pyaar Singh this beating was unjust and not due to his own failings. When I asked him if he had problems with *dham chalna*, he told me he did not. In his case, his position in the moral ecology was secure so climate did not affect his body or breath. Though he was beaten, he was a *sahi aadmi*. The other man who did the beating, had *dham salña*. Pyaaraba talks about *sahi aadmi* or correct man early as he described Shankar Singh and in his answer to the stranger's question about Daulat Singh whose breath(s) also moved.

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<sup>32</sup> The clouds too can affect children; many from birth. As such it is unclear to me if these are signs of future failings or childhood foolishness. I hesitate to say that all troubled breath is related to moral failings but most times when I asked about *dham chalna* interlocutors indicated people with moral failings and the chief affected.

*If he were a right man he would not have gotten into this state.* Here too language is a fascinating clue. *Sahi* can mean both correct and righteous. It links the correct and functioning state of the body with a correct moral state. Adding the Mewari iteration of this saying *how manak* to the mix adds more complexity. The Mewari phrase has two important links. *How* meaning good is related to the Marathi *ho*. It has a similar meaning as the more Persianate *sahi* and combines good and correct. Similarly *manak* is borrowed through Prakrit from Sanskrit and makes links to “man” and human through *Manu*, the first man from whom *dharmic* codes of behavior arise. In each case the correctness of the body connects to the correct action of the person in it.

Shankar Singh was, clearly to everyone, rightly beaten as a thief and his inability to engage an ethical economy was the cause of his sickness. He was not a *sahi aadmi/how manak*. Rightness in action and control of the self comes to be a preventative of uncontrolled breath just as a problem with controlling breath might make controlling the self and *man* difficult. Shankar Singh’s injuries though from his neighbors and family for thievery occurred only once, each time the *Gavada* pass by he suffered another beating. Clouds and the wind that brings them are enforcers of good behavior and reminders of improprieties. Yet the question of violence remains open as Pyaar Singh works through his own experience of violence and lack of *dham salña* as well as Daulat Singh’s presence of *dham salña* and moral fortitude. He struggles to think of a violence and a failing which could have marked Daulat Singh’s body as available for TB.

Daulat Singh while suffering through the first few weeks of his third DOTS course told me a story of his own injury and trouble catching breath. “Do you also have an *dham chalna*? Some injury?” I asked.

Yes. My breaths move. I have for a long time. I've worked very hard all my life; you should have seen the mud here when I was a child. When I was a young man I fought with my father. I had been doing some wrong things and once he really hit me. He is a big man you've seen him. He is much bigger than me. The biggest man in our gawardi and he hit me several times with a bamboo stick on my back. He is tired now but back then he was very strong and he hit me hard. I ran away. I could not catch my breath but I ran. I ran past the last house and into the forest. I was hurt so bad. I stayed there for maybe a week. I just ate what I could find and I hid there so he would not beat me more. Finally I had to go home. My wife was there and she was very young. I went home and got her and we moved here (about a quarter mile from the hamlet where Daulat Singh was born) and built a small hut. You know the kind with a few sticks and cut branches and leaves for shingles. We built it in the old way and she nursed me. After a while, I could do all my work again but we stayed here and now for many years when the clouds come out my *dham* moves.

Daulat Singh's story of his own mistakes, beating and flight to the forest highlights the locally important links between TB symptom, moral behavior, and the environment. What I think this complex constellation indicates is a way of engaging with both the political economy and political ecology and internalizing them as a kind of both moral economy and illness subjectivity. They construct of Ambawati as an interstitial space, and its ambiguous relationship to practices related to the forest and field gestures toward ambiguity of aspiration and occasionally moral aesthetics that shift between jungle and plain. We also hear Daulat Singh contest violence. He makes a point that his father was a very strong man and mentions the bumps and bruises a life of hard work and marginality have given him. Like Pyaar Singh he works to make sense of troubled breath by finding a flaw in his own moral history as well as locating himself as a subject of violence a beating by his father and the structural violence that mud and manual labor represent in Ambawati. Troubled breath and the *gavada* clouds come together for him as a way to both locate the root of suffering in himself but also defer it to the weight of the world. He contests and relents to the dominant discourses of TB sufferers unable to control their desires and minds.



Yet it is not just any kind of clouds and winds that act as moral pneumatics, rather it is a very particular yellow or red cloud, *gavadiyo*. Mithara Singh recalls the day of an accident that injured him.

Let me tell you about one time. A red cloud or yellow, yellow cloud was passing over. At that time I was going to school and I was reading and fell out of the truck, hard. I got injured right here (on his back) and now, believe me, when those clouds come out it hurts again, yellow, yellow color clouds come out and it hurts maybe one hour or two hours but it always hurts.

*Gavada* clouds also link danger with important futures. I walked past Mithra Singh's house in summer and he was sitting squatting on this feet with his knees tucked under his chin. He was panting and looking off into the distance. I asked what was happening. "*maro dham salire*, my breaths are moving," he said. He took short breaths in and out. Panting in the hot air. "Like a dog in the hot air, they pant," a neighbor Khumb Singh described people whose *dham chalta*. Mithra Singh took short staccato breaths in and his chest and shoulders heaved in jerks upward. This bodily state and *dham salña* remade an accident as foolishness. Accidents in Ambawati have high stakes. Mithro Singh's moving breath suggests for him that this accident was not just an accident but it was his fault, his own failure to be watchful that led him to fall. *Dham chalna* highlights the life long effects of simple accidents and points to ways even an accident can be marshaled to cast a moral blame on those who have breathing trouble.

To add another layer of complexity *Gavada* are the yellow clouds that "bring" rain. Those with an eye for clouds point out that six months after *Gavada* appear rain will invariably come. "I will give it to you in writing," Mithra Singh said that day he was panting. "You could write it in your diary six months from now stay home because it will rain hard all day." In short the dangerous wind/clouds that bring pain to some also bring signs of rain and

indeed rain in deferral. Wind can produce grain and when troubled clear it, it can produce fruits and flowers but when troubled can destroy mountains. Wind is the source of joy and the source of pain as we've seen in the Ayurvedic texts and in Ambawati. Wind and affectation by clouds is an important barometer of moral behavior.

The duality of good and bad is seldom a firm one, the clouds that bring rain also bring intense pain for some. A good man (*how manak/ sahi aadmi*) will have delayed benefits while a wrong one pain. Like wind in the Ayurveda they bring connection and grain, but when agitated yield pain, destruction, and calamities for beings. The effects of the climate on the body too can recast the ways bodies are experienced and how the past is made meaningful.

