Introduction

WELL-BEING AND THE SELF

"I have my hands"—that is what the midwife Durga said, smiling, when I asked her if she was scared the night before the government demolished her home. Durga was used to uncertainty. She had built a life here in the Delhi slum of Ghaziapuram twenty-five years earlier, after fleeing an abusive husband. Living on her own as a single woman meant that it was written that she would have to earn for herself, she explained, while tracing a finger across her forehead—the place where destiny is inscribed. When business was slow, she grew anxious. When it was not, she counted her blessings. Even as she kept helping her family in the village, she was never sure what she could count on in return. The clunky government tankers that delivered water to her neighborhood were known to come days late and were hardly guaranteed to fill all the buckets of those who scrambled around their base. Now, even the home around her was about to be bulldozed.

Durga's neighbor and friend Neetu emphasized the vulnerability that women like the two of them shared: "God has given women such a fate that she has to depend on someone or another." The miserly care they received from family and neighbors, their homes that the Delhi government had demolished, and the poor environment they endured—their

Figure 1. Big-City Loneliness. Photo by Mayank Austen Soofi.

health was tied to their relationships, no matter how fragile. Research on the social production of health over the last few decades has focused on how social conditions shape health. Relationships, from the microscale of the family to the macroscale of community and politics, establish the social conditions in which health is forged. The inequalities that structure these relationships have left the health of women like Durga chronically vulnerable. But for women in contemporary India, especially those living in slums, there is no other option *but* to depend on others. And if women tried to do without these relationships, no matter how precarious? Then, Neetu contended, "No one will let her live." Women needed family, neighbors, and the powerful classes. Without these ties, Durga had no hope that politicians might intervene to stop demolition, she had no one to help her haul water, and she had no family to bolster her identity as a mother. Maintaining these ties was a social and cultural imperative.

Yet here was Durga displaying her hands that would remain, alongside her panic over what to do next and her frustration that it was all so fragile. Durga's last patient for the day sat on her bed in the back room. Her work continued as if on any other day, though by now she had gotten her neighbors to remove and sell her roof. Leaves, dust, and chunks of building material from the surrounding commotion of an uprooting community fell onto her floor. While I stood trying to make sense of her calm, she continued, "As long as I have my hands, I can keep eating. God gives everything. Why worry? There is no reason to be sad."

Based on fourteen months of intensive fieldwork with ten families in a Delhi slum, this book argues that women respond to the inequalities that threaten their health by fostering inner well-being. Exploring the centrality of the moral self, this book considers how cultural strategies of resilience buoyed women's mental health while enabling them to navigate their dubious relationships. Like Neetu, women accepted these conditions as their fate. But there were things beyond fate. What was in their hands, what God saw, the strength of their bodies, how they "got ahead," the purity of their hearts: these were words that women used to describe what they made of themselves in spite of their dependencies. I move beyond the reasons that "no one will let [them] live" to the ways that women living in slums continue to do so.

Contemporary advocates for health have endorsed widespread change through attention to the social conditions of health. Yet the large scale and policy orientation of this approach are less concerned with how women negotiate their social relationships every day. This book explores women's relationships with family, community, state, and the environment. While relationships were necessary channels to obtain the *dāl-roṭī* (lentils and bread) needed for survival, women remarked on their hidden consequences. Haphazardly played, relationships yielded disastrous effects on social reputation, piled on long-term obligation, and whittled away one's self-respect. Women could be left with no one to depend on and no moral reserve to sustain them. What was in their hands, they explained, were the boundaries they drew within relationships to maintain their independence and their capacity to define their meaning.

Attention to their moral selves left women with a form of well-being beyond the reach of those on whom they depended. Women intertwined spiritual values of asceticism and endurance with the values of mobility and citizenship endemic in contemporary urban India. Inner well-being did not ease physical ache or mental tension. But when women illuminated the personal strength they used to endure their suffering, they articulated inner well-being as a resource that outlasted present pain. In so doing, women reinterpreted the priorities that both biomedical and political-economic experts have elaborated for their health.

STARTING WITH SURVIVAL

Durga's hands, and the other things she intended to last, were not what I thought I would find when I met her. I came to her twenty-five-year-old slum settlement in the Ghaziapuram Industrial Area first in the summer of 2007 and then returned in November 2008 for a full year of research. I was fixated on Durga's neighbor who kept walking casually through the door, her sari tucked at the top of a pregnant belly that seemed too small on a body that seemed even smaller. Her son who trailed beside her was always sick. Rather than Durga's strong hands, I had pictured someone with her weak body when I first planned to come to Ghaziapuram.

In an atmosphere of such chronic structural violence, how women managed to continue surviving burned as the most urgent issue. The 2011 census figures estimated that 15 percent of Delhi's population lived in slums (Dash 2013), but other estimates pose that 50 percent of Delhi's population lives in slums (Hindu News Group 2009). By 2030, 550 million people in India—more than half the population—are predicted to be living in urban areas (Dhar 2009; Gupta, Arnold, and Lhungdim 2009). The people living in this increasingly common urban form have worse health than those living in the urban areas surrounding slums, often comparable to—or even worse than—the health of the extremely poor rural regions from where they originally migrated (Islam, Montgomery, and Taneja 2006). For the urban poor, there is a dual burden of risk: all of the classic illnesses of underdevelopment that haunted them in the village as well as diabetes and obesity that came from being cooped up in crowded communities (Gupta, Arnold, and Lhungdim 2009).

A large corpus of health and economic survey research on slums emphasizes how the social conditions of poverty intertwine with sexism, racism, and other forms of inequality to generate health disparities. "Such inequalities," writes Paul Farmer, "are embodied as differential risk for infection and, among those already infected, for adverse outcomes including death" (Farmer 2004: 305). Local manifestations of poor health are linked to broader geopolitical inequalities (Nguyen and Peschard 2003).

The residents of Ghaziapuram had seen the wealth of Delhi, like other Indian cities, surge with the onset of globalization. Yet urban planning decisions did little to alleviate slum conditions (Fernandes 2006). Two-thirds of Delhi's slums remained "non-notified." Unrecognized by the government, these slums had poorer water supply, sanitation, and power, and flimsy legal standing. Not only do they barely count as part of the city, their health needs are not counted within health policy needs (Gupta and Mondal 2014). People often lacked access to toilets yet their neighborhood was forced to accommodate a disproportionate amount of the city's waste. They fought and waited and strained their backs to get water, and the air they breathed was more likely to carry industrial pollutants (Shukla, Kumar, and Ory 1991; Tewari et al. 2004; Tovey 2002). The gleaming malls that rose up and highways that kept expanding cloistered the poor into smaller, more segregated spaces.

Before, the courts had ruled that rural migrants to India's cities deserved to have their homes protected in order to preserve their right to pursue a basic livelihood. Now, demolition had become the preferred method of urban development, encouraged by the public interest court settlements of middle-class people. They found slums threatening to their businesses, an eyesore to their aspirations of a "green Delhi," and an obstacle to their city's efforts to polish its shine as a world-class city (Bhan 2009; Ghertner 2010). Only a quarter of those whose homes are destroyed are resettled. People found themselves dumped on the edge of the city in settlements without electricity or water (Menon-Sen 2006; Bhan 2009: 128). To continue working, they rose before dawn to accommodate the ride to a now-distant Delhi. Those who were not resettled scrambled for a new roof over their heads, after their biggest financial asset was destroyed.

Life had always been difficult for migrants, but the present posed new frustrations. As Aamir sighed to me, "The average man runs after money for every single thing."[1] After all, now there was less work to be had. Since the 1990s, India's economic liberalization made secure factory jobs scarcer (Joshi 1999). For rural migrants who sought work in cities far wealthier than their rural villages, there were few options outside factory work. Their village homes had offered few opportunities for education, but now without education, what could they do (Joshi 1999; Papola 2007)? There was little room for negotiation with bosses who demanded more and gave less (Ramaswami 2006). So men sought casual labor and brought home little (Papola 2007), and the women in their households increasingly ventured out into middle-class homes as domestic servants, covering up their contributions in order to make the peace with underemployed husbands (Das 1994; Grover 2011).

Poor people in India have suffered as the state has pulled back its social welfare resources since economic liberalization. Geeta's experience trying to get help for a rash modeled a pattern of how poor Delhi residents tried to get help these days. To get a doctor's advice, she woke up early to battle through Delhi's waves of traffic to get to the hospital. Through the throng of bicyclists to the industrial area, across a maze of cars, to an overflowing bus, down through busy streets, she arrived at a hospital and pulled up her sari to show a nurse the huge rash that extended from her stomach to her back, legs, arms, and neck. "Come tomorrow at nine," the nurses said confidently. "The doctor you need to see will be here then, for sure." There was a vision for what should be available, but often it was not available when it was needed.

The large-scale infrastructure for public health was largely fractured, with urban health care facilities for the poor few and far between, environmental infrastructure woefully inadequate, and few preventive health programs. State welfare programs that were at the core of India's project of development since its independence were now just skeletons of their former robust selves (Gupta 2012). Public health programs that in past decades had been charged with eliminating epidemics had diminished, as if satisfied with extinguishing the outbreaks that threatened the middle class but apathetic about the environmental conditions that sustained health disparities (Chaplin 1999; Gupta 2005). There was room in public services for reproductive and child health and the "essential disease control programs" for HIV/AIDS, tuberculosis, and malaria (Qadeer 2009), but not for the diarrhea, malnutrition, and domestic violence that Durga saw so often in the families that sought her out. Instead of comprehensive health care for the poor, the public sector now limited health care services to the bare essentials (Qadeer 2009).

