**Anecdotes from Bangladesh:**

*A Look at the Intersection of Culture, Gender and the Documentary Process*

By Ora DeKornfeld

In summer 2013, I travelled to Cox’s Bazar, Bangladesh to visually document one woman’s experience with obstetric fistula. I spent three weeks in Bangladesh, filming daily life, conducting interviews and upon my return, editing the footage into a short-form documentary film in which I attempt to convey the personal journey of Anawora, a fistula patient. Initially, the purpose of this paper was to cultivate a space in which I could 1) reflect on my experience in Bangladesh and 2) analyze gender disparity, racial power dynamics and cultural norms in Bangladesh through the lens of the documentary process; however, as this written reflection evolved, the paper became equally about understanding and challenging the limitations of the documentary process itself. Informed by a concrete journalistic code of ethics, I had made assumptions about what the documentary process necessarily has to be. Consequently, during the making of the film, I found myself constantly redefining and questioning what documentary can be while simultaneously reassessing how truth fits into that equation. By taking my skillset and applying it in the field, I tested my assumptions of what I believed the documentary process to be with the reality of how the process transpires and takes form when confronted with a foreign culture. I encountered numerous obstacles that challenged my moral code in a journalistic sense but also on a personal level. In almost every case, these obstacles emerged from my failure to fully anticipate the impact of Bangladeshi gender relations and cultural norms on production. In my mind, these obstacles were preventing me from getting to my story. I wanted to tell the story of a Bangladeshi woman named Anawora and her experience with obstetric fistula, a hole between the birth canal and one or more of the adjacent organs. I felt as though I was crashing into the organization of culture surrounding the specific story I wanted to tell. Upon further reflection, I realize these obstacles *are* part of the story-- both Anawora’s story and the broader narrative of Bangladesh. In the finished documentary, I attempt to show the context of culture in order to both orient the audience in this world and represent reality as I experienced it. In this reflection, I’d like to share some anecdotes that are representative of moments when I reassess my methods and expectations.

**Context**

My relationship with the issue of obstetric fistula begins in Africa a year before the start of this production. I first learned about obstetric fistula on a trip to Malawi while travelling the country with a team of documentary filmmakers. On this trip, we spent a day in the University of North Carolina at Chapel Hill Bwaila District Hospital which at the time, was in the process of opening a new fistula unit. When the lead surgeon explained the condition to us, I was equally horrified by the condition as I was by my ignorance of its existence. The World Health Organization estimates, at least one million women are living with fistula worldwide and that 50,000-100,000 women will develop obstetric fistula each year. Despite these staggering figures, most people in the developed world have never heard of such condition-- I certainly hadn’t. Although this condition was once ubiquitous in Europe and North America, it is now virtually eradicated in these places[[1]](#footnote-1). Poverty is the main underlying cause of fistula. Countries that lack access to education, developed infrastructure, emergency obstetric care, trained birth attendants and gender equality have much higher rates of fistula. This medical condition is crippling both physically and socially; these women experience uncontrollable and constant leaking of feces and urine. Consequently, the issue is surrounded by great shame and stigma. No longer able to have sex, bear children or work, they lose their ability to fulfill their social roles, commonly leading to divorce, abandonment and early death, sometimes by suicide. The issue of obstetric fistula is complex both in how it develops as well as its social and economic ramifications. Obstetric fistulas generally occur after days of obstructed labor. A woman experiences obstructed labor when the baby’s head cannot pass through her pelvic bone. The mother’s soft organ tissue, trapped between the hard surface of her pubic bone and the baby’s head, will deteriorate after several days due to continuous pressure. In 90% of obstructed labor cases, the baby is stillborn and the woman is left chronically incontinent[[2]](#footnote-2). I believe that because these injuries are pudendal and affect the most powerless members of society, the issue is both shamed from conversations in the communities where it is prevalent and underrepresented in the international human rights community.

