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ETHNOGRAPHIC INQUIRY INTO WOMEN'S REPRODUCTIVE HEALTH ISSUES: A METHODOLOGICAL IMPERATIVE

Women's reproductive health issues have received the attention of researchers and policy advocates in India but there is still scope for improving the study approach through the incorporation of cultural perspectives and ethnographic methods that are generally adopted by anthropologists. Such a methodological re-visioning is likely to help overcome the patchy understanding of reproductive health issues by contributing to a more holistic understanding that incorporates the nexus of culture and social norms with reproductive practices, foregrounds the experiences of women and their subjectivities in the contexts of inter-layered social structures of caste, class, and patriarchy, and more importantly retrieve the voices of women that are usually muted or silenced in survey and statistical approaches. This holistic and deep understanding of the issues through the ethnographic approach is likely to improve policy approaches and interventionist strategies for better reproductive health outcomes. This paper highlights the need and relevance of ethnographic approaches to investigate into women's reproductive health issues.

Women's health condition as gleaned from reproductive health indicators is quite depressing to say the least, as every minute a woman dies of reproductive causes, and during their maximum reproductive life span of around 35 years, women generally suffer from at least one reproductive morbidity. Yet, women's health and especially reproductive health is not adequately researched in the field of International public health. For long, reproductive health programmes in India have meant organizing services for family planning and maternal health, while other reproductive health services like abortion services and treatment of gynaecological problems were paid less attention and have not been included as integral part of a reproductive health programme (Pachauri 2011:47). Moreover, if these have been included as an integral part and initiatives have been taken, it did not get proper response or acceptance from women in rural India, thus compelling us to ask the question as to why such a situation persists. What are the reasons for the

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lower utilization of health care services by rural women? Certainly, differences in degree of utilization and success of the health initiatives and programmes are to an extent also rendered by the socio-cultural factors of health and health-seeking behaviour. These socio-cultural factors shape people's perceptions (i.e., in anthropological term known as 'emic-view' which refers to sufferers' perspective or insider-view or views of subjects under the study) on health and disease which further determine their healthcare seeking behaviour. People's perceptions on health and disease may or may not have similarity with medical notions of health and disease. Discrepancy between the bio-medical notion and sufferers' views is one of the most significant factors which affect the utilization of health services while other factors such as lack of awareness, lack of access to health care by poor women due to distance from health facility and time-costs, lower acceptance, cultural norm, traditional healthcare practices, and women's life circumstances cannot also be excluded.

It is often recognized that in rural areas there is 'lack of demand' for health services that is a significant reason for underutilization of health services by poor women. Often women's illiteracy, their lack of motivation and cultural and religious beliefs are blamed for underutilization of health services. However, studies that have focused on women's perceptions reveal that it is often the services that are insensitive to women's needs and are culturally inappropriate. Thus, a wide socio-cultural gap exists between the users and the providers of the services. Therefore, it is crucial to understand the women's perspective in order to effectively bridge this gap. The neglect of the user's (women's) perspective in the design and implementation of health services has frequently resulted in the development of programmes that have not been responsive to women's needs and have therefore, been underutilized (ibid: 50). In this way, focus on perspective and perception on health and care is crucial for a wider understanding of women's health needs and the barriers to utilization of the services so that access to healthcare for poor women can be enhanced.

Perception, Perspective and Women's Health

Local perceptions especially women's perceptions on their own health affairs are significant factors in establishing their health status. These perceptions vary from community to community as every community and society inherits multiple layers of shared ideas and perceptions regarding health, illness and diseases. While bio-medical makes clear-cut distinction between "normal" and "pathological" condition of health and disease, folk discourses render the distinction fluid and malleable and these are likely to differ from one community to another. This phenomenon poses a challenge for medical professionals and health agencies in producing an appropriate healthcare approach to such communities as it is necessary to understand their perceptions of health and ill-health that bio-medical professionals often lack. In this context, the ethnographic method becomes useful since it allows

the fieldworker to understand their perceptions and categories being based on participant observation which is a vital tool in the challenging task of knowing peoples' perceptions, understanding their behaviors, and observing their practices directly.

