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

Sabitra Kaphle, MPHC, MEd, BN

Submitted in fulfilment of the requirements for the degree of

Doctor of Philosophy

March 2012

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.

Acknowledgements

This study would not have been possible without the assistance, support and involvement of many people. Firstly, those mothers who were expecting their babies and had just been through their birthing experiences were the key in this study - without them it has no meaning. They offered their love, care and trust while sharing their stories without asking anything in return. I am indebted to them and I hope that this thesis is faithful to their contributions.

I am equally indebted to my supervisors: Frank Tesoriero, Adjunct Associate Professor of Flinders University; Dr Lareen Newman, Senior Research Fellow of Southgate Institute of Health, Society and Equity of Flinders University; and Heather Hancock, Adjunct Associate Professor of the University of Adelaide. I am grateful for their ongoing encouragement, invaluable support, insightful comments and ongoing guidance throughout the journey. They did not only guide me through the process, they also provided love and care to keep me motivated to complete this thesis.

My special thanks goes to the District Health Office team of the Mugu district for their support to complete the fieldwork in the remote villages. I also wish to remember the support from the colleagues of United Mission to Nepal and International Nepal Fellowship and for their help during the fieldwork. I am also indebted to the families I lived with during the fieldwork who are always in my memory. They kindly offered space to live and food to eat during that time, sharing love and care alongside the hardship in their lives.

I wish to thank Associate Professor Pauline Guerin of Flinders University for her support in arranging baby blankets to take to the mountain villages. I am also indebted to the members of the Zonta Club of the Adelaide Hills who kindly offered some financial support to conduct the fieldwork among women living in the remote mountain areas of Nepal. Their willingness to support this work was invaluable for collecting the stories of women who are so different to those living in Adelaide. I am also grateful to the Department of Education, Employment and Workplace Relations of the Government of Australia for their two year scholarship to start this PhD in Australia.

I would like to take this opportunity to thank the Faculty of Health Science for waiving my tuition fee in the final year of this PhD. Without that support, I would not have been able to continue the research. I am also thankful to the staff of the Public Health Discipline and Southgate Institute of Health, Society and Equity in Flinders University who provided ongoing support during the candidature. I wish to express my thanks to my fellow doctoral students with whom I have shared both happiness and frustration in many stages of this journey. My special thanks goes to Louise Townend for valuable comments while finalising the thesis.

I am highly grateful to Fiona Johnston who agreed to play with the mess of my writing in the final editing of the thesis. It was not easy to deal with the writing of an international student and to make it meaningful to the Western reader. I wish to express my heartfelt thanks to Fiona for her willingness and support to make this thesis meaningful.

Finally, this thesis would not have been born without the understanding and support of my family. My family, particularly my daughter, Sampada and my husband, Rajan Kadel were with me every step of the way providing love, care, encouragement and support. I also would like to offer a very special blessing to my newborn daughter Reva who brought happiness in the final stage of this journey. Similarly, my parents, though they are living back in Nepal, have always been the means of inspiration to me during the candidature. I also would like to remember my other family members and friends in Nepal who are patiently waiting for news of the completion of this PhD.

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

TABLE OF CONTENTS

Contents Page

LIST OF PLATES

LIST OF DIAGRAMS

LIST OF MAPS

LIST OF TABLES

Table Page

Chapter 1: Introduction

This thesis 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. The thesis views childbirth as a socio-cultural experience, that is, that childbirth is an experience which is embedded in family, community and culture. Against the backdrop of the currently dominant medical view of childbirth as an individual physical experience informed by expert knowledge, this thesis argues that speaking to individuals and their communities about their experiences, valuing their lay knowledge and exploring their socio-cultural dimensions can provide a deeper understanding of how to achieve greater childbirth safety.

Childbirth is a powerful personal event in women's lives and also is well supported in the literature as a significant social experience which is essential to the continuation of any society (Carpenter, 2009, Lemay, 2011, Reynolds, 1997). However, the childbirth experiences of women are different according to their culture and society (Callister et al., 1999, Callister et al., 1996, Cooper, 2009, Di Ciano et al., 2010, Hall, 2009, Khalaf and Callister, 1997, Liamputtong, 2009a, Mohammad Ali Beigi et al., 2010, Sawyer et al., 2010, Schneider, 2011). Therefore, understanding the childbirth experiences of women must entail understanding their culture, tradition and social values (Callister and Khalaf, 2009). Some writers who support the social view of childbirth argue that the degree and type of women's choice and control through the childbirth experience depends on society (Dahlen et al., 2010a, Dahlen et al., 2010b, Douglas, 2011, Lindgren and Erlandsson, 2010, Namey and Lyerly, 2010, Snowden et al., 2011). Such factors as gender, power, social status, and the economy will affect women's choice and control, and factors such as these will be the subject of investigation in this thesis.

Section one of this chapter will explain how childbirth became a public health issue and section two will draw on public health concepts to support the socio-cultural focus of this thesis.

1.1 Childbirth: A Public Health Issue

Recent public health research focuses on reducing inequalities of health outcomes related to pregnancy and childbirth within and between nations to prevent adverse results including the unnecessary deaths of mothers and babies in community settings (Blumeshine et al., 2010, Judge, 2009, Luo et al., 2010b, Neidhammer et al., 2011, Pattenden et al., 2010, Rosenthal and Lobel, 2011). In developing countries, there is still a high prevalence of pregnancy and childbirth related complications leading to the deaths of mothers and newborn babies (Beck et al., 1993, Carlo et al., 2010a, Carlo et al., 2010b, McClure et al., 2009, Pattinson et al., 2009). Despite the attempt of the Millennium Development Initiative in promoting maternal and child health (United Nations, 2000), in the South-East Asia region there are still unacceptably high mortality and morbidity rates (Black et al., 2010, Cousens et al., 2011, Friberg et al., 2010, George et al., 2009, Lumbiganon et al., 2010).

It has been recognised that a socio-cultural understanding of pregnancy and childbirth is limited in contemporary medical literature (Haines et al. 2010, Kringeland et al., 2010, Lori and Boyle, 2011, McCourt, 2010b, Sawyer et al., 2010) and several writers argue that the medical view fails to acknowledge socio-cultural dimensions of pregnancy and childbirth (Benoit et al., 2010, Harris et al., 2010, McCourt, 2010a, Titaley et al., 2010a, Titaley et al., 2010b). In addition, several writers argue that the medical understanding of childbirth does not acknowledge traditional birthing practices which exist in some communities around the world; rather, women and family members can be blamed for their poor utilisation of medical services during pregnancy and childbirth (Afsana and Rashid, 2009, Goodburn et al., 1995, Jeffery and Jeffery, 2010, Lang and Elkin, 1997, Moore et al., 2011).

A shift of understanding among public health professionals is evident in public health literature to a view which acknowledges the influence of the broader social context in health. Many public health researchers argue that maternal and newborn health is associated with social determinants rather than merely medical determinants because the socio-cultural circumstances of people are more likely to influence the health and well being of populations in many settings (Bhutta et al., 2010, Brown et

al., 2011, Friel and Marmot, 2011, Houweling et al., 2011, Lawn, 2010, Marmot, 2010). In the new public health era, it is recognised that health is determined by complex interactions of social, cultural, political and economic factors (Baum, 2008). This current view of public health gives value to the lay, or the ordinary person's account of understanding and also to the spiritual dimensions of health (Baum, 2008, Kass et al., 1991, Rogers, 1991). This reflects public health taking a broader perspective of understanding health. Childbirth and its associated mortality rates amongst some groups is one public health concern which needs understanding of the consequences of many socio-cultural factors.

1.2 The Socio-cultural Perspective of Childbirth: Conceptual Basis in Public Health

The socio-cultural perspective emphasises the concept of relationships and interactions within the particular social system. This relationship concept of the socio-cultural view is pertinent in childbirth research. Teman (2011) argues that childbirth knowledge, beliefs and practices are shaped differently according to the socio-cultural setting. Baum (2008) calls the broader social view the new public health approach and discusses the influence of social relationships including gender and power relations in determining health and well being. The Alma Ata (World Health Organization, 1978) and subsequent charters (World Health Organization, 1986, 2005) on health take a broader social view in defining health in which consideration is given to social, political and structural determinants of health.

1.2.1 Definition of the Concept of 'Socio-cultural'

The concept of 'socio-cultural' as it is used in this thesis encompasses a range of dimensions: social relationships; cultural values, beliefs and practices; economic, political and structural factors; religion and spirituality; gender, caste and ethnicity; traditional knowledge; power dynamics; education including formal and non-formal education; and family and societal conditions. These socio-cultural dimensions have been derived from the public health and social science literature, which will be examined in Chapter 2. I am using the term socio-cultural consistently in the thesis referring to either all or several of these dimensions of childbirth experiences. When I discuss one of the socio-cultural dimensions, I will discuss this individually rather

than calling it socio-cultural.

1.2.2 The Socio-cultural Concept in Public Health

The history of Primary Health Care (PHC) since 1978 strongly and consistently supports a socio-cultural view of health. The declaration of Alma Ata developed the concept of PHC which recognises that achieving health requires action in many social, political and economic sectors including the health sector (World Health Organization, 1978). PHC supports a social model of health which is based on the understanding that in order to gain health, people's basic needs must first be met. These basic needs for example are: shelter, affordable food supplies and proper nutrition, adequate supply of safe water and basic sanitation, safety from violence, and social support.

A comprehensive approach to PHC makes abundantly clear that a whole range of social and environmental factors sustain and create good health (Keleher, 2001). Maternal and child health is one of the intervention areas of PHC. Based on principles of partnerships, equity on the basis of need, affordable access to needed services and empowerment of people to help them to be more self determining, comprehensive PHC advocates for the participation of community people (Perry et al., 2011). Comprehensive PHC recognises that health is influenced not only by health services but by a multitude of environmental, social and economic factors. It also emphasises a multi-sectoral approach to health involving all related sectors of development, particularly agriculture, education, communication and other sectors and demands coordinated efforts and engagement with all those sectors (Freeman et al., 2011, World Health Organization, 1978). Comprehensive PHC further affirms that community people are able to identify their needs, to set their priorities and to act for the fulfillment of their needs using locally available resources (Rifkin and Walt, 1986).

This concept of bringing other sectors to health is further emphasised in the Ottawa Charter for Health Promotion (World Health Organization, 1986) which focuses on the influence of social conditions and resources in health. This Charter further affirms that improvement in health requires secure foundations of education, income, sustainable resources, social justice and equity. Re-emphasising the need to

implement the principles of PHC for equity and social justice - because high mortality in developing countries is an issue of health equity - the first People's Health Assembly held in Bangladesh endorsed the People's Charter for Health with the view that health is a social, economic and political issue and above all a fundamental human right (People's Health Movement, 2000). This Charter asserts that the effective implementation of PHC principles can contribute to ensure social equality in health. Further, the Bangkok Charter for Health Promotion recognises the spiritual dimension of health, supporting the broader socio-cultural perspective of health and well being (World Health Organization, 2005). The 30th anniversary of the Declaration of Alma Ata in 2008 provided a renewed policy and research focus in comprehensive PHC (World Health Organization, 2008).

The recent work of the Commission on the Social Determinants of Health (2008) established by the World Health Organization focuses on the underlying societal conditions where people live, which would also be expected to influence women's experience of childbirth. The Commission on the Social Determinants of Health (2008) has produced an explanatory framework that sees differences in health resulting from people's socio-economic and political contexts, their socio-economic position and a range of intermediary determinants including material circumstances, behavioural, biological and psychological factors. This framework recognises the influence of policies, governance, cultural and societal values, social class, gender, ethnicity, education, occupation and income as structural determinants which are critical to reducing existing inequalities in health and also in birth outcomes (Marmot et al., 2008). The social determinants approach takes a broader perspective on improving the social circumstances of people and focuses on the causes of the disease to reduce the health gap (Marmot et al., 2008). This approach is consistent with the definition of socio-cultural used in this thesis.

As in the social determinants of health approach, Labonte and William (2003) argue that focusing on power, participation and policy through community action can change health determinants. Labonte (2009) developed a framework for analysing the social determinants of health in the context of globalisation. Labonte et al. (2011) remind public health policy, practice and research to focus on the social determinants of health to bridge the existing gap. So far, from the Alma Ata Declaration through

to today, there has been consistent acknowledgement of the wider determinants of health including social, economic and political factors in public health theory, practice and research.

The social determinants approach to public health has particularly identified maternal and newborn health as one of its intervention areas (Blas et al., 2011a, Friel and Marmot, 2011). The *Countdown to 2015 Decade Report* produced by the WHO and UNICEF (2010) emphasises taking the social determinants approach to do further work towards improving maternal, newborn and child survival and reducing related mortality. It has been recognised that the socio-cultural circumstances of women are complex and are significant factors in maternal health and newborn survival (Bandyopadhyay, 2011, Bhutta et al., 2010). Thus, understanding the complexities of the socio-cultural circumstances in which childbirth occurs helps us to uncover several dimensions of women's lives which influence their childbirth experiences.

Ron Labonte (1992), a current and noted public health theorist, argues that any single approach to enhance health is inadequate. In this thesis, I choose Labonte's (1992) health enhancement model to support my approach because his model incorporates the generally accepted range of approaches to health and within this, his model offers some insights into how health interventions may relate effectively in a collective context. He outlines three approaches to enhancing health: the medical or high risk approach; the behavioural or multi-risk factor approach; and the socio-environmental or community development approach. However, Labonte's (1992) argument is that medical and behavioral approaches are important but insufficient to enhance health. Thus his socio-environmental approach focuses on high risk conditions, rather than high risk individuals or groups, and argues for allowing communities to define their own priorities and enabling them to make decisions necessary to plan and implement strategies to achieve better health.

The concept of health in Labonte's (1992) socio-environmental approach is a positive state which is connected to one's family, friends and community which includes other factors such as self efficacy, being in control, ability to do things that are important, psychological and social wellness. He defines problems as psychosocial risk factors and socio-environmental risk conditions (Labonte, 1992).

