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Source: Explorations, ISS e-journal, Vol. 6 (1), April 2022, pp. 165-186
Published by: Indian Sociological Society
An ethnography of the ‘labour lines’: how access shaped my study?

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Abstract

Tea plantations being an institutional setup, getting access was a major challenge for ethnographic research. This paper illustrates the challenges I faced in getting access to the field and subsequently describes the process of entering the field, the question of insider and outsider and lastly how access shaped my study. The access led me to study the plantations through the experiences and meanings of the people staying in the labour lines. I contend that access is the key to ethnographic studies. Access does not only influence the ways we collect data but can have a profound implication on the findings and therefore shapes the overall study. Through this access that I gained during my fieldwork, I go on to examine the role of mobile phone in the everyday life of the people staying in the labour lines of a tea plantation in Assam.

Key words: Tea Plantations, Labour Lines, Ethnography, Mobile Phone.

Introduction

Health is an important development concern as it entails in itself issues of social justice, equality and human rights besides primarily taking into account complete physical, mental and social well-being of an individual. Not only is good health a basic right of every individual but appropriate, equality based and dignified delivery of healthcare services a requisite for enhancing the belief of the community in modern medical science.

Absence of good health is not only marked by its clinical manifestation i.e. disease rather ‘illness’ as well, latter being a cultural construction of ill-health. Kleinman, Eisenberg & Good (1978) assert that modern medical profession has in due course become ‘discordant with lay expectations’, wherein a higher focus of medical practitioners remains on identifying the disease and its management, and less attention on managing illness. They further state that such an approach of health management reduces the faith of people in modern medical science or its benefits
to health, on the contrary, resulting in larger dependence on ‘popular’ and ‘folk’ sectors of healthcare. Thus, an increased empathetic involvement of health service providers is essential in order to up-scale the outreach of the benefits of modern healthcare services even in communities and regions which are less privileged and/or those which have a higher inclination towards their traditional culture (Foster, 1962).

Healthcare system predominantly involves both, the service providers and the stakeholders at large i.e. the community. However, while dealing with health it cannot be said that the onus of positive health outcome lies solely on either healthcare provider or on the care-seeker (as there is an array of socio-cultural, economic, psychological and other factors working) but, as noted earlier, definitely a more enhanced and empathetic involvement of the ‘provider’ eases the way for the ‘receiver’ or care-seeker, especially where the force of traditions is high.

Even in communities where modern healthcare practice has made in-roads still the level at which they should be able to bring a positive change has not been possible. Foster (1962) has pointed out that any kind of technological advancement, be it in the field of health, does not at the outset ensure rapid and open acceptance in all instances. It is so because local culture and traditions, social institutions and various psychological factors bear an impact on health, and there is no dearth of evidence suggesting the same (Paul, 1955; Foster, 1962; Foster & Anderson, 1978; Napier et al., 2014). However, how a community at large is engaged in healthcare seeking is also determined by the factors e.g. what are the available healthcare resources at their disposal, who is the ‘provider’, and what kind of health needs of the people are being fulfilled etc.

Informal healthcare providers like shaman, medicine men, healers etc. enjoy local trust, draw respect and faith of the community, and have a wider acceptance by venturing into the social space of the individuals, than an ‘outsider’ physician treating patients in a formal setting like government or private hospital or clinic. Communities having a strong hold of traditional culture find it less easy to incorporate practices which do not hold an explicit sanction of their local customs or traditions as they remain divergent from their traditional knowledge. The most detrimental impact however can be observed in the form of non-compliance or lesser inclination towards use of modern health services which affects a positive health outcome. Thus, in order to increase the level of acceptance for institutional services in such communities the role of institutional healthcare workers becomes even more important and sensitive.
Antenatal care (ANC) in tradition bound communities is one area where a greater reliance on traditional care can be witnessed (Manocha et al. 1992; Bloom et al., 1999; Chapman, 2003; Nelms & Gorski, 2006; Zamawe, 2013; Rout 2016; Shewamene, Dune & Smith, 2017; Mawoza, Nhachi & Magwali, 2019), even when a complete absence of exposure to modern medicine cannot be claimed in them. In such a situation an effective reach of modern medical practice in the community depends upon healthcare professionals, i.e. to what extent the specialist understands the local culture and whether it seems to them essential or not to incorporate local perception for better treatment and health management, and how well they are able to deal with the perceptions of people regarding illness and disease. It is so because local beliefs and practices if not taken into account or disregarded are sure to create a lack of seriousness and belief from the side of care-seekers, ultimately affecting the health.

The present paper in its content tries to explore the significance of cultural sensitivity and competence among institutional healthcare workers (clinicians) with regard to antenatal health. The paper is based on intensive fieldwork done in four villages of Bakshi ka Talab (BKT) development block of district Lucknow, on antenatal care-seeking behaviour. In-depth interviews in the form of detailed case-history were conducted with recently delivered women (RDW) currently pregnant women (CPW) and some special cases of miscarriage/intra-uterine death, and of physician advised medical termination of pregnancy. Healthcare workers in public health institutions present in the selected area and grassroot healthcare workers were also interviewed. Besides, Family members of some selected women (mother-in-law and husband), local traditional birth attendants (TBAs) and supernatural healer were also interacted. Observation was used for a better understanding of the phenomenon.