Clouds affect with injuries those who have not been "right men." In each narrative of cloud affliction, sufferers are particularly those who have trouble breathing due to carelessness and a failure to be watchful. Daulat Singh disobeyed and fought with his father, Shankar Singh was the thief and beaten as such, Mithra Singh was inattentive to what he was doing and fell off a truck, and Bhagwan Singh was gored by a bull. Attentiveness and obedience come to move from outside to inside, and local moral worlds work their meanings on the inner spaces of bodies and the outer spaces of ecologies. Biomoral becomes bodily and atmospheric as well as a difficult prod that makes the dangers of everyday life in poverty indicators of social wellbeing.

### **Words on the wind, breath mobility and power**

Takhat Singh, Ambawati's most prominent tantric took a few of the hot days of summer to teach me a sampling of tantra, healing with invocation. He had learned from Pokharlal, a now diseased and once very powerful tantric from the Meghwal families in Ambawati. Pokharlal and his cousin Megha (who I met and respected much as a progressive

elderly man who lived in the Meghwal Mohalla but also died in 2011) were known for being effective tantrics. They were so effective that when troupes of actors came to neighboring villages to dance plays they would add to the fun by playing with tantra. Megha would “throw a tantra” at the men dressed up as gazels and make their antlers droop. They would struggle to continue the show with antlers pointing downward until Pokharlal would blow a breath (phunk marna) at them and snap the antlers back up straight.

I asked Pokharlal and Megha’s sons how they did this and the sons explained that it was in the tantras they spoke and the breaths they blew to move them, cupping their hand into a tube and blowing a strong breath out to show the action. I did not think much of this story until Takhat Singh taught me the basics of tantra. He insisted that I came early, after bathing and before eating breakfast. He explained that he would teach me the tantra but I could not do “the work” until I completed the correct rituals and stopped eating meat. I agreed to learn. On my next trip to Ambawati I would stop eating meat and we could start the rituals. Takhat Singh thought this was reasonable and he taught me a few basic and protective tantras.

As he finished, making sure I remembered the complicated rhyming verse in Wagri, he said. “The words are as important as being able to move them by blowing.” Takhat Singh said, “First learn this and practice it (the tantra) and then say it. Say it in your mouth and give a blow and then the person will be well.” “So you just give the breath?” I asked. “Just say it face to face, right in front like we are sitting.” He responded, “But do not let them hear you say it. Say it like this, in your mouth, and then give a blow. The problem will go away.” “So it works when the breath goes out?” I asked again. “Yes as the breath moves it goes and the person gets better. Say it, say it in your mouth and when its finished, last, the end, then gives a

blow like this (cupping his hand into a tube he blows sharply out). Just as you give it a blow the problem will go out.” I stammered, “So *pir* baoji and all?”

Anyone, if you come in someone’s clutches, who knows, something, someone, whatever can happen, some black magic, if someone casts a spell, then take a string and make a knotted bracelet. Put it in your hand and then say the tantra, say it three times in your mouth and blow and then say it in your mouth three more time and blow it. Then tie more knots and tie it on the sick person and it will heal. Tantras move when you blow the breath the words made,

Takhat Singh instructed. As he explained it, the power of words came to rest in the breaths that brought them out of the ritually controlled and signified body. Breath was the conduit through which Takhat Singh’s ritual purity, ritual preparation of the body, and the powerful words of tantra he knew, came together. Separate, neither had much power, which is why he could teach me without concern. The words on my ritually unprepared breath were powerless.

Derrida writes of breath as one of the ways the body comes into the moments of defferance between sign, meaning, self, and psyche (Derrida and Lawlor 2011). Here Takhat Singh’s philosophical knowledge argued something different. Breath was where techniques of the body and its words came together to make a powerful ephemeral. Takhat Singh could do things with words because he could do them with his body and with his breath.

Tantra, he explained, works ahead of gods (*Bhagwan u aage sale*). It is a way of inviting or provoking a deity or spirit to do what he asked. Deities are, he argued, bound by the words and the rituals to complete it. In fact the profusion of swearing at deities in Takhat Singh’s tantra and Siddharth’s possession songs suggests that if one cannot convince a deity to do work nicely swearing at them until they are angered and bullied into completing it is a close second option. Takhat Singh’s powerful words of intercession and beratement moved on this breath. The words empowered breath but without blowing them out they could not affect

the change he wanted in the world. By moving they became the “magic words” attached to others who neither uttered nor heard them. “Until you blow they will not get better,” he said. It was not that the words relied on only their sonic characteristic or semiotic meaning; the breaths that uttered them too must be prepared for them to have power and to be exchangeable. The prepared body and right words are linked by breath.

His comment about tantra working a head of deities is important. It draws in part on the basic Hindu theory of *shruti* or hearing as applied to mantra. The concept argues that the point of mantras is enunciation of the sounds of the mantra, and argues that saying the mantra without proper enunciation is as good as not saying it all. When enunciated correctly, however, mantras can coerce a deity into action (Flood 1996). Yet tantra maintains some aspects of Brahminical cosmology while it inverts others (Urban 2003; White 2000). Words are still important but their power sits not in sound but breath. In this case breath as the mover of tantra leaves the three philosophical ecologies and moves to a new space one which is cosmological. Control of the body ritually and breath through tantra has a powerful effect it is a control of the world. Breath does something to the cosmos, coercing a deity to do what Takhat Singh wants. Breath moves from controlling the self and desire to controlling the world, physical and cosmological. Tantra and the breath that it comes inhabit is a demonstration of power to the other and the Other, to climate, to nature, to the body and to social.

Tantric breath and control of not just the body but also the world reminds me of Bansi Maharaj’s discussion of controlling the self. For folks who do not practice tantra breath is a tool to exert power on the self through control of desire. For Takhat Singh that power grows into a cosmological control. He can stand outside the effects of the environment and even

other local moral worlds. Through careful study and bodily purification he can even manipulate them. He was eager to teach me the tantra that could cause a tree to die with a single breath or keep fire from burning. His cosmological control of breath meant a control of what wind can do and the danger breath poses for the body.

Control of self and world through breath and words gives insight on breath and its multiplex power. Power in this context is a kind of mastery over both the self and language. With these two things in check, power can be wielded. Yet by achieving power Takhat Singh can short circuit the moral, climactic, and bodily ecology of breath. Power comes when the balance is tipped and precariousness of breaths relations to the world are longer the dominant theme. The body is controlled and the self no longer so relational. Power as control occurs when the self is protect by breath or from the relations established by embodied breath. Cosmologically it is this tantric breath that can effectively work before God and make deities and other forces in the world do what the breather wants. Power then, as Belamy in the context of a healing imambara not far away in Jaora argues, sits in the ephemeral as a combination of language, bodily processes, ritual body and magic (2011). The power is in breath in part because of its biomoral status. Yet Takhat Singh's breathly power exists by precisely modulating the relations breath builds, his ritual practice makes breath in meaningless and breath out powerful. He does not need to worry as much about the relations built by breath in as he does the power that comes out on breaths out of the body.

