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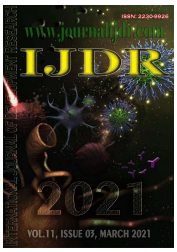

RESEARCH ARTICLE **OPEN ACCESS**

NAVIGATING WOMEN'S REPRODUCTIVE HEALTH THROUGH ANTHROPOLOGICAL RESEARCH METHODS

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ABSTRACT

There has always been a dearth of appropriate methodological orientations within social sciences, including anthropology when it comes to conducting an in-depth and detailed research on women's reproductive experiences. This is largely owing to the fact that, the disciplines that are suppose to research reproduction have started relying, rather inadvertently on the so called "Qualitative Methods" instead of more broad based discipline specific approaches. Research in Anthropology and other allied disciplines namely, Epidemiology, Economics, Demography, Medical Sciences and Population Studies are still carried out in accordance with the "Consensus Models" under which it is generally assumed that the behaviour of a society's reproductive-age women and the other actors is, to a large extent, same. However, on the other hand, the rampant use of qualitative methods as a substitute to the discipline based approaches have now become common place in researching the social cultural dimensions of women's reproductive experiences. In the case of qualitative research, it's being observed that instead of using more suitable and properly directed methods the researchers are using techniques that undermine the need for particular types of evidence, which basically impose various procedural measures that may severely constrain the applicability of the information collected, ultimately leading to substandard research. The main problem with the qualitative research is not in the methods *per se*, but in misguided separation of method from theory, of the techniques and the larger cultural contexts or settings of the study. Multidisciplinary or Transdisciplinary research is necessary for investigating, understanding and improving women's reproductive health, but what is required is, methods that are less narrowly focused, less generic, more theoretical, more widespread in application of the concepts and knowledge generated from relevant disciplines. The present paper therefore advocates a more anthropological approach for gathering and interpreting information that yields insights on women's reproductive experiences especially in the backdrop a pluralistic society like India. The anthropological approach is characterized by its context specificity and the comparative evidence which will lead us to more realistic and plausible conclusions.

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INTRODUCTION

It is now an established fact within Medical Anthropology that "medical systems are cultural systems" (Kleinman 1986). Reproductive Health as a gendered phenomenon has been recognized as an integral part of these cultural systems. Consistent with this classification, the concept of culture has been the most widely used analytical tool in studying medical systems. Therefore given the centrality of the concept to the discipline, it becomes imperative on our part that we first understand the range of interpretations of the concept that exist before we take it to the level of application. This further entails that, how multifaceted and nuanced the concept of culture is especially when we consider its methodological implications for the study of various developmental issues like health and health care. This is succinctly brought out by Scotch (1963) when he remarks, "what comes out of research is not dependent on the *nature* of the problem to be studied but rather on the *way* the problem is studied". The most dominant interpretation of culture within the mainstream anthropological thought is the "culturist perspective" or "culturalism". This perspective of culture sees meaning as, "the essential property of the cultural object, as symboling is the specific faculty of man". According to this particular view, culture is *sui generis*, a thing unto itself, possessing an inner rhythm that confers structure and meaning on every aspect of human life. Given this rather extreme position on culture, meaning is given a degree of intrinsic autonomy of its own, which can only be explained in terms of its own internal and particularistic logic, it cannot be simplified or reduced to external relational forces. The reified notions of such a definition were carried forward into Medical Anthropology to study medical Systems. The stand taken by Fabrega (1979) is an illustration of this view wherein he calls for an "ethnography of illness". According to him illness is collection of descriptive accounts of people who are judged as being ill or who believe themselves to be ill, with explicit attention given to the role played by cultural influences. An alternate perspective in Medical Anthropology that is even closer to culturalism was given by Good and Good (1981) that stressed on meaning centered approach which recognizes all illness realities to be fundamentally semantic and therefore all clinical transactions to be fundamentally hermeneutic or interpretative. In fine, illness to them represents a distillation of understandings distributed within a given cultural system. Keesing (1987) has identified three fundamental shortcomings of the above stated approach of culturalism within Medical Anthropology. First, an understanding of culture as a shared set of symbols and meanings must be qualified as view of knowledge as distributed and controlled. He argues that

socially regulated. Second, culture is constituted not solely by "webs of significance", to use a Geertz's phrase, but also by "webs of dissonance". Cultures, therefore, not only generate meaning, they also produce legitimization of inequality, justification of subordination, agency as denial for exploitation, and disguises for oppression. And finally Keesing cautions that, the cultural metaphors may be read or rather misread too deeply and too literally.