In my research on reproductive health of Chamar women, I have sought to understand women's perceptions and interpretations of their reproductive health and diseases. Illness narratives of women in the community suggest that women do not recognize their reproductive problems as health problems as in their notions reproductive health affairs like menstruation, sexual behaviour and nutrition in pregnancy are taken for granted as life-cycle phenomenon and not considered worthy of medical intervention. Women say these are normal and common phenomena in women's lives during their reproductive years, and are not matters for looking to a doctor at every moment of their reproductive health related problems. Most women consider menstrual disorder and pains as natural phenomenon even as they understand the harshness of the situation that results when the problems are aggravated.

On the basis of my field observations I could infer that individual's and community's perceptions are derived from their social status and their cultural meaning systems on health and care. The perception or 'emic-view' is attributed within the given socio-economic milieu of the household and the community. Hence, women's ideas of their reproductive and sexual health problems varies with their position in the families and society, such that this discourse itself is informed by their interests in other sphere of life indicating that the social reality of interpersonal relations must be taken into cognizance as well. This is reflected, for instance, in their perceptions of the institutional delivery of child. Embarrassing and discriminative behaviour by midwives and health workers at the health facilities shapes women's perception on institutional delivery of child. More often, these women perceive child delivery at home as a better option.

Women also opined that their husbands should not use contraceptive as it causes jaundice and weakness by retaining heat in the body. In addition, during an in-depth interview on issues of contraceptive methods and practices most of women stated that sterilization should be always practiced only by women since they have to do only domestic work and remain in the household. As men bear the responsibility of earning work, it should not be practiced by the husband as it is detrimental for them as it weakens the male body. Even the traditional *dai* (midwife) of the community held the same view. Some women opined that permanent sterilization method such as removal of uterus also weakens woman's body and aggravate various health problems like arthritis, gastric problems and eyes-sight problems.

Interviews clearly suggest that women's perceptions of their sexual and reproductive problems are the outcomes of their socio-economic status.

The majority of the community dwellers in the ethnographic survey is from low income group with the household cash earning being less than Rupees 5000 per month and the men being employed in unorganized labour sector. Consequently, women who have internalized the norms of a patriarchal family, of the male "bread winner", view the use of contraceptive methods by men as detrimental for their health and as causing weakness to their laboring bodies that could jeopardize their roles as bread winners. Even though women do work both inside and outside their homes and contribute to household income, their roles are perceived by the women themselves as only supplementary earners in the family, and so perceive the use of contraceptives for birth control as exclusively a matter of women's concern and who should be opting for sterilization rather than men.

Further, women's health is shaped by certain factors that are deep rooted within the internal dynamics of the family or household, their life circumstances, as well as the wider socio-economic structure within which the families are located. In this context, Soman (2006) argues that women's experiences of ill-health are shaped within the patriarchal norms and associated roles in the family. Women's health and work domains are interdependent and constantly interacting, while the socio-economic position of households influences the extent of the shifts and the differences in the associated experiences and rationales. Despite the fact that all women share similar biology their reproductive health status are profoundly affected by who they are and where they live. Women's reproductive health is enmeshed in multiple dimensions of culture, gender, and the household economic condition, which influence and shape people's perceptions and practices regarding health and diseases, which in turn determine the success and failure of health care initiatives and programmes.

However, research perspectives determine the applicability and generalization of findings of the research. As such, universally accepted definition of reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease and ailment in all matter related to reproductive organ and function" suggests that it should be understood in a framework that is inclusive of gender, culture, economic and medical perspectives as well. As medical perspectives deals with only medicine and symptoms of diseases, it must be understood through its cultural and social aspects as well. Besides medical aspects of health in all its matter, its origin, expression, impression and implications are grounded in socio-cultural bases.

In India, most research conducted on women's reproductive health and morbidity is based on hospital data and is statistically oriented. There is paucity of qualitative studies on women's health issues. For wider understanding on women's perception regarding their health, disease and treatment-seeking behaviour, studies should be conducted with feminist

perspectives employing qualitative methods and techniques. Excepting for studies done by western anthropologists such Jeffrey et. al, Van Hollen and others, few attempts appear to have been made by scholars in India to systematically apply ethnographic methods for understanding women's reproductive health issues (Kanani et al. 2011:146). To understand women's perception it is crucial to listen to women's voices and to articulate their concerns regarding their health. Such an articulation is possible using feminist ethnographic methods.