We see here that tantra, a more or less uniformly believed practice, though known by few, moves through air on the breaths of the devout and learned men who use it for well and for ill. The breath of the other may not be contagious in Ayurveda or because of the infection

it might bring, but in the world of tantra it is more dangerous than contagion and more healing than prayer.

**On ignoring breath:**

Thus far we have talked about the importance of attending to breath, its meanings, its biomorality and its connectivity. Concern for breath abounds in Ambawati and this ubiquity is in stark contrast to the RNTCP. Breath is not mentioned in RNTCP training manuals for staff and sensitivity manuals for government employees. Mass communication strategies focus on completing DOTS, marketing the medicine, and identifying three weeks of cough as a warning sign. No one in any of my RNTCP interviews commented on breath or air except for the district TB officer who commented that a neighboring district had high rates of TB due to rock quarries and silicosis.

Breath and air was not considered by the RTNCP and omitting it was a powerful gesture. Just as Takhat Singh's breath out gave him some power in the world, RNTCP actors manage the world by controlling breaths in. Recall the hospital where nurses and aids covered their mouths in hopes of purifying the air they breathed in and the x-ray technician scolded Daulat Singh for coughing in his air. These ways of not sharing air and breath were important in hospitals. Family members, visitors and dietary staff did not cover their faces when they entered, but after a few days they too started to control the air shared between themselves and their TB patient family member or friend.

In Ambawati similar strategies to manage air take place. Sajjana wrapped her whole face when dealing with TB patients and walking through my neighborhood to keep the air and breath entering her body safe from TB. She asked TB patients to wait as long as possible outside the clinic so as to keep the clinic air clean and protect herself. By not addressing

questions of shared air or ways to help nurses and doctors protect themselves from TB by attending to air flow the RNTCP is fostering a discourse unshared air. These DOTS providers get no training about how to deal with shared air or the exposure they may face during treatment. During a recent engagement in a DOTS center in a Mumbai slum I asked health workers who treated two XDR-TB patients if they tried to manage their exposure. They replied, “We have a good breakfast.”

Covering faces and ignoring air are strategies for not sharing air and breath with people who had TB. By protecting the air they breathe, these clinicians who cover their face are protecting themselves from TB and TB patients as well as severing the relationality created by shared breath and shared air. Ignoring the shared air and space of TB patients the RNTCP is similarly able to distance TB patients and TB as a disease both from themselves and from the urban middle classes they are now a part of. This unshared air and protected breath strengthens an ability to present TB as a problem of the poor and those who deserve it. It also works against a more expansive TB case findings policy, which might recognize a more expansive danger of TB not linked to the individual and his or her cohabitants.

By not attending to breath or air, the RNTCP links TB not to environmental pollution, urban over crowding, or exposure, but further links TB to the poor individual. At the same time, some hospital and community actors acknowledge a shared air but fictively protect their own breath. Not addressing air allows for these kinds of severing relations through shared air and a shared responsibility with the RNTCP. The problem is centered again around the patient.

**On *pranis*: Breath, the soul and selves in Ambawati**

*Pran* (breath), Kamla Devi explained, is different than *has* (breath) and *dham* (breath). For her *has* and *dham* are synonyms for breath as biological necessity and occasionally *pran*



is also a synonym for this bodily process. Though *has* and *dham* are synonymous *dham* has a second rather important meaning, strength. She evoked the Rajasthani saying and then translated it to its Hindi equivalent, “*Thane me dham ve to bane aa jaa, dham hai to bahar aa jaa*, if you have the strength/breath come out (and fight)” This common provocation was for Kamla evidence of the relationship between breath and strength. She pointed out, “See *dham* is breath that gives strength, but *pran* that is life, *jeev*,” I asked inquisitively what she meant by that. “You know, when you cannot breath (*hans lena*) and your breath (*pran*) goes out you are dead. You have no more life. It leaves you. You are just an empty body and your soul goes out and goes into something else (*pravesh karte*). You’re breath goes out and your soul goes out.” Even more intrigued, I asked, “So if your breath goes out where does it go?” “With your soul.” Kamla answered naturally. “It goes stays with your soul,” I asked. “Yes” Memi who was sitting nearby answered. Kamla was more cautious. “Yes it goes with your soul. Everything with a soul has a breath. It must go with the soul and enter a new body.”

I pointed to a centipede walking past “So if I were to kill that living thing (*jeev*) its breath and soul would go out together and enter a new thing.” Kamla responded, “Yes, that also is a living thing (*prani*). Its soul and its breath would go together to another thing.” I asked for more information, “If it goes with the soul then what about ghosts and other things without bodies. Do they have breath?” I asked. “Of course they have breath. When the mediums bring god out doesn’t their *dham chalna*, it’s like a double breath (double sans). When the deity or ghost comes out doesn’t the medium have double breath, ha, ha, ha, he pants.” Memi giggled and recalled, “remember when Buralal used to be a medium, he would breath so hard and when it was the goddess he would go hi hi hi” making a more feminine

breath sound. “So Memi, you know about these things.” I asked, “It’s the deity breathing in the medium?”

“Yes it’s the god and the medium. The medium’s soul is not gone. It just is not present so the deity must breath very hard. Breathing for two souls.” “And ghosts too? I was at an event to subdue a ghost and it was breathing so loudly, panting.” “Yes, who knows maybe the ghost had not been able to breath for a long time, with no body, so he was struggling to breath more. He is still a *prani* even though he has no body right now. He has a soul and breath and as soon as he gets a body he must breath.”

Breath, we see again, is a bodily process but it is connected to more than just the physical body. It is philosophically a part of the subtle body and for Memi and Kamla it is connected to something more subtle than the body, the *atma*, the environment, and the social. Breath I think we can see in Kamla, Memi, and my conversation is multiple and singular at once. There are multiplex words, which in some moments mean the same thing and in others mean something quite different. *Pran* can mean breath or it can mean breath of life. When the *prans* leave people are dealing with death. Indeed a living thing is called a *prani* or something with *pran*. At the same time *dham* can mean strength and breath, but it can also at times, be the breath that keeps the body alive. Another way of talking about death is *dham todna* to break the breath.