The principle strategies included in this approach are: personal empowerment; small group development; community organization; health advocacy; and political action (Labonte, 1992, p.121). The programme is targeted to high risk environments and includes community development programming, enabling communities to make the decisions necessary to plan and implement strategies to achieve better health, which requires allowing communities to define their own priority health problems (Labonte, 1992, p.122). The programme includes both primary prevention and health promotion, in which success criteria are: improved personal perception of health; improved social networks and social support; improved community action to create more equitable social distribution of power and resources; improved community action to create more environmentally sustainable personal, public and private economic practice; and a shift in social equity measures in the direction of greater equity (Labonte, 1992, p.122). In this way, Labonte (1992) takes a broader perspective on enhancing health.

Knowing that childbirth is a part of public health, I am presenting this thesis within the public health framework of understanding socio-cultural determinants as influencing pregnancy and childbirth experiences. The concept in comprehensive PHC of enabling community people to identify their local needs and Labonte's (1992) socio-environmental approach indicate that people have the capacity to make appropriate decisions in relation to their socio-cultural setting. In this section, I have drawn on public health concepts to support the socio-cultural focus of this thesis. In Chapter 2, I will discuss the evidence from sociological, public health and nursing literature supporting the socio-cultural view of childbirth in reference to conducting research among women living in remote mountain areas of Nepal.

1.3 Definition of Concepts - Safety, Choice, Risk and Trust

The concepts of safety, choice, risk and trust will consistently appear in this thesis. These concepts are widely discussed in the literature in relation to childbirth experiences of women but their meaning varies. So, it is important to define these concepts according to their use in the analysis of experiences of participants later in this thesis. I will introduce and define these concepts as they are used in the thesis in

this section. I will provide more discussion of these concepts with the support of the literature in Chapter 2.

1.3.1 Concept of Safety

The concept of safety is used in this thesis within a socio-cultural view and this meaning is supported by social science and nursing literature which provides evidence of the influence on safety during pregnancy and childbirth of such factors as social support (Gjerdingen et al., 1991, Tarkka and Paunonen, 1996), local knowledge and belief systems (Callister, 1995, Choudhry, 1997) and traditional practices (Alp and Özdemir, 2010, Veale et al., 1992).

The term safety in this thesis refers to the cultural paradigm. It means an experience which includes many components: a strong and supportive cultural belief system (Callister, 1995, Douglas, 1983, Lazoff et al., 1988); the presence of tradition and spirituality (Liamputtong, 2009, Lori, 2011); good and supportive relationships (Barker, 2010, Walsh, 2010); trust and respect in relationships (Banks et al., 2000, Downe, 2007); childbirth as an ordinary part of everyday routines (Oakley, 1980); birthing in traditional/community/home settings (Boucher et al., 2009, Douglas, 2006, Leedam, 1985); the presence of family members at birth (Hodnett et al., 2007, 2011); birthing without fear (Dick-Read, 2005); spiritual beliefs and practices (Hall, 2009, Molony, 2006); women exercising some control in the childbirth process (Downe and McCourt, 2004, Kitzinger, 1997, Oakley, 1996); support of a trusted person during childbirth (Hodnett et al., 2007); freedom from risk and uncertainties of survival (Douglas, 1983, Giddens, 1999); and being able to exercise lay or traditional knowledge (Popay and Williams, 2006). The presence of one or more of these components during pregnancy and childbirth experiences will signify degrees of safety. There are different forms of safety described in the childbirth literature: social; cultural; physical; psychological; and emotional. I will be using the term ‘safety’ from now on to refer to either one or more of the above-named forms. The literature basis of the components of safety included in this definition will be discussed further in Chapter 2.

1.3.2 Concept of Choice

Within the social science literature, choice is inherent in the concept of agency and is the key notion of individualised interest (Beck et al., 1994, Mulinari and Sandell, 2009). The concept of external socio-cultural influences on making choices and taking action provides an opportunity to observe how decisions are made in a collectivist culture and the factors that influence making choices during pregnancy and childbirth. The concept of choice may be seen considerably differently within a collectivist versus an individualistic culture.

The term choice in this thesis refers to an opportunity available to women and village people to make decisions according to their interests and preferences. These choices which are made within the context of childbirth are not only individual preferences but are also the outcome of the wider social values, relationship patterns, power influences, cultural beliefs and material circumstances in which childbearing women live. The construction of this definition of choice emerges from the agency/structure debate in the literature which will be examined in detail in Chapter 2.

1.3.3 Concept of Risk

In the socio-cultural view, the medical meaning of risk and its focus on averting risk have themselves generated concerns about the safety of women during childbirth (Horton-Salway and Locke, 2010). Horton-Salway and Locke (2010) argue that the notion of risk in medicine focuses only on physical aspects of pregnancy and childbirth without considering women's emotional well being and safety.

In this thesis, the use of the term risk refers to the medical view that certain decisions or actions will increase the chance of creating adverse birth outcomes. It includes the concepts of risk perception, risk knowledge and risky practices during pregnancy, childbirth and the postnatal period. The associated actions are explained in Chapter 2 with the support of the medical literature as well as a critique of the medical view in the sociological literature.

1.3.4 Concept of Trust

Luhmann (1979, p.8) argues that the function of trust is the 'reduction of complexity'. For Luhmann, trust is when a decision is made by a person on the basis of familiarity, expectation and risk which is present only when the expectation of trust makes a difference to a decision. Luhmann (1979) further argues that reduction of complexity is possible through the establishment of trust. Following on from this, Luhmann et al. (1985) recognise that modern society is organised by complex and tightly integrated temporal structures, where trust becomes a tool to reduce these complexities.

Giddens' (1994) concept of trust has particular application in circumstances of uncertainty and multiple choices. He argues that trust is linked to achieving an early sense of ontological security through screening potential threats and danger. In Giddens' (1991, p.3) view trust is basic to a 'protective cocoon' which stands guard over the self in its dealings with everyday reality. Relating to how modernization and technology have produced risk, Giddens (1991) asserts that risk can be countered by trust and it is the intersection of risk and trust that has a significant impact upon people's experiences and conditions. Banks et al. (2000) argue that Giddens' concept of 'active trust' is increasingly important with the emergence of new social relations in current social structures because he emphasises an opening out of self to others which includes a process of mutual narrative and emotional disclosure. The mutual narrative in Giddens' view is not *a priori* predicated on class or social status but rather on the combination of choices that converge (Bank et al., 2000).

Both Luhmann (1979) and Giddens (1991) see trust as an effective tool for reducing the risk and uncertainties that exist in modern society. Luhmann (1979) refers to them as complexities. The pregnancy and childbirth experiences of women also include risks, uncertainties and complexities in which trust becomes significant. The understanding of these concepts of trust offers me an opportunity to examine who women trust to seek advice and support from in their pregnancy and childbirth experiences. The use of the term trust in this thesis refers to an attribute of relationship which includes mutual relationship, reciprocal understanding and perceived benefits of action. I will be linking these concepts while discussing the findings of this thesis.

1.4 Introduction to Theoretical Concepts

This thesis uses social constructionism and critical feminism as theoretical frameworks to understand the influences of various dimensions of socio-cultural factors on childbirth experiences. The concepts of these two theories are consistent with the socio-cultural approach of this thesis which supports giving meaning and privilege to women's experiences of childbirth, allowing me to value participants' experiences as an authentic source of knowledge.

1.4.1 Social Constructionism

As Bryman (2001) explains, the epistemological position of social constructionism implies that knowledge is the outcome of the interactions among individuals engaging in its construction. This approach informs an examination of how people make sense of their world and respond with different expectations or who has power over them in the process of understanding their dimensions through their own meaning (Crotty, 1998, Goffman, 1974). Therefore, how one person sees phenomena can be different to how another person interprets the same phenomena (Blumer, 1969, Charon, 2004, Sarantakos, 1998) and the meaning made is also dependent on the relationship between particular experiences and the concerned individual (Mead, 1972). The relationship in this construction is guided by the social values of people and of those with which they interact (LeCompte and Schensul, 1999). Thus, from this view, the construction of knowledge about childbirth is influenced by the socio-cultural values of the individual and family, interactions between people, and how one person constructs the meaning of their childbirth experiences can be different to how another person constructs theirs.

Lock and Strong (2010) provide four key features of social constructionism. First, it is concerned with meaning and understanding as the central features of human activities, in which the focus is on how knowledge is constructed (Lock and Strong, 2010, p.6). Second, it has the view that meaning and understanding have their beginning in social interactions, in shared agreement (Lock and Strong, 2010, p.7). Third, ways of meaning making, being inherently embedded in socio-cultural processes, are specific to particular times and places (Lock and Strong, 2010, p.7). Fourth, people are self defining and socially constructed participants in their shared

life (Lock and Strong, 2010, p.8). This means that social constructionism values the collective construction of pregnancy and childbirth experiences, the influences of socio-cultural factors in the construction of childbirth experiences and acknowledges the social construction of childbirth knowledge, which are all important aspects of this thesis. Carter (2009) and Lee-Rife (2010) identify the importance of understanding such interactions and relationships to give meaning to the experiences. Drawing on social constructionism allows me to give meaning to the participants' experiences in this research.

1.4.2 Critical Feminism

Critical feminism is useful to this study. It emphasises privileging women's stories and voices to examine the influences of gendered ideology, power influences and social interactions on understanding the childbirth experiences of women (Horton-Salway, 2010, Walsh, 2010). Further, critical feminism is a liberating approach which enables research participants to contribute to the transformative process of enhancing safety during pregnancy and childbirth

Critical feminism argues that social change begins in people's everyday lives and attempts to minimise imposed hierarchies and exploitative relationships (Agger, 2006). Critical feminism seeks ways to empower people and provides flexibility to accommodate particularly women's subjective accounts (Edwards, 1990). In relation to research, it argues for active involvement of the research participants (Weiholtz and Kecer, 1995). This approach values women's voices and considers women as experts in their experiences (Tritten, 1992). It is therefore by listening to participants' experiences in this thesis that I am able to understand the relationships and influences of many factors and validate the worth of that unique experience (Anderson, 1999).

Based on these two theoretical concepts, this thesis considers women and other participants from the villages as experts in their experiences and values their knowledge as it is constructed through social interactions. Thus, this thesis includes the local voices of pregnant and postnatal women, their family members, service providers and local stakeholders. The application of these theories in understanding the childbirth experiences of Nepalese women living in remote mountain villages

will be discussed further in Chapter 2 and Chapter 3.

1.5 A Missing Consideration: The Socio-cultural Context of Childbirth for Remote Mountain Women in Nepal

In recognition of the country's significantly high maternal and neonatal mortality rates, the Government of Nepal aspires to improve maternal and newborn health through the formulation of various policies and strategies (Morrison et al., 2011). Although a gradual improvement in reducing poor birth outcomes and promoting safe birthing experiences through various interventions is evident in urban and semi-urban areas of the country (Karas et al., 2011, Lee et al., 2011, Morrison et al., 2011), the maternal, neonatal and perinatal mortality rates still remain high with 281 per 100,000 live births, 33 per 1000 live births and 45 per 1000 pregnancies respectively (Ministry of Health and Population et al., 2007).

People living in Nepal's remote mountain areas have particularly poor social, economic and health status (Bennett et al., 2008, Dawson et al., 2008, Lewin et al., 2008). Districts in remote mountain areas hold a low ranking in the human development index (Gagnon et al., 2008). Similarly, the fertility, morbidity and mortality rates are also high in Nepal's remote mountain areas (Bennett et al., 2008, Gagnon et al., 2008, Lewin et al., 2008). Murshed and Gates (2005) argue that the key factors behind this difference are limited access to resources and a strong preference for their traditional healing system.

There is much documentation concerning issues of access to services and traditional systems (Bennett et al., 2008, Morrison et al., 2011, Regmi et al., 2010b). The Nepalese government states that more than 90 percent of mothers living in remote mountain areas give birth in the community without any medical attendance and institutional prenatal care compared with 51.5 percent in urban areas of Nepal (Ministry of Health and Population et al., 2007).

Similarly, the fertility rate among Nepal's poorest group of people living in remote areas is 4.7 children compared with 1.9 children among the wealthiest group living in urban areas, while the infant mortality rate (death under age of 12 months per 1000 live births) is 71 among the poorest group compared with 40 among the

wealthiest group of people (Ministry of Health and Population et al., 2007). Thus, maternal and child survival is a serious issue in Nepal (Johnson and Bradley, 2008). Yet few women have access to trained attendance and inequity in access is severe: only 5 percent of the poorest women had trained care at their most recent birth, compared to a still insufficient 50 percent of the wealthiest women (Johnson and Bradley, 2008, p.31).

Researchers have found that the childbirth experiences of rural Nepalese women are influenced by limited opportunities to make choices (Adhikari and Sawangdee, 2011, Regmi et al., 2010b, Shrestha and Shrestha, 2010). For example in traditional gender roles, most of the women in Nepalese society are considered as inferior to men (Pokharel, 2010). Specifically, within the patriarchal structure in many families, it is assumed that most things should be under the control of men, either father or son. This has influenced fertility behaviour resulting in many births to satisfy the numbers of children wanted by husbands and other family members in Nepal (Ahmed et al., 2010a, Brunson, 2010b, Maitra, 2011, Pandey et al., 2011).

Additionally, the influence of the mother-in-law is critical in Nepalese women's childbirth experiences (Basnyat, 2011, Simkhada et al., 2010, Smart and Regmi, 2008, Subedi, 2011). In the remote mountainous regions of Nepal, even nowadays, married women are still expected to be at home and to serve their husband's family (Bhandari, 2011). Nevertheless, Nepalese women of suburban and rural areas have recently shown success in empowering themselves in a variety of development sectors including health with their active involvement in for example forestry and agricultural areas (Christie and Giri, 2011, Glenton et al., 2010, Jackson, 2010, Kaufman and Crawford, 2011).

Since birth practices differ according to the socio-cultural context as discussed in previous sections, it is not surprising that Bennett et al. (2008) found differences in birth practices among women living in different parts of Nepal. One study has shown that women living in rural areas of Nepal consider childbirth as a routine of their everyday lives similar to other regular domestic and agricultural tasks (Adhikari, 2010), whereas urban women have started to view childbirth as a special condition requiring regular check ups and monitoring from medical professionals (Brunson, 2010a).