At present, there is little understanding of how the broader circumstances of women's lives affect their ability to promote their own health and that of their families. Awareness of the circumstances under which women manage their health and that of their families can provide important insights into both research needs and feasible strategies for improving women's health (Pachauri 2011: 47). Here, the attempt is to understand the need for methodological attention for problem-solving strategies in the field of women's reproductive health. Indian women's sufferings from reproductive health problems calls for urgency of a broader and more adequate understanding as the situation persists across all cross-sections of female population be it rural or urban. On account of a lack of proper methodological base to conduct research into the various issues of reproductive health, the concerns, awareness and knowledge regarding women's health is still inadequate, incomplete and continue to be patchy. It is therefore necessary to inquire into its broader sphere using methods and methodological tools used by sociologists or anthropologists in their respective domains of medical sociology and medical anthropology. Appreciation of ethnographic inquiry into women's reproductive health issues becomes imperative and inevitable as one of the significant methods of qualitative research to find out the causes for perceptional discrepancies, and understand the life circumstances of women in the rural communities that shape their notion and perceptions on reproductive matters, health and well-being. The ethnographic gaze has the potential to cope with challenges in the path of success for improvement in women's reproductive health status, and it may call for a significant re-theorization of women's health and care-seeking behaviour.

What is ethnography?

Ethnography, such as Brewer (2010) defines it, is the study of people in naturally occurring settings or 'fields' by methods of data collection which capture their social meanings and ordinary activities, involving the researcher participating directly in the setting, if not also in the activities, in order to collect data in a systematic manner but without meaning being imposed on them externally. Accordingly, it is premised on the view that the central aim of the social sciences is to understand people's action and their experiences of the world, and the way in which their motivated actions arise from and reflect

back on these experiences. Once this is the central aim, knowledge of the social world is acquired from intimate familiarity with it, and ethnography is central as a method because it involves this intimate familiarity with day-to-day practices and the meanings of social actions (Brewer 2010: 6).

Therefore, ethnographic method may be adequate and appropriate for studying women's issues like reproductive health and gynaecological morbidities since these are not only a bio-medical event but also an outcome of women's and men's social existence.

It needs to be emphasized however, that ethnography is not one particular method of data collection but a style of research that is distinguished by its objectives, which are to understand the social meaning and activities of people in a given field or setting, and its approach, which involves close association with, and often participation in this setting. By extension, Ethnography is, confusingly, both a process and a product as the term can apply both to a methodology and to the written account of a particular ethnographic project. It is not, as is often implied, a pseudonym for qualitative research in general or a way of describing studies premised solely on semi-structured interviews. On the contrary, an ethnographic approach usually incorporates a range of methods and can combine qualitative and quantitative data (Savage 2000).

Though, ethnography has its earliest roots in social anthropology, which traditionally focused on small scale communities that were thought to share culturally specific beliefs and practices, yet now it is applied for any small scale study or social research which is intended to focus on the meanings of individuals' actions and explanations, and is carried out in everyday settings irrespective to its boundary of space and structure. Almost a century ago, Malinowski (1922) hailed as the founder of ethnography made explicit a new standard for data acquisition through immersion in participant observation and interviewing.

While the history of ethnography in health affairs could be traced through studies in different part of the world there are only a few are available in the context of women's reproductive health and are fairly recent. By and large, evolution of ethnographic research in the field of health, women's sexuality, and reproductive health may be traced from earlier studies in the fields of feminism, gender and culture done by scholars from different disciplines. Ethnographic studies in sociology and anthropology have sought to grapple with the basic question of what constitutes health and illness. Kleinman's (1980) study on 'patient and healers in context of culture' is milestone in the medical anthropology. He empirically explores and illustrates the ways traditional specialist or healer capture and control over sufferer's mind and treats his/her problems in given culture and setting. A number of studies have thrown light on conceptual and empirical framework of women's

health and have noted that reproductive health is a broad concept consisting of aspects of women's sexuality and maternal health as a whole, and sets the stages of health in childhood, adolescent, adulthood and old age, and determines the health status of the next generation as well. A pioneering study in this framework is Mead's *Coming of Age in Samoa* (1928) which set a milestone in anthropological and ethnographic explorations of intersections between women's sexuality, culture and lives. The study suggested that differential behaviours, sensual and emotional experiences relating sexuality among women are a cultural reflection rather than biological. Among *Samoans*, the biological responses of sexuality are same but individual's responses to their sexuality are different. This difference according to Mead reflects that it is completely a matter of socialization. Following this perspective, Douglas ([1966]1988) presents an ethnographic explanation of menstrual purity and danger, and women's sexuality in Indian societies. She argues that a society or social structure in its meaning and concept is a powerful image with form and well defined boundaries. In her analysis of Hindu society, she highlights beliefs and the relations among the body, rituals and ideas such as integrity, unity and purity, and observed that the social structure and relation is represented in the human body in form of rituals and beliefs.