Second, breath controlled is a way of allowing the soul to take over, to manage itself through the body. As such it is an important way to think about subjectivity. It prevents Kamla Devi, Memi Bhai and I from thinking of a simple mind/body split or of a total coherence. It points to the importance of structural inside the body and outside the body by highlighting breath flux, change and rotation. Breath and wind, we have seen time and again

in this chapter, are important because of movement and connection. When it stops bad things happen, blockages occur, mountains move, sin happens and self-control ceases. It mediates the subject and the world but neither wholly places the world or the social inside the body. At the same time breath takes the body and puts it in the world, on the wind.

**On breath theorized:**

Breath is often the pivot around which a Euro-American theory of ontology circles. To breath is to be. Yet, as limits of things that breath change, so must ontology. As Kamla and Memi point out, ghost and deities, people, animals, and plants are all beings or *pranis*. What is fascinating, though, is the biomoral nature of this thing/process that makes us beings and the ability to control it seems to make us, in part, human. Breath is neither coherent nor totally controllable. It points to the persistence of bodies and biology in culture as well as the relations it builds, socially, environmentally, morally and in embodiment. Breath also bears on bodies, and it is a process on which both moral failures and victimhood of bodies and souls are written and read. Ignoring the sharedness in breath is a way of ignoring commensality as well as shared danger, othering TB patients and personalizing their suffering while delegitimizing the forms of violence they connect to it.

The self in South Asia, Holdrege and others have argued, is not dialogical between self and other in a Euro-American sense (Holdrege). Rather it is a relational self. The self is in part in the relationship between body and soul. It is also built up in the relation to the environment. It is also found in relations between the individual and the social, the individual desire and the moral. In each moment the self is relational, building itself neither in mimicry nor in denial of the other but adjacent to it. It is not built in intersubjectivity unless the definitions of relationality can be broadened along with the definition of what a being. I have

suggested just a few of these relations, particularly the ones sustained and highlighted by questions of breath.

It is in this relation that care of the self as Foucault (Foucault 1988; Foucault 1994) suggested does not work in South Asia and why we are again cautioned from using a too Foucauldian perspective on a South Asian subjectivity. People in Ambawati by Foucauldian reckoning do not manage a care of the self so as to be better political subjects. Folks in Ambawati foster relations to other things to better work on the self. By establishing a particular relationship to the jungle or the plain, people build a self with characteristics of that place. They breathe it in and it becomes a part of them. Just as Daulat Singh referred to the mud in Ambawati as part of him, we must look very closely to the ways the relational self is built up in location and in local moral world. This kind of building of the self then internalizing the local moral world, its ecologies, its wind patterns, its meanings and its mud, so that when some part of the body is affected, like breathing the entirety of the precarious self is affected.

At the same time the experience of violence, structural and physical, becomes part of the lived experience of breath. Relations to the environment and moral are wrapped up in the experience of violences and troubled breath. Denying shared breath and air is another way of denying these violence. Bodies run down by hard work, marginality, and exposure are instead explained as a failure of self creation and managed desire, being it sexual, edible, or to addictive substances like cigarettes and alcohol.

Foucault argued that care of the self is fostered by relations to power and to politics, as such the state has most effectively built itself into the subjectification process (1994). In his European philosophical and historical account he generates a model in which the state comes

to achieve control of the self through fostering particular modes of relation to and care of the self that build both docile, confessional subjects and willing political subjects (1994; 154). However in this case the self is not built simply in reflective relationship with the self or with the other, it is in relation to a host of other factors. Care of the self then becomes much more complicated and much less simple to identify. Care for others, care for the environment, and care for the local moral world becomes as important as a care of the self reflectively. At the same time by ignoring these forms of care indexed by breath, the RNTCP's lack of concern for breath might read as a lack of care for TB patients.

To be clear, breath is a mode of caring for the self, but as such it is sustaining and modulating a relationship between body and mind. This is not to argue that South Asian selves are neither dialogical nor reflexive. Instead, I think it is important to point out that self as a dialectical process between self and other (Hegel 2004) or even a dialogical one between self and many others (Jackson 1998) is less important as a relational one which harkens back to the kind of hydraulics Marriott suggested so long ago. I would suggest we consider a pneumatics of the self in which breath moves and changes relations, enacts some and forecloses others, but in each case breath links back to subjectivity, moral personhood, and a self caught between body and soul, the gross and the subtle. An RNTCP outside this pneumatics of the self can only see troubled breath as danger sprouting from a lack of self care and pertinence.

Tantra, too, showed that breath comes to be a space in which bodily techniques of the self and power in language come together to create an ephemeral ability to do things in the world. All of this points to a subject that is concerned about the self in aspirational processes of managing the world but at the same time is faced with the persistence of internal processes

and desires. Desire is like breath, only partially manageable and its power only partially attained by acting on the world. Subjectivity is both precarious and pernicious, like breath. Each breath is a fragment and a fractal of the greater breath of life that even Takhat Singh cannot control, though he may have a tantra to prevent the *prans* from leaving the body. Ontological being is manageable by power, by breath, by culture. Like power and culture, breath is not constant or static. Like culture, it is characterized by movement and the moment when it is bounded and caught it slips away (Clifford and Marcus 1986; Marcus and Fischer 1999; Steedly 1996).

Breath becomes an ideal way to theorize power and care of the self. It is partial and whole at the same time. It gives glimpses but never the whole picture. Care of the self through breath is complicated and important to think about for TB care. TB and the RNTCP's DOTS stifles this kind of management of the self at the same time as it is understood as rooted in initial lack of care of the self anyway. TB sickness in Ambawati is not a whittling down and coming nearer to an essential self as the romantic era Europeans suggested (Sontag 1988). Instead it is a loss of control of the self. Being unable to manage breath comes to be sign of crumpling under the pressure of violence and an inability to manage the thing that makes for life, humanity, and moral personhood.

DOTS and its direct observation of therapy further stabilizes this idea that TB builds an irresponsibility or inability to care for the self and through caring for the self the nation. A DOTS patient who does not take his medicine is failing the nation just as Gandhian formulations suggest that a person unable to control the self through abstinence is unable to become a good political actor of *swaraj* (Alter 1996). Yet the persistence of the desiring body and pious soul remain and this kind of inability to control the self puts the soul in danger.

The soul is connected to breath. The troubled breath will go with the soul to the next body.

Whether or not it will be settled or troubled in the next being is difficult to say, indeed ghosts cough and wheeze.