Other bedrocks to sustain population health and alleviate poverty crumbled. During my fieldwork, the government mysteriously cut thousands of people from the rolls of its government-subsidized ration program, an eerie sign of parliament's ongoing debate about doing away with ration cards all together. Meanwhile, in the stores and open-air markets beyond the ration store, prices of basic food supplies rose dramatically. In the absence of promised state services and protections, many poor people in India petitioned politicians and local leaders who mediated their access to municipal services, guaranteed their safety, and assisted with their personal needs (Blom Hansen 2005; Harriss 2005; Weinstein 2008). When these relationships did not facilitate the services that were needed, people in slums were left high and dry. They may drill wells for themselves (Anand 2011) or shell out precious cash for fake documents (Srivastava 2012). Or, like Durga, they may have no one to halt demolition.

Medical anthropologists describe "how harmful social conditions and injurious social connections" can lead to intertwined illnesses that reinforce one another (Singer and Clair 2003: 429). The social suffering that women experience makes them vulnerable to illness, and that illness in turn makes them vulnerable to more social suffering (Mendenhall 2012). Indeed this insecurity was manifested in the health of women living in slums. For people living in low-income neighborhoods, illness is considered "part of ordinary life" (Das and Das 2006). Illness can be a revolving door into which different family members step, so that at least one family member in 35 percent to 45 percent of slum households is always suffering from something (Karn and Harada 2002). Though fever, cough, and diarrhea receive less attention from public health campaigns, they are responsible for the greatest loss of productivity. Yet their chronic presence wears down the attention allotted to treating them. Over time, many people living in poverty have neither the time nor the money to treat them, waiting until they can take it no longer—incidentally, when it is often difficult to treat (Mitra 2009). For many of the families living in urban poverty in South Asia, there are tough decisions made about who would benefit from family resources for medical care and portions for food, with women often facing the short end of the stick (Cohen 1998; Das and Das 2006; Jesmin and Salway 2000; Palriwala and Pillai 2008; Rashid 2007b; Vera-Sanso 1999). When there is cash at home to treat poor health,

Table 1 National Family Health Survey (NFHS) Data on Delhi, 2005–2006

	Slum	*Nonslum*	*Poorest Quartile*
Infant mortality rate	54.1	36.1	55.7
Under-five mortality rate	72.8	40.4	70.8
Percentage of children (12–23 mo.) with all basic vaccinations	51.7	67.0	39.9
Percentage of births delivered in a health facility	33.4	68.4	17.0
Percentage of children with stunted height[1]	50.9	37.9	57.3
Percentage of children with stunted weight[2]	35.3	23.9	45.5
Nutritional status for women			
BMI <18.5 (thin)	21.2	12.8	32.0
BMI <17.0 (moderately or severely thin)	7.9	4.7	11.2
BMI ≥25 (overweight or obese)	20.3	28.9	7.9
BMI ≥30 (obese)	6.4	8.6	1.2
Nutritional status for men			
BMI <18.5 (thin)	22.4	13.0	26.9
BMI <17.0 (moderately or severely thin)	6.5	2.8	6.9
BMI ≥25 (overweight or obese)	10.5	20.0	6.5
BMI ≥30 (obese)	1.4	3.2	1.2
Number of women per 100,000 females who have medically treated TB[3]	376	206	549
Number of men per 100,000 males who have medically treated TB[3]	391	190	507
Women experiencing spousal abuse[4]			
Physical or sexual violence ever	28.0	12.4	37.2
Physical or sexual violence in last 12 months	21.9	8.8	29.2

NOTE: Figures are from the Census definition of slums, defined by the Office of the Registrar General and Census commissioner as areas specified a slum by state or local government (even those not formally notified): a "compact area of at least 300 population or about 60–70 households of poorly built congested tents, in unhygienic environment usually with inadequate infrastructure and lacking in proper sanitary and drinking water facilities." All data reported in Gupta, Arnold, and Lhungdim 2009.

1. Children under five years whose height-for-age index is two standard deviations below the median WHO child growth standards.
2. Children under five years whose weight-for-age index is two standard deviations below the median WHO child growth standards.
3. This measure is used to increase the reliability of reporting on TB, so that symptoms are not confused with another illness. However, these figures likely represent an underestimate of actual prevalence.
4. Percentage of ever-married women aged 15–49 experiencing violence from spouse.

symptoms can be read as illness. But when there is not, family members inadvertently may read even symptoms of severe illness as normal (Das and Das 2006: 193–94). With public hospitals overflowing, people living in slums tried to soothe their repeated illnesses through visits to the various medical practitioners who dot their communities. While the service of these local practitioners is sometimes reliable, often their expertise does not adequately address the complex conditions they face (Das and Hammer 2007; de Zoysa et al. 1988; Das and Das 2006).

Researchers have highlighted how women living in communities like Ghaziapuram are bound by patriarchal relationships that limit their autonomy and make them vulnerable to physical abuse (Haider 2000; Visaria 2000). The high incidence of domestic violence in their households is partly responsible for mental health problems that affect a full half of women living in slums, more than twice the rate of those living in urban nonslum areas (Kumar et al. 2005). Midwives like Durga, who respond to reproductive health problems, have ample work even though women seek treatment for not even a third of the reproductive health problems they face. From marriage onward, pain and reproductive illness persist for women, shaping the contours of their mental and physical health (Ramasubban and Rishyasringa 2008).

When fragile social conditions engender such bodily vulnerability, the word that researchers repeatedly use to describe people's basic existence is "survival," what is named "the most basic right" (Farmer 2005: 6). Many researchers have argued that the imperative of survival reorganizes the priorities of people living in poverty. As Susan Seymour writes in her comparative study on the family practices across classes in Orissa, "Whereas middle- and upper-status women usually responded 'being a wife and a mother' when asked what brought them the most satisfaction in life, lower-status women responded 'surviving'" (Seymour 1999: 145). Or, writing about women living in a slum in northern Delhi, Meenaski Thapan notes, "A woman's embodiment is rarely experienced for pleasure or joy; the body is an instrument for survival. In this sense, the body becomes the weapon with which there is a desperate attempt to contest the harsh realities of everyday life in the fight for survival" (2009: 133). In her writing about poor domestic workers and the higher-class women whose homes they clean, Sara Dickey comments that "they too are concerned with keeping inside spaces clean and protected," although generally these concerns are more extensively elaborated amongst higher-class women (2000: 480). However, domestic workers are preoccupied by other worries, she writes, "having insufficient resources to provide for their families' daily survival needs," worries that are "more 'real' than are employers' fears that their households and class standing will be dissolved" (2000: 481). Survival seems to peel away all else, from kinship to bodily meaning to household standing, in a bid for continued existence. As Haider (2000: 30) wrote, through her fieldwork with women in a Delhi slum she learned "their claustrophobia at being trapped in a heavily congested squatter settlement; their monotonous daily work in the effort to access basic minimum needs, especially water; their unending endeavor to make two ends meet somehow; their nagging fear that their hutment might be demolished at any time making them live in constant anxiety and insecurity; their curtailed freedom of movement; their muting; their reflections on their lives in an urban city—often only echoes of information given by their spouse; their almost non-existent relationships with their husbands; their alienation from the larger urban social and cultural milieu."

In this powerful passage, Haider encompasses the expansive scale of social determinants within individual experience. Every relationship that these women have—with environment, state and city, neighborhood, and family—is fragile. Across these four accounts, researchers describe "survival" as women's imperative, requiring work, fighting, and accepting relationships beyond their control.

IN SEARCH OF CHANGE

Researchers and reformers have articulated an ambitious agenda to make sure that survival would not be such a bruising fight for women living in India's poor urban communities. As much as the vulnerability of these women may be clear, no single public health agenda has been coalesced to address it. The priorities set and the means suggested to achieve them vary drastically by the researcher, policymaker, or activist recommending them. Some researchers and reformers draw from multiple perspectives to address the health of people in slums; others vehemently disagree with approaches that they felt misrepresented the problems and provided only shallow solutions. Here, I outline several of the main approaches and the forms they took in wider Delhi, though many of these efforts were not felt directly within the lives of people within Ghaziapuram.

Researchers of the social production of health school argue that any health system must be "placed within a national effort to provide food, water, shelter, sanitation, education, and other basic needs" (Narayan 2011). If basic needs do not take precedence, then public health efforts will be consumed in curing disease, rather than preventing and promoting it. For women like Durga and her neighbors, this needed to start with securing their basic citizenship (Sen 2011). When people living in slums are not counted as part of society, then neither are they provided with basic infrastructure for everyday life, much less provisions for health care (Shetty 2011). Delhi's urban policy, as well as the Indian government's approach to urban policy, must include poor people in its planning, rather than forever moving them to the side (Baviskar 2006; Menon-Sen and Bhan 2008). Counting poor urban communities as part of the city requires providing them with clean, reliable water, sewers that remove waste, provisions to create latrines in people's homes, and public toilets for those who cannot afford them in their homes. Once infrastructure is there, health and hygiene will follow (Renu Khosla, personal communication with the author, August 21, 2009). Further, some researchers argue that health will not improve without fundamental changes in economic policies. If Aamir is forever running behind every rupee, then how could he ever afford basic necessities, much less have any long-term security? Economic policies that encourage more stable employment are necessary to ensure that people like Aamir can escape repeated cycles of poverty (Menon-Sen and Bhan 2008). Without such basic changes to livelihood, government programs to support basic welfare can only have shallow effects (Gupta 2012). This broad grouping of reforms looks less at what is in Durga's hands and more at rebuilding the basic policy infrastructure that shaped her poverty and health: urban policies that provided security for the poor, basic environmental infrastructure, and economic policies that ensure more stable livelihood.