The women afflicted by this injury do not have a voice in the media; their story is not being told. Making an issue visible is one of the most effective ways to raise awareness. I operate on the assumption that audiences become intimately linked with an issue when they can see the face of a subject telling her or his own story in her or his own voice. Fistula remains a relatively hidden problem because it cannot be shown photographically. While it is not uncommon to see advertisements of teary-eyed children with cleft lips, the taboo of showing vaginas in the media and the pornographic association of such images makes it impossible to use the same approach with fistula. In my video, I leverage the power of story to circumvent that which cannot be shown.

While there is little conversation surrounding the issue of obstetric fistula, what little exists is discussed in a Sub-Saharan context. I wanted to expand that conversation. I began researching the impact of fistula in South Asia, the region with the second highest rate of fistula. As I learned more, the scope of my research narrowed. I began to have pressing questions about what fistula looks like within the Islamic context. The issue of women in Islam is complex but I believe that looking at one story can provide some insight.

As I continued to research, I connected with the Freedom from Fistula Foundation which has partnered with the HOPE Foundation for Women and Children, a clinic in Bangladesh. HOPE Hospital is located in southern Bangladesh, a region with the highest rate of maternal death and injury in the country.[[3]](#footnote-3) Southern Bangladesh is largely rural and has poor access to healthcare. Although obstetric fistula is the most common birth injury in this region, HOPE is the only clinic in the area that offers fistula repairs.

After learning more about this issue, I was left with a sense of urgency to give these hidden women a voice by providing them with an outlet to share their experiences and a platform to perform their narratives. The documentary is equally about empowering these women to tell their stories as it is about remediating and sharing their stories with an audience at home. For this reason, I rejected the standard issue-driven documentary approach wherein I would give the audience a comprehensive understanding of the issue at large, filled with statistics, trends, and expert interviews. I didn’t want to create a video where others told the story of fistula. Instead, I sought to create a character-driven documentary where a single woman could share her story. I believe that by portraying the personal and human side of the story I was able to inspire an understanding of and sympathy for the issue at large.

**On the Ground:** *Obstacles & Insights*

Three months later, my production assistant (who is also my sister) and I were on a plane headed from Dulles to Doha to Dhaka. When we landed in Dhaka, I was immediately struck by the viscosity of the air, saturated and heavy with humidity. The large airport windows were fogged with condensation as if we had landed inside a sweaty water bottle on a hot day. The last leg of the trip was an Emirates Airlines flight from Dhaka to Cox’s Bazar. The rickety 40-person plane was outfitted with once bright purple and yellow seats. We took off without any sort of safety briefing or video and enjoyed a turbulent ride to the South.

Hasnain Nayak, the COO of HOPE Hospital, collected us at the airport. As we speed out of the airport’s dirt packed parking lot, I was immediately struck by the chaotic traffic and the swarms of men. Though I have travelled extensively throughout the developing world, the Bangladeshi traffic was unlike anything I’d ever seen before. I felt like we were in a videogame where the goal was to get to HOPE hospital as quickly as possible while swerving potholes and dodging the frenzy of cars, rickshaws, bicycles, cows, dogs and other farm animals. All this despite the road being the width of a one-way road in the US. The second thing that caught my attention was the absence of women. The dusty paths that lined the streets were filled with dense foot traffic-- but everyone was male. My sister turned to Hasnain and asked, “where are all the women?” Hasnain met her comment with a look of amused confusion. “What do you mean ‘where are they?’ They are there,” he said, ushering out the van window. We looked but didn’t see any women. We resumed small talk when suddenly Hasnain begins wildly pointing out the window. “See, there’s a woman!” he says. I look to find a small woman, totally covered with the exception of her eyes, carrying a large canvas bag in one hand and holding the hand of a child in the other as she adeptly navigated through a sea of men. It was immediately evident that gender relations here are more pronounced than I had anticipated. Men dominate the public sphere. This instilled a fear in me. In order to make the documentary, I had to travel and navigate the public sphere and in so doing, I transgressed these gendered boundaries. The dominance of men heightened my awareness of my gender and acted as a constant reminder of how vulnerable I was.