As a matter of fact, much of Indian literatures are intended in encountering women's lives, ways of socialization, work, household responsibilities, and health relations with gender perspective in an ethnographic manner. In this vein, Dube's (1986) essay on biological symbolism "Seed and Earth" brought a heightened sensitivity to the cultural discourses of reproduction and their implications for women's lives. She suggests that in Hindu society more especially in village Hindu societies the realm of ethno-reproductive beliefs and the religious theories of conception and procreation perpetuate the underlying principles of patrilineal kinship wherein women are placed at resource-deprived and subordinate status. In an ethnographic work Jeffery et al. (1989) demonstrates the dramatic impact of women's subordination on their health and their survival in young age. Owing to their low and subordinate status women are deprived to make decisions about reproduction of their families. Their 'everyday lives', struggle for their own survival and for the production and reproduction of their families, repeated childbearing and to have to act in limiting their fertility are conditioned even though women are aware of its disadvantage points. Producing portrayal of women's concerns from cultural and gender dimension, these anthropologists focus on women's work, status, childbearing and other issues surrounding reproduction.

Issues of growing-up of the female body, and the ways of socialization of girl child locate and perpetuate gender power relation and disparities in rural Indian families and society. Socialization and treatment within the family sets women's subordinate status in the family. Dube's (2001) pioneer

ethnographic work on 'The Gond' tribal community provides excellent material on this debate. Encountering the construction of gender among 'Gond' community this work presents a deep penetration in matters of underlying principles of patriarchy wherein a girl's marriage is just a matter of her destiny, her membership in in-law's household depends upon continuity of marital ties which further depends on woman's attribute of 'motherhood'. Motherhood is defined mainly in terms of producing male child.

However, only few ethnographic studies have examined women's experience of reproductive health and gynaecological problems. These studies draw attention on women's everyday lives, health issues and its association with their social surrounding. Focusing on various aspects of women's reproductive health as pregnancy, childbirth, issues of contraception, and transition in health practice in cultural background with reference to poor women in Tamil Nadu, Hollen (2003) presents an ethnographic monograph describing women's experience of child birth, the dilemmatic conditions of poor women who on one hand desire to avail of the benefits of modernity and want their children born at health facility, while on other are afraid of being discriminated by health professionals when their children are delivered at the health centers.

In addition, other ethnographic accounts have highlighted issues of high fertility, maternal mortality and low utilization of clinical pre-natal care services prevailing in rural areas due to interplay between cultural and structural factors that influence reproductive decision making (Gupta, 2012). Poor women attribute the most serious pregnancy and obstetric complications to human or spirit induced reproductive threats of witchcraft and sorcery. Bharati (2013) in an ethnographic account of the Konda Reddi tribes of Andhra Pradesh demonstrates beliefs and related practices regarding women's reproductive matters throughout their reproductive career. She pointed out that infertility is primarily considered to be the deficiency of the women, and their barrenness often attributed to some supernatural agency. In this context, exploring the cultural base of women's reproductive affairs, Narashimhan (2011) has described much on 'menstruation purity and pollution', its symbolic aspect and the changing concepts of menstrual taboos. She finds out why menstrual pollution is crucial for the *vattima*'s sense of Brahminhood. The study concludes that changes in menstrual pollution rules among the *vattima* have to be seen in conjunction with changes in other spheres of *vattima*'s life. Observing menstrual pollution inside the home is one of the ways in which Brahmin-hood can be sustained in changing society where class and caste equations are getting changed rapidly.

However, the first qualitative research centered to women's reproductive and gynaecological problem purely with ethnographic approach was conducted in 1990 based on a project supported by ford foundation (Pachauri, 2011).

These identified anthropological and sociological works on social construction of the body, sexuality, local notions of illness and healing, the connections between gender, work and health, rural lives and social structure and thus provide significant insights on thinking about a holistic understanding of women's health especially in the context of rural and marginalized communities. Adding to these, my research on reproductive health of the Chamar women intended to provide an ethnographic account about how women's health and diseases in a given socio-cultural environment are perceived, cognized and responded to by women of the Chamar community.