**Cultural diversity, sensitivity and cultural competence in healthcare**

Understanding of culture, cultural diversity, ideas of culture relativism and cultural pluralism have been the focus of anthropological enquiry, which anthropologists have vehemently vouched for. These ideas extend a very important perspective that cultural plurality is an essential feature of human groups which brings forth its diversity. Each human group has its own specific culture which is valid in itself with no inherent superiority or inferiority of status. Having a dominance of tradition and customs in no way reduces the possibility of any culture or community not to have best available healthcare resources at their disposal.

The idea of cultural diversity with inherent validity has a huge practical value.
While dealing with human problems of practical nature an enhanced role of technological and scientific advancement has been increasingly noted. Traditional communities, as noted earlier, experience a challenge while adopting and adapting with fast paced scientific and technological changes. Health is one domain which has immense potential for marked improvement through scientific advancements in the field of medicine and health care. However, to what extent these advancements have been able to enter into the lives of those having a traditional culture has constantly attracted the attention of social scientists in general and anthropologists in particular.

Domain of health and healthcare has over time shown to have a dominating influence of social and cultural factors across the world. Terms like ‘social determinants’ (WHO, 2020) have been widely used while taking into account the socio-cultural context of health. However, what becomes essential is to know that whether at the grassroot level social and cultural factors, cultural diversity and sensitivity are taken into consideration and brought in actual practice or not by the ‘providers’ in the delivery of healthcare services.

Need for cultural competence in healthcare has been time and again felt and reiterated in the field of medical practice, education and research. Cultural competence in health care according to Cross et al. (1989) takes into account the development and delivery of health care services ‘…in a culturally appropriate way in order to meet the needs of culturally and racially diverse groups’. The word ‘competence’ as used by them implies ‘…having the capacity to function within the context of culturally-integrated patterns of human behaviour as defined by the group’. Cultural competence strategy takes into account that cultural diversity of patients should be given due credence and be dealt with empathy so that any inequality or underutilization of health care services may be mitigated and better patient care and health outcomes may be achieved. It is an ability of health care professionals to develop a set of skills to interact with and provide effective high-quality care to patients from diverse cultural backgrounds, and to locate those socio-cultural factors that might affect the process of patient’s care and health management (Carrillo et al. 1999; Betancourt et al. 2010).

Relevance of cultural competence and culture sensitivity in providing patient-centric care remains high. It is so because when cultural beliefs and value system of the people are taken into consideration then their belief in formal healthcare system gets strengthened (Srivastava, 2019). However, Kleinman et al. (1978) assert that ‘…biomedicine has increasingly banished the illness experience as a
legitimate object of clinical concern’. They assert that unless cultural meanings of the people, their idea about illness and disease will not be taken into account by clinicians or healthcare workers while treating, till that time belief in and adherence of patients/people with ‘formal’ treatment will continue to lack vigour. It will be ‘less satisfactory and less clinically effective’ to the people as the medical logic will not be able to find its way in their understanding and thus compliance with treatment will reduce resulting in less effective outcome of the treatment (Kleinman et al. 1978). Thus, in order to improve the level of trust and interactions between the patients and healthcare workers and to improve healthcare utilization it is essential that cultural sensitivity and competency should be effectively brought into practice (Thackrah & Thompson, 2013).

Recalling the forgotten

As stated at the onset, there is an impressive ream of deliberations on the structural constraints in higher education in India. They highlight the delimiting impact of the academic bureaucracy, stultified institutional and intellectual growth among other things. It aids in understanding an unreflective, and to a great extent anti-teacher and anti-student bureaucracy, and hence non-regenerative social science. The bureaucratic authorities, institutional structure, and governing bodies are key actors and driving factors. In such a scheme, we can easily decipher an allegedly disembodied category of teacher as an unproductive or incompetent scholar. Also, there is a narrative of victimhood in which teachers are victim of market, state, and bureaucracy and the students are victims of a bad system and bad teachers, as it were. It is, however, erroneous to mistake the pawns, the teachers and students, as docile bodies.

Likewise, there is a strong liturgy of lament about the practice of sociology in the region of South Asia. Emphasis is placed on the decline in the quality and standard in sociological researches, teaching and learning. A glorified notion of ‘rigour’ underpins the two other attributes, quality and standard. Paradoxically, there has been a contemporary call for pluralising sociology, without a concrete plan or exemplars on ‘how to pluralise’. It thus is mere hobby-horse in intellectual deliberations detached from the practitioners, teachers and learners. There are many ways of doing sociology, intellectually as well as emotionally, vocationally as well as professionally, experientially as well as textually. This is where it is imperative to juxtapose the ‘diagnostic deliberations’ with ‘pedagogical pursuits’. In addition to comprehending the issues of structural impediments, arguably, it is imperative to explore the micro-issues involved in teaching and learning. After all, sociological
focus on inequalities out-there (social structure) cannot be separated from that on inequalities in-here (practices in the institutes of higher education). This divide between looking at self and the world is certainly as much a bottleneck as is the obsession with ‘buzzwords’\(^iv\). This simple idea may not persuade the disciplinary orthodoxy, and hence the preponderance of perpetual divide between self and the other plagues the sociological attention to any issue, question, and idea on the anvil of sociological analyses.

