intima
a journal of narrative medicine

The Operation: The Value of Ethnography in Highlighting Social and Personal Complexity

By Vaidehi Mujumdar

As an undergraduate at Dartmouth College, I conducted a 4-month long ethnography in the heart of Mumbai through my school's anthropology department. Ethnographic research was conducted to address the inner workings of an NGO that worked with street families in two urban and peri-urban communities of the city. The research, which I had been working on since I was a sophomore, eventually turned into a senior thesis in medical/socio-linguistic anthropology and has helped mold my journey as an aspiring physician. I wanted to highlight the importance of ethnography as a tool for personal introspection. In academic circles, ethnography is used as a research tool to build narratives and social lives around a particular topic or population. However, as I conducted my own research and read ethnographies written by other women, I began to learn more about myself as an Indian-born American female of reproductive age living in the heart of Mumbai.

It all started with an operation.

The NGO's health intake form included a question that asked women if they have had "the operation" or would like to get it in the future. "The operation" referred to tubal ligation, a form of female sterilization. From my observations, it seemed the NGO encouraged this form of social and reproductive planning because other forms of contraception were not used primarily due to cultural and economic restraints. From the health records, it seemed that none of the males had undergone vasectomies, and I did not hear anyone mention vasectomies as a form of family planning.

Based on my analysis of the 120 female health records, it was clear that condoms and birth control pills were not used at all. From looking at each female health record, I discerned that 75 out of the 120 women of reproductive age had undergone tubal ligation through the NGO's health program. Out of those 75 women, 50 percent were twenty-five years of age or older.

Surprisingly, and also not that surprisingly, for many of the Hindu and Muslim women, religion was not a factor in their decisions to get "the operation." However, several women voiced to me that when they had gotten pregnant before the tubal ligation, they had not considered getting an abortion – arguably another "operation" that was at play in this setting and that brought with it other forms of social complexity. After receiving the tubal ligations, several women stated they felt like a huge mental burden had been lifted. They felt at least a piece of what can be termed "social suffering" was alleviated because they did not have to worry about providing for a baby, going through pregnancy, or as I later learned – losing a baby. Miscarriage and infant mortality were big

issues in these communities as proper prenatal care was often not adhered to due to social, monetary, and religious reasons.

The dichotomy between pregnancy prevention and termination suggests a hesitation that could be ascribed to religion, lack of access to hospital or clinic facilities, or lack of knowledge that an abortion could be performed. However, the complexity of the decisions cannot be summed up in generalizations about religion, poverty, or lack of access. The mental and physical decisions that led these women to forgo abortions are tied up in a complex history of abortion stigma (Speed 2009).

Although abortion stigma is recognized in India, Mumbai, and the two communities I worked with, it is poorly theorized. Kumar et al. (2009, 625) suggest, "[T]he social production of abortion stigma is profoundly local. Abortion stigma is neither natural nor 'essential' and relies upon power disparities and inequalities for its formation." In the communities where I worked, stigma contributed to the idea that women who have abortions are not "normal." The social construct of abortion created an "us versus them" mentality.

My research did not go in-depth into abortion stigma. However, further research, perhaps using a stigma scale developed by the International Federation of Gynecology and Obstetrics (IPAS), could shed light on stigma as a social control used to dehumanize and devalue women who need or decide to terminate pregnancies (Shellenberg & Tsui, 2012). The IPAS scale measures stigmatizing attitudes, beliefs, and actions at individual and community levels and evaluates stigma reduction interventions. Expanding this scale to interviews and investigations in these communities and tracking those measures would result in more concrete perspectives on how different women's health interventions or community health programs could be better targeted.

Although my initial study did not focus on women's issues or sexual and reproductive health, I was drawn to the intricacies of these women's health choices. Inhorn (2006) proposes that reproductive-aged female anthropologists find themselves focusing on reproduction in their research. Women scholars are "attracted to [this] fundamental aspect of female experience not shared by men" (Inhorn 2006, 351). This one-sidedness may detract from getting a more complete picture during ethnographic work, so I made sure to step back and keep my own positionality, and that of others, in mind. By being aware of my own internalized ideas about womanhood, reproductive health, and my own body, I was able to better connect with the women in the community and create a connection that sought to alleviate the inherent "differences" between them and me.

Throughout my research, I was drawn to witnessing these stories told by women who, in all of their differences, spoke of similar issues and experiences. My research and eventual thesis highlighted several anthropological principles, theory, and history–but I am most proud that my senior thesis became a place where I could share stories not often heard or had been dismissed, or not witnessed with the respect they deserved. My time in Mumbai became a personal journey, and through it I learned how powerful ethnography can be as research tool to tease out a patient's story with a careful sensitivity deserving of someone's narrative.

Works Cited

Inhorn, M.C. (2006). Defining women's health: A dozen messages from more than 150 ethnographies. *Medical Anthropology Quarterly,* 20 (3), 345-378.

Kumar, A., Hessini, L., & Mitchell, E.M.H. (2009). Conceptualising abortion stigma. *Culture, Health & Sexuality*, (11) 6, 625-639.

Shellenberg, K.M. & Tsui, A.O. (2012). Correlates of perceived and internalized stigma among abortion patients in the USA: an exploration by race and Hispanic ethnicity. *International Journal Gynecology and Obstetrics,* 118 (Suppl 2), S152-9.

Speed, S. (2009). Gendered intersections: Collective and individual rights in indigenous women's experience. *Human rights: An anthropological reader* (pp. 239). Hoboken: Blackwell Publishing.

Vaidehi Mujumdar is an aspiring physician interested in the social determinants of health and narrative medicine. She graduated from Dartmouth College with a double major in biology and anthropology modified with ethics. She is Indian-born American, an amateur ethnographer, and strongly believes health and social justice are intrinsically part of the same story. Vaidehi is a certified rape crisis advocate and currently a fellow at HealthCare Chaplaincy Network, an NYC non-profit that integrates spirituality into healthcare. Her writing has been published on *Feministe, Brown Girl Magazine*, and *The Almost Doctor's Channel.*