However, beyond this level of description of traditional systems, there is a lack of evidence to develop deeper and more useful understanding of childbirth practices and the perception of safety during pregnancy and childbirth in remote mountain areas. The need for understanding women's experiences in relation to improving positive birth outcomes in Nepal has been identified only recently in social and anthropological literature (Basnyat, 2011, Brunson, 2010a, Regmi et al., 2010b, van Teijlingen et al., 2010), yet these studies have focused only on the urban and low-hills areas.The voices of women living in mountainous areas of Nepal are yet to appear in the literature.

Regmi (2008) and Basnyat (2011) write about the tendency towards blaming women for not respecting biomedical knowledge and practices during childbirth in Nepal where medical practitioners and health professionals consider traditional childbirth practices as the causes of negative birth outcomes. Brunson (2010a) provides evidence from a semi urban area in Nepal where although medical services were available, traditional practices were preventing decisions about getting medical assistance during pregnancy and childbirth. This evidence indicates that there is room to develop a deeper understanding of factors influencing birth outcomes and related experiences.

Indeed, women of childbearing age in remote mountain villages of Nepal become pregnant and give birth like millions of other women in other settings and are also living within an era of emerging influences of the medicalised model of maternity care. However, their birthing experiences remain strongly linked to their socio-cultural dimensions of living which might be different to women living in other cultural settings. This highlights the need for understanding the various dimensions of women's lives influencing their pregnancy and childbirth experiences and leading to higher fertility, morbidity and mortality rates in remote mountain areas of Nepal. Therefore, this thesis aims to uncover the local voices of such women in order to understand the factors which have an impact on their experiences of pregnancy and childbirth.

1.6 The Research Aim, Question and Specific Objectives

This research aims to uncover local voices in order to understand the factors which

have an impact on women's experiences of pregnancy and childbirth in remote mountainous Nepal.

Research Question

What factors influence the pregnancy and childbirth experiences of women living in remote mountain areas of Nepal and how do these factors interrelate?

Research Objectives

1. Examine the pregnancy and childbirth experiences of women living in remote mountain villages of Nepal,
2. Explore the socio-cultural factors that influence their pregnancy and childbirth experiences,
3. Examine the relationships of the many socio-cultural factors that influence safety during childbirth in remote mountain villages of Nepal.

1.7 A Note on Language: Expressions and Use of Specific Terms

Throughout the thesis, there are a number of terms and expressions which require justification regarding their use. Consistent with the feminist approach discussed earlier, I have adopted the feminist concept regarding the use of language which aims to uncover injustice, inequality, taking the side of the oppressed and powerless (Wodak, 1989). Kitzinger (1972) argues that language socially controls how women live because it expresses the views and perspectives of society. She believes that women's experiences are unspoken because there is no language in which the experience can be expressed.

Hunter (2006) points to the dominant paradigm in Western childbirth which has considered the mind as separate from the body and views women's bodies as machines in which the problems are fixed through medical interventions. In a feminist work on gender and science, Fox Keller (1986) discusses the perceived differences in language between the dominant medical paradigm which is objective and mechanistic versus the alternative feminine paradigm of language which is subjective, emotional, intuitive, artistic and in tune with nature.

In feminist discourse on women, Stewart (1994) agrees that feelings of humiliation

can occur if disempowering language is used to describe childbirth because the language used gives form to experience. As an example, in feminist discourse the word ‘birth’ or ‘childbirth’ is used in preference to the medical word ‘delivery’. On the basis of these arguments, the language I use in this thesis respects the socio-cultural dimension of village people. In this thesis, I use the terms ‘childbirth pain and problems’ rather than the medical terms ‘labor and complications’. In some places, I use local terms where adequate translations cannot be made. This thesis is written in the first person because it allows sharing of the voices of participants more actively.

Additionally, there are some terms used in the thesis which require clarification. These terms are defined as it is used in this thesis.

Indigenous Group

Indigenous groups are the groups of the population who are listed as indigenous nationalities of Nepal. The indigenous group of people in this study comprises the Tibetan descendants who have occupied particular areas of the study district and established their settlements for several generations. In the thesis, this group is known as Lama. The non-indigenous group involved in this thesis is Chhetry.

Remote Mountain Areas

Remote mountain areas refer to the high altitude ecological zone of Nepal. This study uses one administrative district to represent the remote mountain areas, which ranked as the lowest in the human development index of 75 districts of Nepal during the study period (District Development Committee, 2008).

Collective

The term ‘collective’ in this thesis refers to the involvement, interactions, relationships and influences of family members and other people from the village in the pregnancy and childbirth experiences of women. In other words, this refers to the social practice of giving priority to all people who are involved in making decisions about pregnancy and childbirth in the village.

Normal Birth

The term 'normal birth' in this thesis refers to a birth which occurs in a community setting without any professional attendance or medical interventions. In other words, this refers to a spontaneous birth which completes without external medical, technological or professional interventions.

Birth Outcomes

The term 'birth outcomes' in this thesis refers to the 'outcomes' that are experienced during pregnancy and childbirth. These outcomes are categorised as positive or negative. Positive outcomes refer to healthy outcomes including the survival of mother and baby/babies. Negative outcomes refer to illness, abnormalities, premature losses including the deaths of mother and baby/babies.

1.8 Outline of the Thesis

This thesis comprises seven chapters as follows.

Chapter 1 has provided the introduction to the thesis where I have presented the conceptual and theoretical foundations of taking a socio-cultural perspective in this thesis. I have discussed the public health concepts of viewing health in a broad social framework and the relevance of social constructionism and a feminist critical approach. I have introduced the research aim, the research question and objectives.

Chapter 2 reviews, analyses and discusses the evidence in relation to childbirth experiences of women. In Chapter 2, I will situate the socio-cultural view of childbirth to women living in remote mountain areas of Nepal.

Chapter 3 provides a detailed description of the methodology of this research, in which I will provide the practical approach to the thesis.

Chapters 4, 5, and 6 present an analysis of the findings of this research and the key themes which emerged from the data. In these three chapters, I will provide descriptions of each of the key themes and sub themes, referring to the narratives of research participants. There will be a section at the end of each chapter which highlights the key findings.

Chapter 7 of this thesis will draw the key arguments and explores the possible implications for policy and practice in order to provide better care and thus make pregnancy and childbirth a safe event for women in remote mountain areas of Nepal.

Conclusion

Childbirth is a socio-cultural event. Thus, understanding the meaning of childbirth requires exploration of the factors which influence childbirth in a particular socio-cultural setting. This chapter has provided background information for this study which aims to uncover local voices in order to understand the factors which have an impact on women's experiences of pregnancy and childbirth in remote mountainous Nepal.

As a reflexive researcher, I have established my position in this research as a feminist critical researcher and explained the theoretical concepts of social constructionism and critical feminism in relation to a broader social view of understanding childbirth. I have identified the critical areas which need exploration in understanding the meaning of the childbirth experiences of women living in remote mountain areas of Nepal. The next chapter provides evidence in relation to a socio-cultural perspective of understanding pregnancy and childbirth experiences linking with the circumstances of the women in this study.

Chapter 2: The Socio-cultural View of Pregnancy and Childbirth

The previous chapter provided an introduction to the socio-cultural dimension of health. The concept of involving people in the process of comprehensive PHC and taking consideration of the broader social context of social determinants of health provides a solid foundation for taking a socio-cultural view in this thesis. As I clearly noted in Chapter 1, there is missing a consideration of the socio-cultural context of childbirth for remote mountain women in Nepal, where birth is a socio-cultural experience. So, it is important to develop more understanding of the use of the socio-cultural concept in childbirth. Therefore, this chapter provides a discussion of the socio-cultural view as it is written about in much of the childbirth literature.

There are a number of reasons for focusing on the socio-cultural view in this study. Firstly, as has already been touched on in Chapter 1, the socio-cultural view acknowledges the complexities and diversities of influences on women's childbirth experiences. Secondly, the socio-cultural view allows me as a feminist critical researcher to give authority to the knowledge women have about their pregnancy and childbirth. Thirdly, it allows me as the researcher to assert that women have ownership and control of the childbirth process within their community. Fourthly, it allows me to consider a diversity of dimensions of women influencing their pregnancy and childbirth. Finally, the socio-cultural view is based on the concept of giving an opportunity to women to share their experiences. These features of the socio-cultural view provide an opportunity to understand the complexities and diversities of pregnancy and childbirth experiences of women living in remote mountain areas of Nepal. This chapter focuses on these socio-cultural dimensions in relation to safety during pregnancy and childbirth.

2.1 The Meaning of Pregnancy and Childbirth

Childbirth in Nepal is steeped in social and cultural meanings (Basnyat, 2011). Cultures and traditions do vary from one place to another, yet certain human experiences such as pregnancy and childbirth may be considered as universal

(Lupton, 2003). However, such experiences are interpreted and understood differently in different communities (Castells, 2010, Teman, 2011). Women living in both Western and non-Western cultures situate their childbirth experiences within the socio-cultural circumstances of their lives (Douglas, 2011, Lori, 2011, Lozoff et al., 1988, Mann et al., 2010). Similarly, rural and semi-urban women's pregnancy and childbirth experiences heavily reside in their socio-cultural circumstances (Basnyat, 2011, Regmi and Madison, 2009).

Barker (2010) and Walsh (2010) argue that the pregnancy and childbirth experiences of women are influenced by their socio-cultural system and embedded relationships. This concept of relationship is a core concept which is relevant to exploring the influences of such relationships on the pregnancy and childbirth experiences of women. Oakley (1984) argues that the culture in which childbirth occurs provides norms that influence attitudes, values and interpretations of personal experiences. Similarly, Callister et al. (1999) add that socio-cultural values, beliefs and practices have influences on motherhood. Steinberg (1996) exemplifies this view by considering childbirth as a part of women's daily routines of household work. While in rural Nepal, Smart and Regmi (2008) found that women see childbirth as a normal and ongoing task.

Certain cultural practices help to create safety in women's pregnancy and childbirth experiences (Alp and Ozdemir, 2010, Downe and McCourt, 2004, Heilemann et al., 2000, Lewallen, 2011). For example, traditions of helping birthing women by providing warmth and massage by experienced female relatives or traditional birth attendants during the birth contribute in promoting safety during childbirth (Bolam et al., 1998, Homsy et al., 2004, Kamal, 1998, Lefeber and Voorhoeve, 1998, Mesko et al., 2003).

Proponents of the socio-cultural view of childbirth criticise the Western medical view for separating women from their community and describing childbirth as an individual physiological experience requiring only medical interventions (Cindoglu and Sayan-Cengiz, 2010). Lupton (2003) criticises biomedicine for not considering childbirth as a part of social life and cultural processes, but rather as an objective body of scientific knowledge outside culture. Additionally, some writers argue that the Western medical view considers socio-cultural factors as risk factors for adverse

health outcomes during pregnancy and childbirth and consequently women are confined to give birth in institutional settings (Kontos, 2011, MacKenzie Bryers and van Teijlingen, 2010, Sargent and Gulbas, 2011). In Nepal, women who do not use medical services during pregnancy and childbirth are blamed by health care providers for causing maternal and newborn deaths (Basnyat, 2011, Smart and Regmi, 2008, Thapa, 1996). However the recent studies by Brunson (2010a) and Basnyat (2011) show that many Nepalese women prefer birthing within their community.

The socio-cultural situation in Nepal is considered by some to be negative because they see its effect as a barrier to accessing medical services which they think are the best solution to prevent childbirth related deaths. Bennett et al. (2008) argue that the childbirth tradition in Nepal prevails negatively on maternal, newborn and child health. Thapa et al. (2000) further comment that the culture and tradition often prevent women from accessing and utilising essential health care services and thereby increase maternal, newborn and child mortality. Dahal (2008) considers the practice of giving birth in the cowshed as a risk producing task. Similarly, Schubert et al. (1997) consider childbirth pollution as the cause of adverse birth outcomes. Nevertheless, as discussed earlier in this section, culture and tradition are valued by rural Nepalese women as a way of gaining safe pregnancy and childbirth experiences.

Although childbirth is a similar physiological event for all women around the world, how one woman perceives birth is different and unique compared with another woman (Oakley, 1996). Remote mountain women's perspectives of giving meaning to childbirth have not been well covered by previous researchers, who have predominantly focused on women in urban and semi-urban areas in Nepal.

2.2 Forms and Authority of Knowledge

There are two forms of knowledge commonly discussed in the social science and public health literature; one is expert or scientific knowledge and the other is lay or traditional knowledge (Henderson, 2010, Popay et al., 1998, Raymond et al., 2010). In Chapter 1, I made clear that social constructionism and critical feminism allow room for the socio-cultural view which opens up the possibility of giving authority to

lay knowledge. Popay and Williams (1996) identify three ways in which lay knowledge can inform health practice. First, awareness of lay knowledge can provide a more nuanced understanding of the factors contributing to health. Second, the incorporation of lay knowledge and lay theories of disease causation can contribute understanding by highlighting the opinions that people hold about the causes of illness. Third, when subjective experiences of ill health are not confirmed by more objective measures, the medical definition of health and illness is privileged over the experiences of the individual. However Popay et al. (1998) argue for incorporating the subjective lived experiences of individuals and for recognition of the impact of structural restrictions such as poverty and disempowerment on understanding behaviours which influence health. This concept of lay knowledge is significant for understanding pregnancy and childbirth experiences because in many cultures the traditional knowledge is valued more than medical knowledge.

In relation to pregnancy and childbirth, there are consistent arguments for giving importance to lay knowledge. Several social science writers argue that the opportunity should be given to women to control their childbirth process and to experience childbirth according to their knowledge (Jordan, 1988, Mead and Newton, 1967, Oakley, 1980). Other feminist writers argue that the use of traditional or indigenous knowledge during pregnancy and childbirth is paramount in ensuring safety (Diener, 2009, Kitzinger 1972, 2001, Smith et al., 2011). In these writers' view, safety entails women's ownership and control of the childbirth process, without medical and technological interference.