"If health is of the people and for the people," other researchers argued in a nod away from policymakers, "the people have to be at the centre of health action" (Paul et al. 2011). Communities themselves would power the reforms in this vision. Already research has shown that people living in urban low-income communities internationally helped themselves through resource-sharing relationships (Stack 1974; Gonzalez de la Rocha 1994) and providing protection from stigma (Mullings and Wali 2001). These reformers build on changes in public health and development programs since the late 1970s and early 1980s. As it became apparent that the global development agenda was slow in delivering its promises to improve health globally, activists gradually assembled the nongovernmental organization (NGO) model buoyed by concepts of community development and social change, Paulo Freire's work on critical pedagogy, and feminism (Gupta and Sharma 2006). NGOs could provide services in gaps where public efforts have fallen short, while empowering communities to initiate social change themselves (Nadkarni, Sinha, and D'Mello 2009). In Delhi, *mahilā pañchāyats* (women's councils) exemplify this approach. Women facing domestic violence, dowry harassment, or a lack of support can bring their husbands before a community-based council to have their dispute heard and receive recommendations for its resolution. With the legal system operating at a sluggish pace and police a threat more than a resource, *mahilā pañchāyats* are often the lead institutional players in adjudicating family disputes for low-income urban families (Grover 2011; Magar 2000). In the process, members generate community-based solutions for a key health problem. Beyond women's councils, reformers and researchers suggested that community members could play an active role in community education, planning health programming at the local level, and promoting healthy behaviors (Paul et al. 2011). Advocates of this approach reason that because people in low-income communities struggled through the same challenges and possessed collective social resources for health, health development would benefit from institutionalizing their homegrown expertise.

A number of researchers assert that grassroots activism leads the charge for change. These researchers see community-based activists as distinct from community work within established health development programs. Now institutionalized within the development establishment, NGOs did not address the more fundamental forces of inequality that threatened low-income communities. By fighting "against the process of economic adjustment and the intensification of their own exploitation by demanding the right to work, reservation in jobs, political participation, education and welfare for the poor," grassroots organizations "assert their entitlements of equality and improved health" (Qadeer 2009: 247). While some organizations fight for the large policy changes forwarded by advocates for the social determinants of health, many others push for change through piecemeal efforts that make changes one community at a time. Citizens' organizations have enabled poorer residents to lobby for electricity and land claims (Chatterjee 2004), negotiate with international developers about sanitation projects (Appadurai 2000), and arbitrate for control over illegal space (Anjaria 2011: 63). These organizations' resistance to professionalism gives them greater freedom in the demands they can make. Where political restrictions tied the hands of policymakers and programmatic obligations distracted community NGOs, researchers and reformers believed that grassroots activism could promote policy change from the ground up.

Other advocates argued that focusing on communities as a whole did not account for the way that gender inequity weighed women with more health problems than men (Raj 2011). Stronger laws could help women advocate for their rights, but even more so, researchers have noted "societal norms that tolerate and accept violence are widely prevalent in Indian society" (Visaria 2008). These entrenched norms reverberate in women's overall access to care: their needs have little priority within families, and they have little power to make their own decisions about the care they want (Jejeebhoy and Varkey 2004; Mishra and Tripathi 2011). Researchers argue that educational efforts should further women's ability to voice their needs within families as much as spread awareness among their husbands, families, and broader communities that violence is wrong and that women deserve better support (Jejeebhoy and Varkey 2004; Koenig et al. 2006; Nidadavolu 2004).

Finally, many health researchers left the macroscale of social conditions in favor of improving the health care through which people in slums tried to alleviate their health problems. To address the broad range of illnesses that they faced, women like Geeta and her neighbors were faced with a dizzying array of health care practitioners (Indrani Gupta, personal communication with the author, August 12, 2009). They were not all affordable or accessible, nor were they all good. Consequently, researchers suggest people living in slums would benefit from increased awareness about good care, so that they can differentiate their options and choose best (Agarwal et al. 2007). Reformers have stressed how the quality of practitioners and the accessibility of public hospitals are in dire need of improvement (Das and Hammer 2007; de Zoysa et al. 1998), particularly so that people in slums have more options than the community-based registered medical practitioners (RMPs) that they depend on (Das and Das 2006; Kamat and Nichter 1998). In this way, Geeta should be able to get care when she needed it, having hospitals ready to serve her, and practitioners close by to avoid her taxing trek. In addition to improved health care, researchers felt that people living in slums needed better awareness of preventive care before they became weak or sick. Educational initiatives could play a vital role in promoting early childhood development, reproductive health, and good nutrition (Paul et al. 2011). Women living in slums face considerable reproductive demands, these researchers argue, but may not realize how their decisions to receive pre- and postnatal care, delay childbirth, or use contraception have huge advantages for preventing health complications (Jejeebhoy and Varkey 2004; Ramasubban and Rishyasringa 2008). Often, women living in slums may not understand the severity of particular symptoms that they or their family members may face, leading to escalation of illnesses that could be readily addressed (de Zoysa et al. 1998; Jejeebhoy and Varkey 2004). Improving the options for health care and expanding families' awareness of when health care was needed would ease the suffering of people living in India's low-income urban communities.

Weaving their way through many of these approaches are several key threads. First, housing, food access, infrastructure, livelihood, and access to health care are basic necessities without which people living in urban communities will continue to be chronically vulnerable to ill health. The challenges of poverty are experienced in a particular way in Ghaziapuram, let alone India, but overall, the basic ingredients that people in Ghaziapuram lack for their health are those which are necessary for health everywhere. Efforts that do not address this on a large scale will have limited impact. Second, people living in urban slums *collectively* face many of the same obstacles to health, even as women bear a distinct set of challenges that men do not. Because many of the threats are collectively experienced, communities are well poised to improve health through providing small-scale resources (savings groups and informal courts) that substitute for that which they lack, adapting programs to their particular needs, and demanding the services that they need the most. Third, if women knew that they deserved good care within the household and their families supported them in this, then domestic violence could decrease, maternal and child health would improve, and women's overall health would be strengthened. Collectively, these approaches prioritize health outcomes, agreeing on the goals of improved mortality and decreased burden of disease, though they debate the steps to get there.

BEYOND SURVIVAL: WELL-BEING AND THE SELF

From Ghaziapuram, the old public health structure was felt through the government hospitals where Jyoti trekked with little hope, the billboards announcing messages of disease prevention that dotted occasional roads, and the women's and child development centers that they had heard about in other neighborhoods, but not this one. Closer to home, however, was the area NGO with its savings group, *mahilā mañḍal* to hear domestic violence disputes, and rotating public health campaigns. Other small organizations sat in surrounding communities, rich in services but dwarfed by all of the homes and families they were charged with serving.

When I came to Durga's neighborhood, I had hoped to learn just how she managed to survive. I asked women about the community resources through which they helped themselves and the impacts of the social conditions they lived in. "Yes, we help each other out," agreed Padma. But the conversations I had expected to have about neighborly assistance often just led to gossipy tirades. This person was lying about abuse at home or that person was responsible for clogging the local drains. Rather than joining efforts for collective action, I was brought along to discreetly lobby for special rights in front of policemen and to political rallies that would later be deemed "useless." Even the poor health status that seemed so clear in researchers' concerned words gradually disintegrated. When, from her perch on Durga's stoop, Padma solemnly told me that she was *ūpr-jānīwālā*—about to go to heaven—because of her poor health, Durga yelled back out, "she's not going anywhere!" Saraswati complained of her chronic weakness from constant work, poverty, and abuse. Yet after meeting a middle-class friend of mine who came to visit, she proclaimed her comparative strength. Where was the community? Why was health status confusing?

As I became more involved in family and community life, I observed a number of women's decisions in everyday life that seemed disconnected from their well-being. At least that was how it seemed to me. I became wrapped up with particular situations that made no sense to me in the context of women's regular reports of weakness and financial insecurity. Saraswati's wrists became increasingly thinner as she stopped eating in the wake of her husband's violence. When Neetu's fights with her husband reached their peak, she announced her seemingly sudden distrust of her dear friend Durga—her one option for intervention. As the date posted on demolition notices drew near, Geeta and her neighbors seemed ambivalent about whether it would actually happen. And Durga made a point to comment on how dirty other women's homes were—even as they seemed to share the exact same barriers to water and sanitation.

In the midst of so many physical threats, I grew frustrated with the stories that women told me every day about their complicated relationships. They seemed less important than issues related to their survival (i.e., Farmer 2004). I was unsatisfied with Saraswati's explanation for why she would not eat, angry with Neetu for cutting off the one friend who could talk sense into her husband, frustrated at the lack of urgency as demolition approached, and annoyed with the fact that hygiene seemed an opportunity to differentiate oneself.

