Cancer is a process of proliferation. Proliferation of cells, of suffering, of medicine, of technology, of stories. It touches bodies, individuals, families, communities, and nations. It has touched the lives of the women living with cancer in India, whose stories fill this book. It has touched their husbands, daughters, sons, neighbors, doctors, nurses, counselors, and spirit mediums, who also appear in this book. It has touched me. It more than likely has touched you too.

This book is about how women experience and give meaning to cancer in India in the early twenty-first century. How do women think about cancer causality and risk? How do they come to know they have cancer? What measures do they take when they receive a cancer diagnosis? What are their experiences with biomedical and other treatment and healing modalities for cancer? What are their opinions of the recent push for cancer screening and early detection and treatment for women? I am interested in understanding the meaning of cancer in general because, despite the fact that each type of cancer represents a discreet disease, most people worldwide view cancer as a broadly defined disease and have strong feelings and opinions about cancer as an all-encompassing category of disease. At the same time, this book focuses particularly on breast and cervical cancers in India both because these are the two most common cancers among women in India and because the emerging global public health interventions to promote cancer screening for women draw these two reproductive cancers together in their educational programs.
and in their clinical screenings, with consequences for how women view and experience these cancers.

My focus is on the experiences of lower-class, lower-caste (more accurately, oppressed-caste) women who are the targets of these global public health interventions. Throughout this book, I draw from accounts I collected during ethnographic interviews and casual conversations with women in the South Indian state of Tamil Nadu between 2015 and 2016 (see Map 1). By listening carefully to the narratives of the women who generously gave their time and shared their stories and perspectives with me, I came to understand how sociocultural factors (including gender, class, caste, ethnicity, and religion) and political-economic transformations (impacting labor, agriculture and
food production, the environment, family structure, and public healthcare) affect women's encounters with cancer. In this book, I present these women's insights so that we can appreciate how sociocultural context shapes the cancer experience.

My goal is twofold. First, I offer this ethnography in the hope that it will prove valuable for global and local public health planners and practitioners seeking to improve health and healthcare for all. Second, while keeping cancer at the center of this study, this ethnography sheds light more broadly on sociocultural dynamics and political-economic changes in India today and on South Indian women's—particularly socioeconomically marginalized women's—perceptions of the social worlds they inhabit. As other anthropologists have noted, borrowing a phrase from Claude Lévi-Strauss, cancer is “good to think with” because the meanings people attribute to it and the ways people respond to and engage with it tell us a great deal about core cultural values and social relationships.

The stories offered by the lower-class and -caste women at the heart of my study make abundantly clear the extent to which their class, caste, and gender positions intersect so as to inform their perceptions of cancer causality and risk and their journeys navigating their cancer diagnosis, treatment, and care. Through their narratives, these women articulated a wide range of critiques about sociocultural and political-economic systems that had marginalized them and that jeopardized their health and well-being. Contrary to the educational messages of public health campaigns, which attributed reproductive cancer risk to individual choices associated with sexual and reproductive practices, diet, and exercise, the women in my study attributed the risk of cancer in their communities to a host of economic, environmental, and social factors beyond their control that had rendered poor women's bodies vulnerable to these cancers. Contrary to doctors who would scold them for being irresponsible by coming to the hospital too late, or for having irrational fears and harmful superstitious beliefs, women cancer patients were quick to point out how the nexus of their class, caste, and gender position constrained their search for cancer treatment and respectful care.

The social stigma of a cervical or breast cancer diagnosis led women to reflect on and assert their integrity as good women. Lower-class and -caste women patients recognized that their triply marginalized social status had heightened the stigma of these reproductive cancers and compounded the threat cancer posed to the prestige and honor of themselves and their families.
They also understood that their subaltern status exacerbated the challenges they faced in their search for diagnosis and healing. Their reflections on their own perceptions and experiences with cancer shed light on the everyday precarity of their lives. They felt that their precarity and reliance on the welfare meted out by state and civil society organizations had curtailed their ability to publicly voice their complaints. This ethnography serves as a conduit for a subaltern critique that is already present but too often politically silenced. The experiences and critiques of my interlocutors are intertwined. They commonly described cancer as both a sign and a result of the inhumane, unjust, and amoral contemporary era, resembling the Kali Yuga. The Kali Yuga is a Hindu concept that refers to a dark, unjust era, as I discuss further below. Yet these women’s stories also demonstrated how creative and resilient they could be throughout their therapeutic ordeal with cancer as they worked in concert with networks of caregivers to find ways to survive in the face of staggering odds, even while sometimes questioning their will to live in the process.

