Discipline of Public Health

School of Medicine

Faculty of Health Sciences

UNCOVERING THE COVERED

Pregnancy and Childbirth Experiences of Women Living in Remote Mountain Areas of Nepal

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Doctor of Philosophy

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Certificate of Originality

I certify that this thesis does not incorporate without acknowledgement any material previously submitted for a degree or diploma in any university; and that to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

Signed----------

Abstract

The ongoing effort to reduce maternal and neonatal mortality in developing countries has not been able to achieve the expected level of success. Although there has been progress in increasing access to medical care during pregnancy and childbirth in many countries, the associated mortality in most developing countries remains high. The Western medical model has often failed to consider the socio-cultural dimensions of women living in diverse cultural settings. The maternal and neonatal mortality rate in Nepal is still a serious public health issue. Although the maternal mortality rate of the country is declining, the neonatal mortality rate is still significantly high. The maternal and neonatal health situation in the mountain areas of the country is even worse, where the majority of births take place at home without professional assistance.

This qualitative study draws on local voices in order to understand the factors which have an impact on women's experiences of pregnancy and childbirth in remote mountainous Nepal. This study uses social constructionism and critical feminism to gain an in-depth understanding of the pregnancy and childbirth experiences of women. Fieldwork was conducted in a remote mountain district of Nepal with in-depth interviews being undertaken with pregnant and postnatal women, family members, service providers and local stakeholders in the two remote mountain villages. Data were analysed using an inductive thematic approach of qualitative data analysis from which three key themes emerged: the tradition and culture of childbirth; women, their relationships and childbirth experiences and the complexity of the context of the women. It was revealed in the study that the childbirth experiences of women are a collective socio-cultural construct which happens in a complex socio-cultural setting. A complex interaction of socio-cultural factors was found to be influential in shaping women's pregnancy and childbirth experiences which impacted their safety. The contribution of both socio-cultural and medical paradigms is therefore argued for to enhance safety during the pregnancy and childbirth experiences of women living in the remote mountain villages of Nepal. This needs consideration at both policy and practice level.

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Preface

I was the only child of my parents born in a hospital because of the problems while my mother was trying to give birth at home. Being the youngest child, I did not get the opportunity to observe my mother giving birth but I was able to hear the childbirth stories of my mother and grandmother. My grandmother, who is now 98 years old, was one source of historical knowledge about the tradition and culture of childbirth in Nepal. She had all her births in the Goth (animal shed), experiencing several losses of newborns. During the time of my mother, my grandmother was the source of knowledge and support during childbirth. Later on, I saw my mother taking the role of helping my two sisters-in-law during pregnancy and childbirth. There was a dark room without a window in the corner of our house, where my mother experienced the birth of her other three children. After 17 years, my sister-in-law came back from the capital city to give birth to her second baby in the same dark corner of the house. After the experience of hospital birth of her first baby, my sister-in-law decided to come to the village to experience traditional childbirth.

It was about 20 years ago when I saw my next door aunt having labor pains for about three days at home. I noticed that her mother-in-law called the traditional birth attendant on the third day to help her to give birth. My aunt ended up having a healthy and live baby in the evening of that day. Both my sisters-in-law and aunt spent their 21 polluted days staying in the dark room in the corner of their house in the village. At that time, observing the cultural practices in the village made me upset about being a girl, thinking about the future of my life. I thought that I would be going the same way during childbirth. Around the same time, my paternal aunt died because of not being able to give birth in a remote village. I heard from my grandmother that she went through 19 pregnancies but did not have any live children. My child mind was upset hearing this reality but I did not have any clue at that time why mothers and babies die during childbirth. Instead, I wished to not get married and to remain safe.

There was a dream in my family to make me a medical doctor, but I ended up being a nurse midwife. During the nursing training, I got the opportunity to learn about the medical causes of death of mothers and babies during childbirth. So I then thought it

was beyond my aunt's ability to access medical care from her village. But when I started my clinical work in the hospital, I saw most of the women coming to the hospital were from the urban areas. Then I started working in the rural villages where I saw women still giving birth at home in the traditional and cultural way. It made me think about the childbirth services and preferences of rural women and their socio-cultural circumstances of living. Several encounters with women experiencing childbirth problems and related pregnancy and newborn losses in rural villages did not give me peaceful thoughts and I started thinking about them all the time.

While I was giving birth to my first daughter, I was in a district hospital of my marital town. Though I was myself a qualified nurse, I did not find my birth a satisfactory experience. The hospital was overcrowded and I was asked to rest on the dirty floor of the hospital on a bare mattress after the birth. I did not find myself medically and emotionally safe in that environment. I requested the discharge nurse, but she did not let me go home. I spoke with the attending obstetrician and convinced him that I would feel better at home than staying in the hospital environment. Finally he gave me discharge but with the condition that I would be responsible for any problems arising after leaving hospital. I agreed with their terms and conditions and went home. I did not experience any valuing or respect of my feelings, knowledge, skills and ability while I was giving birth in the hospital.

It was a really big dream to achieve a PhD for a village girl like me in Nepal. Both my personal and professional experiences prompted me to initiate this PhD. My commitment to work for improving maternal and newborn health in rural and remote areas of Nepal contributed to the production of this thesis. While I was trying to finalise the thesis, I got a message from home that my grandmother had died. I felt empty. I became disillusioned about my writing. Nevertheless, I was awakened by her dearest dream that her granddaughter would find ways to make remote Nepali women's childbirth experiences more safe and satisfying

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