But my urgency to focus on what I saw as essential for their survival did not acknowledge these women as "fully embodied and affective interlocutors" (Jackson Jr. 2010: 285). I had a hard time understanding that daily concerns were just as important as the weighty matters (Khare 1995: 148). I was interested in using the personal experiences of people living in poverty in the name of international moralities about the social determinants of health. Yet focusing on the structural violence that I saw at the heart of their lives abstracted their lives from the complex moral systems in which they lived (Butt 2002). I did not know what well-being meant to them, nor did I understand what they did to create it.

While social conditions explained the vulnerability of women's health, they did little to explain the decisions that women made daily. Like others, I had inadvertently relegated well-being to distinct domains and sidelined strategies I deemed less productive of survival. Because I had separated the shared conditions of poverty from the realities of social diversity, I had felt that political matters that promote survival should not be distracted by private personal grudges. Because I saw individual well-being apart from the social meaning of family, I was sure that women's efforts for well-being should not be compromised by their social need for families. My concern for physical survival threatened by social conditions failed to explain the meaning of the fear of evil magic between neighbors, the desire to promote family relations even if they are abusive, the disdain of neighbors' hygiene, and the retreat from collective political action. These decisions mattered too. I had dismissed important axes of meaning in slum life because of the type of well-being for which I searched.

For women, the constrictions of the social determinants for health were paired with what they saw "in their hands" every day. What was "in their hands" was what *they* could do. Only through months of analysis did it occur to me that the "me" and the "I," the *jīv* or *man* (self) in Hindi, the "good" or "bad" person in gossip, the person women described in relationship to God—that these all outlined a cultural model of personhood that shaped their notions of "body, soul, mind, and emotion" (McHugh 1989: 77) as much as of well-being. In all of the situations that made no sense to me, women articulated different stakes of well-being by elaborating a moral self. In this way, women challenged social determinants of health perspectives that "tacitly assume that agency and will are themselves socially scripted" (Greenough 2009: 31). Their perspectives questioned several of the key assumptions of efforts set out to improve their health.

Following what women shared of their lives, I consider two intertwined forms of well-being: that which is relational, and that which is outside of relationships, alluding to otherworldly unity. The moral principles that guided them urged me to see beyond their physical vulnerability to consider the consequences their social conditions had on their self-respect (Bourgois and Scheper-Hughes 2004: 318). They lived anxiously, assaulted by legal, social, cultural, and moral stigma (Baviskar 2006; Bhan 2009; Chandola 2010; Ramanathan 2006). Their prescriptions for well-being urged protection in their social interactions, discipline in their mobility, generosity in their families, and creativity in their environment.

Much of what was in their hands were the relationships through which they lived in these precarious structural conditions (i.e., Parson 2010)—the relationships without which, as Neetu said, women could not live. For people living in poverty, power operates through their relationships in their daily lives: both their relationships with the powerful that generated their poverty as well as those through which they act in the world (Green 2004; Harriss 2007: 3). In South Asia, though women's relational well-being has been considered first and foremost through the family, I follow other scholars who point to the lived dynamics of relationships beyond the immediate family (Han 2011: 12; Povinelli 2006; Stack 1974) that are equally a part of daily life even as their cultural value may be diminished. I explore the social relationships—family, neighborly, political, and environmental—in which Durga and her neighbors were embedded through Janet Carsten's formulation of relatedness, as "indigenous ways of acting out and conceptualizing relations between people" (1995: 224). Throughout, women described how they retained their individuality within sociality (Ewing 1991; McHugh 1989; Raval 2009; Trawick 1992b).

When women espoused hard and fast expectations for their relationships, they seemed to confirm the formal "symbols and systems" of kinship, caste, and society frozen in social anthropology (Donner 2008: 4). However, as I looked more carefully over all that women had shared, it was clear how much ambivalence guided their relationships, so I began analyzing the widely divergent feelings they expressed about each of their relationships (Ewing 1990; Peletz 2001; Trawick 1992b). I reconstructed the practices and feelings of particular relationships to capture the fine distinctions that women drew between the ways they were engaging with others, the permanence or ephemerality of their engagements, and the meaning they attributed to their relationships (Weston 2001).

Yet as women negotiated the relationships that they needed for survival, they looked inward and upward. These women were not simply Hindu, Muslim, or Sikh. Among them was a Sikh woman who worshipped Sai Baba, a woman born Muslim but now Hindu, Hindus who went to Muslim saints' graves and lower-caste magic healers, and those who refused to speak about God. Yet there were commonalities in how women indicated their gaze upward as they named God, judgment after death, and right action, or *karmā*. I asked less who God was and paid more attention to what women said God did and meant.

In this paired gaze—toward the relationships in front of them and to the deeper spiritual resources within and beyond themselves—Hindus engage their selves within two levels of reality, one worldly and one other-worldly. The "worldly" consists of the reality before them: the body, the caste, the family, and the social status into which they are born (Khare 1993: 201) and the social conditions they lived in now. For instance, Mrinalini explained that God was called upon to help in the life before her, to "make the sadness less, erase the sadness, [for this] we put our hands together to pray to God."

Yet as she continued in her description, her requests gradually disappeared and God subsumed her within something larger:

> God you are the giver, you are the eraser, of our children, of our people, the one who gives us sadness. This is why we go to God's door. God gives people startled breathlessness, upon having faith in God. Because the one who gives life is him. That is why people take God's name at the time of dying and the time of living as well. Only in the name of God are words given and the one who gives is only you. Only you erase our sadness, decide the moment of our death, only you do good. The days are only yours, as you keep us in this *karm*. This is the faith that man has in God.[2]

Rather than her self as the giver of birth to her children, God was the giver of her children. Rather than Mrinalini as the caregiver of her family, preserving and nurturing life, God was the sustainer and eraser of life. Rather than her own ability to give or seek comfort, to make good or even cause harm in this world, Mrinalini argued that God was the giver of sadness, suffering, and goodness. Rather than marking her personal history through days, Mrinalini argues that the days in which she lives, and the *karmā* (action) through which she lives them, are not hers. A true understanding of God, in Mrinalini's description, requires erasure of the self.

Scholars have written that all individuals, whether they realize or not, are also part of another existence in which their individuality is dissolved, earthly distinctions and desires are nonexistent, and the self is subsumed within the Universal (Khandelwal 2004; Khare 1993; Parry 1994). To realize the dissolved self is to adopt acceptance of God's will rather than seek action and realize one's impulses (Krause 1989: 566), acknowledging how "much of this life still remained unknown and unseen" (Khare 1993: 201). Geeta's take on what was unknown and unseen was more cynical. (After all, that was Geeta.) Geeta posed with irritation, "What does God do for health? He does nothing for health. Everything is according to his wants." But what began as her annoyance balanced out to a wider portrait of God. "Everything is in his hands. He keeps us happy; he annoys us. Everything is in his hands alone. There is nothing in the hands of people."[3]

Within this world, it was assumed that people living in slums as much as those in "hi-fi" apartments will act for their own prosperity and success. I should study and get a good job, said Saraswati, and she and her family should *āge baṛhānā*, get ahead. But this should be done in the right way, warned Neetu. She explained, "God gave us existence from several sides, so God said to do *karm*" (right action). Channeling this voice, she narrated, "'I am giving you your very existence, so with this hand do your *karm*. Do not do anyone wrong, do not touch anyone, do not look at anyone and be jealous, do not steal from anyone. . . . You need *roṭī* (bread) and salt so in this spend your time, in this remain happy.' God said this."[4] Though karma is associated with the accumulation of merit for the next life, Neetu argued that one's obligation to act well in this life was reciprocity to God for the life you were initially given.

But Hindus and Muslims alike believe that their actions in this world would resonate beyond this moment. In the aftermath of demolition, Padma (born Muslim, and now identifying as Hindu) put it this way: "This is why they say that you give your hand to someone, it is that very hand that will take you ahead. If you give someone one thing, then God will give you ten more. I am telling you the truth. If you give someone on your doorstep one rupee, God will give you ten. If you keep that one to yourself, then someone will say, 'Look, what a horrible person. Take it, bastard, you'll die of hunger.' That's what is said."[5] Collectively, actions will be evaluated through a day of judgment (for Muslims) (Rahman 1989: 167) or through karmic reward or punishment in rebirth (for Hindus) (Babb 1983b). In either case, the intentions behind one's actions will be known (Babb 1983b: 180; Rahman 1989: 167). By doing good action (*karmā*) unattached to outcome throughout their worldly lives, people cultivate their souls. Muslim thought offers a related prescription, to protect the inside, divine self by controlling one's outer bodily senses (Ring 2006: 150).