POONGODAI’S STORY

I open with the story of a woman I call Poongodai. As with most of my interviews, I conducted this one in Tamil. Tamil speakers often pepper their speech with English words; when they have done so, in the translations I have placed those English words within quotation marks. Unless otherwise indicated, all of the quotes from interviews in this book are translated from Tamil.

Poongodai was fifty years old when I met her at the Rural Women’s Social Education Centre (RUWSEC), a small grassroots nongovernmental organization (NGO) run by and for rural Dalit (oppressed, lower-caste) women that has long focused on women’s health. I had traveled 60 kilometers south by car from my hostel on the Indian Institute of Technology–Madras campus in Chennai (the capital city of Tamil Nadu), where I was staying for the summer. On the day of our interview in July 2016, Poongodai and her husband had come to RUWSEC from their nearby village for a monthly support group meeting for cancer patients and survivors. She had undergone three months of treatment for cervical cancer at the Cancer Institute in Chennai, where she received fully subsidized care. Because she lived too far away to go home in between her treatments, she had remained in the general ward as an inpatient alongside many other female cancer patients for the full three months. Other women staying with her on the ward had traveled even farther than she had,
some from Tirunelveli at the southern tip of the state (twelve hours away by train and much longer by bus) and some from the adjacent state of Andhra Pradesh to the north. Poongodai had received free treatment because her family lived below the poverty line, but her family had had to shell out 1,000 rupees as a bribe to their Village Officer to get the income certificate they needed to prove she was eligible for that subsidy. Poongodai had been discharged from the Cancer Institute and returned to her village three months prior to our meeting, but she was still undergoing cancer treatments on an outpatient basis, traveling almost four hours round-trip by bus to reach the hospital.

A Dalit woman with no formal education who had four grown children (two daughters and two sons) between the ages of twenty-four and twenty-seven, Poongodai had spent her life working as an agricultural daily wage laborer, doing the backbreaking work of transplanting rice paddy in other people’s fields in her village. Daily wage labor is locally referred to in Tamil as *kuli* work (often spelled in English as “coolie”). In some contexts this is considered a pejorative term that connotes colonial servitude. Colonists used the term “coolie” to dehumanize migrant laborers by conflating their identity with their mode of payment, calling workers coolies and thereby justifying their exploitation. However, people in contemporary Tamil Nadu who are engaged in daily wage labor use the Tamil term “*kuli*” to refer to work for fixed daily wages; they do not use it to refer to their identity. So I have chosen to use the term to refer to this form of labor in order to remain true to the accounts of my interlocutors.

Poongodai also earned some income working through the government’s Mahatma Gandhi National Rural Employment Guarantee Act (MGN-REGA) scheme. She and many other women I met referred to this program as the “100 days” program because, in theory, the rural poor were entitled to paid work for one hundred days. In Tamil Nadu most of this work involved water management-related projects (building ponds, bunds, and irrigation tanks for paddy fields), but in 2016, the state was facing one of the worst droughts on record, so these projects had come to a virtual standstill and my interlocutors reported that that extra income had mostly ended.

Poongodai also owned a goat that she was raising for meat. She had previously owned two cows, which she milked for her family’s consumption and for sale. She had recently sold her cows because she had become too weak to take care of them due to her cancer and because she needed the cash from the sale to support herself and her husband, who was suffering from oral cancer,
which is the most common form of cancer among men in India and the leading cause of cancer death among Indian men. She and her husband both received cancer treatments free of charge at the Cancer Institute; however, they had to spend a lot on diagnostic tests in private clinics. They had sold their two cows for 8,000 and 9,000 rupees respectively and had pawned Poongodai’s only pair of gold earrings to cover the costs of their tests.