Researchers argue that in rural Nepal, people have their traditional knowledge about pregnancy and childbirth which influences their choice to give birth in the village setting and to take care of the newborn using traditional massaging practice (Adhikari, 2010, Karas et al., 2011, Shrestha et al., 2011, Stone, 1986, Tuladhar, 2010). During the birth, women trust traditional knowledge more and prefer their mother-in-law's or other village women's help because in this way birthing women get the opportunity to experience safe childbirth without the fears of the medically trained health care providers who consider childbirth as a risky event (Osrin et al., 2002). In this way, the socio-cultural view allows women to exercise both the authority and power of their traditional knowledge to control the birthing process

according to their interests and preferences. Women's trust in the traditional knowledge is a component which contributes to gaining safety.

Apart from the proponents of the socio-cultural view, several writers criticise the Western medical view in that it gives authority to medical knowledge to control pregnancy and childbirth, which results in women's bodies being likened to birth machines and the obstetricians, physicians and nurses as the mechanics to operate women's bodies using their knowledge (Davis-Floyd, 2001, 2003). In Western maternity care, there is limited opportunity for women to resist medical authority and to incorporate their interests and preferences during childbirth (Kroker, 2004, Levesque, 1980, Records and Wilson, 2011, Stevens, 2011) and institutionalisation of childbirth is considered mandatory to minimise the risk during childbirth (Carlo et al., 2010a, Johanson et al., 2002, Riessman, 1992, Souza, 2010).

The authority of medical knowledge does not only separate women from their socio-cultural setting, it also ignores women as subjects of experiences and controls pregnancy and childbirth within institutional settings (Hadjigeorgiou et al., 2011, Johanson et al., 2002, Kitzinger, 2011). Further, the Western medical view has blamed both women and their helpers for being irrational and incapable of managing risk during pregnancy and childbirth (Lupton, 2003, van Teijlingen et al., 2010). Because of the fear of death during childbirth in the medical view, pregnant and birthing women tend to remain silent and place their confidence in the doctor (Reiger, 2001). In this way, the authority of medical knowledge has controlled birthing experiences without taking notice of the socio-cultural dimension of women. Consequently, the use of medical knowledge to ensure low risk from the medical viewpoint implies reduced safety during the childbirth of women who follow social norms, cultural values and traditional practices.

Critical feminism values everyday life situations while understanding the meaning of experiences and considers women as the experts in their experiences. It also describes medical domination as oppression in order to gain safety during pregnancy and childbirth (Gunew, 1990). Further, it is argued that knowledge comes from experience (Gunew, 1991). Thus, women create knowledge from their everyday life experiences which is valued as an authentic source in feminist research (Letherby, 2011). Similarly, social constructionism assumes that knowledge is constructed

through social interactions, influences and relationships as well through social construction (Conrad and Barker, 2010). Additionally, both Labonte's (1992) socio-environmental approach and comprehensive PHC approach argue for giving importance to community knowledge and involving community people to take action according to their knowledge and expertise in health relatedsituations. So, in both public health and social science literature, the place of lay knowledge is considered significant in enhancing health. It is therefore the authority given to traditional or lay knowledge of pregnancy and childbirth which contributes to enhanced safety.

Nepalese women in rural and semi-urban areas value the authority given to their traditional knowledge during pregnancy and childbirth and accept non-professional village women helping them to give birth within their community rather than going to hospital and using medical interventions (Beun and Wood, 2011, Bolam et al., 1998, Tuladhar, 2010). Women living in urban areas of Nepal have expressed their dissatisfaction with the control of medical professionals while giving birth in hospital (Basnyat, 2011, Regmi and Madison, 2009). However, the reliance on traditional healing systems in rural areas of Nepal demonstrates childbearing women's trust and confidence in the traditional knowledge (Carlough, 1997, Mesko et al., 2003, Oswald, 1983). These studies referred to have involved urban, semi-urban and rural areas, therefore, the evidence is still lacking about the perspective of remote mountain women in Nepal. Thus, giving authority to traditional knowledge provides an opportunity for understanding and possible ways forward for transformation based on that authoritative traditional knowledge in relation to pregnancy and childbirth experiences in remote areas, as these may be different to Nepalese women's experiences in urban and semi-urban areas.

2.3 Ownership of Experiences

Both social constructionism and critical feminism aspire to give ownership to the people of their experiences (Weingarten, 1991). There are two different forms of ownership discussed in the literature, one is individual and the other is collective. Labonte's (1992) socio-environmental approach values community capacity to take necessary action and focuses on collective ownership of health outcomes. This thesis also values collective ownership of pregnancy and childbirth experiences which

allows the involvement of family members and other support persons during the birth. The socio-cultural view provides the opportunity to involve other people according to the preferences of birthing women, which contribute to gaining a shared experience (Davis-Floyd, 2003, Jordan, 1988, Jordan and Davis-Floyd, 1980). This shared experience further contributes to confirming the collective ownership of the childbirth which occurs in the village setting.

The birthing place is one of the factors that influence ownership of childbirth experiences (Callister and Khalaf, 2009, Downe and McCourt, 2004, Markens et al., 2010). The above writers are mostly concerned about women's ownership of childbirth experiences in hospital settings. Khalaf and Callister (1997) argue that the ownership of childbirth experiences is developed through the ability to control the birthing process and women's feeling of safety during the birth. However these writers focus on individual ownership and individual control of childbirth where safety means no death or injuries or sickness. This is different to the focus of this thesis which sees safety emerging from the collective ownership of pregnancy and childbirth experiences

Social constructionism claims that experiences or phenomena are not simply subjective experiences, but that social conditions change the meaning so that the phenomenon is not subjectively owned but is socially constructed (Crotty, 1998). For example, in rural areas of Nepal, Regmi and Madison (2009) found that birth is a social event in which there is a culture of sharing problems and helping each other to manage problems. When problems occur during childbirth, the most preferred attendants are older women, either the mother-in-law from the house or other women from the village who have had a child themselves (Mesko et al., 2003). These childbirth attendants control and manage the childbirth process which thus produces collective ownership of the experiences in the case of birth occurring in the community setting.

Several writers argue that when childbirth occurs in an institutional setting, the power to control the childbirth process goes to the medical professionals during the birth and women become powerless (Downe and McCourt, 2004, Kitzinger, 1997, Oakley, 1996). Childbirth then becomes a physiological condition requiring continued monitoring by medical professionals and keeps women in a controlled

institutional setting which violates the women's right to control the process of birth (Hodnett et al., 2010). Consequently, rural women in many countries tend to prefer to give birth in the community which provides safety during childbirth (Boucher et al., 2009, Olsen, 2011, Rijnders, 2011).

Rothman (2000) argues that childbirth and motherhood experiences are a part of women's lives which should not be taken away from their socio-cultural embedding. Several studies have found that in rural Nepal, it is family members rather than the woman who make decisions about the place of birth, type of care and persons helping to give birth (Acharya and Rimal, 2009, Basnyat, 2011, Regmi et al., 2010b). These studies demonstrate that the collective culture of childbirth experiences is common in rural Nepal. The socio-cultural view supports the concept of collective ownership of experiences which is constructed through the involvement of family members and which contributes to producing safety during pregnancy and childbirth (Benson et al., 2010, Morley and Macfarlane, 2011, Squire and Beverley, 2009). So, while women help other women, their experiences are built through the influences of relationships and interactions which contribute to the collective ownership of childbirth experiences.

2.4 Dimensions of Safety, Choice and Risk in Childbirth

Chapter 1 provided the operational definitions of the concepts of safety, choice and risk as they are used in this thesis. While constructing the definition of these concepts, many aspects included in the definition were derived from the literature. This section discusses these concepts with the support of sociological, medical, public health and other childbirth literature.

2.4.1 The Socio-cultural Concept of Safety

As mentioned in Chapter 1, the concept of safety in this thesis is based on the socio-cultural view of safety. Mansfield (2008) demonstrates the crucial influence of relationships in determining the birth experience, whether a birth without medical interventions or home birth or hospital birth. Continuous support of family members and other known persons from the community have been found to be beneficial to women during pregnancy and childbirth (Hodnett et al., 2007, 2011). The quality of

the woman's relationship with the support person and care givers is one of the key factors influencing the childbirth experiences of women (Hodnett et al., 2011). Thus, relationships are one of the major components of safety during pregnancy and childbirth.

Callister et al. (1999) provide evidence about the cultural and spiritual dimensions of safety in the context of women living in different cultural settings. In their research, women were more concerned about protecting themselves from cultural and spiritual threats during pregnancy and childbirth. Further, Douglas (1992) mentions that safety during childbirth is concerned about maintaining the existing childbirth knowledge, beliefs, traditions and practices of a particular socio-cultural setting. Douglas's view of safety, also known as a culturalist view, focuses on socio-cultural safety taking social circumstances and relationships in to the account (Douglas, 1992).

In the socio-cultural concept, safety is a perception which helps to elucidate the influences of social relationships on childbirth meaning. Douglas (1992) argues that how safety is perceived depends on which social and cultural group the person belongs to. There are many studies showing the perceived differences in views of safety according to a person's cultural belief system (Callister and Khalaf, 2009, Sandall et al., 2010, Smythe, 2010). The socio-cultural concept of safety emphasises two major themes: first, concerning the different types of knowledge which inform the perception of safety, and second, the moral dimension of safety (Lupton, 1999, p.18). This concept further acknowledges that different people have different forms of relationship which can influence their perception of safety (Lupton, 1999).

In practice, many researchers argue that focusing on cultural and spiritual safety promotes satisfaction and ownership of their experiences by childbearing women and their respective cultural groups (Eckermann, 2006, Kildea et al., 2010, Kruske et al., 2006, Liamputtong, 2009a, Rumbold et al., 2011). Thus, the concept of safety in this thesis includes several socio-cultural dimensions of women in order to analyse how these factors contribute to enhance the safety of remote mountain women during pregnancy, childbirth and the postnatal period.

2.4.2 The Concept of Choice - Agency/Structure Relationship

As introduced in Chapter 1, the term choice is widely discussed in the childbirth literature in relation to decisions about the birth place, care providers and care model. As also mentioned in Chapter 1, the concept of choice in this thesis is based on the agency/structure concept. In this section, I will discuss this concept of agency/structure in relation to pregnancy and childbirth.

In the literature, the concept of choice is commonly associated with the notion of individual autonomy and responsibility and the individual's right to make informed decisions. The concept of agency refers to an individual's capacity to act independently and to make their own free choices, where structure refers to those factors such as social class, gender, religion, ethnicity, culture, and traditions that seem to limit or influence the opportunities that individuals have (Luttrell, 2007). Walsh (2010) argues that there is a tension between personal agency and social structure in a critical perspective of childbirth. Walsh (2010) further shows that academic theories and the childbirth literature at both policy and practice levels, reflect this agency/structure tension with the former being concerned with informed choice and notions of control and the latter with autonomy and compliance. However, Nilsen and Brannen (2002) argue that human behavior is determined by external forces including a range of socio-cultural factors and social actions.

The concept of choice in the structuralist view attempts to overcome the division between structure and personal agency by emphasizing that the nature of structural circumstances influences the act of choosing (Giddens, 1984). In his concept of structuration, Giddens (1984) emphasises the productive role that actors themselves play in the maintenance and recreation of social codes and norms. For Giddens (1984), structure teaches agents who help to form the structure in a circular process. Giddens (1984) thus argues that human practices and activities are not imposed social actors, but are continually recreated by them via the very means whereby they express themselves as actors. The structure, social norms and codes exist and are transformed through this recreation process. He emphasises the practical consciousness that social actors deploy in the course of their lives to sustain or transform the structural components of their society.

This structural concept provides the necessary understanding to analyse what components of a social system are in the interest of participants to continue and what need transformation, and how changes can be made where transformation is required. There therefore may be both individual and social agency working as the actors to create structures which will determine what choices women have in relation to pregnancy and childbirth.

2.4.3 Sociological Critique of the Medical Concept of Risk

As introduced in Chapter 1, the concept of risk in this thesis refers to the medical paradigm. In this section, I will discuss the sociological critique of the medical concept of risk during pregnancy and childbirth. The term risk consistently appears in the literature in reference to birth related problems and birth outcomes. The perception of risk is a major component of the childbirth experience which influences women's choices of birth place and birth attendants, including the way they describe childbirth (Lindgren et al., 2010). The birthing process in biomedicine is grounded in metaphors of risk in which professional control and medical interventions become a routine strategy (MacKenzie Bryers and van Teijlingen, 2010). Additionally, there are dangers of medical interventions; for example, taking women away from their community setting or not allowing women to use their traditional practices, which hinder safety during childbirth (Crossley, 2007, Kitzinger, 2000).

Indeed, the medical risk epistemology divides pregnant women into 'high-risk' and 'low-risk' categories (MacKenzie Bryers and van Teijlingen, 2010). The risk categorization in childbirth assumes that the obstetric model is better for high-risk women and the midwifery model of care can be an option for low-risk women (Dowswell et al., 2010, Mayor, 2011). Thus, the medical risk approach which sees childbirth as an individual experience is some distance from the socio-cultural view. The broader focus of the socio-cultural context of women has not yet been the focus of the medical model. It is therefore limited in going beyond the risk approach and in understanding and responding to the many socio-cultural factors that are critical to pregnancy and childbirth.

The sociological view of risk is different to the medical view. Beck's (1992) 'Risk

Society' ties social risk implicitly to the concept of reflexive modernization and argues that the wider environmental and social risks which are a product of techno-scientific modernization create a threat to safety. In Beck's (1992) view, our own production and technologies produce the risks. That means society is a risk producer. This further implicates many technologies, including medicine, as being a risk producer. Giddens (1999) argues further that the danger and uncertainties we are facing today have been created by the growth of human knowledge, rather than resolved by it. This supports the socio-cultural view I take in this thesis, that medical knowledge and associated technologies/interventions actually produce other risks and contribute to lack of safety during pregnancy and childbirth.