We make a right turn off the main road and roll up to a dusty patch of dirt outside of HOPE hospital where we are greeted by Dr. Shoaib, the CEO of Hope Hospital. My sister points out that Shoaib is a less goofy but equally ridiculous, Bangladeshi version of Michael Scott from the NBC sitcom, “The Office”. Like Scott, Shoaib loves to be included, randomly inserting himself into others’ conversations to assert his authority. He is short, only about five feet tall, and his grey moustache complements his tidy Henna-dyed maroon hair. Shoaib has a plastic doorbell on his desk which acts as a makeshift intercom. Every morning Shoaib calls us into his office for tea and logistical planning. To order the tea, Shoaib uses his intercom system to summon one of the two young kitchen girls. The minor oversight in the intercom’s design is that it’s not connected to anything. The battery-operated, plastic intercom is not unlike something you might find at a Dollar Tree. It makes a generic doorbell ring that can only be heard when standing within ten feet of the device. As a result, the girls almost never hear the bell. After we finish our milky tea, we relay our plan for the day. No matter the plan, Shoaib suggests an alternate plan, which sparks a 45-minute back-and-forth during which we both talk but never seem to understand one another. Typically, around minute five, my sister disengages and journals in her travel book, while I am left to struggle through the litany miscommunication. Miraculously, we usually end up back at my original plan. The whole interaction typically takes just under two hours.

The Shoaib routine is just one example of the many cultural disconnects I confronted every day of production. Cultural and language barriers, in addition to my own western expectations, lead me to question whether anything was being communicated at all. I had expected to work in conjunction with the hospital. Instead, I found Shoaib and his coworkers had their own ideas about how the documentary process should go. Every step of the way, I had to convince them of the validity of my plan. This added a bureaucratic element to the process, diverting time and energy away from the creative part of the process.

**Detained:** *An Introduction to Miscommunication*

After a brief tour of the hospital, we made our way to the hotel and collapsed into the kind deep sleep that’s only possible after travelling for two days. The next day, I woke up with a fever. I told the hospital I would not be filming that day. I slept the entire day and through the night. The next morning, I felt considerably better. After our usual song and dance with Shoaib, we were passed off to a nurse in the patient ward. “The patients were supposed to leave yesterday but we detained them so that you could film,” the nurse informed us cheerfully. I had the same feeling I get when my dog brings me a dead squirrel*—* her eyes expectantly awaiting admiration for her good deed. It was clear this woman was very happy that she was able to help us but it felt so wrong to detain the patients against their will. I couldn’t believe that these women had been recovering in this hospital away from their families for 30 days and now it was going to be 31 days because of *me*. I explained to the nurse that it was not necessary to “detain” the patients for my benefit. I felt very uncomfortable with the situation but the nurse assured me that the patients were happy to stay. “They like it here because they don’t have to work and they can just rest,” she explained. “They are happy to stay.” That seemed to make some sense but I wanted the nurse to ask two of the patients, Nokima and Anawora, if they wouldn’t mind staying an extra day just to be sure. I watched as the nurse spoke with Nokima in Bangla. Nokima, who had been incredibly bubbly, high energy and smiley up until that point, looked devastated. The nurse returned to inform me that Nokima was thrilled to stay an extra day. I couldn’t understand their conversation, but Nokima’s body language said so much. It seemed highly unlikely that Nokima was happy to stay. This situation presented a moral dilemma I had never experienced before. Unable to speak the language, I was at the mercy of the bilingual hospital staff. Because I am a white women and the patients are poor, rural, Bangladeshi women, I factored in the imbalanced power dynamic when I pitted the nurse’s translation of the patient’s response against what I guessed the patient had actually said. I debated whether to believe the nurse or to follow my instincts and cues I picked up from Nokima’s nonverbal communication. After some internal debate, I asked the nurse to discharge Nokima and Anawora. We ended up interviewing and shooting b-roll of both Nokima and Anawora while they waited for their rides home.