Thinking of pedagogy in the time of pandemic requires steering clear of the dominant modes and means of analysis, and returning to the reasons why scholars resist the invitation to become pedagogues. This need not amount to falling back on the famous ‘call for indigenisation’. Much water has flown over the call for indigenisation. But behind such a call there were significant intellectual-polemical stimulus that ought to be retrieved. One such insightful observation is about ‘captive mind’ (Alatas, 1972) that was aimed at revealing the intellectual laziness of those who seldom question the content and methods of knowledge-transaction. The calling out of captive mind also aimed at incorporating the local-contextual social thoughts in the curricular and pedagogic practices of teaching and thus responded to ‘academic dependency’ (Alatas, 1993). This was not to debunk theories, which emerged in the European context; this was however to debunk the uncritical emulation of European theories. These issues, of epistemological significance, are crucial for a context-sensitive disciplinary scholarship (research, curriculum, knowledge-production and dissemination).

In this light, the backdrop of pandemic compels for a rethinking about the course-curriculum and pedagogy. Perhaps it has been much easier to talk about these and other such issues in a manner of intellectual deliberation than perform it through a curriculum, let alone pedagogy. The task becomes much more challenging when skepticism about the engagement with the contextual particularities is expressed through the phrase of ‘methodological nationalism’, an intellectual apprehension that sociology of particularities will be a compromise on the ‘universal-cosmopolitan’ characteristics of the discipline. It takes the notion of indigenous with a pinch of salt to suggest that it is a discursive product loaded with colonial legacy, orientalist approach, and idealism of nation-building in post independent countries \(^v\). The students along with teachers spontaneously resort to the local/contextual while engaging with the textual, in a pedagogical plan to render teaching and learning into a context sensitive endeavour\(^vi\). A life-threatening situation of pandemic makes this endeavour even more like an existential necessity.
And hence, the following section elucidates a possible phenomenology of pedagogic pursuits in the context of pandemic. It is not merely about online education, instead, it is about how playfully teachers and students alter the given.

**Pregnancy and the local rationale on antenatal care**

In the selected area pregnancy is believed to be a special state and a highly vulnerable phase in a woman’s life. It is believed that proper care should be taken during this phase to avoid any complication. However, there remain some who believe that pregnancy becomes a special state requiring attention only when some health issue arises. Another commonly held belief in the area regarding pregnancy is that even though attention and care is required to avoid any complication still it is not a disease or a sick state as no matter how much care is taken each expectant woman faces some or the other problem at some or the other point of time in pregnancy because of associated vulnerability.

Any problem during pregnancy is either identified broadly as a physical problem or a supernatural affliction e.g. god’s fury, bad dreams, evil eye, spell bound air (*shaitani-saaya*), or any supernatural misery caused by an adversary etc. Accident cases are also resigned to supernatural cause on most occasions even if resorting to medical care. In normal course, in order to avoid any adverse situation both medical and supernatural care is sought as a preventive measure.

Risks, threats and dangers signs associated with pregnancy are not overlooked but which problem or condition is considered to be a risk or a danger sign is uniquely defined in the area which on several occasions is different from the medical perspective e.g. haemorrhage is one important locally identified danger sign but largely explained with a supernatural logic. Treatment sought by locals could either be only supernatural i.e. visiting a *naut* (indigenous/supernatural healer), or a combination of supernatural and medical care depending on how at individual/household level the problem is interpreted. In very few instances the treatment sought is limited solely to medical care.

Local knowledge on pregnancy related risks or danger signs is cumulative as it is based on traditional beliefs and practices passed down over generations as well as understanding gained from exposure to modern medical practices (over the years) focussing on institutional care at grassroot level, due to the role of state. However, in the selected area the biggest source of information on danger signs or risks or even general antenatal care is still a person’s family and informal social network and only secondarily any healthcare worker. It is here that traditional knowledge
gains an edge.

Treatment or care sought for any problem depends upon the nature of the problem as understood. Preventive and curative care both form an important aspect of total pregnancy care in the area. For it, locals take the route of both formal as well as informal domain as what is most desired is best possible care, according to one’s capacity, for the unborn and the expectant woman. Any compromise on the belief pattern is not preferred. Formal institutional care includes both public and private sector but predominantly public health institutions. Informal pregnancy care includes folk and supernatural healers, traditional birth attendants (TBAs) along with an individual’s family, extended kinship and social network. As local culture is bound by traditions so informal domain of care has a dominating influence over how pregnancy will altogether be managed. However, individual experiences, socio-economic condition, access to health care resources also influence the course of care-seeking.