Beck (1992) and Giddens (1999) argue that risks often require experts' identification and calculation so that lay people must rely on experts' advice in many cases about what risks are prevalent and how to deal with them. Lupton (2006) argues further that the expert's judgement about the risk can create threats and uncertainties in childbirth which thus hinder safety as I have defined it. The lay concept of risk is supported by the cultural and symbolic approach which considers risk as a part of shared cultural understanding and practices (Douglas, 1966, 1991, 1992, 2002). Douglas's (1992) thoughts on risk stem from her theorising on the cultural meaning associated with concepts of purity, pollution and otherness which is highly relevant to the childbirth practice of certain cultural groups. Lupton (1999, 2006) comments on Douglas's view of risk as a cultural strategy whereby communities make sense of danger and threats they perceive from outsiders and in which their risk beliefs and practices contribute to maintaining social cohesion and stability.

Lupton and Tulloch (2002) argue that risk is inseparable from the social and cultural lens through which we view it and understand it. However, Eckermann's (2006) argument about the influence of the medical risk concept on the well being of women during and after childbirth who are exposed to the threat of medical and technological interventions to their safety is significant to consider in practice. It reflects that there are different views about risks and how they impact childbirth decisions and practices. However, I use the term risk in this thesis to refer to the medical paradigm, in which risk is defined as a harmful outcome of an action.

2.5 Dimensions of Power and Empowerment

Power is another important construct, to the extent that in public health, power is recognised as the key concept for understanding social inequality in health. Unequal distribution of power in relation to gender, ethnicity, income status, social class, locations and many other factors has been considered as a major obstacle to bridging the existing gap in health (Marmot et al., 2008). The exercise of power is not only an action of domination or control but also turns out to consist of the manipulation of thoughts, attitudes and social relationships which requires assuming some responsibility (Kuokkanen and Leino-Kilpi, 2000). In this thesis, the term power includes both supportive and unsupportive influences.

One form of power is legitimate power which is defined as the authority that individuals hold in family and society (Connell, 1987). Another form of power is referent power which is defined as individuals having the ability to be a frame of reference and serve in the role of a significant other (Rodin and Janis, 1979). Another form of power is expert power which is a social power brought into a relationship, through education, knowledge, skills and experience (Buchmann, 1997). Power exerted as a form of coercion is called coercive power and the power gained as a form of reward is known as reward power (Molm, 1997). In Connell's (1987) view, men's legitimacy in power is highly evident in many societies but women hold a higher level of referent power which mediates gender differences in influencing their practice.

Power originates from everywhere and is involved in all human interactions (Foucault, 1979). Connell (1987) identifies the power dynamics at both family and societal level and their influence on women's autonomy. Iris Marion Young (1992) develops related insights into the presence of coercive power even where overt force is absent. She notes that oppression can designate, not only brutal tyranny over a whole people by a few rulers, but also the disadvantage and injustice some people suffer because of the everyday practices of a well-intentioned liberal society. Young terms this 'structural oppression', whose forms are systematically reproduced in major economic, political and cultural institutions (Young, 1992, pp.175-76).

Power can be also understood as a relation, in which people are not dominated but

empowered through critical reflection leading to shared action (Ball, 1992). The feminist concept of power as collective action pushes towards a transformation of existing structures and the creation of alternative modes of power sharing (Luttrell, 2007). In public health, it is argued that reducing inequalities in health requires changes in the distribution of power and power relationships (Solar and Irwin, 2010).

Empowerment is another dimension in public health which is discussed in terms of enabling people to create positive change for better health outcomes (Wallerstein, 2002). Theoretically, there are multilevel constructs about empowerment representing both processes and outcomes for individuals and their community settings (Israel et al., 1994). At the individual level, psychological empowerment illustrates the concept that includes people's perceived control in their lives, their critical awareness of their social context and their participation in change (Zimmerman and Rappaport, 1988). Community level processes include people's ability to work cross culturally as well as outcomes of transformed conditions (Wallerstein, 2002). The empowerment in comprehensive PHC includes the concept of enabling people, both individuals and groups, to gain mastery over their own affairs, by increasing their capacity to make choices and transform those choices into desired actions and outcomes (Van Olmen et al., 2010).

The concept of community empowerment as Laverack and Labonte (2000) define it is the means by which people experience more control over decisions that influence their health and lives. This concept focuses on collective ownership and collective actions to enhance health. Further, Laverack (2004) sees empowerment as a shift towards greater equality in the social relations of power. So, the concept of empowerment in public health emphasises community control of resources and community involvement in making decisions and taking necessary action (Laverack, 2011).

Both power and empowerment are relevant concepts to the analysis of influences in the pregnancy and childbirth experiences of the women in this study. During pregnancy and childbirth, there are ongoing power interplays among women, service providers, care givers and other people (Lindgren and Erlandsson, 2010, Schneider, 2011, Stevens, 2011). Additionally, there is power at play at the family level and societal level (Regmi et al., 2010b). So, there are different forms of power and

different patterns of relationships influencing the childbirth experiences which will be examined in this thesis. Similarly, the concept of empowerment allows valuing the collective ownership of pregnancy and childbirth experiences. Additionally, it offers the opportunity to examine the childbirth experiences of women in terms of their involvement in making decisions about their choices.

2.6 Dimensions of Gender and Relationships

Within a socio-cultural view of childbirth, gender is one of the dimensions that has significant influences on women's childbirth experiences (Davis-Floyd and Sargent, 1997, Davis and Walker, 2010, Lazarus, 1994, Sapkota et al., 2010). Gender refers to those characteristics of women and men which are socially constructed (Commission of the Social Determinants of Health, 2008). The influence of gender relationships is sometimes critical in the childbirth experiences of women in enhancing safety (Mumtaz and Salway, 2009, Simkhada et al., 2010a, Shroff et al., 2011). In Nepal, previous studies conducted in semi-urban and urban areas have shown that the childbirth experiences of women are highly dependent on the nature of gendered family and societal relationships (Basnyat, 2011, Brunson, 2010a, Regmi et al., 2010b). This provides the basis to examine the extent of gendered influences and how they influence the childbirth experiences of the women in this study.

Feminist researchers have also supported the socio-cultural view to understand women's issues related to childbirth and motherhood (Fivush, 2010, McNamee and Gergen, 1992, Quek et al., 2011, Stoppard, 2000, Weingarten, 1991). Morley and Macfarlane (2011) argue that the socio-cultural perspective considers gendered power relationships as a part of larger societal discourses that shape systems and practices through negotiation to produce supportive influences. Childbirth is also a part of socio-cultural events which are influenced by common social practices, cultural values and relationships in which gender and power come side by side (Benson et al., 2010, Squire and Beverley, 2009).

Gendered divisions within society affect health through unequal distribution of power and responsibility, whereby girls' and women's lower social status and lack of control over resources expose them to health risk (Commissions of the Social Determinants of Health, 2008). Gendered norms and assumptions define different

roles of men and women which give domestic responsibilities to women, limiting their opportunity to access other educational and economic resources (Walby, 1997). In Nepal, there is gender based discrimination, where girls and women get limited access to resources, opportunities and services (Stanley, 1982). It is therefore important to analyse how the gendered division of responsibilities and gender based discrimination influence the pregnancy and childbirth experiences of remote mountain women in Nepal.

The influence of family and societal relationships in pregnancy and childbirth experiences are widely discussed in both the sociological and public health literature (Barker, 2010, Khalaf and Callister, 1997, Kitzinger, 1972, Mead and Newton, 1967, Oakley, 1996). The supportive role of family members, especially the mother-in-law, has been critical during the pregnancy and childbirth of Nepalese women (Basnyat, 2011, Simkhada et al., 2010, Smart and Regmi, 2008). This relationship is highly contested in the literature exploring the submissive status of the daughter-in-law and the powerful status of the mother-in-law, because childbearing women have also expressed resistance and resentment in response to the unfair treatment they receive from their mothers-in-law (Regmi et al., 2010b). This creates the opportunity to explore the tensions and complexities of this relationship in the pregnancy and childbirth experiences of the women in this study.

2.7 Structural Dimensions

As well as gender, other structural dimensions including ethnicity, income, education and place of living are associated with maternal and newborn deaths (Joseph, 2011, Lansakara et al., 2010, Luo et al., 2010a, Mann et al., 2010, Myers, 2009, Phillips et al., 2009, Urquia et al., 2010). The socio-cultural view of childbirth recognises the influence of these structural dimensions in understanding the pregnancy and childbirth experiences of women (Conrad, 2010, Gergen, 2001, Walsh, 2010). Several studies demonstrate the association of these dimensions of women to birth outcomes and show that indigenous women, women with low income status, women with low education status, remote and rural women are more likely to experience still births and neonatal losses (Blumenshine et al., 2010, Janevic et al., 2011, Lisonkova et al., 2011, Rosenthal and Lobel, 2011a, Yang and Walker, 2010). These studies

acknowledge that there are disparities in maternal and newborn health which are influenced by socio-cultural determinants including country specific policies, strategies and resources.

Unequal access to safe childbirth services is considered as one of the main reasons for socio-economic disparities in maternal and newborn health in the public health literature (De Brouwere et al., 2010, Fotso et al., 2009, Joseph et al., 2007, Sharma et al., 2007). In Nepal, it has been recognised for decades that women living in the mountain districts have difficult geographic access to quality maternal health services which has caused poor birth outcomes and contributed to higher numbers of maternal and neonatal deaths (Acharya and Cleland, 2000, Sharma et al., 2007). Some other studies demonstrate distance to hospital as the cause of poor utilisation of prenatal and childbirth services in rural areas of Nepal (Dhakal, 2011, Joshi, 2010, Tuladhar, 2010). This means we cannot simply blame women and their culture and traditions for causing childbirth related deaths, as there are wider determinants.

Studies have consistently demonstrated that women's educational attainment, social status, household economy and decision making power are associated with health care seeking behaviour for maternal health services, including maternal and newborn survival in developing countries (Ahmed et al., 2010b, Desai and Alva, 1998, Elo, 1992, Kruk et al., 2008, Raghupathy, 1996). Similarly, the socio-economic position of the individual including their income, education, social class (gender and ethnicity) and occupation is identified as the structural determinant of creating inequities in health (Solar and Irwin, 2010) and focus is given to increase access to transport, food supply and other basic resources for survival (Bambra et al., 2010). In Nepal, studies have reported geographic inequity in the provision and utilisation of maternal and newborn care services, with rural and remote areas of the country having limited access to services (Bhandari et al., 2011, Halim et al., 2011, Morrison et al., 2010).

Socio-economic barriers are identified as resulting in the poor health of remote and rural people in Western countries as well (Drummond et al., 2011, Mueller et al., 2010). These structural factors influence women's autonomy and childbirth experiences and are identified as being associated with maternal and newborn health (Blumenshine et al., 2010, Culhane and Goldenberg, 2011). So, the issue of women

living in remote mountain areas of Nepal might be different to the issue of women from other areas in relation to childbirth experiences.

2.8 Dimensions of Culture, Tradition, Religion and Spirituality

Culture and traditions are the other dimensions of the socio-cultural view of pregnancy and childbirth. In many cultures, childbirth is considered as an untouchable and impure event (Choudhry, 1997, Regmi et al., 2010b, Thaddeus et al., 2004, Thapa, 1996). In the above cited cultures, women are kept in isolation after the birth of their baby. In some other cultures, the bleeding after childbirth is considered normal to clear the impurities of women (Cedercreutz, 1999, Matsuyama and Moji, 2008). In cultures where childbirth practices are highly traditional, women prefer giving birth within their socio-cultural boundaries without any medical interventions (Callister et al., 1999, Douglas, 1991, Obermeyer, 2000). Women in some areas of Nepal still experience childbirth in a highly traditional fashion, being consigned to the Goth (animal shed) to give birth and to spend their polluted postnatal days (Regmi and Madison, 2009, Thapa et al., 2001, Thapa et al., 2000). Culture and tradition are therefore important to examine in relation to the childbirth experiences of women in this study.

The use of traditional birth attendants (TBAs), which are locally known as Sudheni, to help women during childbirth is a common practice in many rural villages of Nepal (Falle et al., 2009, Rhee et al., 2008, Thatte et al., 2009). TBAs are traditional, non-formally trained, independent and community based providers of care during pregnancy, childbirth and the postnatal period (World Health Organization, 2004). Women's preference for using a TBA during the birth is linked with the factors of easy access to their help in the community setting and the lesser cost than accessing professionally trained health workers (Bolam et al., 1998b, Borghi et al., 2006, Sreeramareddy et al., 2006). Moreover, even in some places where medically trained care is available, women have more trust in the experienced women in the village to seek help from during the birth (Brunson, 2010a, Mesko et al., 2003b, Wagle et al., 2004). As a result, having a TBA to attend their birth is still the preference of women in rural communities in Nepal (Thatte et al., 2009).

Religion and spirituality are other dimensions which have influenced the way of

describing childbirth and shaped practices in Nepal (Edson, 2009, Ghimire and Bastakoti, 2009, Uprety and Adhikary, 2010). For example, there is a belief in a supernatural power to which people link the causes of childbirth related deaths (Ghimire et al., 2010, Kohrt and Hruschka, 2010). Thus, traditional faith healers are invited to perform rituals to overcome the threats to survival during pregnancy and childbirth (Eigner, 2010, Ghimire and Bastakoti, 2009, Kohrt et al., 2009, Kunwar et al., 2010). Further, the Hindu religion has influenced the positioning of women as the subordinates to men (Acharya and Rimal, 2009, Luitel, 2008). It has also created differences in access to information, health resources and health status through the caste system of social positioning of women in Nepal (Bennett, 2005, Bennett et al., 2008). Thus, religion and spirituality play critical roles in relation to safety during pregnancy and childbirth.

To sum up, this study uses the opportunity to reveal the pregnancy and childbirth experiences of women living in remote mountain villages in Nepal, including their associated cultural beliefs and traditional practices. It will help in understanding to what extent remote mountain women are continuing the traditional cultural practices or whether they are shifting to other dimensions of childbirth. Further, this research uses the opportunity to look at the preferences for and trust in formal and informal care providers and to examine the motivating factors for preference and trust. Therefore, taking a socio-cultural view provides the opportunity to understand and examine several dimensions of women's pregnancy and childbirth experiences which are actively involved in creating knowledge, constructing values and shaping practices in the remote mountain villages of Nepal.