Towards a Synthetic View of Culture: As the ongoing discussion reveals, culture is produced and reproduced as part of social process and therefore cannot be explained merely as the formal working out of an internal logic (Wolf 1982). No doubt that medical systems like other social systems have an internal orderliness to them in the long recognized sense, they are much more than mere symbolic representations of social relations. Yet the pertinent question that still needs to be answered is, what is the source of their order, their pattern? In reply to this question Wolf says that, it is the structure of social relations that confers power over codes and communications. There is thus an economic, political and historic embeddedness of the cultural systems that result in a particular type of behaviour. However, there was also a response to the this situated theory of culture within Medical Anthropology that was spearheaded by Nancy Scheper-Hughes and Margret Lock (1986), who are of the opinion that,

> "While the macroeconomic and political economy perspectives have served as a useful corrective to the endless pursuit of medical and psychiatric exotica characteristic of conventional ethnomedical, community case studies, they have . . . tended to depersonalize the subject matter and the content of medical anthropology by focusing on the analysis of social systems and things, and by neglecting the particular, the existential, the subjective content of illness, suffering, and healing as lived-in events and experiences". Scheper Hughes and Lock 1986: 137.

The present paper therefore calls for an alternative approach in which symbols and meanings are neither obscured nor overly stated, and in which culture is explicated in non cultural terms. The intention is to bring together, the views of Sidney Mintz (1973) and Eric Wolf (1982) who state that traditions and cultures may appear to be confining, and with changing time even maladaptive, but with closer examination we often find that what has been painted as blind custom is neither blind nor customary. On the other hand, the related yet different view of Scheper-Hughes and Lock (1986) who contend that there is no mechanical relation between political economy and medical systems; rather the construction of illnesses and understandings is mediated within the space or realms of experience.

Rationale for the Study

Implications of using Qualitative Approach for Health Research: Qualitative Methods have now become common place for studying the cultural and social dimensions of healthcare. An attempt is being made in this paper to bring to the fore the potential contributions of anthropology which is based on the empirical comparisons of particular societies. Even though in qualitative research the methods are derived from various disciplines, the knowledge and concepts of anthropology are underused when compared to other social sciences. This state of affairs becomes all the more important because the salient feature of anthropology is to see "biomedicine" and "healthcare" as culturally constructed and at the same time situated within the local contexts. It does not depend on static taxonomies and consensus models that are torn apart from their social contexts. Further, transmissibility and prevention takes precedence over understanding people and treating them as just a set of conditions rather than humane and complete individuals. This is owing to the innate assumption of body-mind dichotomy of the medical sciences and the related disciplines. In fact culture and its various reifications discussed earlier are seen as mere residual and extraneous categories not relevant to the etiology of the diseases affecting humans. As an outcome of this, using biomedical approach and the methods of allied disciplines like epidemiology and demography, narrows down the investigation process for both practitioners and the people, with the sole intention of improving the "compliance" or "adherence" to the interventions. Anthropology on the other hand does not assume the concepts used by biomedicine as a normative and universal monolith. Rather, it helps converting the peculiar into familiar for both practitioners of biomedicine and the lay man. Some of the most useful and relevant anthropological research for evidence based healthcare has considered the difference between epidemiological, clinical, and people's point of view in particular contexts and thereby give valuable insights on the implications on the methods used. (Kaufert and O'Neill 1993, Davidson, Freknel *et al.* 1992). What people say can be different from what they think and do. This goes unrecognized in qualitative research as it mainly depends on one go interview methods. The critical linkage between language and action fundamentally informs anthropological research using participant observation. Qualitative research in healthcare falls short of identifying nuances of normative statements (what should be happening), narrative reconstruction (what has happened in past), and actual practice (what really happened). Even though participant observation may not always be feasible because of time and resource constraints, but the essential methodological lessons from anthropology are transferable (Mitchell 1983).