Equipping Ethnography on Women's Health

Ethnography is carried out in everyday settings using several methods, and focuses on the meanings of individuals' actions and explanations, rather than their quantification. In addition, it emphasizes the importance of context in understanding events and meanings and takes into account the effects of the researcher and the research strategy on the findings. Thus, it becomes significant in health and healthcare researches especially related to women's sexuality, reproductive health and morbidity in a rural setting.

Ethnography of women's health issues entails inquiry into very intimate and private matters of sexuality and reproductive health of women and therefore should be restricted to women only and performed by a female ethnographer. Men however can be interviewed directly on other issues such as their perceptions on women's health and illness, nutrition, work and status, institutional delivery, uses of contraceptives, utility of care facility, fertility and child spacing, son preference to further supplement the data gathered from women and could appropriately be used in the analysis.

However, use of some specific techniques of data collection and analysis method like feminist interviewing, narrative analysis, active listening, and mixed-method approach for data analysis may be seen as advantageous in different ways. Let us focus on ways wherein these techniques and methods equipped the ethnographic accounts.

Active listening is one of the important and widely used interviewing techniques particularly in qualitative research. It can be best described as "involved listening with a purpose". It is a set of techniques designed to focus the attention of the interviewer on the interviewee and helps the interviewer in increasing the length and depth of interviewees' responses. It involves strategies such as restating the interviewees' message, responding empathically, and using prompts or repetitions to extract further information from the interviewee. In general, active listening aims to deepen the interviewer's understanding of the interviewees' preoccupations and interests by creating empathy and making the speaker feel well listened to. In this way, the interviewer encourages extended responses by showing an interest

in the topics being discussed and asks questions that encourage the interviewees to reveal more.

Active listening intended to probe on responses on sexual and reproductive affairs would entail further probing questions such as 'Why do you think so...?' you mean to say that…., how do you find it so…? etc. The probing creates further avenues for exploration. Therefore, it can be a useful technique for researchers in order to elicit women's in-depth responses.

In addition, 'feminist interviewing' is another significant technique. To gain access to social meanings, observe behavior, and work closely with informants and perhaps participate in the field with them, several methods of data collection tend to be used in ethnography, such as in-depth interviewing, participant observation, personal documents, and discourse analyses of natural language. These methods are much privileged by acquiring "Feminist interviewing." "Feminist interviews" show heightened sensitivity in redrawing the power relationship between respondent and researcher in order to get better access to the subject's voice. This involves a critique of conventional interviewing that is masculine in the language use reflecting the power imbalance between respondent and researcher. However, openness, emotional engagement and the development of potentially long-term relationships based on trust and emotional reciprocity are attributes of "Feminist interviews". By redefining the nature of the face-to-face encounter, that researcher and subject become co-equals, momentarily breaking down the social hierarchies (Brewer 2010: 69). Feminist interviewing advantages not only researcher's understanding about what women think and why they think so about their reproductive and sexual health and problems but also create a convenient site wherein female respondent feel comfortable in talking about their very intimate affairs. It allows the researcher and respondent to build rapport and a sense of mutual trust in talking about intimate matters like sexual behavior, reproductive anatomy and function. It allows the researcher to get inside women's heads so to say, to read their mind and feel their pains similarly. Being a female observer a scholar can read the facial expression of the respondent. Facial expression helps in understanding of feelings and pains of sufferers. Feminist interviewing helps with assessing reality of situation. If respondent's cognition about her health status or disease is not proper, mean to say if she cannot tell about the disease or disorder of reproductive functioning and organ her facial expression and words give meaning to her recognition that only a female researcher can understand.

Indeed, in the process of collecting data from subjects (normally women), the researcher seeks to empower them in their particular setting, enabling them to deal better with the problems they experience being women. In the mutually collaborative interview setting where the researcher and the subject woman are co-equals, it is possible for a sensitive feminist ethnographer to help the subject to realize for themselves how they have internalized

patriarchal norms and power relations both within and outside their households and could help them change their perceptions which is a necessary requisite to bring changes in behaviour.