**Interviews & Translators**

 Translation proved to be a trying yet illuminating experience throughout the entire process. The information relayed by the subject varied greatly depending on the gender of the translator as well as the context in which the subject was being interviewed. The hospital had promised to provide me with a translator. We quickly realized their definition of “we will provide you with a translator” really meant “there are several semi-bilingual people who work at the hospital who may attempt to translate for you if they can find the time in their busy schedules”. Dr. Shouiab acted as our translator for the first two interviews but later had to return to his CEO duties. The information we received from these interviews were very matter-of-fact as Shouiab often did not give the women time to think or elaborate on their answers. Shouiab seemed to be rushing them and cutting them off once he felt he had heard enough.

Communication was a constant struggle. It is still unclear how much of that is due language barriers and how much can be attributed to Bangladeshi social codes. For example, Bangladeshis have a hard time telling you no. Instead, they give you whatever they believe to be the most agreeable answer. This proved particularly difficult when asking for directions: “Is the hospital to the right?” “Yes.” “Is the hospital to the left?” “Yes.”

After a brief stint with a very sweet, physical therapist with a devastatingly poor grasp of the English language, we realized we’d need to find our own translator. We ran into a man named Mohamed Max who spoke English better than anyone we’d met so far. After receiving Shouiab’s approval, we invited him to be our new translator. Max helped us interview two women but something felt off. We asked Max to relay messages for us, using every powerless speech mannerism and hand gesture we could, in order to suggest respect and kindness. Instead of relaying the message, Max would answer for the woman without making any attempt to communicate with her at all.

“No Max, we want you to ask them if its okay first,” we’d say.

“No problem.”

He’d bark something in Bangla which didn’t really sound like a question. The way he treated and talked to the women didn’t seem to communicate the same sentiment we had communicated to him. It was unclear if his tone seemed off to us simply because the languages are spoken differently or if he really wasn’t translating our words at all. By the end of the day, it became clear that he felt superior to these rural women. He commanded them instead of asking like we requested. I did not feel comfortable having Max represent us*—* translating our words and requests into authoritative orders. At the same time, I found myself questioning whether it was culturally appropriate for me, a visiting foreigner, to challenge the way he interacted with them. I understood that he was treating the women in a way most any Bangladeshi man would. We soon realized it was inappropriate and ineffective to use a male interpreter when interviewing a woman in a Muslim society about any issue, let alone a pudendal one. For this reason (and some weird rumors about Max being blacklisted by the police for a history of robbery and assault on tourists) we had to bid adieu to Max.

 We moved onto translator number four: Hazera. We met her in the lobby of our hotel one morning. She studied at London Metropolitan University in London, she had worked as a translator on documentaries before and she was female*—* a perfect match. She proved to be wonderful. She demonstrated genuine kindness towards the women and their condition. She bonded with them ways a man could not and she seemed to be a true friend to them.

With our new crew member, we returned to Rajarkul village, the village we had gone to with Max. We re-interviewed Noor Ayesha. Standing around four foot eight inches, Noor Ayesha is roughly sixty-years old (though no one here really knows how old they are) with wrinkled brown skin and lips that curl inwards. She suffered from fistula for 40-years before overhearing about fistula surgery from a HOPE hospital PSA vehicle affixed with a loudspeaker. Her husband has since passed away and she now lives at her family-in-law’s house. Her family-in-law is abusive. Even from our brief visit, it was evident that her family life was not pleasant. We interviewed Noor Ayesha in front of her house while the rest of the family crowded around the front door, peering out and shouting remarks while she tried to tell her story. We asked the family to go inside so that we could interview Noor Ayesha in private but still they pressed their eyes and ears against empty spaces between the wooden slats in the walls. Despite the prying eyes, Noor Ayesha told us about being married at 14 and the subsequence physical abuse. She endured obstructed labor for four days. She explains, “After four days, they brought a nurse for the labor. They cut the head of the baby off with a razor blade. By cutting the head off, they took the baby out.” She believes the midwife cut the tissue between her bladder and birth canal in the process of removing the baby leaving her urine incontinent for the next 40 years.