Significance of sources of care during pregnancy besides bio-medical care e.g. local healer, herbalist, TBA etc. form the psycho-social support of the people. A supernatural or indigenous healer is able to describe a problem based on day to day events and nature of social relations of individuals (at the levels of kinship, neighbourhood and community) with an inherent supernatural rationale about the problem being faced. Such explanations are contingent upon various human emotions of jealousy, hatred etc. (Horton, 1967). They treat any problem or provide preventive care during pregnancy by incorporating total social life of the care-seeker which is mostly absent during a consultation with any medical specialist.

Thus, in the selected area the entire perspective surrounding pregnancy and antenatal care is holistic in nature considering it not only to be a physiological condition but also a bio-psycho-social reality, with a strong influence of informal domain of care.

Understanding cultural competence in antenatal care: local view vis-à-vis medical view

In the selected development block, over the years, extent of institutional healthcare services has increased. Over here public as well as private health institutions are present. Major public health institutions include six primary health centres (PHCs), three community health centres (CHCs) and one district combined hospital (DCH). Of them, CHCs and DCH are the main sources for seeking institutional ANC services. At the grassroot level, auxiliary nursing midwives (ANMs), anganwadi
workers (AWWs) and accredited social health activists (ASHAs) form the main institutional healthcare force delivering services through *anganwadi* institution.

Preference for public health institutions for ANC services remains high in the area as they are free and affordable. Thus, majority of expectant women have a higher exposure to public health facilities and only on lesser occasions or during some emergency a private facility is sought. However, what is important to note here is that the experience at the former is considered less satisfying. This adds up to the need for the effort for understanding what factors are responsible for it.

Local women assert, as noted earlier, that most of the information regarding pregnancy and its associated care throughout is received from some senior female either from own family or extended social network. However, information on TT vaccination or ANC visits in general is given to them by grassroot health care workers. At the village level, village health and nutrition days (VHNDs) are organised in which the expectant women have a chance of interacting with ANM besides ASHA and *anganwadi* worker (latter two being village based) while making the antenatal visit, but visits made to CHC/DCH and interaction with doctors/physicians is always held in high esteem and given more importance. This remains so even though interactions on most occasions are considered not satisfactory. At local PHCs the level of ANC services are not up to the recommended level.

What is unique about these ANC visits made to CHC/DCH is that they are time consuming but the time of interaction with doctor for consultation is very short and impersonal in nature. The doctor prescribes required tests, reports of which after being conducted are taken back to them for consultation. Although exposure to medical procedures have gained a wider acceptance in the area but the kind of interaction between an expectant woman and the doctor is believed to lack a sense of familiarity and an association which women rather feel with grassroot healthcare workers or TBAs (or any local elderly lady providing such services with experience) or in alternative course with a local supernatural healer/herbalist. The reason for a high level of formality with a doctor is vividly explained by local women.

Except in few cases, nearly on all visits ASHA accompanies the expectant women for consultation with the doctor, as a part of her institutional duty. Explanation of the case is sometimes preferably taken from ASHAs by the doctor as the former is able to explain it in common medical terminology. During a consultation session a doctor takes the medical and obstetric history of the expected women, does physical
examinations as required and asks about any problem or difficulty being faced, as a part of routine examination. Enquiry about detailed medical and obstetric history as well as any problems being faced is the most important and sensitive aspect of interaction between expectant women and her physician. It decides the nature of interaction between the two and also the level of satisfaction of the former.

History taking, as noted in the field, even though an important step is the most affected aspect of interaction between an expectant woman and the physician. Many local women reported (when details of obstetric history were collected by the researcher) that they skip giving the exact number or details about their past miscarriages or still births which they believe happened due to some supernatural affliction or even fear or bad dreams. It is so because doctors do not buy their explanation and believe that such beliefs are ‘irrational’ and cannot be taken as explanation for any adverse obstetric condition like miscarriage or still birth. On certain occasions they are rudely dismissed. For locals their beliefs hold immense value as they find it valid based on their traditional knowledge. Thus, in order to avoid any embarrassment, women prefer skipping the details at times.

Similar is the case with enquiry about any problem being faced e.g. abdominal cramps or case of mild haemorrhage etc. In these events even though a doctor may be consulted but for some the first resort is a local naut or a TBA in whom they instil strong faith as these illness episodes are on most occasions believed to have a supernatural etiology. If a consultation is made with a doctor and they ask about the perceived cause from the women e.g. whether any heavy labour done or weight lifted or improper food or medication taken, many a times the latter falter as some remain unclear and those who have a clear idea about the reason remain reticent at times because they believe that they would be verbally reprimanded by the doctor and be held responsible for negligence.