Besides all the techniques, 'participant observation' is inevitable in doing ethnography. Being a participant observer a scholar strives to deconstruct and reconstruct the micro-processes of thinking and consciousness of sufferers, natives or the subject of study. This endeavour advantages scholar's efficiency in interpreting behaviour and its associated meaning from native's or subject's point of view. A participant observer could understand what a given context or event could mean, whether it is a response of social environment, and the ways in which events are linked and drive each other. Thus, by focusing on micro-processes and dynamics of thinking and consciousness, participant observation provides an opportunity to understand associated meanings of context from insider's point of view. By doing so, a researcher can relate associated meanings with other aspects of life and can predict on contexts.

Nonetheless, narrative analysis is equally important in research methods. It strengthens the ethnographic enquiry by giving it a context. Narrative, in very simple terms, refers to "a common mode of communication". A narrative is understood as a spoken or written text giving an account of an event or series of events, chronologically connected. It articulates emotional understandings of self and other. Indeed, a narrative account which is basically qualitative information about the subject and matter actually speak louder than numbers or quantitative data. Considering so, illness narratives are taken as the main technique for obtaining episode specific descriptions of selected women's reproductive illness. These illness narratives taken through the feminist interviews do potentially deconstruct the lay perceptions and ideas about women's issues. The technique fosters the ethnographic inquiry as it is enriched with episodic description having multitude of dimensions of respective matter. Narrative accounts are sources to understand the mechanism of construction of the perceptions and ideas, and the process of sharing of these perceptions and ideas in the community.

Further, an ethnographic inquiry into reproductive health and morbidity issues does not produce complete, problem-solving findings until and unless it employs both qualitative and quantitative data in a complementary fashion. The mixed-method approach, therefore, enriches finding of the research. In addition, ethnographic accounts or qualitative study can complement quantitative study and vice-versa. I mean to say that understanding of subjective experiences would supplement to estimate the extent of problem that is measured by numbers and percentages in quantitative study. Hence, ethnographic data could be analyzed best by acquiring mixed-method approach. This approach is imperative for descriptive researches, such as women's health, since they engage in exploration of subjective

understanding and reality of intimate matters like sexuality, sexual violence, reproductive health, and behaviour. In such kind of matters both qualitative and quantitative data are significant when these are placed together in an analyzed text. While the quantitative data provide us information on the incidence of women suffering from reproductive illnesses in numbers, it may not be enough to reveal the nature, extent and history of ailment. Qualitative data has the strength to reveal the complexity of women's perceptions about their bodies and their health in diverse geographical/cultural settings and populations. Hence, it provides facts about the reality of life when these data are analyzed with assistance of statistical and numerical materials. Therefore, ethnography equipped with mixed-method approach to the study of health status of women provides opportunities for the integration of a variety of theoretical perspectives such as anthropological theories, sociological theories, feminist theories, and others. Therefore, it should be opted as the best method for research on women's reproductive health.

Concluding observations

Reproductive health issues of women in India are very complex as it entangles issues of sexuality, maternal morbidity and mortality, abortion, lack of male responsibility for contraceptive use, domestic violence, and above all poverty, work burden and poor nutrition. These issues evolve around the complex web of gender relations and power structures. Unlike men, women's reproductive health matters as womanhood and motherhood is a universal phenomenon irrespective to caste, class and religion but its experience, expression and responses have variations across societies that are a byproduct of cultural configuration of different traits. These cultural traits comprise kinship, marriage pattern, rituals related to health matters, women's work and participation, patriarchy, gender relation, religion, geographical environment, changing socio-cultural norms, and acculturation etc., and all of these linking together determine health status of an individual and community.

Thus, health and illness being a bio-cultural event, is developed or diminished in a social climate produced by the well-functioning or malfunctioning of the social system composed of various subsystems like medicine, education, religion, cultural practices and also the existing social structure and cultural configuration. Gender disparities within households, resource poor rural settings, issues of availability and accessibility of health care are important aspects that condition women's reproductive health. Gender and patriarchy are the ground where socio-cultural norms and patterns play significant role in determining health status particularly of rural women. Being a woman is an arena of subordination and deprivations. In deprived and resource poor conditions women adjust their lives through different survival strategies. These strategies comprise cultural practices, rituals, different perceptions and ideologies. Therefore, no study on issues of women's health

could be complete without adequate understanding of their survival strategies and lives. Then, understanding the lives of rural women is imperative in encountering women's health problems. It is essential to know and grasp meanings of rural lives, ways of survival in resource poor societies, and ever changing socio-cultural environment which influences women's perceptions and practices of survival strategies.