This is a common problem in rural Bangladesh. Typically, Bangladeshi women give birth in the home with the help of a traditional birth attendant, or *dhai.* Studies conducted by UNICEF show that 85 percent of deliveries in Bangladesh take place at home[[4]](#footnote-4). Less than a quarter of these are conducted by a skilled birth attendant. Dhais have no formal medical training and often don’t know what to do when confronted with obstructed labor. Dhais’ improvised attempts to expel the baby range from jumping on the woman’s pregnant belly or, such as in Anawora’s case, lubricating the woman’s vagina with detergent. If women gave birth in hospitals with the aid of trained midwives, they would be better able to detect when something’s gone wrong as well as have access to life-saving emergency obstetric procedures, such as Caesarian sections. In Bangladesh, the status of women is so low that most women do not have the agency to decide when they become pregnant and where to deliver the baby.

Though Noor Ayesha’s fistula has been fixed, she still suffers from many gynecologic complications and is in a lot of pain. This condition on top of her old age makes it impossible for her to work. “I have to depend on them. When they give food, I eat. When they don't give food, I don't eat,” she whispered to us. Noor Ayesha felt her stillbirth ruined her life. She says, “If that baby had been alive, I would not have this problem [fistula and poverty]. If the baby had survived, I would go back to my husband.”

Noor Ayesha shared her story with us in a way she hadn’t when Max was there. With Max, she gave us the facts but wouldn’t elaborate. For instance, she told us she developed fistula, but she did not mention the anecdote about the razor blade. Conversely, she seemed much more at ease with Hazera-- almost comforted by her presence. She thanked us for asking questions about herself and she seemed to appreciate our genuine interest in her well being. Finally, she thanked us for not bringing Max back*—* “He was very unpleasant,” she said.

Hazera translated Anawora’s interview next. At this point, Anawora had been resting at her parents house for ten days. She stayed at her parents house in order to buy more time to heal before returning to her husband. Her husband had threatened to divorce her if she was unable to have sex with him after the operation.

After the usual exchange of tea and sweets, we set up for the interview in the kitchen. Her parents’ house is comprised of three rooms: the kitchen, the bedroom and the front room. The walls were made of sticks and twine, providing no real visual or auditory privacy. We asked Anawora if she was anxious at all about returning to her husband. She essentially told us that she was eager to return to him so that she could fulfill her wifely duties. She answered the subsequent questions with the same enthusiasm. Her answers were generally inconsistent with her responses in the hospital interview. Hazera suspected she was not being honest because her family was listening through the wall. With Anawora’s approval, we decided to relocate to our hotel. In private, Anawora’s tone changed. She became serious and, for the first time, she seemed to express true sadness and deeply rooted fear. She told us that her most recent operation was her fourth surgical attempt to fix her fistula. She shared with us the threats made by her husband-- how he has promised to divorce her if she is still unable to perform sexually after this operation. The thought of returning to her husband gives her severe anxiety. She explains:

“I cannot have sex. I am still leaking and there is no improvement. I think about this a lot. It makes me dizzy and I fall on the floor unconscious. It's traumatized me so much that it hurts when I talk about [it]. I am thinking a lot about it. With each of the four operations, my life has been made different. I don't feel any strength. I am thinking what will I answer to my husband's family… If he remarries, I will cease to exist. Now I exist for him but if he remarries my place will be totally gone. I will have no respect.”