The point I am making is not to say that breath is wholly a technique of the self and care of that self that can be disturbed by TB. This would be too simple. Instead I am arguing that troubled breath does not just disrupt the ability to care for the self; it disturbs the relations through which the self is constructed and comprehended. Labored breath makes relations to the environment, the social, the body, the mind, the moral and the economy all difficult to sustain and manage. Breath is a way of conceptualizing that relationship. As such breath only becomes a care of the self as it fosters these multiplex relationships. To understand it in a simple Foucauldian way is to misunderstand both the South Asian self and the types of ecologies and cosmologies established by breath as a biomoral substance.

Breath as biomoral is a mode of relating to others that is deeply affected by ideas about the nature of substance (Marriott and Inden 1977). Biomorality then might be thought as biosocial. It is inflected by both the physiological experience of a process that is affected by its place in a complex of meanings and language. At the same time meaning and language is affected by breathing as a physiological process. This dialogical relationship between bodily experience, the body, and meaning comes to matter for biomorality and being an embodied subject in the world it affects processes of the self as well as the ways the self can be cared for and reflected upon.

Bansi Maharaj showed us early that though breath is often an unreflexive bodily process it is anything but meaningless and should not be taken for granted. He raised questions of exchange, control, violence, the environment, as well as body and soul that

followed through each elaboration of breath. These themes are important and when accounted for breath becomes incredibly cultural, relational, and an even bigger trickster than simply breaking bounds between self and environment, mind and body, inside and outside, material and ephemeral.

Each breath is important especially in Ambawati where ecology, history, ideas and society come together to make every breath important and every moment of agency a decision which could tip the balance between success and failure, desperation and aspiration, respectability and violence.



## Conclusion.

### On voice, muddling through and hope

Let me not take sides right now on the validity of these forms of censorship and their principles, but rather analyze, as a beginning, the facts of a problem. Nowadays, a reflection on hospitality presupposes, among other things, the possibility of a rigorous delimitation of thresholds or frontiers: between the familial and the non-familial between the foreign and the non-foreign, the citizen and the non-citizen, but first of all between private and public, private and public law, etc (Derrida and Dufourmantelle 2000:49).

As I was beginning the introduction to this dissertation, searching my memory for a perfect vignette that never came, I slept restlessly for several nights. On the second, night I had a dream. It was not particularly noteworthy until a figure arrived. The figure was a man from Ambawati, a man I had not seen for several years. I had come to know the elderly Megha early on in my fieldwork in Ambawati. He did not say anything, but he watched me for some time as I went about my dream life. I woke troubled.

This was not the first time Megha came to me in a dream. Megha died in May 2011, a few months before I started long-term fieldwork. His son tore down Megha's one-room house and built what neighbors called a bungalow. It is a long, four roomed house with marble floors, an indoor toilet and a large kitchen. This son, however, lived in Ahmedabad, and the house sat empty until I rented it during my fieldwork. I was surrounded by Megha's three other sons, and my relationships with them, his grandchildren, and great-grandchildren grew. I knew Megha when he was alive and respected him as a leader of the community who, though illiterate, was discerning and interested in educating his children, and moving his community out of untouchability and into the sanskritized mainstream. Still, he was one of the last of the Meghwals to carry away dead animals and the last to tan hides, make drums, and repair shoes.

I first dreamt of him on a cold night after a *jagran* in the Meghwal family goddess' temple. This particular temple was important to Megha. He traveled often to the village and temple his ancestors left eight generations before. The goddess would occasionally choose him as her medium and he seemed very devout. The temple had recently been renovated. The old mud structure had been broken and replaced by a cement room painted red and white, the goddess' colors. Sleeping there, between Megha's youngest son and oldest grandson, I thought little of the dream. I assumed my mind had been working through missing him and being close to his family in this place that meant so much to him. Yet when I went home to Ambawati, I told Vajeram, his eldest son, about the dream.

I told him quietly and privately, because when men like Megha come in dreams it often means that they are unhappy, that their souls are wandering, and that they are willing to trouble their families if the families do not provide a statue in which the soul can take material form. I told Kashiram about the dream, "Meghaba came in my dreams in Mavli. He did not say anything. He just looked at me. He had his white turban and he looked happy. He started to speak but stopped. I was sleeping between Raju and Suresh in the temple. Why do you think he came to me?"

"Oh papa has been coming to Bhagwatilal's wife too and my daughter Basanti. We will have to seat him<sup>33</sup>. Bhagwatilal wants to do it soon. Just light incense and pray for his soul, he will go away. If his emotion comes<sup>34</sup> don't be afraid, he is a good man, but make sure you tell me. Anyway, it is good if he comes to you. They only come to those who are good and honest, people who are trusted and without malice."

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<sup>33</sup> Bring a statue and complete the rites to help Megha inhabit that statue.

<sup>34</sup> Kashiram used the common phrase to refer to possession here meaning if he were to inhabit my body.

Kashiram was worried that Megha might possess me in order to give himself voice and make a claim on his family. He never did possess, me, but in October 2013 Bhagwatilal, Kashiram and Suresh went and bought a snake statue for their father and completed the rituals to seat him. Today they worship him and ask for his help in times of difficulty. Megha became an ancestor spirit.

This latest dream came after the ritual. Not sure what to make of it, I sms-ed Devendra, a young man in Ambawati. I asked him if they had not yet seated Megha and why he would have come again to my dream. Devendra answered, “He is just coming to check on you. You are writing about us, no? He wants to see how you are doing. What did he say?” I wrote back, “He didn’t say anything, Devendra, he just looked at me.” “Yes he is just checking on you.” Devendra replied. “Just light a lamp and I’ll go visit him for you.” With that the conversation moved to other things.

Interactions with ghostly men like Megha are common. Indeed, during my fieldwork, much ritual and social work was done to manage ghosts. I traveled along with Devendra and four other Meghwal men to a small city south of Udaipur where they chose five snake statues for ghostly Meghwal men who the community seated.

Ambalal, the stigmatized TB survivor, was one of my fellow travelers. He felt he needed to seat his father. Ambalal knew that his father was unhappy and causing problems for his family and wanted to be installed. TB and other sickness were some of these problems. Ambalal’s father had been possessing Ambalal’s aunt and mother in violent fits and prophecies and was also said to have caused quarrels between the brothers.

Devendra’s father Motilal had been killed by TB about 10 years before. Motilal was possessing Devendra’s aunt, the ghost’s sister, who wailed, wept, and breathed very heavily

anytime he came into her body. Devendra's grandfather also needed a statue as he was causing bouts of mania in his eldest son and quarrels between husbands and wives. His great uncle, Bhavesh's grandfather was coming in dreams too. Another man had been sending snakes into his son's home, making him unable to keep a job, and causing significant domestic tension. The ghostly five men had caused these misfortunes in an attempt to be installed again in the world of the living and take part in the life of their families and communities as wise old men and ancestors.