Poongodai was diagnosed with Stage I cervical cancer in 2014, just a few weeks after her husband’s cancer diagnosis. She had been experiencing heavy white vaginal discharge (leukorrhea), fever, and pain in her pelvic area for a couple of months and had finally gone to see a doctor, fearing she had typhoid. Doctors had recommended immediate treatment following her cancer diagnosis; however, even with her persistent symptoms, she had put off getting medical care for herself for two years in order to take care of her husband, who was already receiving treatments at the Cancer Institute. That women tended to prioritize the health and well-being of other family members before taking care of themselves was a theme that ran through all of my interviews and reflected the gender norms at hand. By the time Poongodai was admitted to the hospital for her own treatment in 2016, her cancer had advanced to Stage III. She began her treatments while at the Cancer Institute but had to curtail them when her white blood cell count became dangerously low due to the radiation and chemotherapy; she was discharged without completing the full course of treatment. She felt that her lifelong hard labor had weakened her body, leaving her not only susceptible to cancer but also unable to withstand her cancer treatments.

When I met Poongodai, she had very short hair that was just beginning to grow back after it had fallen out in clumps during her chemotherapy treatments. The bright pink pottu (bindi) on her forehead perfectly matched the color of her sari. But her demeanor was bleak and broken. She spoke softly and with downcast eyes as she described the shame she and her husband felt because of their cancers:

We feel like it is very disgusting [asingam] that we both have cancer. It is so embarrassing for other people to see us like this. Our prestige/honor/respect [kauravam] has been diminished. Some people in our village say it is because of our bad intentions [yennam] that we are now experiencing this illness.

A few weeks after she returned home from the hospital, her goat had crossed the fence between her property and that of her neighbor and eaten a newly
planted sapling in her neighbor’s field. Upon seeing this, the neighbor came stumbling out of his house drunk and yelling, saying that her intention to destroy other people’s property in this way had given her and her husband cancer. He framed it as a form of karmic justice. She continued to recount this story to me:

So then I came crying and I yelled at the gods, asking, “What sins have I committed?” Even my husband never wishes ill on anyone. So, why would we get such an illness? I cried, saying that we had become objects of ridicule for others in our village. Ever since then I have been worried about what other people are saying about us in their homes.

Poongodai was not only concerned that people in her village might blame them for their roaming goat. She was also deeply worried that people would question her morality and spread rumors that she was sexually promiscuous and that it was because of such behavior that she had come down with this disease. As she said,

People say things like, “She must have gone around with everyone she likes. That is why she has the disease.” When my husband and I both have this problem, then so many people who see us, think badly about us. There are so many people who do bad and cruel things—rich people who destroy the country. But they are fine. We are good, humble people from lower, humble families [thazhthka kudumbangal], so why should we get this thing? I think it is because of all the kuli work I have done since I was young. We are getting this thing [cancer] while rich people are getting fat. This is the way things are these days in the Kali Yuga.

Poongodai also suspected that her father-in-law’s sister’s son had used sorcery to inflict cancer on her and her husband, though she did not discuss this openly with others in her village. There had been a land dispute, and when she stood up and protested this man’s attempt to claim some of the family property, he had threatened her, saying: “Watch out for what I will do to you. Let us see how you live.” Three months later, she and her husband were diagnosed with cancer. Ever since then, Poongodai had tried to avoid this relative at all costs.