Hazera explained that without the social and economic security of having a husband, Anawora will be further ostracized and left to beg for money. It would be near impossible for Anawora to secure a new husband given that she is unable to bear children or have sex. Rural Bangladeshi society is not structured in a way that allows for a woman to be socially or economically independent. Anawora’s divorce would result in much more serious ramifications than just being single again.

**Hospitality Culture**

The strong hospitality culture posed another hurdle in the filmmaking process. Whenever we visited a woman’s home, we were immediately asked to sit. We would sit politely in thin plastic chairs and play the staring game with the dozens of village kids huddled around the front door while our subject would prepare a plate of fruit, bread or sweets and something to drink. She would then return to the kitchen, leaving us to eat the offering with the men of the house and our translator. I would peck at the fruit my doctor had warned me multiple times not to eat wondering at which point it’d be appropriate bring out the camera. I wanted to tell them that they were very kind but we needn’t such an elaborate greeting every time we came over. Though it felt wrong, I had to accept that this is Bangladeshi custom and I tried to surrender myself to it. After all, who was I to challenge their customs simply because my Western upbringing made me feel greedy for accepting the sweets and lemon soda?

Beyond the moral guilt, the strong hospitality culture made it difficult to film life as it naturally unfolded. In the short time we were there, it was impossible to breakout of the role of guest. I was never able to achieve a level of invisibility and I felt so present in every situation. Anawora and family would sit and watch as we reluctantly finished out plates. It was always an awkward and forced transition into the documentary part of the visit. I asked Anawora what she’d normally be doing at this time if I weren’t there. She said she’d be washing dishes. So I said, “okay, can you please wash dishes then?” In the moment, it felt orchestrated and violated my notion of how filming a documentary naturally unfolds. Though we expressed to Anawora several times that she should do whatever she would normally be doing if we weren’t there, it seemed that she only felt comfortable violating hospitality rituals when specifically asked to do so. Despite this, I believe the edit reveals an element of truth. While the images reveal what her life looks like, her interview expresses what it feels like.

**Emotional Performance Culture**

Nonverbal communication in Bangladesh is radically different from that in the United States. Based on my observations and conversations with locals, I learned that it is not customary to perform one’s emotions in Bangladesh. This made it difficult to capture emotional moments on camera. This was especially clear when it came time for Anawora to say goodbye to her father and return to her husband’s house. I anticipated this would be a very powerful moment given that she was leaving the safety of her family and entering back into a situation where she risks divorce, homelessness, marital rape, abuse and ultimately, losing her place in society. Instead of an emotional goodbye between father and daughter, the scene looks more like a woman saying something inconsequential to an older man before turning to walk away. It’s unclear if they know each other or if she’s just asking for directions. As a filmmaker, I hoped the shot would reveal dramatic unfolding action. I planned to use this moment of vérité to act as a major plot point. Instead, the discrepancy between what I had anticipated and what actually happened forced me to reevaluate how I would tell the story. Instead of vérité moments, I relied primarily on interview to carry the story.

**A Woman Myself**

Being a woman myself presented another obstacle. The centrality of gender in Muslim culture caused me to become hyper-conscious of my body and the modesty of my clothing and posture. Because of this, I did not feel comfortable getting various shots that would require me to put my body in a position that Bangladeshis might interpret as provocative. For example, I avoided spreading my legs which is required in my squat maneuver where I push my elbows against the inside of my knees to steady the camera and get a low-angle shot. Though it may sound slightly ridiculous, when you are in the field you find yourself in a variety of strange positions. In Bangladesh, I felt as though there was a spotlight on my body, which was additional baggage to the many things one has to consider during a documentary shoot. I was thinking, “oh quick, get that shot,” while simultaneously considering how my physical body would be interpreted. Given the male dominance of the public sphere and the stigma of women travelling alone, I did not feel safe exploring the town or villages. I only went to visit Anawora when the hospital was able to take me, which severely cut down the amount of time I was able to spend with her. This lack of mobility hindered the breadth of shots and scenes I was able to film as well as the level of trust and friendship I was able to build with her. That said, I don’t think this documentary would have been possible at all if I were not female. I don’t think the women would have opened up to a male in the same way they did with my female film crew and myself.