2.9 Understanding Childbirth Experiences of Remote Nepalese Women: Government Policy and Everyday Practice

The Western biomedical approach to childbirth considers birthing as an individual experience and so broader contexts beyond the individual are outside of the parameters of this approach (Conrad and Barker, 2010). It therefore does not consider childbirth as a collective experience and women in relationship to their family and community. To the extent that this Western biomedical model does not take into account broader community contexts beyond the individual person (Torsvik

and Hedlund, 2008), it is limited in understanding and responding effectively to the childbirth experiences of many Nepalese women. More than 80 percent of births still occur in the community without any medical and technical help (Ministry of Health and Population et al., 2007) and more than 90 percent of births in rural areas happen outside the medical setting, with the support of family members, TBAs and other female relatives (Bennett et al., 2008).

However, the Nepalese government's policies and programs aim to make pregnancy and childbirth less risky rather than enhance safety. The overall goal of the government is to improve maternal and neonatal health and survival especially among poor and socially excluded communities (Government of Nepal, 2006). This goal firstly focuses on equity because it is about unequal treatment for equal outcomes, so the overall goal implies a focus on giving equal access to care to socially excluded and disadvantaged groups. Further, it sees poverty as a barrier to access to care. In addition, there are eight key output areas specified in the safe motherhood plan of the government in which the notion of safety focuses on reducing the risks during pregnancy and childbirth. These key output areas are: equity and access; services; public-private partnership; decentralisation; human resource development (skilled birth attendants); information management; and physical assets and procurement/finance in which caste, ethnicity, religion, gender and poverty are identified as barriers to essential health care service utilisation (Government of Nepal, 2006, pp.3-4).

The government's safe motherhood plan focuses on changing the practices of people to increase their utilisation of emergency obstetric care services, with an increased emphasis on attendance of skilled providers (doctors, nurses and assistant nurse midwives), birth preparedness and complications readiness during pregnancy (Government of Nepal 2006, p.8,). The plan is informed by biomedical evidence and the approach that the government has taken is focused on improved institutional service utilisation with the expectation that this will increase maternal and newborn survival rates. Though it is important to ensure each woman has access to care during pregnancy, childbirth and the postnatal period, the government has a limited focus on improving maternal and newborn survival in remote areas. It seems that the government is lacking a focus to address these differences in relation to enhancing

safety during pregnancy and childbirth.

Further, professional practice in Nepal is influenced by the medical view because the health care practitioners are trained in the Western biomedical way (Subedi et al., 2011). Though most of the women living in urban areas accept biomedical care, the utilisation of services during pregnancy and childbirth is still below the expected level (Brunson, 2010a). Further, there is a gap evident between the cultural and medical construction of pregnancy and childbirth knowledge which has influenced women's use of biomedical care in Nepal (Regmi and Madison, 2009). The cultural construction of pregnancy and childbirth knowledge of rural women has led to the preference for birth in the community setting with the support of the mother-in-law or another experienced female from the village (Regmi, 2010, Simkhada, 2010). In this case, rural women accept the control of family members and other support persons from the village during childbirth (Brunson, 2010a).

Although there is an assumption in the biomedical approach that the physical risks during pregnancy and childbirth can be averted through continued surveillance and medical interventions, it seems limited in achieving safety as I have defined it in the case of Nepalese women where there are many socio-cultural factors at play during pregnancy and childbirth. This is because pregnancy and childbirth are a socio-cultural experience in collectivist Nepalese society. Thus, Nepalese women's preference for giving birth in the community is linked to the opportunity for involving family members and other trusted support from the community to control the birth process (Basnyat, 2011). This notion of control is significant to the women because they may not get a similar opportunity for controlling their birth process in the medical setting where birth support is offered by professionals.

There is an increasing attempt to promote the utilisation of institutional pregnancy and childbirth care in Nepal (Borghi, 2006, Manandhar, 2004, Mullany, 2007). The Government of Nepal is now providing cash incentives to women if they attend antenatal checks and have an institutional birth (Barker et al., 2007, Ensor et al., 2009, Powell-Jackson et al., 2009). There are other funds offered at the community level to provide for women and families accessing medical services during pregnancy and childbirth (Morrison et al., 2010). The incentive schemes and other funds related to increased utilisation of services are good attempts; however, using

incentives as motivating factors limits the ability of women to make choices in relation to their preferences. Consequently, despite these initiatives of the government which aim to increase utilisation of medical services, rural women in Nepal are still avoiding medical care and continuing the tradition of giving birth in the community (Brunson, 2010a).

Amidst this growing concern there remains a limited understanding of the pregnancy and childbirth experiences of women living in remote mountain areas of Nepal and how appropriate and useful institutional birth could be for them. Most of the available literature about childbirth in Nepal is based on the evidence from urban and semi-urban areas, yet Carson et al. (2011) argue strongly that remote areas differ in many dimensions from rural and urban areas, including in relation to health, demography, and education. This thesis therefore argues that the available evidence in Nepal does not provide enough understanding about the preferences of women living in remote areas who differ along such dimensions from women in other areas of Nepal. The way childbirth is viewed and described might be different because women in remote areas come from different ethnic groups and also have differences in socio-cultural background compared with women living in urban, semi-urban and rural areas of Nepal.

Although it is important to consider the higher maternal and neonatal mortality rates in Nepal, given the arguments about negative consequences of the medicalisation of birth and acknowledging that birthing is a socio-cultural experience, applying the Western biomedical approach to childbirth raises serious concerns in relation to women's physical and social ability to access care, community acceptance of care, the socio-cultural background of people and concern for safety in the diverse community cultures of Nepal. This is because the Western biomedical approach does not address the many socio-cultural forces that are critical to the pregnancy and childbirth experiences of women (Fox and Worts, 1999, Oakley, 1996). This emphasises the importance of the socio-cultural approach to determine the safety of remote mountain women during pregnancy and childbirth.

Indeed, giving the opportunity to women, family members and other people from the community to share their experiences is one step towards seeing what is happening in relation to pregnancy and childbirth in mountain villages. Moreover, recognizing

the many forces which oppress Nepalese women within their community provides an opportunity to identify and get a deeper understanding of the processes for promoting the safety of women in remote mountain areas of Nepal. This research is liberating in a sense because it enables women and the community to gain shared ownership of their experiences within the village setting.

2.10 Developing Shared Understanding and Collective Ownership – Theoretical and Conceptual Basis

As introduced in Chapter 1, critical feminism is one of the approaches used to provide a theoretical foundation for this study. Several socio-cultural dimensions of childbirth discussed earlier in this chapter are consistent with the theoretical assumptions of critical feminism.

Critical feminism is committed to overcoming oppression resulting from unequal social relations specifically those related to gender (Nast, 1994). In other words, the commitment to the emancipation of women is central in critical feminism. The central themes of critical feminism include inclusiveness, cooperation and collaboration, mutual respect and trust, multiple ways of knowing, and collective action that challenges the marginalisation and silencing of women (Ironside, 2001). Given that pregnancy and childbirth are predominantly women's experiences, this approach can be meaningful and enlightening to enhancing safety. This approach offers the opportunity to analyse the diversity of pregnancy and childbirth experiences of women and associated issues of power and oppression that arise from various socio-cultural differences (Hughes, 1995). Similarly, the central tenets of empowerment and transformation in critical feminism allow women to claim ownership of their pregnancy and childbirth experiences.

Critical feminism draws on the concept of oppression. Freire's (2000) critical pedagogy, particularly his 'Pedagogy of the Oppressed' rests upon the vision of social transformation through liberation and opposition to oppression, which is also the central focus of critical feminism. The critical pedagogy that Freire (2000) developed focuses on concepts of oppression, conscientization and dialogue. Freire has given value to collective knowledge and action. Central to Freire's pedagogy is the practice of conscientization that is coming to the consciousness of oppression and

the commitment to end that oppression. To end the oppression, Freire (2000) offers an approach which instigates dialogue between the oppressors and the oppressed. In this dialogical approach, the assumption is that the oppressors are on the same side of the oppressed and that they engage together in a dialogue about the world. The dialogue between them uncovers the same reality, the same oppression and the same liberation, which he calls collective liberation (Freire, 2000). This collective liberation is what the critical feminist theorists are also aiming for. So, this thesis is based on these theoretical assumptions which are relevant to researching the pregnancy and childbirth experiences of women.

Irish Marion Young, in her book 'Justice and the Politics of Difference', argues that the ideal of community presumes subjects who are present to themselves and subjects who can understand one another, as they understand themselves, thus denying the difference between subjects (Young, 1990, Young and Danielle, 2011). Young's (1990, p.234) concept of 'politics of difference' offers an understanding of social relations without domination in which persons live together in a relationship of mediation with outsiders, whom she calls strangers, with whom they are not in community. Young (1990, p.244) further argues that people deny the differences and do not trust and respect the people they do not know. Therefore, people strive for mutual identification, shared understanding and reciprocity (Young, 1990, Young and Danielle, 2011). Young (1990) highlights the differences existing in current society and envisions a society which denies oppression, values reciprocity of understanding, fosters social relations of equality and shares common values. Young (1990, p.251) argues that mediating with the people who are not parts of the community and who share their differences makes it possible to create a good society, which in her term is an 'unoppressive city'.

Heath (2007) introduces the concept of collaborative dialogue and suggests three different dialogic themes in relation to collaboration. Firstly, Heath (2007) argues that dialogue generates new ideas, thoughts, processes and outcomes. Secondly, Heath (2007) acknowledges the diversity of ideas and argues for community dialogue and creativity which can contribute to negotiating differences elicited by diversity. Thirdly, Heath (2007) argues that dialogue allows for reciprocity and symmetry between participants in which power is shared and negotiated in decision

making situations. In line with Freire (2000), Heath (2007) argues that dialogue enables participants to share their ideas and negotiate power in their relationships which raises consciousness and leads to transformative and more liberating relationships. Consistent with Young (1990), Heath (2007) argues further that dialogue allows the conditions to be built that can counter the talk and action that silences the community voices, which is a form of oppression.

Heath (2007) argues that in collaborative dialogue, stakeholders negotiate power from a position of mutual interest. Heath (2007) argues further that community collaboration is better achieved through dialogue among the stakeholders that emphasises creative outcomes in the communication situation. Heath (2007) exemplifies the diversity in ideas leading to innovation and creativity through negotiation of power and reciprocity in relationships. Heath (2007) found that the reciprocity and symmetry visible during the conversations encouraged further dialogue among the stakeholders to develop shared understanding. Heath (2007) sees dialogic moments as the means of transformation to gain community collaboration.

So, Freire (2000), Young (1990) and Heath (2007) see oppression as the central issue of current society. The theoretical approach of critical feminism focuses on fighting against oppression for social equality. Freire's (2000) concept of dialogue, Young's (1990) concept of mediation and Heath's (2007) concept of collaborative dialogue provide the opportunity to act for liberation through ending oppression in society.

In this section, I have briefly introduced the central themes of Freire's (2000) 'Pedagogy of the Oppressed', Young's (1990) 'Politics of Difference' and Heath's (2007) concept of collaborative dialogue which offer opportunities to explore many dimensions of the pregnancy and childbirth experiences of women living in remote mountain villages of Nepal. These central themes are also consistent with the key tenets of the critical feminism I am using in this thesis. As this research values the collective ownership and shared understanding of the pregnancy and childbirth experiences of women, these concepts provide a solid foundation to argue that pregnancy and childbirth are not only individual experiences but also collective socio-cultural experiences. While discussing the findings of this research, I will relate these concepts where relevant.

Conclusion

The socio-cultural view considers pregnancy and childbirth as a collective socio-cultural event which involves many dimensions of women and the community. This view recognises the influences of many factors and relationships in childbirth safety. Considering the limited understanding of the socio-cultural dimensions of remote women's experiences in Nepal, bringing to this study the local voices of women from these areas, and those of other influential people, is important because their voices need to be heard before taking any action.

While government policies and programmes in Nepal have focused on increasing service utilisation and professional attendance at birth, the relative positive aspects of birth in the village setting are important to explore. This is because we must raise the question of what impacts these policies and practices have on safety in these communities because while their intention is to decrease risk, there is a chance they may erode safety. This study takes the opportunity to provide an understanding of the perspective of women and other people from the remote mountain areas of Nepal to address the existing gap between medical constructions of knowledge as reflected in policy and cultural constructions of knowledge as evident in childbirth practices in the community setting. As this thesis values collective construction and ownership of childbirth experiences, the theoretical approaches of social constructionism and critical feminism provide a solid foundation. Similarly, Freire (2000) and Heath's (2007) notion of dialogue and Young's (1990) notion of mediation provide extra assistance in analysing the pregnancy and childbirth experiences of women living in remote mountain villages of Nepal.

The methodology of this research is also designed to take the socio-cultural dimensions of women and the community into account in ways which acknowledge their local knowledge and practices in relation to pregnancy and childbirth. The next chapter will describe the methodology of this thesis.

Chapter 3: Methodology

The discussion in the previous two chapters powerfully advocates for women to be central and for socio-cultural factors to be taken into account in order to enhance safety in pregnancy and childbirth, about which the community is the expert. The views of social constructionism and critical feminism about the influences, relationships and construction of knowledge about pregnancy and childbirth provide the theoretical benchmarking for this thesis. Public health and social science literature recognises the critical influence of many socio-cultural factors on safety during pregnancy and childbirth. Similar influences are evident in the childbirth research in semi-urban, urban and rural areas of Nepal. There is yet however limited understanding of the factors that influence the childbirth experiences of women living in the remote mountain areas of Nepal.

This chapter will detail the research approach in this study including the theoretical approach and the methodological approach which were adopted to uncover local voices in order to understand the factors which have an impact on pregnancy and childbirth experiences in remote mountain areas of Nepal.

3.1 Research Approach

Oakley (1980) suggests that the rationale for studying what happens to women when they are pregnant and give birth is to suggest why they react to childbirth in the way they do and how their experiences of childbirth can be enhanced in terms of safety. She further argues that 'the complexities of childbirth experiences of women need an extensive sociological analysis of relationships of experiences and birth outcomes' (Oakley, 1980, p.114). Oakley (1980) took a critical perspective in analyzing the relationship between socio-cultural forces and the experiences of women during pregnancy and childbirth.