On the other hand, reasons for any problem being faced, if explained according to the traditional beliefs of the people (having supernatural explanations) offend the doctors. It is for this reason that doctors prefer an ASHA to be always present with an expectant woman during consultation. Bad dreams, which are locally considered to be an important cause of concern during pregnancy hold nearly no significance to a physician. Thus, any perceived problem related with pregnancy which is explained through a supernatural etiology with no apparent scientific explanation lack relevance to a physician. Locals believe that physicians show less sensitivity and understanding towards their traditional beliefs and cultural knowledge. This does not allow them to have increased familiarity with the latter. What a local healer
does is, capture social relations and life of the individuals, rest it upon psycho-social analysis and provides treatment with use of some medicinal herbs, talismans, acts etc., which seems a ‘holistic’ treatment for the problem and holds value to locals.

Besides this, a detailed institutional counselling on danger signs or general problems at large is not present. It is not so that counselling is not done at all but as the duration of the time of consultation with the doctor is short because of high patient count so the information received is less and more general in nature. At the grassroot level also no serious initiative is taken to adequately counsel the expectant women before-hand. Thus, the total local view regarding pregnancy and antenatal care which is believed to be holistic in nature is not catered to at public health facilities.

Doctors at the local public health institutions, on the other hand, provide their take on the scenario. They remain of the view that they are totally invested in providing proper medical attention to the women coming for antenatal visits. They assert that there remains a shortage of time of interaction with these women as the patient count in CHCs and DCH is very high. Giving extensive consultation time to a single patient/woman would affect the services to be given to other antenatal attendees who take out time especially for these visits and come to the hospital. Their focus remains more on providing essential ANC components to the attending expectant women as making another visit soon is not easy for many. Doctors take a more diagnostic and practical approach where for them attending the expectant women with a proper medical diagnosis and treatment is important.

Interactions with expectant women, according to doctors, shows huge variation as they come across ANC attendees with varying level of educational qualification and socio-economic background. However, what remains a common point according to them is that the beliefs of locals are tradition bound and not based on scientific laws.

For doctors it is any physiological condition that has to be treated as that could affect the health of both mother and unborn. They do not delve deep into enquiring the social relations as a local healer or a village level dai (TBA) would do. This leads to lack of proper handling of some important antenatal concerns at the institutional end e.g. dread and anxiety associated with pregnancy. Lack of proper counselling on it leads to continuous interpretation of it as a supernatural concern for which care and support of local healer and informal social network is sought. Cases of dread or anxiety perceived due to bad dreams are not taken to any physician. It is commonly believed that a physician can do nothing about it, rather
in certain instances they are taken to the naut. In this regard Foster and Anderson (1978) opine that ‘alternate’ forms of medical care fill the gap of psycho-social support during pregnancy in the lack of proper institutional intervention in this domain. Thus, women are not able to take the advantage of modern medical practice during instances when proper institutional counselling could help in alleviating pregnancy related anxiety. This can be done by clearing all the doubts through scientific explanations empathetically by a physician.

Not only cases of illness episodes but general counselling on diet etc. is also not considered very satisfactory by local women, who believe that doctors mechanically advise about diet and rest during pregnancy. They don’t ask about their family or social conditions, household (or other) responsibilities etc. They just prescribe a diet and if in the next visit the concerned marker/condition (e.g. Hb level) does not improve then they are scolded. Women lament about the less empathetic antenatal consultations at public health facilities. They believe that the entire responsibility of their pregnancy health is put over them which is not at all in their hands as they are predominantly financially dependent besides having to bear the brunt of existing patriarchy.

In private health facilities the patient care is believed to be better than at public health facilities still incorporation of local beliefs and values is lagging in these facilities also, the only difference being that ‘they are listened to’ i.e. women believe that women and their family have a still better chance of communicating their issue (than in public health facilities) but acceptance of their traditional beliefs is less in private facilities as well.

**Conclusion**

Sensitivity for and understanding of local cultural beliefs and practices is the key for providing quality healthcare. Lack of competence among physicians in incorporating cultural specificities of people during treatment not only results in reduced adherence with medical treatment by the latter but also lowers the level of their trust in institutional care.

Cultural competence increases the possibility of having a better understanding of the total condition a patient is in, factors responsible, and how and to what extent local culture is influencing a patient’s health. This helps in providing a patient-centric care to care-seekers and also helps in counteracting any locally held belief against the modern medical practice in a culturally sensitive way which may have the potential of adversely affecting a person’s health.
In order to be culturally competent, as Betancourt & Green (2010) emphasize, ‘a buy-in is critical’ from clinicians, meaning that only when they believe in the value of local culture and traditions and its impact on quality healthcare then only they will be able to incorporate it in their practice. It becomes essential that clinicians are made to understand ‘emic’ view about health, disease and illness in general and pregnancy in particular in the present case through advanced training so that locals do not attribute lesser weight to the significance of institutional care. This paper is developed through the field encounters of my doctoral research, where I am exploring the embeddedness of mobile phones in the everyday life of the people staying in the labour lines of a tea plantation in Assam. The rationale behind choosing tea plantations was to locate the ubiquity of devices like mobile phones in the daily life of tea garden labourers and their families who were historically kept isolated. The reason for using the ethnographic method was to see the mobile phones in a holistic way and not reduce to the technology itself (Horst & Miller, 2006, p.11) and delineate the experiences of the people instead of defining them by standardised and imposed measures (Slater, 2013, p. 11). Also, the mobility aspect of the handheld device made it important for me to observe and participate in the everyday. Ethnographic studies call for a prolonged stay in the field where the idea is to immerse into the life of the people being studied.