**Audience**

The video’s target audiences are Vimeo users as well as students and community members in the triangle. I seek to engage the audience on three critical points: 1) to foster an empathy for Anawora and thereby an empathy for all women with this condition or who are at risk of developing this condition, 2) to inspire audiences to educate themselves further on the issue and 3) to provide the audience with the practical tools while engendering the emotional impetus necessary to make a monetary donation. Viewers can donate directly to the HOPE hospital or to its partner, the Freedom from Fistula Foundation. Soon, viewers will also have the option to donate directly to Anawora. I am currently in the process of setting up a personal fund for her. I am collaborating on this project with Hazera.

I built a personal portfolio website to house the finished documentary. The video will also live on Vimeo, the HOPE Hospital website and the Freedom From Fistula Foundation site. By embedding the video into several different web platforms, I will be able to reach a wider, more diverse audience. Additionally, there will be three separate film screenings at the end of April. The first screening will take place at UNC in the FedEx Global center. The film will also be screened at HOPE Hospital in Bangladesh. Finally, I will submit the film to various film festivals, creating conversation in the national and international film crowd.

**Unpacking**

When we landed in Washington D.C., the streets seemed impossibly clean and incredibly wide. There was something eerie about the relative serenity of the streets. We glided over smooth pavement, adjacent cars only honking or passing when necessary. I was in a daze. As I write the conclusion to this paper, I realize that I am only just beginning to digest my time in Bangladesh. Free from the discomfort, consternation and chaos of being in a foreign space, I have been able to see how truly fantastic and otherworldly my time there was.

As a documentary filmmaker, I seek to tell truthful stories. This project has made me reconsider how to most effectively do this. Going into this project, I understood the impossibility of attaining objective truth in documentary; nonetheless my goal was to come as close to that as possible. I was aiming to document Anawora’s story with a high degree of invisibility. I hoped to capture her story as it occurred and as she relayed it to us. Instead, I found that intervention was necessary in order to get at something close to the truth. For instance, taking Anawora to the hotel instead of interviewing her within earshot of her family actually allowed her to share a more honest account of her life. I learned that by intervening in this way I was able to document a more accurate account of her reality despite violating the journalistic rules I had been taught. I no longer feel the need to pretend my documentary is objective. I understand that I will always have an impact on the story. Despite my obstacles, I believe I was able to understand and convey a truthful depiction of Anawora’s struggles. The individual moments and images captured on tape do not necessarily encapsulate truth. However, as a filmmaker, I seek to tell stories that get as close to the truth as possible. I feel a personal obligation to craft this material into an end product that is larger than the sum of its parts.

I am beginning to think that embracing my impact on the situation and being transparent about process is a more honest approach to documentary. If I were to redo this documentary, I would tell the story in first-person. This would allow the audience to see the cultural and language barriers I encountered in turn creating a better sense of what daily life in Bangladesh is really like. When I pursue stories in the future, I will be intentional about allowing my experience to inform the shots and edit.

1. Arrowsmith, Steven. Phone interview. 8 May 2013. [↑](#footnote-ref-1)
2. One By One. "HOW DOES OBSTETRIC FISTULA HAPPEN?" One By One. www.fightfistula.org (accessed March 20, 2014). [↑](#footnote-ref-2)
3. ["Maternal mortality estimation at the subnational level: a model-based method with an application to Bangladesh." *World Health Organization*. N.p., n.d. Web. 1 Apr. 2014. <www.who.int>.](http://www.bibme.org/) [↑](#footnote-ref-3)
4. [UNICEF. "Women and girls in Bangladesh." UNICEF. www.unicef.org/bangladesh (accessed March 23, 2014).](http://www.bibme.org/) [↑](#footnote-ref-4)