However, policies and programmes regarding reproductive health and well-being are formulated on the basis of internationally acclaimed definition of reproductive well-being or health which has been presented by the ICPD (International Conference on Population and Development) held at Cairo in 1994. Here, reproductive health has been conceptualized as "a state of complete physical, mental, and social well-being and not merely an absence of disease and infirmity, in all matters related to reproductive system, function, and process". Notably, the given definition does not focus on actual status rather its focus is on an ideal status. By assuming the notion of the complete well-being, it renders the notion of health as an absolute, while health is a relative concept that is socio-culturally produced. Therefore, it demands deeper inquiry into matters of individual's relationship with the social environment. In fact, women's reproductive health and problems are socio-cultural concepts that have evolved and been determined by perceptions of individual and community as well, and differ from one individual or another, and from one community to another community. Therefore, such perceptions of disease and health should be taken cognizance of in health programmes and initiatives. In this regard, listening to women's voices which have been missing from policy debates, in order to understand women's perspectives and experiences about their own health ought to be important objectives of women's health research.

In addition, non-medical (socio-cultural aspect), local and community's perceptions towards women's health, illness and well-being must be understood using appropriate methodologies and frameworks to ensure and improve women's health and care status. This may open new window to see embedded meaning and the ways this meaning system constructed. It would provide a leeway to recognize the gap between lay worlds of illness, problem and suffering and the way illness and suffering is constituted in medical and health care systems.

Nonetheless, in a rural setting, the village of *Mayapur* in Ambedkar Nagar district, where I conducted a yearlong ethnographic fieldwork on the Chamar women's reproductive health, the ethnographic method turned out to be the preferred and an imperative one in inquiring into women's reproductive health issues. While conducting field work, I observed an interesting contradiction between women's status and the exercise of their agencies as reflected in their health care-seeking behaviour. While a majority of women admitted that a woman should tell her husband everything, should not go to anywhere without his permission, or take any decision regarding

their sexual and reproductive affairs, I found many women exercised their agency against their subordinate status and internalized patriarchal ideology, and sought care and services without the knowledge and consent of their husband in cases of reproductive matters such as seeking abortion, uses of contraceptives, and choice of contraceptive method.

Notably, the structural surrounding and individual's position in the family shape the reproductive behaviour and response. Thus, discrepancy in what they say and what they actually do opens a new window to see and analyze women's lives and health status in a village community through the participant observation method. Though, ethnography derives holistic data from multi dimensions such as social and economic aspects, gender relations, cultural dominance and determinacy etc. and provides a comprehensive account of rural life and culture, it also render possible to read peoples' behavior, thinking and action, and the actuality of situation of what people say and what they do. Thus an appreciation of ethnographic inquiry becomes imperative for broader understanding of women's reproductive health. Ethnography may be an appropriate methodology in women's healthcare issues in numerous ways. It may be a proper way of accessing beliefs and practices, allowing these to be viewed in the context in which they occur and thereby aiding understanding of behaviour surrounding health and illness (Boyle, 1994). It is therefore helps to explore women's views on health, the experience of illness or delivery of service. By extension, ethnography can show how the effectiveness of curative or health interventions can be influenced by sufferers' (women's) cultural practices and how ethnocentric assumptions on the part of health professionals and programmers can affect health initiatives and programmes.

However, like other approaches to research, ethnography has its limitations. One of limitations of ethnographic method is that researcher's subjectivity can sufficiently influence research writing and research findings which is the outcome of conversation between researcher and respondent. Another argument given as a disadvantage is that ethnographic findings cannot be generalized. Nonetheless, ethnography on women's health does not usually aim to produce findings that can be generalized but it provides in-depth knowledge of the given situation. It can be useful in a pre-design stage of women's health research and can generate questions for further research that can be followed up by other methodologies.

Finally, what I want to demonstrate in this paper is that ethnographic research method is particularly useful in conducting research in the area of women's reproductive health as they allow the researcher and local women to build rapport and a sense of mutual trust in talking about health problems related to reproductive anatomy and behaviour. Ethnography also opens a window find out what women think and how they cope about their health, sexuality and reproductive problems. It can provide an understanding of

women's lives in the given social surrounding and organization. Through this a researcher could deconstruct the perceptions and unfold suffers' behaviour in the given social system. Therefore, it allows comparison between what people say and what they do, and can help to unravel the production of local perceptions regarding health in a particular setting, which would go a long way in identifying the factors determining the success and failure of health initiatives for women.

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