Getting access to the field is the first and the most crucial step. The problem in getting access to the field, reveals the nature of the field, it provides insights into the social organisation of the field (Hammersley & Atkinson 2009, p. 41) in my case it is the institutionalised set up of the plantations. Plantations are colonial enterprises and still bear semblance to it. The sociocultural and political distance of plantations creates a unique cultural history of itself (Chatterjee, 2001, p.5). They present an interesting contradiction, on one hand they are embedded in the socio-economic realities of the region they are located, on the other hand, there is a clear distinction from it (Banerjee, 2017, p. 11). The present day labourers are the descendants of the indentured migrant labourers brought by the Britishers from Central India. The labourers were forced to stay in the housing lines irrespective of their social and ethnic background, the labourers were under constant surveillance and all aspects of their daily life was disciplined and controlled, and had very little or no contact with the outside world (Sharma, 2011; Behal, 2014). Over the years the management has become lenient, it became evident during my fieldwork too. Dwindling production and lack of work in the tea garden has forced more and more people to go to the nearby town and villages. However, still very restricted number of outsiders visit the plantations, and the entry to the labour lines
Taking the issue of access as the central theme, this paper focuses on four aspects of my ethnographic research in the plantation. First, I will describe the challenges I faced in getting access to the field. Secondly, I will describe how access is not permanent but has to be negotiated all along. Thirdly, my personal attributes and multiple identities with the community remained crucial to my access in the lines where I lived, observed and participated in daily life. Fourth and lastly, I will elaborate how access shaped my study and helped me focus on the ‘everyday’ in plantations which includes both work and social life. My research is not limited only to the labourers but include their families too. I contend that as an ethnographer, it is imperative to be open to the challenges and let it shape the study instead of going with some rigidly held notions about the field and line of query.

Gaining access: pre-field reflections

With the initial aim to capture the nuances of mobile phones in tea plantations, I started exploring ways to get permission to conduct my field study. I chose the district of Sonitpur in Assam, given my familiarity and the contacts I had in the tea gardens located there. I spoke to one of the Assistant Managers of a tea garden over the phone (10th October 2017), he asked me to write to the Manager. I clearly stated the purpose of my study and sent the necessary documents in the email, duly acknowledged and backed by my supervisor to the manager. However, I did not receive a reply. I also wrote to authorities of the various tea gardens located in Sonitpur. All my attempts to get access had failed. In the meantime, I met one of the managers of a tea garden (10th January 2018). He checked the application in his computer in my presence. He allowed me to visit the tea garden for a few days. However, I was not allowed to visit and meet the labourers on a regular basis. He remarked sarcastically, “Even I want to know how people in the tea garden use the mobile phone, as they are not educated enough and I have seen them using”. The manager further asked me to contact the Assam Branch of Indian Tea Association (ABITA). I visited the office of the Tezpur Zone of ABITA and met the Zonal Secretary (11th January 2018). He told me being a ‘local’ woman, I should not have faced any problem in having access to the tea gardens. However, for the last 5-6 years, the tea gardens are apprehensive about allowing researchers to conduct studies inside plantations. He said researchers in the past have misused the access given by the gardens, leading to a negative impact on the image of the tea companies. He also spoke about the need to strengthen mobile phone network inside the gardens as it would also facilitate management activities in the garden.
During my fieldwork later, I found that despite poor network, most of the families have at least one mobile phone in the household. However the labourers say mobile phone was not needed for the work in the tea garden, rather it was mostly used by the people who go out to the nearby town and villages for work. I was also asked to contact Guwahati and Kolkata Office of ABITA and other associations like Tea Association of India (TAI).

In the meantime, I got permission from one of the biggest private individually owned tea company in Upper Assam. The owner told me they would extend all support and would allow me to conduct my study in one of their tea gardens. However, given my own experiences in finding access as well as based on the advice of my doctoral committee, I decided not to go through the owner as it might narrow down my perspective. The means through which we get access to the field affects with whom we can speak to and how the participants respond (Reily, 2009, p.5). Given my own experiences in getting permission to conduct the study and after consultation with my doctoral committee, I decided to enter the field through a Community Radio station based in Dibrugarh. The radio has access to the tea gardens. I joined Brahmaputra Community Radio Station (BCRS) popularly known as Radio Brahmaputra as an intern, assisting the community producers in conducting their live programs and also helped them in creating awareness on socio-economic issues.