Context Specificity and Comparative Evidence: The focus on particular which anthropology insists, through documenting the complex details of everyday life, provides an important corrective to misleading generalizations and abstractions of qualitative research, which can actually flatten the cultural diversity of different settings. Once the analysis of specific is completed, general insights can be drawn through the comparative approach at a more macro level. Just as most health professionals specialize in various aspects of disease, organs or parts of human body, similarly medical anthropologists specialise in particular regions of the world or fields of research. This specific knowledge is a major source of comparative evidence, like clinically specific knowledge, it is informed by the core disciplinary underpinnings like indigenous knowledge systems, cultural relativism and holistic approach.

Questioning the Conventional Categories: Anthropological methods are iterative in nature, and are not devised keeping in mind the "reply induced questions" and therefore do not restrict the tools and techniques of data collection to a given target population. Although qualitative methods can be undoubtedly useful in operational terms, genuinely new insights are rarely obtained that ultimately fail to accommodate the central feature of social sciences – that is redrawing or reconfiguring the conventional categories of data collection. Deriving from the tradition of critical medical anthropology, meaning, classification and explanation of the categories can be re-examined. For instance, qualitative researchers have been involved in developing quality of life measures by interviewing specific patient groups so that they can identify what are the aspects they consider to be relevant. However, a more anthropological approach might ask what quality of life means? Not only to patients but also to all the possible stakeholders, like health professionals, policy makers, NGOs and so on. And it might also ask why, under the current medical system, that a particular aspect is valued more than others. Therefore, during the process new relevant categories may be generated that are more inclusive rather than exclusive especially in a diverse society like India (McKevitt and Wolfe 2002). This particular ability of anthropological methods is associated with development of ethnographic study of "other cultures" under which, the nature and boundaries of the apparently basic categories like family, marriage, kinship, polity and medicine included could not be presumed but require an inductive empirical investigation. Thus, the anthropological approach, rather than taking a category as given and investigating the information about it, begins with investigating the form and content of the category itself. The author tries to illustrate the same through the study of women's reproductive healthcare in rural South India.

Status of Women's Reproductive Healthcare: There has always been dearth of theoretical as well as empirical attention being paid to the influence of women's role in reproductive healthcare especially

among lower echelons of Indian society. Instead, it is blatantly assumed that even in societies where men are overtly dominant, like the ones in rural north Karnataka, decisions concerning women's reproductive healthcare and their subsequent well being are made by women themselves. But the fact of the matter is that the actual circumstances under which the women interact with their male partners in matters relating to reproduction - or even subordinate to them - have rarely been considered in an in-depth and qualitative manner, at least in the Indian context of rural north Karnataka. In many societies, including that of rural north Karnataka, control over the means, goals and consequences of reproduction are critical to the healthcare process wherein both men and women participate in a kind of dynamic equilibrium ordained by the cultural constraints of their own. Thus, the contexts within which these reproductive relations operate are characterized by conflict, consensus or an eclectic mix of both, and these contexts have been seldom subject to systematic investigation. The reason for this, to a large extent is that the academics in social sciences including the anthropologists have historically seen reproduction as a "women's topic", as women's body has been considered as "site of reproduction". Methodologically speaking, couples, nuclear families, members of the same reproductive age-group, gender-wise, income-wise, age-wise sample sizes are not the only units of consequence for the analysis of women's reproductive healthcare; particularly in the rural north Karnataka. However, what is overlooked is that the members of such units and their behaviours and relationships, for most part, may not be the same. For instance, highly ritualistic kin-groups, localized Patrilineages, inter generational and inter caste relations, *Aya* and *Jeeta Padhati* (Jajmani System) and peasant – agrarian relations can also be critical. The inter linkages and mechanisms that bind these levels can be studied in depth only through an ethnography informed qualitative methodology. It is the peasant based agrarian form of social organization that constitutes the core of rural north Karnataka. Village communities here embody a culture which needs to be deciphered threadbare if we are to come out with clear-cut and actionable solutions. Rural north Karnataka is based on the same basic principle of Indian society which primarily centers around a kin based agrarian social system which pervades all aspects of the social life. This has far reaching repercussions on the ability of woman to control her own sexuality, in the form of choice of marriage partners, planning her pregnancy and her reproductive career as a whole.