Looking in both directions, people commonly oscillate between worldly distinctions and otherworldly unity. As Sarala put it, "There is no difference between the wealthy and the poor. There are differences between the things [that they have]."[6] And, in parallel, they alternated between the poles of individual action and acceptance (Khandelwal 2004; Khare 1993; Khare 1984),[7] allowing Mrinalini to pray to God for intervention and to accept that God decides everything. Thus, as much careful reflection on action is exacted through the self, there is also an acceptance of action's limits in favor of accepting divine control (Khare 1993: 204; see also Shweder 2008: 75–76). Because dissolving the ego allowed women to let go of the anxiety of when to accept and when to act, it brought them peace. "In taking the name of God," reflected Neetu, "you find peace. . . . God stands by you in every crisis. In every crisis, in sadness, in happiness, in everything is my God. Everyone's God."[8]

Describing women's cultivation of their selves in such challenging circumstances requires ethnography, for only ethnography can demonstrate how women's everyday decisions represented varied forms of action, negotiated ambiguous feelings about relatedness, and acted through multiple selves. Other studies have explored the self as an object of development and the state, elaborating the types of moral qualities that are deliberately inculcated through state programming, and articulating the ways that people respond to and incorporate such concepts within their subjectivity or self (Biehl, Byron, and Kleinman 2007; Karp 2002; Pandian 2008). Although I acknowledge that state and development programs have shaped, in some ways, the different forms of self that I write about, I contest the "remarkably persistent" notion of third world people's "over determined lives" (Khandelwal 2004: 4; Mohanty 1984). They surely were interacting with the moral projects of the state and development that they encountered in the television serials they watched, in the strict language of the doctors and NGOs that served them, and in the expectations of their family members and neighbors to consume and to present themselves in particular ways. Yet my aims are different. For a group of people whose circumstances have been defined by what is beyond their control, I ask what they determined through their selves and how their selves reflected their well-being. Women's concepts of well-being inadvertently interacted with the varied institutional moralities of the public health, often agreeing with or tempering these viewpoints but sometimes representing parallel moral worlds with different stakes and priorities (i.e., Zigon 2009).

Following others who argue that well-being in South Asia draws together moral, social, cosmological, and physical worlds (Kakar 1989; Khare 1996; Lambert 2000), I examine how women built well-being from the inside through negotiating their relationships and cultivating their selves. Alongside the social conditions that made them sick, women living in South Asian slums faced other profound changes in the present that shaped the context in which they seek well-being.[9] In the following four sections, I explore the broader terrain in which women made sense of their lives and defined their priorities.

RELATIONAL WELL-BEING AND FAMILY SECRETS

When I had begun my research with my field assistant Saraswati, I explained that part of my interest was the role that families played in health. That was fine, she responded, but then she cautioned that "No one will tell you the truth about their families." In a place where initial introductions began with an iteration of one's family members and daily conversations began with how they were, the extreme interest in family seemed incongruent with her allegations of widespread secrecy.

Scholars have long pointed to how personhood, and also well-being, in South Asia is "relational." Being part of the family, and being nourished by the collective, is core to well-being (Kakar 1978). Many feminists have argued that relationality is particularly significant for women, and that their "well-being thus depends not only on a woman's sense of herself as an individual, but also on her relationship with others in her extended family and community" (Thapan 2009: 132). Rather than seeking autonomy, women grew personally as they became further intertwined within family relationships and activities (Menon and Shweder 1998; Seymour 1999: 279; Trawick 1992b). If all of this was true, then women depended on someone else to live not just because they needed to, but because being intertwined with others contributed to their well-being. Was the secrecy that Saraswati alleged due to women's desire to obscure their ambiguous feelings about family? Or was it because they were unsure of who their families were? It gradually became apparent that women's silences were connected to their own questions about what their family changes might have said about themselves.

Like most other South Asian women, Saraswati moved between her natal and her married family households over the course of her lifetime. From physical posture to daily routine and form of address, she adjusted every detail between these worlds. Women defined their lives and their selves through the adjustments these transitions required. In contrast, men often stayed within the same family over time, a family that gradually enveloped new family members (Lamb 2000; Menon and Shweder 1998; Raval and Kral 2004; Vatuk 1990). The ability of women to "maintain enduring mental representations of sources of self-esteem and comfort" is what enables them to adjust to the extended family they make their own (Ewing 1991: 132). In this sense, the well-being of women's relational self depends on their ability to maintain an individual self within these relationships. But in contemporary South Asia, as household forms have changed over time, they have demanded a new definition of relational well-being. No longer did women always have to adjust to living with their husband's extended family. No longer did men always remain at home.[10] How could women become increasingly intertwined with relationships when city life truncated their families?

The way that women told their family histories changed as women got to know me. Marriage breakup is increasingly common, particularly in poor urban settings, with women often as the initiators (Parry 2001; Grover 2009; Jesmin and Salway 2000: 693; Rashid 2007b: 116). For women, being sick, their husbands' affairs, unpaid dowry, and not having children were all factors that they felt put them at risk for being abandoned (Das and Das 2006: 81; Jesmin and Salway 2000: 694; Rashid 2007b: 111). They, in turn, considered abandoning their husbands because of their lack of employment or inability to provide (Rashid 2007b: 116; Jesmin and Salway 2000: 694). Whereas usually women continue to rely on their parents to arbitrate disputes after marriage, women who chose their own love marriages retreat from kin, feeling "hesitant about complaining, approaching and bringing their marital grievances to their natal kin, as they feel they cannot hold their parents accountable for their current situation" (Grover 2009: 26; see also Das and Das 2004: 53). Because leaving family even in the case of abuse was stigmatized, I tried to minimize my questions about leaving and respected women's silences. In some cases, I chose to follow up with questions later, finding that with increased time and changed circumstances, women might be willing to share their experiences.

Outside the question of whether relations would last was the question of the type of support that relationships provided. To whom was what owed? Women's rights to family resources in both their affinal and natal families—from maintenance to land—were contingent on their interpersonal relations and investments, such as sending remittances and investing in village land (Palriwala 1993: 54; Das and Das 2004: 72; Jesmin and Salway 2000: 698). Older women sometimes traded the security of living with their children with control of the household budget, which they relinquished to sons and daughters-in-law—who did not necessarily have their best interests in mind (Vera-Sanso 1999: 589). At times, families made efforts to cut off poorer relatives through marriage or movement (Bear 2007: 187). Migration introduced new inequities into questions of sharing with distant family in rural areas. With infrequent visits, the spouses of migrants controlled their money more tightly and shared less with extended family (Palriwala 1993: 70). Adults earning through urban wage labor did not feel the pressure to contribute financially to their families as they would have working on family land (Jesmin and Salway 2000: 692). Some families used the concept of togetherness and love to elicit help, only later to deny family members' requests "because we have our own expense to worry about" (Bear 2007: 190; Vatuk 1972: 135). The families I became closest to asked me for sympathy in their own struggles to ask for fair financial support, described the tense negotiations that happened when I was absent, and, at times, awkwardly invited me into their debates about family contributions as they happened right in front of me. When women wanted care from their families but did not receive it, they asked themselves how to make family meaningful in the absence of care.

Even if family did not provide care, it was still needed as a symbolic gateway to other resources. Though callous domestic violence was looked down on within low-income neighborhoods, other women felt unable to intervene if the broader kin network was not assisting in any way (Das and Das 2004: 56). Thus, even when women faced neglect and abuse, they still had “a stake in maintaining relations” (Das and Das 2004: 6). Other women feared that, without their families, they faced rape and serious abuse if they were to live on their own (Jesmin and Salway 2000: 702). In a setting where family goings-on, including violence, are largely public, women displayed whatever family they had to for neighbors to avoid the shame of being without family (Grover 2011; Sangari 2005). Thus, as women were careful about the way that others watched them in public, they knew that family was one of the vehicles through which they were known. Women used their neighborhood social interactions to reflect on what their family practices said about themselves.

Numerous studies show how women oscillate between foregrounding their individual self and absorbing themselves within a collective self. At times, some women asserted, it was important to forgive abuse (Das and Das 2006: 52). In swallowing the pain, women submerged their individuality within the family. They might purposefully reinterpret illness symptoms as normal bodily signs to accommodate financial stress or to prioritize other family members' health (Das, Das, and Das 2012; Das and Das 2006). In this most intimate way, shared needs became embodied, though often unequally. Women's sense of justice was not lost; it just remained unexpressed (Khare 1998: 222). Yet embedded within the need and desire to have a family-based self, women grasped their individuality tightly. Even poor women in arranged marriages challenged male authority through their moral entitlement to refuge at their parents' home (Grover 2009: 14). Men were fully aware of women's ability to make claims for themselves and sometimes nervously joked that their rights to sex and visiting their home villages were contingent on resources that their wives demanded (Ramaswami 2006: 217, 220). As women now commonly work and accumulate their own savings in secret, relations between husbands and wives have shifted, with women now less likely to accept the addition of other wives and less willing to tolerate abuse or neglect (Jesmin and Salway 2000: 695, 698; Parry 2001: 803; Rashid 2007b: 117; Roy 2003: 118).

All of these dynamics suggest that women were neither encompassed wholly by family patriarchy nor simply self-interested individuals. Women invested themselves in relationships, while making their relationships tools to build their selves. Though women were aware of the distance between their family realities and their ideals, they also remarked on why the ideals were worth hanging on to, and what was felt in relational well-being. Women's sense of themselves within family relationships shapes the distribution of resources within families and the practice of family caregiving that produces health.