**Entering the labour lines as an intern**

Access to the field remains one of the major challenges in ethnography, from entering the field to building rapport, problems related to access remain throughout the data collection process (Hammersley & Atkinson 2007, p. 41). After contacting the station manager of the community radio over the phone, and sending him necessary documents, I first went to conduct a pilot study in the first week of April 2018. I visited a few tea gardens with the help of Radio Brahmaputra community producers and assisted them in conducting and recording radio programs. I selected two tea gardens based on the access and the rapport that I developed by visiting the tea garden multiple times during my pilot study. The purpose of selecting two tea gardens was to compare and contrast and find out how the distance with the town leads to differences in adoption and adaption of mobile phones by the people staying in the tea garden. With the help of the community producer and station manager, I fixed a house in one of the labour lines for my stay. I realised while the study was a priority for me, and all my endeavours revolved around it, when I came back after a gap of two months for my prolonged field study, access has to be
negotiated again. I believe that the authority of the station manager might have forced the community producer to agree to my field visit and the stay. When I came to the field for a longer stay in June 2018, it took me considerable time to convince the host family in the labour line. In the meantime, I continued to visit the tea garden along-with the community producer and with other people from the radio station to build contacts. The problems and the time constrain made me revisit my proposal and rethink my approach towards the study, and I decided to restrict my field to just one tea garden.

I was in the field between June 2018 to February 2019, and stayed in one of the labour lines between September 2018 to February 2019. During my stay, I came to know why the family was at unease when they came to know that a woman from Guwahati is going to stay at their house. There was also a wedding in the house, they discussed among themselves for many days, how a woman from Guwahati can stay with them with minimum facilities? Finally, after the wedding, they agreed to my stay. The woman in the host family in the line was one of my key informants, she was a sardar (garden supervisor). She happened to be the first woman sardar in the tea garden where I conducted my fieldwork. On Sundays, she used to take me to the various lines and made me familiar with people in positions like sardar, line chowkidar (watchman) and few families of the labourers. After visiting once with her, I used to go the lines alone and visit the households on my own. Also, since I had visited the lines with the people working in the community radio, few young men and women were already known to me with whom I exchanged phone numbers. My rapport with the community producer who also hailed from one of the tea gardens and my stay at the woman sardar’s house was crucial in my acceptance at the community level.

Insider and outsider

In ethnography the key instrument to data collection is the researcher herself. I had two experiences in the field, which made me realise how my social background and personal attributes were crucial to my access to the plantations. During the initial period of my fieldwork (June 2018), there were two interns at the community radio hailing from Delhi, intrigued by the exotic nature of the tea plantations which they were visiting for the first time. They decided to go on their own and start clicking pictures during working hours. The field manager noted, and the Assistant Manager was called in. They were asked to give the camera and destroy the pictures. On one hand, this instance made me exercise caution during my fieldwork and I made sure my activities don’t disturb the labourers during the working hours. On the other, it
reminded me of my familiarity with the field, the difficulties I faced in getting access to the field, and the field for me was not exotic and was part of my growing up. The second instance happened during the last leg of my fieldwork, in February 2019. I met a researcher from one of the public universities in India. She also hailed from Assam, but she was of different ethnic origin. With the help of the community radio, she visited the field for a week. After seeing the problems in getting access to the people and management, she abandoned the idea of researching the people in the plantations. Later while conversing with me, she assumed how her ethnic background, which has a history of conflict with the people she intended to study, could affect her fieldwork and prevent her from getting an insider perspective.

The ethnographer’s role is to socialise with people and community they are studying, the idea is to gain both ‘emic’ and ‘etic’ perspective (Fetterman, 2010, p. 11). If the researcher is studying an unfamiliar setting, it might take time to mingle and gain insider perspective, while if the researcher is studying their own community there is a chance that they might miss certain aspects. The community, I am studying is not the one I belong to, at the same time being born and brought up in Assam, it is also not a community, that I am completely unfamiliar with. Growing up in a village in Sonitpur district, living around three to four kilometres away from a tea plantation and surrounded by ex-tea garden labourers, it was not a completely ‘unfamiliar setting’ neither it was ‘home’ as my interaction and understanding were limited. I was aware of the morning factory siren, the noon siren, the evening siren and also the sound of the clock pendulum inside the tea garden indicating the bagaan (garden) time that is 1 hour ahead of Indian Standard Time. The sound of the films that were screened during Durga Puja and Diwali, everything was audible, however, it rings more in my ears now when I am studying the lives inside the tea plantations. Therefore, throughout my ethnographic journey, a sense of self-reflexivity allowed me to evaluate my own position.

Besky (2014, p.35) argues that it was her familiarity with Nepali language and her appearance that she could just walk in the Darjeeling plantations during her fieldwork. My own identity as a Bihari married woman and familiarity with Sadri language was quite pivotal in building rapport with the people. Given my own background, there was no major make-over that I needed especially for the field stay, however, I made sure that I look married by wearing the symbols of marriage like sindoor (vermilion) and bindi (coloured dot worn on the forehead mostly by married women). These symbols remained the first point of query for the people whom I was meeting for the first time. The second line of the query was for how long I have been married and whether I have children. Being married helped,
especially to mingle with girls and married women and it also gives a sense of security in unfamiliar surroundings (Coffey, 2009, pp.79-83). Though one of the queries was, how can my husband allow me to stay with strangers? For the women in the tea garden, even going to their relatives' house is very restricted and if the wife tends to stay out for long, I was told, she will be looked with suspicion.