In public health, Baum (2008) has identified four main applications of qualitative research methods: to study and explain the economic, political, social and cultural factors that influence health; to understand how people interpret health and disease and make sense of their health experience; to elaborate causal hypotheses emerging from epidemiological and clinical research; and to provide contextual data to

improve the validity and cultural specificity of quantitative survey instruments. Wilkinson (2000) argues that current research into identifying social determinants of health should focus on following the issues across the interdisciplinary boundaries where they emerge from rather than trying to understand what the determinants are. Smith (1999) advocates for the identification of methodologies that have the potential to ensure that research with remote people can be respectful, ethical, sympathetic and useful.

The biomedical research approach tends to favor objective collection of data by outsiders, ignoring the ideas, knowledge, perceptions and experiences of the people being studied (Winch and Hayward, 1999). This study aims to uncover local voices, which thus demands subjective accounts of participants. Qualitative methods are therefore chosen to document accounts of participants' experiences. Baum (2008) argues for the appropriateness of qualitative methods in public health since they are well suited to studying complex situations and offer much to the study of public health. Informed by this view, this research is qualitative in design.

Qualitative methods are viewed by feminist researchers as more compatible with critical feminism's central tenets, which allow women's voices to be heard, providing them with the opportunity to express their feelings, share their knowledge and explore their reality (Bryman, 2001). Although methodological issues and the complexity of understanding childbirth experiences have been discussed in the literature (eg Brown and Lumley, 1998, Larkin et al., 2009, Pitchforth et al., 2008), discussion has not adequately addressed the ways of resolving these issues to enable women and other people involved in pregnancy and childbirth to own their experiences. Thus, I have used the theoretical approaches of social constructionism and critical feminism as an epistemological basis in this thesis, which allows me to explore the complexities and diversities and to arrive at a contextual understanding of remote mountain women's experiences of pregnancy and childbirth in Nepal. These theoretical approaches allow me to view childbirth as a collective socio-cultural construction of experiences and also enable participants to claim the ownership of their experiences.

3.2 Methodological Principles

I have noted in section 3.1 that social constructionism and critical feminism inform the appropriate way to deepen understanding of childbirth issues in complex community settings. With the aim of exploring the complexities, uniqueness and diversities of childbirth experiences of women living in remote mountain villages of Nepal, these theories value community knowledge and give authenticity to the sources from which such knowledge is constructed (Locher and Prügl, 2001). Furthermore, the comprehensive PHC concept supports the view that community people know their problems and are able to identify appropriate approaches for dealing with their problems (Hurley et al., 2010). Using a qualitative research design, I drew on some methodological principles to guide the research process.

There are three main methodological principles I followed in this research: 1.) I valued participants' experiences as authentic sources of knowledge, 2.) I considered pregnancy and childbirth experiences as naturally occurring interactions, and 3.) I valued the concept of the researcher's reflexivity in research.

3.2.1 Experiences are An Authentic Source of Knowledge

Feminist researchers have emphasised the importance of valuing traditional knowledge while making meaning of the childbirth experiences of women in their socio-cultural dimension (Martin, 1990, Oakley, 1986). Stacey (1994) argues that community people should be considered as experts while making meaning of their experiences because they are the ones embedded in the context while constructing the experiences. Popay and Williams (1996, 2006) posit a pivotal role for lay knowledge in deepening our understanding of issues and they advocate creative and new research methods to make this knowledge visible and accessible to those engaging in health debates. They argue that knowledge is created through interactions between researchers and participants. In this research I value the experiences of participants and their involvement in giving meaning to the data. This contributes to producing new knowledge about many dimensions of the pregnancy and childbirth experiences of women living in remote mountain villages of Nepal.

Armstrong et al. (2006) and Popay et al. (2003) argue that people's personal

accounts create meaning, incorporating the ways in which they interpret their reality, how this reality affects them and the way they think produces better outcomes. The participants' personal accounts of experiences in this study help me to develop an understanding of knowledge creation in order to reconstruct practice in ways that enhance their descriptions and understanding of their pregnancy and childbirth experiences. Macintyre (2011) argues for giving importance to people's experiences in understanding social inequalities in health and giving value to the lay knowledge of the people and their personal experiences in everyday life equal credibility to medical knowledge. In this study, I give credibility to the traditional knowledge and both individual and collective experiences in relation to pregnancy and childbirth.

3.2.2 Pregnancy and Childbirth Experiences are Naturally Occurring Interactions

The research setting being naturally occurring interactions (Guba and Lincoln, 1985, p.25), allows me to respect the socio-cultural context of participants in this study. This concept in research seeks to understand social reality as it happens, which provides rich descriptions of interactions in natural settings (Bryman, 2001). I have valued this concept and adopted it as a guiding principle in this study. Social researchers value naturally occurring interactions as authentic sources of information (Charon, 2004, Mead, 1972). This consideration allows me and the research participants to develop both trust and familiarity while interacting.

Charon (2004) argues that when an individual makes interpretations of their experiences, they link them both to the individual and societal level. Consequently, even the personal experiences of childbirth become collective through the involvement of social interactions. As childbirth is a part of everyday life events in remote mountain areas of Nepal, this thesis seeks to explore pregnancy and childbirth experiences within the everyday life settings of women. While understanding the meaning of experiences, I give value to both individual and collective constructions of pregnancy and childbirth experiences as they occur in the participants' socio-cultural setting.

3.2.3 The Researcher's Reflexivity in Research

The researcher's reflexivity is one key concept which determines the impact of the research process on the quality of research findings (Burgess, 1984, Hammersley and Atkinson, 1983, Reed - Danahay, 1997, Vann Maanen, 1988). Reflexivity is defined as a process of critical self reflection and an acknowledgement of the inquirer's place in the setting, context, and social phenomena he or she seeks to understand and is also a means for a critical examination of the entire research process (Schwandt, 2006). Thus, the researcher's reflexivity represents a methodical process of learning about self as researcher, which, in turn, illuminates deeper, richer meanings about personal, theoretical, ethical, and epistemological aspects of the research question (Kleinsasser, 2000). Schwandt's (2006) concept of reflexive process included in the definition refers to the documentation of the setting, context and phenomena. My reflexivity in this study was maintained through reflexive notes of each interview and reflexive journaling of fieldwork.

Reflecting the two approaches of social constructionism and critical feminism discussed in previous sections, my role during the fieldwork was to facilitate participants to share their experiences in relation to pregnancy and childbirth. I did that by helping them to talk about their perceptions, feelings, expectations and experiences through in-depth interviewing. I also had an opportunity to observe the events and interactions happening in the family apart from the conversation with the participants. I documented these observations in reflexive journaling which gave me more understanding of the family and their social circumstances. This reflexivity added value to the data while analyzing and interpreting the findings of this study. Both my conversation with participants and observation of the household events helped me to enhance the richness in the data which contributed to the quality of the research findings.

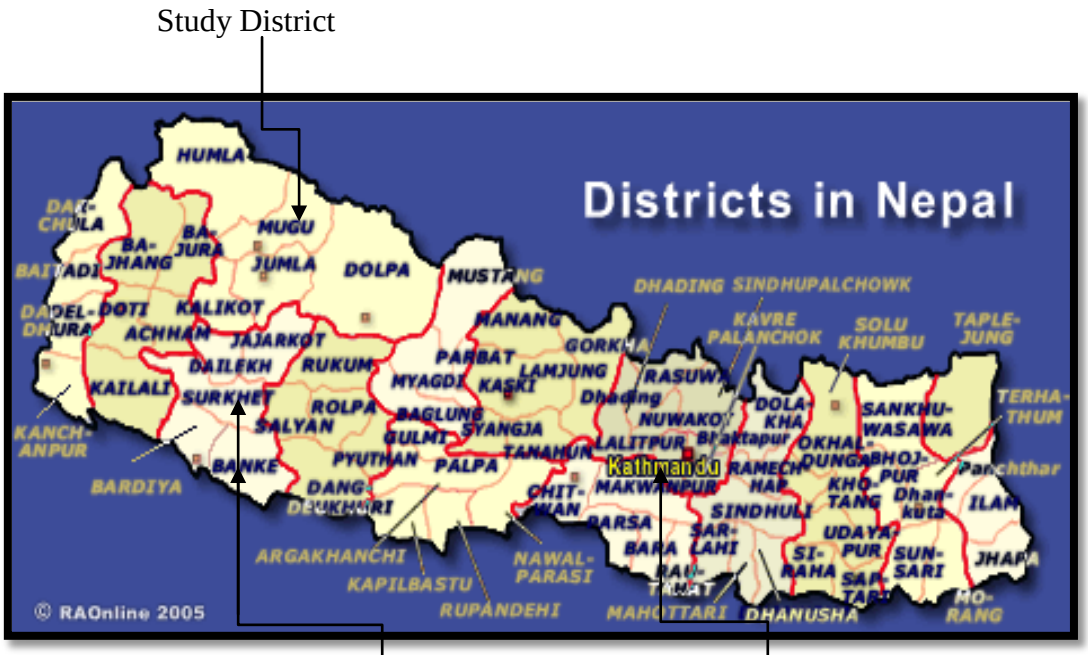
3.3 Field Work

The fieldwork of this study was conducted in two remote mountain villages of Nepal where I was involved in participants' everyday life activities during the course of data collection. Considering the weather and working seasons of the mountain areas, the fieldwork time was scheduled from February to May 2010, because the villages

are usually covered in snow from late November to January which constrains the movement of the people. As soon as the snow starts melting, generally in April, the cropping of potatoes and barley starts in these areas. The people usually harvest their potatoes, barley, oats and grains by September. When the field work started in the villages, it was still cold as there was still snow on the top of the mountains where the people went to crop their potatoes and barley. I took the opportunity to spend the weather transition time in the villages because the villagers migrate to the high altitude farming areas when the climate is ready to start cropping.

3.3.1 The Field Area

The Mugu district of Nepal was purposively selected to conduct the field work of this study. Mugu is one of the 75 districts which are located in the Midwestern region of Nepal (Rimal et al., 1997).



Map 1 - Nepal Country Map

Source: http://www.raonline.ch/pages/news1/maps/npdistrictmap2s.gif

Mugu district is one of the poorest and most remote districts in Nepal where most families only manage to grow enough food for six months of the year (District

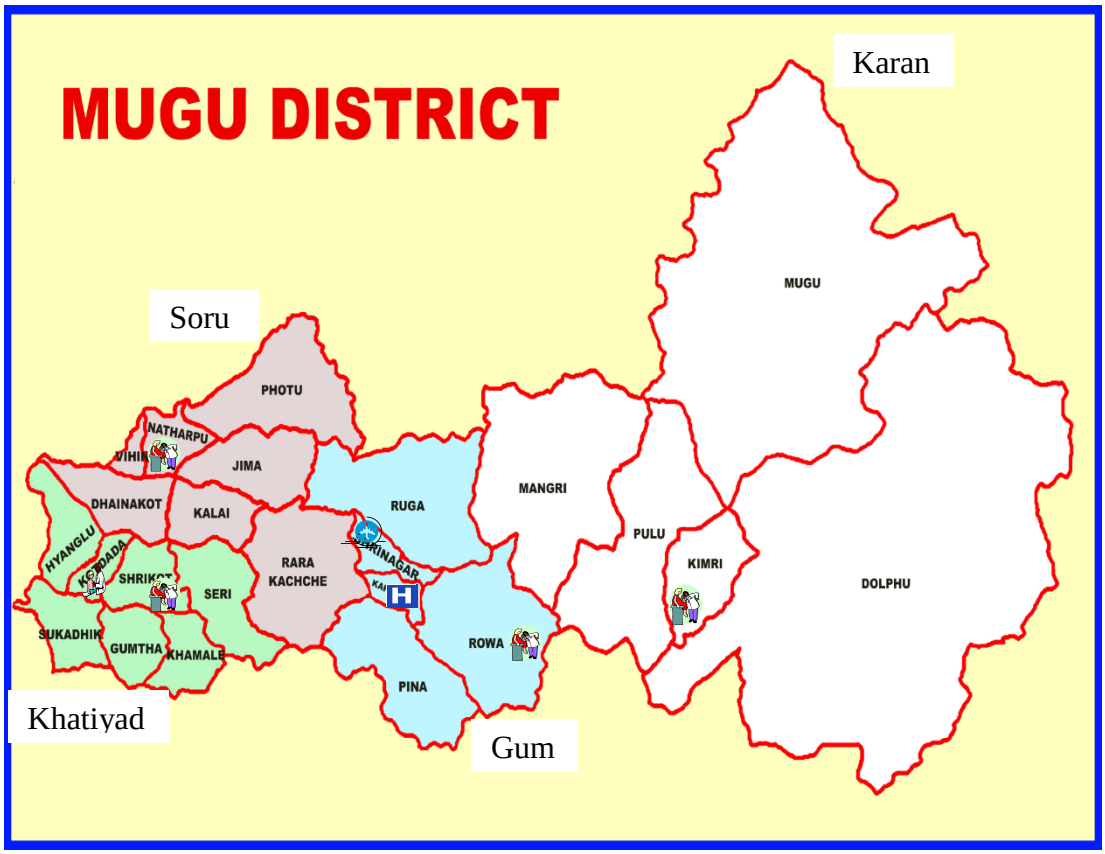
Development Committee, 2009). The social structures, cultural practices and lifestyles of the people living in different parts of the district are diverse in relation to their ethnic background (Bista, 1972). The people living in the northern part of the district bordering China are considered indigenous and follow Tibetan values and the Buddhist religion; they are known as Lama people (District Development Committee, 2008). The study villages are snowy during the winter, and the areas bordering China were cold during the time of this research with snow still on the peaks of the mountains.

Only 5 percent of the total area of the district has fertile land which causes food shortages (District Development Committee, 2009). The total population of the district is 55,605, in which the female population is 49.2 percent and the average family size is 6.1 (District Development Committee, 2009). Chhetry is the most predominant ethnicity in the district with the highest percentage of the population (49 percent), whereas the indigenous group is the fourth largest population (9 percent) and the other 42 percent of the total population comprises numerous other ethnic groups (District Development Committee, 2008).