UNKNOWN PUBLICS, DANGEROUS SPACES

Geeta admonished me to mind myself in public. "Stop acting like a buffoon, for one," she noted. I should lower my voice and eyes and keep to myself. In the open, whether they were on her front stoop or at the bus stop, one neither knew who others were, nor what they might be trying to do to you (Ramaswami 2006: 217; Khan 2007: 529). Even going to the bathroom out in the open was a time for caution; everyone had heard stories of women assaulted at such a time (Haider 2000: 389). Geeta's lecture urged me to mind not only my physical mobility, but mobility more generally: appearances were not always what they seemed these days. As transformative as was the mobility offered in the present, in equal volume came accompanying uncertainties. The anxiety provoked by mobility in India has been discussed mainly as a middle-class preoccupation (Bhatt, Murty, and Ramamurthy 2010; Dickey 2000; Frøystad 2003; Lukose 2009). But Geeta's comments suggest that social anxiety is more democratically distributed, including among people living in slums. People had good reason to hide their true identity: manipulating their identity could allow them more freedom or power. To navigate others' manipulations unscathed required practices of surveillance.

While caste continues to play a role in shaping marriage as much as politics, more researchers have focused on the ways that *class* organizes social relationships across caste—whether to bring people together in political claims (Appadurai 2002; Chatterjee 2004) or to foster shared protection in urban neighborhoods (Datta 2011; Ring 2006; Unnithan-Kumar 2003). But this togetherness was carefully balanced and usually short-lived. With neighbors of diverse class and caste backgrounds, it was easy for people to feel apprehensive about the quantity of their assets and their self-presentation (Das and Das 2004: 6). From anxiety sprouted the feeling of alienation and the fear of what must be lurking beneath the identities others displayed. Living within a neighborhood hardly constituted belonging to that place, and often women perceived social distance between themselves and those around the corner. Fear of movement made many women's worlds even smaller (Chandola 2012a; de Zoysa et al. 1998; Ramasubban and Rishyasringa 2008).

In slums, communication networks spun much faster than those of isolated wealthy neighborhoods, connecting washing areas, front cots, and dense, thin-walled housing. As sites where power is publicly contested, neighborhood spaces in low-income areas carry "the danger of being overheard, of having words misinterpreted and returning as accusations, all contribut[ing] to a sense of foreboding" (Chatterji and Mehta 2007: 82). With so many differences between neighbors, rumors quickly accelerated small family problems into dramas on a larger stage (Jesmin and Salway 2000: 694). Parents were terrified of adolescent romances that could bloom under their noses, marring their children's relationship futures (Magar 2000: 16; Marrow 2013). Women were careful to steer clear of certain neighborhoods. Not only could certain neighborhoods physically endanger them, but neighbors watching their movement could speculate about what women's passage through such unsavory locales revealed about their family's true character (Chandola 2012a). As I went back and forth between households, women were specific with me about what I should share and what I should not—which family details, which costs, and what we did together.

The stakes of public interaction were high. As neighbors and local leaders reproduce caste hierarchies, flaunt class differences, send messages of religious exclusion, and demonstrate their power, they build a foundation of everyday violence (Das 2006). When daily neighborhood fractures collide with powerful state-engineered campaigns, everyday violence is transformed into violence of a different scale—as in the sterilization campaigns of the Emergency or the 1984 and 1992 communal riots in Delhi and Mumbai that left thousands dead (Das 2006: 157; Chatterji and Mehta 2007: 66). Smaller episodes of violence punctuated these outbursts. Fights over water sometimes left people dead. The names of neighbors could show up in lurid criminal reports in the newspaper.

This might be a brave new world of imagining, but imagining that occurred strategically, with full awareness of all of the threats that loomed (Lukose 2009; Marrow 2013). Reputation, as a gateway to sharing daily work and engendering future marriage prospects, was a carefully conserved resource. More often than not, imagining could be lonely. Women struggled to reconcile the fraught process of how others tried to know their selves with their own assertions of what they wanted their own selves to be. For as intertwined as lives were in new urban communities, intertwinement did not guarantee intimacy.

INDIA'S NEW OPTIMISM: MIGRATION, WORK, AND CHANGING SOCIETY

As much as material poverty has remained—and in some ways increased—post-1990s economic liberalization, economists have shown that measures of social dignity have improved (Kapur et al. 2010). Shifts in politics, livelihood, and residence show multiple cases of "an accumulating sense of change" (Khare 1984: 73) amongst Dalits[11] and lower castes, urban migrants, and residents of slums. Residents of slums are mostly poor, but not equally poor; mostly lower-caste, but not entirely lower-caste; mostly less educated, but not entirely uneducated; moderately urban, but often still connected to rural home places. From the outside, diverse people get made into a population of "slumdogs"—or, alternatively, toilers or the subaltern (i.e., Pendse 1995). But economists have fractured this monolith, uncovering where people have come from and how they shape their trajectories through the urban opportunities they make for themselves. Those who have migrated to cities and live in slums may not be the countryside's poorest or most desperate. Sometimes it is those who have the capital to make the move who do (Banerjee and Kanbur 1981; Kundu 2007). As stigmatizing as the label of "slum-dweller" was, for many people, consciousness of their poverty began with their arrival to the city (Haider 2000: 43).

When I traveled with Durga and Sunita to their home villages, they pointed out to me the vast distance between their small city *jhuggīs* and their larger family homes. Their city homes could only say so much about them. Over time, many migrants living in Delhi's slums have increased their wealth, gradually obtaining better jobs as they gained access to better networks of information (Gupta and Mitra 2002). For Dalits particularly, the migration of family members has reverberated into social shifts in their rural homes, increasing the power of their families within village politics and loosening the hold of patron-client obligations (Kapur et al. 2010: 47; Witsoe 2011: 81). No longer could it be said that interdependence between caste groups (i.e., Dumont 1980; Kolenda 1967; Wiser and Wiser 1971) was the basis of the society. Status and place said as much about people as who they were gradually becoming. In other words, how much did Durga and Geeta feel like the slum-dweller that I had made them out to be?

In Ghaziapuram, I spent afternoons with women as they sewed buttons and beads onto clothing for export and screwed on the caps of hundreds and hundreds of pharmaceutical tubes. As they counted the few rupees they received in return, it seemed just another example of the decreasing wages of so much work in India, particularly after liberalization (Joshi 1999; Papola 2007). But as the months passed by, people eagerly offered to take me to their factories and schools. An eighteen-year-old girl showed off the miniature dresses and pants she had made as samples for the vocational sewing program she had joined to prepare young women to work in factories. Shaista's son proudly displayed the labels he was making in a Ghaziapuram factory and explained how he was learning the computer software that would let him design the next ones. While rightfully emphasizing the lack of advances in income, job security, or power, researchers have been challenged to illuminate how mobility is also a transformation of meaning, a meaning displayed in people's investment in their education and work.

Changes in work patterns can bring increased demands even as they also alter the social status of people who are lower-caste and poor. No longer living with their employers, domestic servants now worked part-time for several different households and rushed between their different employers' homes. But they avoided the overwhelming expectations of a full-time employer and were freer to make their own lives that defied the boundaries that their employers nostalgically recalled (Ray and Qayam 2003: 538; Dickey 2000: 469). Even if traditional caste occupations like leatherwork were not left behind, lower castes and Dalits sometimes felt that leaving behind the demeaning ideas tied to them was sufficient to feel transformed (Khare 1984: 73; see also Bear 2013).[12] In this climate, there are numerous poor and lower-caste families that put faith in education as a tool for mobility, despite the frustration of government schools and the overall costs of education (Munshi and Rosenzweig 2006; Naudet 2008). Increasingly, low-wage workers articulated how, even if they could not determine their wages and security, they could articulate the meaning of their work and what it represented about themselves.

Through politics people were expanding their access to state services. Political relationships received more attention as a new form of hierarchical patronage, in which poor people were granted services through corrupt means (Blom Hansen 2005; Weinstein 2008; Harriss 2005; Witsoe 2011). The contemporary political field stretches from formal political parties to temporary alliances, leaving in their wake "discomfort and apprehension in progressive elite circles" (Chatterjee 2004: 47). Poor urban people in contemporary India route urban governments toward serving their needs in ways unstipulated by formal urban planning (Connors 2007; Edelman and Mitra 2006; Jha, Rao, and Woolcock 2007). With the passage of the Right to Information Act in 2005, residents of slums not only negotiate for their rights through making demands, but also scrutinize the government's activities (Kabra and Wadhwa 2004). People living in slums are called the "kingmakers" of politicians, since residents of slums vote much more frequently than anyone else in cities, giving their votes and receiving urban services (Connors 2007: 96).[13] In the rural states of Bihar and Uttar Pradesh, from where many of Delhi's migrants hailed, Dalit and lower-caste people have ascended to positions of political leadership, giving the key perception that "power had changed" (Witsoe 2011: 79).

But even as these political relationships generated amenities and votes reciprocally, it was unclear how much people living in poverty could count on them. Were politicians sincere, or did they manipulate appearances for their own ends? Politicians put more effort into the appearance of providing services rather than actually *providing* them (Connors 2007: 79). The burden of discerning politicians' intentions lay with their constituencies. "We have to accept with a lot of caution now what people say, do, and mean," one Lucknow Chamar[14] explained, "for they either do not do what they say, or do so, but for their own covert purposes, or say vigorously what they actually never mean" (Khare 1984: 115). While new politics offers the potential to upset hierarchies, engaging in political relationships is felt to open the self to risk for usury.