Being a female researcher, I had access to women gossips, their warmth and affection. They confided in me and shared about their mother-in-laws, their natal homes and the day-to-day problems they face in the plantations. Also, few young men and women, who were either studying or were literate to varied degree remained very accessible to me and helped me in conducting interviews and discussions. The young people being the avid users of mobile phone remain the most interviewed group. From being an intern at the Radio Station during initial visits to the field to being referred to as gotia (guest) both these identities led me to engage with the community at various levels.

**The ‘everyday’ and the labour lines: concluding remarks**

The plantations are unique spaces, which are both the work and living spaces for the people staying in the lines, so when I say the field, the field for the participants is the place where they both live and work. As mentioned previously, the difficulty I faced in accessing the plantations made me restrict my study to just one plantation. It made me to look at the social life of the labour lines and how the spaces are produced and reproduced, taking the labour lines as the unit to understand the plantation. Further, my study included people across age groups and not only the labourers who work in the tea garden but also the retired labourers, other people who work as daily wage labourer, teachers, the young students. As the study progressed, I excluded the managerial perspective and instead confined myself only to people staying in the labour lines, which included the majority of the people, the labourers, the sardars, and the chowkidars.

The everyday life was central to my study, the motive was to consider the everyday communication activities and locate the mobile phone in that. I preferred observing the everyday life in the labour lines, where economic life is interlaced with the social life. I did not want to interrupt the working hours as the tea pluckers got paid more when they plucked more leaves. What then exactly constituted participant observation in my field study? In my case I stayed with the people I was studying, I lived with them. I participated in their everyday life by cooking and eating with them or by visiting the market. The embodied ethnography led me to observe and participate in the everyday life of people staying in the lines, their festivities. Even
when I stayed in the line, it was not easy to conduct interviews and discussions as both men and women used to go for work, women were mostly busy in tea garden work and domestic chores. The labourers come to their house after day long work. I was advised not to venture out after it gets dark. The school going and college going students were also not available during holidays as they go to the town to work as daily wage labourers. Besides, as most of the people did not converse much with people outside their lines or the garden, they were often left bemused with my queries and I had to ask in many ways. It was mostly during the winter season (December 2018 to February 2019), that I was able to conduct interviews and discussions, as there is not much work in the tea garden. On working days, I visited the Anganwadi centres and schools as the labour lines mostly becomes empty with only very young children and elderly people staying at home. The access to the households and the various events and functions taking place in the households and the lines provided me with deep insights which I would have missed had I not stayed there. The mobile phones while deemed very important for emergency situations mostly lie at the periphery of the daily lives. Every line is an entity in itself, after the family, it was line affiliation that matters.

The institutional nature of the field called for a sensitive approach in conducting ethnography, it influenced much of my research methods. I was immersed in the field for 8 months, continuously reflecting on the life inside and outside the plantation. While the community radio helped me in accessing the tea garden, later it was my engagement with the community that helped me in carrying out the study. The purpose of my research initially was to focus on the role of the mobile phones in the everyday life of the people staying in the plantations but as the research progressed and I delved deep into the literature and immersed more into the field, I noted one missing aspect of the plantations life in the available literature, the plantation labourers are often looked through the lens of backwardness and marginalisation, the everyday details remain missing from accounts. Most of the studies are either quantitative or collected from tea pluckers while they are at work in the tea garden, the access and the acceptance of the community makes my work go beyond their working life and attempts to bridge the gap between the working and social life. The homogenous construct gets destroyed when we look into the details.

\[1\] In 2014, a report titled “The More Things Change: The World Bank, Tata and Enduring Abuses on India’s Tea Plantations” was released by Columbia Law School’s Human Rights Institute. The report depicted the poor living conditions inside the tea plantations of Assam and West Bengal. The report can be accessed at
ii The name of the tea company, tea gardens has not been disclosed for ethical reasons. Even for the tea garden under study I am using pseudonym.

iii Community radio is basically a radio station where local people participate and produce their own programmes. The radio caters to local information needs, address social issues.

iv BCRS is the first non-commercial community radio station of the north-east India. It was set up as a part of the Centre for North East Studies and Policy Research (C-NES). Since 2009, the radio station caters to the information and communication needs of the people staying in the tea gardens, river islands and other villages and urban slums located nearby Dibrugarh. BCRS is located in Maijan Borsaikia village near Paltan Bazar, Dibrugarh.

v For those who go to study and work outside, the garden time has become obsolete. However, for the tea garden labourers especially women it still holds importance and they adhere to that for their daily routine.

vi The language has its origin in Chotanagpur plateau, it acts as a connecting link between the people belonging to various castes and tribes staying in the tea garden, who are originally from diverse background. As a Bhojpuri speaking person, I understand the language.

REFERENCES:


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