The overall healthcare scenario of women in South Asia has become major source of concern for researchers and policy makers alike. Women's health in general and reproductive health in particular is one of the most neglected areas (James L, Sandra Laston *et al.* 1998, Pachauri 1994). Motherhood is often perceived as a virtuous experience that gives status to women in a society, but at the same time it is also associated with pain, suffering, fear and even death. This gets manifested in an abnormally high rate of maternal morbidity and mortality caused by haemorrhage, infection, high blood pressure and obstructed labour, which is in turn symptomatic of highly inaccessible health care services (WHO 2016). In 1995, 515,000 women died during pregnancy or during childbirth; out of these only 1000 were in high-income countries and rest were in the developing world (UNICEF 2001). 5.6 lakh women die every year during pregnancy and childbirth of which 1.17 lakh are from India (Sule 2009**).** 99% of all maternal deaths in 2008 occurred in developing countries with Sub Saharan Africa and South Asia accounting for 57% and 37% of all the deaths respectively. This is owing to the fact that only 50% of women avail skilled delivery care and the other 50% do not take assistance or do not have access to such skilled care (Idris, Gwarzo *et al.* 2008). The situation in India is even more dismal. A recent 2000, World Health report-WHR chronicles a glaring and massive deterioration of reproductive health situation of women in India.WHR puts India on the 51 'slow progressing' countries with respect to infant, child and maternal mortality. According to the report, in India, virtually every five minutes a woman dies of complications related to pregnancy and child birth. By this, India has gained the dubious distinction of having the highest estimated number of maternal deaths in any country during 2000, that is, 136,000 deaths in one year. It is reported that more than 100,000 women die each year in India of reproductive health related causes. Maternal Mortality Rate-MMR in India is 407 as against 60 in China and Sri Lanka. In India, over two-thirds of women give birth at home. This is close to 85% in rural areas and 95% in remote areas. Efforts are still on to biomedicalize the reproductive health care services provided to women by promoting the option of home delivery with an accessible and skilled care (Huque, Leppard, *et al.* 1999, Geefhuysen 1999 cited in Blum, Tamanna *et al.* 2006). However, there is little qualitative evidence to compare the indigenous home-based reproductive health care services with that of the biomedical care provided in the hospitals. This is the reason as to why the objective of 'Safe Motherhood' that forms the corner stone of a nation's population policy is still a contested phenomenon. Studies on home-based delivery care have largely focused on the biomedical orientation of traditional birth attendants, and very few attempts have been made to understand and bring to the fore the indigenous beliefs and practices that ultimately account for safe-motherhood (Sibley, Sipe *et al.* 2004, Bergstrom and Goodburn 2001).

CONCLUSION

It is evident from the above discussion on both, namely, concept of culture and qualitative methods that, we have definitely fallen short of dealing with certain critical aspects of the disadvantaged and marginalized sections of society viz. women and their reproductive health. It is only by applying a suitable methodology to these areas of heath research by keeping in view the above given perspectives which includes both the processes of indigenization and modernization, that we will be fulfilling our ethical imperatives of 'equity' with 'distributive justice' (Oliver and Pearsman, 2001). In spite of India being a signatory to the 1978 Alma Ata Declaration of 'Health for All by 2000' we have hardly met the target. In fact, the target has been pushed to 2020.

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