In combination with public policies, these efforts for mobility at the household level shape how and if people overcome poverty (Krishna 2010: 112). By looking at mobility as "improvements in self-respect in daily interactions" (Kapur et al. 2010: 40), scholars may be able to measure more of the possibilities that this moment might offer, no matter how small. These transformations suggest that as much as poor or lower-caste people are vulnerable, they may not define themselves preeminently through their vulnerability.

PHYSICAL VULNERABILITY, PHYSICAL TRANSFORMATION

South Asian models of relatedness have emphasized a physical dimension to relationships, through substances that bind people to one another and to their environments (Carsten 2001; Daniel 1984; Marriott 1968; Östör, Fruzzetti, and Barnett 1982). In South Asia, write scholars, ancestors are made through offerings of milk (Lambert 2000), ingesting soil and water ties people in kinship to land (Daniel 1984; Lambert 2000), and the qualities of food being exchanged orders caste relationships (Marriott 1968). A properly cooked meal brings a cook in conversation with the divine (Aklujkar 1992) and joins two families properly in marriage (Khare 1976). Yet when it comes to the environment where many South Asians actually live now—in urban slums—all we see is an environmental abyss (Chaplin 1999; Davis 2006).

Yet the slum environment was a key tool that many families used to change their circumstances. For many families in slums, the process of building and moving between homes in slums was a never-ending task (Dupont 2005). As they moved between homes, families traded one type of security for another. Some families who could afford to stay in rented rooms in lower-middle-class neighborhoods elected to live in *jhuggīs,* small huts that are sometimes free-standing, sometimes attached to other homes. This move swapped better plumbing and piped water for no toilets, more polluted water, and greater risk of demolition. But it allowed families to avoid investing significantly in an urban home while demolition policies were in flux. If demolition policies were in their favor, they gambled for a plot in a resettlement colony where they anticipated greater security (Chandola 2010). If urban infrastructure improvement schemes prevailed instead of demolition, owners might opt for a different form of security. They might choose to move on from their improved environmental situation, using the profits to better their circumstances in other ways (Anand and Rademacher 2011: 1764–67).

Poor families sometimes joked about the dubiety of their wagers: What assets really mattered? In the case of homes, for instance, their accommodations often looked the same. But as they compared their homes, they asked who was better off—did it depend on their comfort in the present or the future payoffs of their real estate choices? (Ramaswami 2006: 220). While people living in poverty are frequently required to respond to chronic emergencies, these housing strategies are a way to build long-term assets (i.e., Appadurai 2002). In light of this, I waited for families to discuss their homes before initiating my own questions. After many visits, many families affirmed homes that they had disparaged in initial conversations with me, showing the stigma they had anticipated from an outsider.

In Delhi, middle-class people use gating and restrictions within their homes to segregate themselves from the poor and lower-caste people who work for them (Dickey 2000; Waldrop 2004). But through consumption, environmental segregation is made hazier. Perhaps poor people would be kept out of parks in middle-class areas and their *jhuggīs* demolished. But other aspects of physicality were not so easy to control. As one domestic employer worried, poor servants could "dress up to the standards of almost us . . . you might not be able to figure out that they are people working for somebody as servants" (Dickey 2000: 479). Since liberalization, lower-caste people improved their material lifestyle significantly as they began to use commodities that were formerly only symbols of their inclusion (Kapur et al. 2010: 39, 42). Farm laborers that used to subsist on sugar cane juice to get them through their long days were now eating more vegetables (Kapur et al. 2010). Through the use of commodities, lower castes and poor people challenged who counted as "good people" (Frøystad 2003: 167) and shed the symbolic markers of their exclusion. These physical markers opened the ability to reimagine the self, but they also posed new burdens to take part in a consumer lifestyle that was barely attainable (Han 2011).

Environmental approaches to health have stressed how physical conditions engender health: whether the tuberculosis and respiratory infections that arise from overcrowded housing (Firdaus and Ahmad 2013), the stunting that emerges in neighborhoods with a paucity of affordable nutritious foods (Hassan and Ahmad 1991), or the chronic diarrhea that results from inadequate water and sewage facilities (Karn and Harada 2002). Attention to the nuances of the physical conditions of people living in poverty presents additional questions. For the best physical conditions are not always clear, as the joking about uncertain housing strategies reveals. Changes on the plates and in the clothing fabric of people living in poverty show that, even as much as remains to be changed, smaller pieces of the environment already have.

THE "HERE" AND "THERE" OF RESEARCH: RESEARCHER AND INTERLOCUTOR POSITIONS

From the first time that I met Durga and her neighbors, they asked me about the "there" where I would share what I learned. From their experience of poverty that I saw at the center of their lives, they alluded to the frame I placed around it and the audience to whom I displayed it. The widespread interest that the reformers and researchers had in slums meant that residents of the slum where I did research were familiar with outsiders coming to collect their experiences of living there. Women knew the questions researchers asked and the glossy materials that resulted. Yet people in their community were not uniform in how they felt about whether this was right or not. On the day their slum was bulldozed, community members accosted an activist there to document the event. The day before, none of the media outlets we called thought it was newsworthy enough. Now men demanded angrily of the activist, "What is the point of doing anything now? There is nothing that will come of doing this now!" While some nodded in agreement, Ritika commented quietly, "He is not wrong. He wants to show how this is experienced to show what happens to poor people in this city." In the stern advice and chiding comments that women gave me daily, they reminded me that their lives must be considered more fully than the binary of "have or have-not" into which I often pushed them (Anand 2011; Chandola 2012a; Chandola 2012b; Ghannam 2002; Gibson-Graham 2006). Everyone wanted to get their dirty stories, but no one was interested in staying around for anything besides that—be it long-term relationship or learning anything more than they intended to.

Bent on fighting misrepresentations of the women who I knew (Khare 1995: 148), I sought to explore survival when perhaps survival's pressing needs were not the only ones pressing. In "feeling sorry" for the women with whom I did research, "guilt-ridden" condescension prevented me from really listening (Domínguez 2000: 366). However, the women with whom I did my research quickly pointed me toward my own misrepresentation of how their lives should best be understood. My field notes were turgid with my tense conversations, confused expectations, and irate frustration with women. The "politics of rapport" meant that whatever closeness we built laid on a foundation of their questioning my assumptions about them and what research was supposed to be (Jackson 2010). I follow High (2011), who suggests that, in light of the steep power differentials between anthropologists and their interlocutors, anthropologists should account centrally in their analysis for "the formative relationships made" that entail "the direct experiences of pleasure, desire, and guilt" (High 2011: 229).

I had often felt it necessary to explain my research to women in ways that explained the audience it would reach. I emphasized why their voices had not been counted: people outside the slum who made laws or worked in NGOs, the wealthy, and foreigners like me said that slum residents did not know about health, and we needed to prove them wrong! If we did, I explained eagerly, maybe we could change the ways that they were treated. But women repeatedly reframed my research in terms of *my* education, rather than the benefits of applied knowledge. Saraswati suggested that if we just explained to women that if they gave interviews, they would be helping me to get a good job, only then would they participate. It was good to do studies (*paḍhāī*), women agreed, that is what they would help with. They recontextualized my study within the real. No matter what hope I might have had for this research, there was little to no chance that anything that I produced would reshape their lives. Studies were great, but the value of abstract knowledge was questioned.

I emphasized that, unlike those who left afterward never to look back, I would remember them when I was gone. I tried to represent myself as someone motivated by what was right, and that my intense fieldwork meant that I understood the long-term reciprocity expected. Geeta corrected my self-righteous statements on my second trip there: "You're here for work. That's what brought you here. You said you would call when you went back to America after your first trip here, but you did not." Where I had tried to emphasize myself as a caring participant, Geeta required me to reference the fact that my interaction with them was research at its root, not simply motivated by individualized care. Women repeatedly held me accountable for the sentiment for them that I avowed. If I really cared, then why was I always chasing interviews? If I really cared, then why was not I willing to come visit just to watch television or roam around the city for fun? If I really cared, then why was I always focused on work? If I really believed in their medicine, then I needed to take their home remedies (*gharelū ilāj*). If I really believed in their creativity, then I needed to eat their food. And if I really honored their houses, I needed to nap in their beds and pee in the same places they did—even if I did go home to a middle-class neighborhood in the evening. If I really respected them, then I would not point out their trash heaps or cover my nose next to the drains (*nālās*). From the negative comments that I heard repeatedly about the local NGO, I realized that I could not neutrally engage with both, so I passively cut ties with the NGO and stopped attending most all of their events. To be different from other researchers, I needed to prove that I was interested in them, in our relationship, in enjoying each other's company. Not in "*jhuggī-wāllāhs*" (people living in *jhuggis*), but in *me,* Neetu, or in *me,* Geeta, or in *me,* Saraswati.

As if to follow this, my relationship with each family was drastically different and evolved dramatically during the course of my fieldwork. During fieldwork, I became very close to Saraswati, Durga, Geeta, and Neetu's families. I also spent time with the families of Padma, Shaista, Mohan, Mrinalini, Sunita, and Jyoti. I spent time with all of these women (and one man, Mohan) and their families in their homes and sometimes accompanied them elsewhere. Each of these families connected with their neighbors for interviews that I did on health and histories of the slum, including Asha and Hema. I hired Saraswati from April to October to help me conduct my interviews. Part of the evolution of these relationships was driven by practical realities. (Durga moved back to the village, and much of Mohan's family moved.)