The group of five men who needed statues, a spirit medium and I rented a car and though cramped drove the hundred kilometers to Rishbadev near Salumber to buy the statues necessary for the event. We found the correct lane just outside Rishbadev's large and contested Jain temple. The medium and the men walked to the first shop and looked at some of the snake statues. The statues came in a rather standardized forms, some snakes had one head, others had two and a few had five. We needed four one-headed snakes and one five-headed snake. The statues were brightly painted cobra forms with the head at the top and body coiling down in a spiral carved in relief on dark sandstone. The first shop seemed nice but the men felt the eyes on the snakes were not pleasing and we tried another. We walked to the end of the lane and back, searching for the right images among the twenty or so shops. Finally after almost making a complete circle we spotted a small shop with well-made images. After choosing five images to the specifications set out by the family goddess and the men who would soon occupy them, my friends asked the sculptor to prepare the statues for use by polishing them, making any small adjustments and writing the ancestor's name at the base of the relief. As this was happening, each of us went to the Rishbadev temple to offer a small packet of saffron paste and sandalwood and give a small donation. This step was not to be

missed and Kumar shows that the routes the men and I traveled are common among South Rajasthan's Meghwal and Rawat communities as well as other low castes (2014). Returning from the temple, the men each bought a small white cloth and a red string. The statues, once ready, were covered in the shroud and tied shut with the red string like a corpse being readied for cremation. Before we left we haggled on the price and gave the sculptor fifteen rupees in lieu of the traditional coconut. The sculptures, once covered in their shrouds, could not be held upright and the men carried them like children in their arms, unless the crowd became too tense when they hoisted the sculptures onto their shoulders.

Settling back in the car we drove to a small temple just below the dam of Rajasthan's largest lake, Jaisamand. In the flood plane below the dam sits a small temple for the snake/hero deity Gatodji. Called Gogaji in other parts of Rajasthan, Gatodji was an historical figure from northern Rajasthan and like other local heroes he died in fighting during pre-Mughal Afghan raids (Elliot 1869). However, in Mewar Gatodji seems to link more closely to Tejaji the hero who died from snakebite while protecting cattle. In either case Gatodji takes the image of a snake and occasionally a living snake incarnation to be the arbiter of truth and discernor of authenticity and purity. The statues are taken to Gatodji's temple to be, as my fellow travelers put it, "attested, you know like if you go to a notary he looks over the papers and if they are all correct he stamps them to show that he is in agreement that they are proper. The dabs of saffron at Gatodji and putting the statues in with the deity mark that the statue is real and acceptable." So we completed this ritual and very carefully went back to Ambawati being sure to treat the now attested statues gently and never standing them upright.

As we arrived we piled out of the car, each of the five sons holding the stones that would soon come to be new homes for their fathers and ancestor spirits, a search for an

available woman of the men's sanguine kin. Finally Sagar a pregnant granddaughter of one of the men arrived with a tray for pooja. She did a small ritual greeting, first to the five statues giving each a tilak on the white cloth before moving on to do the same for those who had gone to purchase them. While we had been away buying stones the women had readied three baby cradle swings and tied to them in the rafters of each of the men's homes. Three of the men were directly blood kin, two brothers and a son. They stayed in a large cradle together. The men gently laid their still shrouded statues down in the cradles and women fussed to find milk and kheer to ritually offer hospitality and sustenance preferred both by infants and snakes. As women swung the cradles, they made the cooing sounds one often does for small babies and welcomed the men. The men's wives and daughters-in-law were careful to keep their faces veiled, as they would need to once again keep veiled in sight of their husband and elder male relatives. For the three nights before the statues were ritually installed the neighborhood's wives and daughters sang devotional songs and lullabies to those who would now be called Purva Boaji, ancestor spirits.

The night that we were to enlist the goddess' help in installing the bodiless men in these statues came quickly and as night fell the sons went to get the small platform ready, cleaning the space and the already seated ancestors and beginning the rituals as the women stayed inside the village singing to the Purva Boajis. When all was ready and the medium who had been invited from Meghaba's temple where I had the dream asked that the men go into the village to get the statues. As we came to Ambalal's house and told the women that we needed to bring the statues to their new home Ambalal's mother became possessed by his father. I was surprised and afraid.

Chunaba had taken hold of his wife and she writhed on the ground panting heavily and occasionally crying. Ambalal went to her and held her up as Chunaba through her said,

“Do you know what happened to me? Do you know how I died?”

“Yes papa,” Ambalal answered.

“You know where I died, son? And you know where you will seat me? There, where I died. You’ll serve me, right? You’ll take care of me and remember me at holidays and call me to events?” “Yes, papa we will remember you and serve you of course.” Ambalal answered.

“Where is my Naru? Where is Naru? Call him to me.” Chunaba rasped as we called for Naresh his youngest son. As Naresh arrived Chunaba asked the same questions again but this time he added, “Naru you’ll care for you mother and be good, not drink too much and take care of your brothers. You have to talk to them and keep in the community. You’ll stay here to serve me?”

Chunaba made all kinds of claims on his family. He wanted his sons to get along and act like brothers. He wanted Naresh, who had moved to Udaipur as a laborer, to move home and care for his mother. He made these claims just before his image left the family house for the last time, before he left the village to reside at the safe distance provided by the family’s well. When he calmed down, he questions answered and his claims heard, he left his wife’s body. We took the statue along with the others, their planed inhabitants too made similar interventions before leaving the village for the nightlong ritual to seat them.

After a night of invoking the goddess and each of the men who would soon become ancestors, at around four in the morning the medium possessed by the goddess removed the white cloth, decided that each was acceptable and instructed each man that this would be his. In that moment each of those women the men tended to possess came rushing in. The men

had possessed them again to make more claims on the sons and brothers gathered. They had a list of demands that ought to be met. After this dense event the medium held each of the statues vertical for the first time since they came to Ambawati. The sun was rising as the goddess left. Ambalal, another medium, and I rushed out to call his closest kin to their own well where Chunaba would come to reside. In the hubbub I could not find my sandals and Ambalal and the medium left as I searched for them. They were in a hurry as they crossed the wheat stubble between the goddess' devra and Chunaba's new devra. I caught them about half way and I could see his family members coming from their own houses in our neighborhood.