On top of all of this, Poongodai was ashamed that her and her husband’s cancers were placing an enormous financial burden on their son, who lived with them and who was now supporting them along with his wife and two children while simultaneously pursuing evening studies to get a degree for a better job. During the daytime her son worked for a small company and was
earning 10,000 rupees monthly (which was then the equivalent of US$149). This was a respectable income for members of their family and the Dalit community in their village, but it was nearly impossible to make ends meet supporting six people on that income. Her son’s wife could no longer earn money because she had to stay home to provide all of the caregiving needed for her young children and now also for her ailing in-laws. The repairs needed to fix their broken roof would have to wait, and meanwhile, water came pouring into their house every time it rained, though thankfully that was rare that year because of the drought. With their reduced household income, they struggled to maintain the healthy diet that had been recommended by Poongodai’s doctor. Ironically, one of the things Poongodai’s doctors had recommended when she was discharged was that she drink a lot of milk. After selling their cows, they could not afford to purchase milk from others.

Before her illness she and her husband had been financially self-sufficient, even if they lived on a very modest income. She had been earning between 5,000 and 6,000 rupees (US$75–90) each month and was proud that through her hard labor she had been able to raise a son who was on the cusp of moving into the middle class. But because of her illness, she could not even contribute 10 rupees. She could not bear being dependent on her son and lamented that her and her husband’s cancers were shattering their dreams for the son to break into the middle class.

Ever since being diagnosed with cancer she had suffered severe pain in her legs and hips and was too weak to continue agricultural wage labor and household chores, such as sweeping and hand-washing the clothes and cooking vessels, all of which require bending, squatting, and stamina. During our interview, she found it uncomfortable to sit still for long and was constantly shifting her position to relieve her pain. She was grateful to her daughter-in-law for doing all of the household work and for not ostracizing her or making her eat from separate plates as some families did when caring for cancer patients due to fears of contagion. Poongodai said that on the advice of the public health counselors at both RUWSEC and the Cancer Institute, she had urged her daughter-in-law and her own daughters to get cervical and breast cancer screenings as soon as they turned thirty and to continue to do so regularly so that they would not have to endure her misery.

Poongodai had prayed to the Hindu goddess Mariamman—a popular goddess among Dalit communities in Tamil Nadu—every day since she could remember by lighting a small oil lamp in the Mariamman temple near
her house. Straining hard to hold back the tears gathering in her eyes, she admitted that she felt betrayed by the goddess, for she and her husband were both suffering from cancer at the same time:

I went to temple and shouted [to Mariamman], “See what days you’ve made me face! Even if I had nothing more than a rupee in my hand, even if I had to make do with nothing to eat but *kanji* [rice porridge], I always spent money to buy oil for the lamps I lit for you. Every day I came here to pray to you, and now you have put me in this position.” I went there and cried loudly.

In her search for some explanation as to why she and her husband faced this grave misfortune, she had consulted a Brahmin astrologer to learn whether it was a result of planetary misalignments and to ask about her future. The astrologer told her that her difficulties should wane by the end of the Tamil lunar month of Aadi (from mid-July to mid-August). That was just a few weeks away from the time of our interview. She had decided that if she continued to suffer physically and to be tormented by the people in her village after Aadi, she would convert to Christianity. She thought perhaps it might help because of advice she had received from of a group of Christian women who sometimes visited to pray for her and other patients on the hospital ward and who brought biscuits and juice and even saris, shirts, and *lungis*.7 Then she added in a whisper,

If that also does not work, I will do something to myself.… I want to finish my own story. I don’t want to live when my body is so very tired. People scolded me, saying, “You have been cured and now you want to die?!” … But I am angry with the gods. Praying to them has done nothing but bring me to this.

As I wrapped up our conversation, my research assistants and I urged her to talk to the psychological counselor at RUWSEC to help her cope with these feelings and find a reason to live. While I always maintain the confidentiality of people whom I interview, this time I made an exception and we informed the RUWSEC counselor about the last part of our conversation with Poongodai, before we made the journey back to Chennai at the end of a long and emotionally trying day of fieldwork. The counselor promised to reach out to Poongodai right away. While I thought that psychosocial counseling might help somewhat with the issues of stigma and blame that Poongodai and her husband were experiencing, I had doubts it could do much to address the economic crisis her family faced as a result of cancer.

The story of Poongodai is not representative of all of the women I met. But