As I negotiated the research process, I spent time with different people, trying to fill in additional perspectives, a point that tested loyalties and caused hurt on both sides. My interlocutors' inspection of my relationships also played a part. Because several of my interlocutors were quite powerful in the community (and one had allegedly treated her neighbors cruelly), I had to distance myself from them at times. Though I had hoped to reach out to include Dalits within my study, it proved difficult, as the women I was already close to commented endlessly on the danger of speaking with "those people." There were others who were targets of great disapproval within the community whom I continued to spend time with anyway. In the histories that women shared with me about their present and former neighbors, women argued for whom I should do my research with and whom I should not. Particularly after the demolition, when I traveled between distant homes, I followed women's warnings to go only to the homes of people I had known from beforehand and avoid travel at night. Finally, my relationships were guided by what women expected of me and shared with me, as well as how I related to each of them. With Geeta and with Saraswati both, we joked that we bickered like old married couples—because we did. They repeatedly demanded that I account for my promises and, in so doing, asked me to be a different type of researcher and a different type of friend. It was easiest to become close to women who let me do things alongside them in their households and were willing to critique me directly. In most all of my relationships, there were periods of closeness and periods of questioning. It is because of these different relationships that each of these people shows up differently in this book.

There were moments when people took hold of me like a microphone and said, "This is what you must tell people." Aamir ranted into my tape recorder that they were sick because the government did not clean their streets. Sunita pointed to the German funders who blindly trusted the NGO to spend their money as they said they did. Geeta's neighbor pointed to the violent murder attempt that happened within their community. But most of all, people said it with the way they welcomed me into their home—"you'll tell them in the U.S. how we took care of you." Women took pains to allow me to be normal too, rather than always stay a strange outsider. Saraswati, for one, was willing to use her metal slotted spoon to protect me. When I came to visit her in her new room for the first time after demolition, the kids on her lane swarmed around the door to see the white girl visiting. Laughing, she handed her two-year-old the cooking spoon and pushed him toward the door. "That's right," she said with a smile, "hit them! Hit them!" In moments where people told me, "say this," they assured me they knew I was always learning and documenting. I have tried to write this book with the families I worked with on my shoulder (as Durga describes later), asking what values they wanted me to show them trying to approximate, and the true struggle that it took. By hearing "this is what you must tell people," I do not remember only the positive, but remind myself to whom I have the greatest accountability (cf. Domínguez 2000: 366). And the times that I understood incorrectly, the mistakes are mine alone.

But more often than these clear moments of what they wanted me to tell were many others when I heard, and then later recorded, sordid details about neighborly and family life. When women complained to me about their husbands' inability to hold down a job, their disappointment with relatives who neglected them, their neighbors' false portrayals of themselves, did they remember I was a researcher? These moments always frightened me, because I was afraid that in sharing their private lives later in my analysis, I would reveal things that people had meant to keep secret from me or had meant for me to keep secret for them despite the caution I had taken with explaining research consent and confidentiality. Yet alongside my awkwardness, I agree with others who have interviewed South Asian women that such private interviews enabled a free criticism of family members and intimates that was not always available in daily life (Menon and Shweder 1998: 144). In women's commentary about my research, they adjudicated my claims about what it was. Though my anthropological practice was motivated by respect, and what I hoped was an "anthropology of love" (Domínguez 2000), dealing with the expectations of my interlocutors was "complex and often ambiguous," as much as it was "gritty [and] guilt-ridden" (High 2011: 230). They painted a picture for me of how research was potentially humiliating, usurious, and useless for them, built on the appearance of sincerity and promises that were easily snapped. They asserted that there was no "they"—Saraswati was different from Neetu, and Neetu was different from Durga. I was to pay attention to each of them for who she was, the decisions she made, and what brought her to this place. Though our relationships were based in research, I should do the dignity of treating them as more than research subjects and come and play with them, acknowledge the equality we shared, and remember the differences between us. What follows in these pages is a result of our interaction. As Khare reflected on his research with Untouchable women, "My memories and writing relate with and respond to *their* ways of remembering, forgiving, and forgetting within their world. We both are at the center . . . reflecting on each other and on our respective cultural locations and self-limitations" (1995: 147).

They pointed me to bigger questions than I had known to ask, questions that the contemporary landscape in India posed for slum-dwellers and government ministers alike, men and women, adults and children. They placed the exclusions that they faced alongside a constellation of other daily priorities. Though I had peered onto the small stage of the slum to understand their lives, they opened the curtains wider, to new possibilities, new questions, and new ways of understanding themselves.

BOOK OUTLINE

Can families be meaningful for women even when their demands outweigh what they provide? Chapter 1 examines how women asserted their own strength in the midst of abuse and neglect. Data from sustained observations of families, private conversations with women, and formal interviews about family care are combined in this chapter to compare women's ideals of family life with the frustration of enacting them in daily life. Being a good person, they explained, meant "living for others." At the same time, they asserted to family the care they deserved. The ability to sustain this care "through a thousand sadnesses or happinesses," as they put it, demonstrated their powerful faith and closer proximity toward a selfless ideal. Yet exercising such strength was an emotional and physical struggle that wore women down. Nearly every woman had broken ties of marriage or family. Keeping these histories secret, however, ensured that women, rather than neighbors, retained the ability to judge their moral meaning. These mental health strategies enabled women to make claims for their own health needs within their unequal family relationships. Through embodying the value of living for others, somewhat ironically women reminded themselves of their own individual strength.

In chapter 2, I examine why women were deeply suspicious of the neighborhood social networks on which they relied. Through the sordid tales they recounted, women argued that neighbors used others in their own immoral schemes of mobility. They preyed on hard-earned gains and threatened families' stability. As much as they engaged with others, all the while women carefully protected themselves. This chapter revisits public health and anthropological research that holds that low-income neighborhood relationships facilitate advocacy, social support, and resource sharing. Women's private commentary on their relationships, in conjunction with my observation of them in action, enabled me to see the varied techniques through which women retained charge of their interactions. They bolstered secrecy about their own identity, suppressed bonds, and yet still knew each other's lives intimately. Women challenged the notion that the solidarities that generate daily health endure over time. Instead, their experiences indicate that what endures beyond the social resources of everyday health promotion were independence and accountability for their own actions.

Why would residents of a slum facing impending demolition assert that they were "getting ahead" in society? Chapter 3 considers how families made sense of their own citizenship as demolition of their industrial slum ended an era of cooperation between their families and political patrons. In interviews on their migration experiences to Delhi, residents explained that previously patrons had given them formal recognition and incentives including everything from water to medical care, recognizing the importance of their labor and their expansion of the urban frontier. But as demolition approached, women offered a moral concept of citizenship that emerged as I participated in stalled community efforts to protest demolition, watched families plan for the future, and engaged women in reflection in the months afterward. Their decision to live in Delhi, house or no house, was a quest to "get ahead" (*āge baṛhānā*). Men and women recounted the physical insecurity, poverty, and loneliness they suffered in exchange for longer-term mobility for their families. While they hoped that demolition could be halted, women argued that public protest would make them vulnerable. Avoiding the dangerous networks of politicians whose nodes reached into the slum community itself required families to get ahead on their own. Though researchers have celebrated how collective advocacy enables communities to improve social conditions, this chapter suggests that families' calculations for health are motivated by complex notions of security.

Chapter 4 examines the way that women used the slum environment as a tool for personal and social redefinition. Urban planners and environmental historians have long pointed out how the unequal urban environment stacks the odds against the health of the poor. Women spent their days immersed in managing their home environment, especially because of their responsibility for domestic respectability and their caregiving obligations. From initial disgust when they first migrated, women's reactions to the slum environment slowly changed. Over time, they described its potential. In a series of semistructured interviews about home health practices and the causes of illness, women elaborated their sense that attention to the environment could build a different kind of health. Women's efforts to endure, rather than escape, the harsh climate built physical strength that made them less vulnerable to sickness. I observed the hygiene techniques and housing decisions through which, surrounded by an industrial slum, women established home microenvironments that ideologically and physically separated their families from the slum around them. Though women's transformation of the slum was limited, they used their environmental practices to communicate self-worth in the midst of social stigma. This chapter suggests that practices to manage environmental hazards and promote hygiene have deeper ramifications for self-definition.

The conclusion offers suggestions for the book's findings to be employed. I offer recommendations to adapt domestic violence and hygiene promotion programming that is extended by NGOs in many slums. Bringing together findings on neighborly and community relationships, I will recommend to policymakers that women's cooperatives, a development practice for empowerment and problem solving in low-income international communities (Galab and Rao 2003; Hossain et al. 2004; Magar 2003; Roy, Jockin, and Javed 2004), must account for the potential for abuse within these relationships. I address how community-based participatory methods frequently utilized in public health (Mullings et al. 2001; Sabo et al. 2013; Silverstein et al. 2010) and celebrated in anthropology (Appadurai 2002; Chatterjee 2004; Harriss 2005; Holston 2008) can be adapted for populations that, despite shared poverty and health risks, are highly fragmented. I offer suggestions on how health care policy could build on the health-seeking strategies commonly employed by women in slums. Finally, I use the findings of this study to propose several methodological recommendations and new themes to be followed up in further study.