We reached the well to a rather terrifying sight. Ambalal and I were startled. Chunaba had come to his cousin and his wife at once, and both were writhing on the ground near the well. His cousin, a lively woman, was screaming as if in pain, "My time, my time is running out. My time. Hurry, my time is running out." In the moment I thought that Chunaba no longer wanted to be cooped up in a statue but I soon realized that we had cut close the time before which the auspicious moment for such activity ended. The two women writhed and writhed as their families gathered, other women struggling to keep veiled in the presence of Chunaba tried to keep them from falling in the well or from their clothes from coming off. Eventually Chunaba left his cousin and his presence in his wife was reassured that he would be stood up in time. Just as soon as he was clam the medium too fell into possession, this time it was Bheru and he mediated the relationship now between Chunaba, the supernatural, and his family. Chunaba laid out his demands and slowly Ambalal, touched by all of the other men in his family, wedged the stone image up on the top of the stone and mud platform. He anointed the image and Chunaba with oil and gave him a flag to mark his territory as well as a mirror to see his new image. He tied a turban on the stone and broke a coconut. After a while



longer of mediation between the family and Bheru, the ritual was complete but for the sacrifice of a black goat to the goddess for her work in mediating the entire process. The extended families all five men arrived by mid-morning and the goat was killed and cooked, feeding over a thousand of the now ancestor's extended kin and friends.

The ritual complete things went back to normal, but Ambalal and the other men who had seated their fathers were careful to go each Saturday to worship and make offerings to the new ancestor spirit. I outline this rather long and complex ritual because in two of the cases it was catalyzed by TB. TB had killed Devendra's father and Ambalal came to know that he should seat his own father after being afflicted by TB. It is in this way that we can see TB and these ancestor rituals come to mediate and invoke a particular relationship of kinship often ignored by anthropological inquiry, that of fathers and sons. In Ambawati TB has seemed to invoke kinship time and again, particularly the relationships between fathers and sons. Daulat Singh's son brought him to the hospital at Bari and it was the same father and son relationship that Daulat Singh links to his first two failed treatments. Sohan Singh ran himself ragged trying to keep his family afloat after the family's chief non-agricultural wage earner, his son Siddharth, became sick. Hameraba's TB related strife was in a large part due to his lack of a son while Ambalal's father's death haunted the family and his affliction with TB came to mark his son.

Families too were re-made in the forms the state uses assess poverty and sons became adults in the eyes of the state in a strategy to disperse assets. Men we saw in classical Ayurveda were the most commonly afflicted by *Rajkashya* and this had to do with sexuality and labor. In short TB it seems is wrapped in the relationship between fathers and sons, both as sons work to build a life of their own and when father manage the change of generations.

Caregiving when seen in this way is important, sons worked hard to manage their father's illness and the knowledge that they would eventually die leaving the responsibility for the family to the sons.

Yet fathers and sons killed by TB or some other untimely disease return to check up on the living. Their voices echo back and forth to the past and the presence of fatherly ancestor spirits gesture as much to reproduction as production and to the rotation I have highlighted in this text. What becomes clear is not just that communities and families matter but that kinship is worked and reworked in medicine. That moments of illness and social suffering ought be parsed, not just with a view to social forms of life but also the forms of kinship and reckoning relatedness, is important for contemporary and fragmented anthropology. I have not highlighted masculinity but I have instead chosen to look to the ways fathers and sons work to manage a relationship to generationality, changing experience and forms of aspiration. Asking how fathers mediate changing times and how sons manage their own relationships to what in anthropology we have come to see as structure also asks us to consider embodiment changing over time and think of bodies remembering experience and memory as well.

Indeed a small amount of literature on North Indian father son relationships argue that for what appears to be unmarked high caste society the relationship between fathers and sons is a tense one. Sax following Kakar and others has argued that the relationship between fathers and sons is tense, minimally communicative and distant (Derné 1995; Inden and Nicholas 1977; Obeyesekere 1990; Östör, et al. 1982; Ramanujam 1986; Sax 1997). They argue that this is in part a function of joint families and the need to prevent a splintering off of nuclear families. What seems to be the case here though is that families are more flexible and

can be both joint and nuclear at once. Indeed the ritual I show here is one in which the father is authoritarian but rather than foster a kind of oedipal killing of the father a kind of rebirth of the father comes to the fore. I suggest this because it opens a window on the possibility that the relationships between fathers and sons, the state and the citizen, production and reproduction, individual and patriline might need to be thought again in the context of a changing India. In doing so we get a sense of the ways TB and kinship might help us see a way in which global structures, discourses, and practices can be lived and embodied. Still the question of these bodiless men's voices arise and with them the question of claims making and voice within and without a body.

While I lived in Ambawati, families of other men I had known seated their ancestors. Two of them had died early from TB and when they possessed the medium after their instillation they wheezed. Devi Singh, a neighbor and friend who died from TB was also beginning to possess his wife and in wheezing voice ask for his own statue in the Rawats' devra.

In each case, these men were to become ancestor spirits, made claims on the living and, give voice to injustices within the family and community and contest changing social orders (Kumar 2014). When Devendra's grandfather was summoned to be seated in a statue, he gave a long list of demands before he would stop troubling his eldest son. He required the man to stop drinking and to treat his sisters well, to stop fighting with his wife and to stop keeping anger in his heart. The grandfather had a voice and a memory, an intimate knowledge of what had and was happening.

Megha came to check up on me, to check my work and inhabit my voice a little. Ghosts of TB inhabit Ambawati and my own voice. They are dangerous and powerful. They

do not just haunt but they sicken, kill, and trouble as well as heal and generate life. As such, I read my dream about Ambawati as signaling one of my own key concerns about this work, that of representation and voice. How do ghosts have voices, how do I write about Ambawati and give a voice to those people I knew there in deferral, mediated by my own voice and language? How can I represent their experience with TB as well as those of nurses, bureaucrats, doctors, and others I met? How does one build a voice that is haunted and haunting, which recalls the past and makes a positive contribution to the present? It has been a struggle, and Megha needed to check on me. He reminded me that this voice and dissertation is not mine. It is a collection of thoughts and ideas created in conversation. With any luck, it will begin a new conversation with new and old voices.

When thinking through TB with the multiple voices checking mine, I have been forced to wonder time and again about a now old question in anthropology regarding structure and agency, particularly when structures are global, deferred and powerful, and when the agent is in a position of marginality and domination. These questions, though tired, have regained significance in an early-twenty-first century context of Arab Springs and Syrian Winters, Venezuelan social protests and Turkish park occupations, Ukrainian revolutions and failed appropriations of Wall Street. The questions of structure, agency, resistance and change have marked the twenty-first century in mass movements hearkening not to the anti-colonial movements of the twentieth century but the revolutions of Europe in the nineteenth. Renewed consideration of the respective roles of the marginal and the popular when faced by global regimes of power and subjectivity are now returning to the center of our thinking about the contemporary world historical movement.

In Ambawati, I was looking at TB care that in many ways marks and is affected by agency or structure in everyday life. I looked to what people actually did. I have done my best to situate them as Jean Comaroff did: “I set out to explore the role of the Tshidi as determined, yet determining, in their own history; as human beings who, in their everyday production of goods and meanings, acquiesce yet protest, reproduce yet seek to transform their predicament” (1985:1). Yet in working to accomplish this goal, a question that links to now canonical work by Scott (1985), E.P. Thompson (1963) and the subaltern school (Guha 1988) came forward: must forms of life which “produce yet seek to transform their predicament” —in this case biological, social, and economic—require a reflexivity and an agonism of resistance? Or can resistance be an effect of the muddling through of everyday life? Do people seemingly outside, along side, or left out have voice in a system?

Though there is no shortage of political consciousness in Ambawati, few there would see themselves as a proletariat or as resisting anything. They do, however, consider themselves to be making the most logical choices to keep life in a fine balance, and more importantly, that prevent them from slipping off the side of the balance tilted towards abjection and desperation. Few would see a story about breath or decisions to visit the Bengali doctor as resistance, but in each case they create a resistant bacteria and are read as resistant by global health and the Indian state. In short, Ambawati seems to suggest that what can be read as resistance is not so much performed as it is embodied and lived in small acts that have seemingly little greater subjective significance but might carry important global effects.

Three texts provide important anthropological foundations for an argument that resistance must require consciousness to be performed: Jean Comaroff’s *Body of Power, Spirit of Resistance* (1985), Aihwa Ong’s *Spirit of Resistance and Capitalist Discipline*

(1987) and Michael Taussig's *The Devil and Commodity Fetishism* (1980). In each of these, the supernatural, divine, and religious come to be spaces in which critique of capitalist labor practices occur. Resistance comes not as armed resistance in the early subaltern school work, but rather cultural and supernatural spaces. Yet for all three texts, resistance requires an assumed proletariat consciousness. In making this assumption the texts assume that critique and resistance are deliberate acts only deferred and fragmented in the immaterial realm. In these canonical works, resistance is a kind of conscious performed while domination is embodied.

My work has shown something different. What may look like forms of resistance, at least in Ambawati, are as embodied as domination. Moreover they exist in modes of muddling through that are as much a part of a system as against it. What looks like resistance can and does occur in a form of life that is not oppositional or bare. Ways of being that could be read as forms of non-participation, criticism and contestation in Ambawati are ways of getting by. Yet they can be as dangerous as they are agentive and contribute to forms of microbial drug resistance and exclusion that are undoubtedly life-threatening. Resistance is embodied by people already marked as backward and problematic but who have also significantly fewer options and must build their lives in a space which is for the most part overlooked by the very structures they might seem to be resisting. Resistance is then building a life where state healthcare is poor, where the state has abdicated care to the community and where critique is at the same time a request for services.

These are simple strategies of self-protection, care, and making sense of a world in which danger could loom at every corner. As such, what can be read as performance and acts of resistance are not thought or felt, but rather come to be part and parcel of a reasonable set

of actions and making sense of a world marked by a dearth of options. Resistances, bodily, social and microbial, in my work come not as the effects of agentive decision-making, speaking truth to power or non-compliance, but rather as everyday processes of making sense of a world in which one must do more with less and make a livable dignified role for one's self on a slanted stage. Overt acts of resistance are rare events, but the everyday project of making a life in uncertainty with limited options is itself defiant. We should not be too quick to read these as resistance, but rather see them as making do and working to access elusive systems and program in many cases out of reach.

I hope this work has argued for an attention to the middle spaces, of mediation and immediacy where voice and resistance occur. I have tried neither to deny the ghosts living in Ambawati—nor the ghosts living in the RNTCP system—a voice. Doing so has required a new form of listening that makes me step out of binaries like those of voice and silence, dominance and resistance, body and mind, consciousness and affect.

I have tried not to take a view so critical and cynical that it writes off the RNTCP as unable to provide care or as corrupt agents of biopower. Instead, I have tried to show a few of the small ways in which the RNTCP is linked into global discourses as well as the ways in which the RNTCP itself might stand in the way of solving the problem of TB. Two such examples were in the examples of transparency and proof set up by the RNTCP and the unquestioned assumption that community-based care means care without support from the medical community. I looked to the ways the poor access private medical care and the ways that care builds a self generated market through pharmaceutical efficacy and bacterial resistance. I've engaged each topic on its own terms to try to interpret and find moments in which change might be possible, neither rejecting nor totally accepting the terms of any. At

the same time, I have worked to think through the ways people try to both make sense of themselves as citizens and as the poor in a context of a “disease of poverty” and a pastoral state. I have suggested that attending more carefully to the ways poverty is lived might help us think of what it can mean both outside assessments and what these assessments may do in building selves and voices to make claims on the state and others. Finally, I have examined breath as a nexus where all of these things come together—policy, community, state care, the market and ecology—to interpret ways TB sufferers and the structures built to help them place the onus not just for care but for disease on the sufferer.

In each instance, I have tried my best to think about values and what really matters for the people I write with and about. How is my own voice and body making a space for other voices and what do my own preoccupations foreclose? What is Megha checking to make sure I have said?

In short, this dissertation is a deconstructive but not destructive one. I have worked through the many layers of body, society, meaning, biology and state to think about the ways these things interact and look for a few places that Derrida might call hinges or places where articulation is made and where some other aspect of the problem of TB might be revealed. I look to the structures, their absences and presence, and the play in between them not to destroy them but to find new ways of setting out and mediating a life and an intervention between the hard surfaces of life.

For me this has not been a taking sides between Ambawati and the RNTCP, between the biological and the social, or between the state and the subject. Instead it has been an attempt to look to the seemingly rigorous frontiers between each and draw on the traces created by separations (local/global, bureaucratic/ersatz, state/subject, power/abjected,



social/biological, material/ephemeral) to look at where they lead and what they can teach us both about global health intervention as well as social life and suffering.

Voices and ghosts like those I met in Ambawati matter, as they in their coughing, wailing, afflicting and helping break these separations and rebuild them not to break out but to build from the old again. My goals here have been to show the fault lines and the places where change might come as well as where the ghosts might be pointing, the spaces haunted by discourses unseen and unchallenged in the public eye but ready to burst at the seams, giving a little hope in difficult times.

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