Plate 1: Geographic Terrains of the Mugu district – Photo Credit: Author

Geographically, the district has different terrains (Plate 1). There is a beautiful lake called ‘Rara’. The villages are scattered in different terrains. The different villages are occupied by different group of people. This research is focused on the Chhetry

and Lama groups of population in the Mugu district of Nepal. In the district, about 90 percent of people use the Nepali language (District Development Committee, 2009). Geographically, the district is divided into four areas: Khatiyad, Gum, Soru and Karan, and each area comprises five to six village development committees (VDCs), which are the lowest administrative unit of the government (District Development Committee 2008). The participants in this study were selected from two villages of this district, one from the Karan area and another from the Gum area. The Karan area is mostly occupied by Lama people who are Tibetan descendants and the Gum area is mostly occupied by Chhetry people.



Map 2: Mugu District Map, Source: District Development Committee, Mugu

Within the Mugu district there are several health facilities at different levels in the health system structure including one district hospital, one Primary Health Care Centre (PHCC), eight Health Posts (HP), 16 Sub Health Posts (SHP) and two Ayurvedic Health Care Centres (AHCC). The main facilities are shown in Map 2. However, according to the most recent district report (District Development

Committee, 2008) only five of these health facilities including the district hospital were officially listed to provide maternal and newborn care services. Nearly half of the population did not use the services provided in these health facilities because of the distance factor, and 7 percent of the people also expressed no trust in the care provided in these service centres. Another 25 percent identified the problem of unavailability of health workers (District Development Committee, 2008). According to the district report, more than 20 percent of the people in the district still preferred using traditional healers during illness instead of going to the health care centres.

3.3.2 Study Villages

Participants in this study were selected from two villages of the Mugu district. I named these two villages as the first village and the second village.

The First Village

This village (Plate 2) is located two days' walking distance from the district hospital. People living in this village follow Buddhism and Animism. Their only means of transporting foodstuff to the village is by donkey. They have a seasonal migration trend, where they move to the plains area during the winter because of the high snowfall. During summer, which starts in April and ends by October, they go to the high altitude farming land.

Plate 2: First study village - Photo Credit: Author

In the first village they use Tibetan script in reading and writing in the community and speak Nepali language in conversation with outsiders. The practice of early marriage is common. Most of the marriages in this group occur by negotiation between the girl and boy, and are not arranged by parents. Some women in this village give birth in the Goth (animal shed) and others choose the outside corner of the house. The duration of childbirth pollution in this group varies from three days to 15 days. They do not have any formal childbirth services available in the village; the closest professional help is located at the district hospital.

The Second Village

This village (Plate 3) is about half a day's walking distance from the district hospital. This group has comparatively better access to food because of their location being closer to district markets. They have no seasonal migration but are permanent settlers in the village. The participants involved in this study from this village speak Nepali language and follow Hinduism. Early marriage of girls is a common cultural practice in this village compared with other parts of the country. Marriage in this group is arranged and occurs according to the interest and preference of parents, generally from 12-15 years of age. The duration of birth pollution in this village is generally 15 days to 30 days. The Goth is the most common place of giving birth. This village also has a birthing centre where there is a professionally trained midwife providing 24 hours childbirth services.

Plate 3: Second study village - Photo Credit: Author

3.3.3 Maternal Health Initiatives and Resources in the District

The maternal health programme in Nepal is based on the concept of 'Safe Motherhood' introduced by the World Health Organisation and focuses on family planning, antenatal care, safe delivery, and essential obstetric care (World Health Organization, 1994). The Government of Nepal also launched the Nepal Safer Motherhood Project (NSMP) in March 1997 to improve maternal and neonatal survival and reduce maternal and neonatal mortality. The NSMP was limited to only 10 districts until 2004 and most of the remote districts were not included. In 2005, the Department for International Development (DFID) of the UK provided the next level of funding to implement the Maternal and Newborn Health Project (MNHP) through the Support to Safe Motherhood Programme (SSMP) in a few more districts of Nepal. Mugu, which was the lowest in the Human Development Index and had no emergency obstetric care services, was chosen for the expansion of basic emergency obstetric care services in the district hospital and for the implementation of the MNHP in order to reduce maternal and newborn mortality (Support to Safe Motherhood Programme, 2006).

The United Mission to Nepal in partnership with the District Health Office (DHO) started the implementation of the MNHP programme in the Mugu district in October, 2005. The focus of the programme was on: policies; strategies and structure; social empowerment; services; and information management (Support to Safe Motherhood Programme 2006, p.39). This programme has focused on both service strengthening and community awareness aiming to increase access to quality emergency obstetric care services and information. The district hospital started to provide 24 hours basic obstetric care services in July, 2006 (Support to Safe Motherhood Programme, 2006, p.46). Four health facilities in other areas of the district were upgraded to provide 24 hours birthing services in local level (Map 2), however only two of them have provided services since their establishment (Chapagain, 2010).

Since 2009, the national government has also supported a safe birth incentive programme in which women are entitled to get 1500 rupees (approx. US$20) if they give birth in a district hospital or another certified birthing centre in mountain districts (Family Health Division, 2009). Recently, the government has also made provision for giving a cash incentive to those women who make at least four visits

during their pregnancy to a prenatal clinic (Family Health Division, 2010). However, the impact of these initiatives on women's pregnancy and childbirth experiences is not effective in the remote areas where services are geographically hard to access. In the study area, although there is one birthing centre building established in both villages, services are not available because of the unavailability of professional midwife. The nearest health facility where women can access basic maternal and newborn care services is one day's walking distance from the first study village, and the district hospital is two days' walk from the first village and half a day's walk from the second village.

3.3.4 Status of Women in Remote Mountain Villages

In Nepal, as in other developing countries, women are among the poorest and most vulnerable group of people (United Mission to Nepal, 2010). The situation of women living in the mountain areas in Nepal is different to women from other areas of the country in relation to their socio-cultural pattern (Cameron, 1998). Most of the women in remote mountain villages are illiterate and not exposed to places beyond their social, geographical and physical boundaries (Dahal, 1996). The health status of women is low; they have a high burden of unpaid domestic and farm work, at the same time as a high burden of continuous pregnancy, childbirth and childrearing (Panter-Brick, 1989). Generally these women also suffer from malnutrition. In the study district, women have the lower life expectancy of 42 years, compared with 44 years for men (District Development Committee, 2009).

Women living in remote areas of Nepal have been widely considered as 'oppressed' and 'disadvantaged' because of their relative poverty (Acharya et al., 2007, Gwatkin et al., 2005, Shrestha, 1994). Although women following Tibetan philosophy have a comparatively respected position in their society (Watkins, 1996), the status of Hindu women is marginalised due to gendered social and religious norms where women are supposed to follow the wishes of their husband (Cameron, 1998). In the study villages, some women follow the Hindu religion and some others follow Buddhism. However, there is an influence of both religions in their practice. In some instances, only one of these philosophies drives their status and in some cases both do.

3.4 Recruitment of Research Participants

At the time of the study, the participants comprised either pregnant or postnatal women (given birth within the four weeks prior to interview), their husbands, mother-in-law, father-in-law, service providers and local stakeholders of the community. A purposive sample (Morse, 1989) of 25 pregnant or postnatal women was invited for an in-depth interview. As the study aims to uncover the local voices, participants purposively chosen for this study were regarded as experts and considered as enriched sources of knowledge developed through their experiences.

Criteria developed for the selection and invitation of participants of this study were:

1. Women living in the village who are married, pregnant (more than 24 weeks of current pregnancy) and expressed willingness to participate in the study;

2. Women living in the village who are married, have given birth within the last four weeks and expressed willingness to participate in the study;

3. Husband, mother-in-law and father-in-law of the above women who expressed willingness to participate in the study;

4. Service providers at local and district level who expressed willingness to participate in the study;

5. Local stakeholders of the two study villages who expressed willingness to participate in the study.

Using these criteria, there were 25 women (pregnant or postnatal), five husbands, five mothers-in-law and one father-in-law who participated in an in-depth interview. The need to work outside the village made it impossible to access more mothers-in-law and husbands to be involved in the study. Despite that, a majority of husbands who were living with their wives and who were asked to participate in the research did not express their willingness to participate. They said that they did not see any importance in being involved in women's pregnancy and childbirth issues. All of the participants were interviewed by the researcher mostly at home while they were working.

Similarly, interviews were conducted with service providers and local stakeholders who were involved in women's childbirth experiences. In the service providers' group, there were five people involved – a female community health volunteer, a midwife, a local health worker, a traditional faith healer, and the medical doctor working in the district hospital. In the local stakeholders' group, there were four people involved – a journalist, a school teacher, an indigenous leader and a local political leader.

3.4.1 Recruitment Process

In the first stage of the recruitment process, I met with a female community health volunteer (FCHV) and a local health worker in the community to identify the pregnant and postnatal women. Then I provided a letter of introduction and a brief summary of the research in Nepali language to the FCHV to share with potential participants (See Appendix 1 and 2). The FCHV then approached the pregnant and postnatal women for their acceptance to be involved in the study. The FCHV shared the information about the project to all potential participants of the study and collected the names of interested women. Then I approached those participants who had agreed to participate in the study. I put their names in the recruitment list and interviewed them individually with informed verbal consent. The age range of the women involved in this study was from 17 years to 43 years, and only one woman was a first time expectant mother. Among them, only five mothers had experienced their first childbirth in the hospital. Numbers of pregnancies each woman had experienced ranged from one to 11, and the age at marriage ranged from 13 years to 25 years (See Appendix 3 and 4 for more detailed information about the pregnant and postnatal women participants of this study).

Once I completed the interviews with the women recruited for the study, I then requested the FCHV to approach their husbands and mothers-in-law to ask if they wished to be involved in the research. Only those who were available and interested in participating were interviewed. Finally, I identified service providers and local stakeholders in the community on the basis of information revealed during the in-depth interviews of the women and family members. All stakeholders and service providers I approached to be involved in the research accepted my invitation and participated.

3.5 Ethical Considerations of the Study

Many qualitative researchers, and especially those working in critical approaches such as feminist research, have championed equality in the researcher/participant relationship (Walsh and Downe, 2005). The status and integrity of research subjects is most visible now through mandatory ethical approval procedures (Rice and Ezzy, 1999). The ethics approval process in this research was based on the concept of protection of individuals from harm through maintaining confidentially, anonymity and informed consent. Qualitative researchers often take this further than the single approval process at the beginning of their studies by explicitly keeping participants informed at all stages of the research process, and by attempts to ensure that participants encounter respect, transparency and openness (Walker, 2009). This emphasises an ethical underpinning to all research endeavours, beyond mere adherence to ethical procedures (Hansen, 2006).

This study followed the procedure of ethics approval and has maintained the universal standard of research ethics according to Australia's National Health and Medical Research Council (NHMRC) guidelines. I applied to and received the approval for conducting this study from the Social and Behavioural Research Ethics Committee (SBREC) of Flinders University of South Australia. I also received written permission to conduct the field work in two villages of Mugu district from the Family Health Division of the Department of Health Services of Nepal. Before involving the participants in this study I gained permission from them following the verbal consent procedure because of their lack of literacy. In the case of the pregnant and postnatal women, I also gained the permission of their family before initiating conversation with them, since it was culturally appropriate to do so. Letters of ethical approval and permission for this study are provided in Appendix 5.

Further, the ethical aspect of the study draws on the concept of deontological morality; the question of whether the research treats participants as they ought to be treated or as they have a right to be treated (Osrin et al., 2009). Schuklenk and Ashcroft (2000) observe that public health research lends itself to utilitarian morals within which it should maximise health or satisfaction for the greatest number of people, and in which an action may be justified by its overall results rather than by

its effects on the individual participants. This perspective, known as consequentialism (Schuklenk, 2000), is attractive but difficult to maintain practically. Nevertheless, Osrin et al. (2009) point out that a focus restricted to individual self-determination does not necessarily resonate with our experience of social life, the connectivity between people and the public health agenda. In this study, I was particularly conscious of my previous introduction as an employee of the private sector with the health workers and my involvement in district level maternal health programmes. I tried not to influence participants by bringing in these experiences of involvement and connection during the research. I made every effort as a researcher to clarify my objectives and role in the village.

I tried to maintain confidentiality, anonymity, informed consent and the researcher-participant relationship throughout the study, making appropriate decisions according to the situation. However, it was not possible to maintain the confidentiality of the conversation where participants lived in close physical proximity to others. In a culture where talking with someone privately is not commonly acceptable, I had to accept the presence of other people in some cases during interviews. Such presence of other people during the interviews was acceptable to the research participants.

Indeed, I made appropriate attempts not to harm the research participants, adopting a number of strategies while conducting the research. Firstly, I gained informed verbal consent with each participant and also with their family where necessary. Secondly, I adopted a flexible approach respecting the circumstances of the participants in order to maintain ethical standards in the research process. This was because childbirth was a more painful event for some women who had experienced the loss of their newborns. In such situations, where participants felt uncomfortable sharing their experiences, I stopped the interview and re-scheduled the time for another interview. Thirdly, I told them clearly in the beginning that they could share only the experiences they wanted to, I did not force them to answer any question for the purpose of the research. Fourthly, I told them to invite me where and when they would like to have the conversation. I also told them to stop the conversation any time they wanted to stop. Some women actually stopped the conversation because of the presence of their husband or mother-in-law or father-in-law. I acknowledged

every encounter and respected the decisions of participants in all stages of the interview.

However, dealing with complexities and maintaining the ethical standards of the research was not an easy task while the research was aiming to privilege experiences within their socio-cultural dimension of living. Indeed, I attempted to understand the childbirth experiences making every possible attempt to maintain the ethical aspects and quality of the research. The flexibility and reflexivity adopted during the field work helped me to maintain the ethical standards and to get data which was rich in insight.

3.6 Sources of Data

This study used face to face in-depth interviews as a primary source of data. The secondary sources of data in this study were the researcher's reflexive diary, field notes and related documents such as policy documents and photographs.

3.6.1 In-depth Interviews

As mentioned earlier, I conducted in-depth interviews with the research participants of this study. The interview process applied the process of a two way conversation (Rice and Ezzy, 1999), in which the participants were open to sharing their thoughts, feelings, emotions, stories and experiences in relation to their pregnancy and childbirth. As Sarantakos (1998) recommends, I used the technique of semi-structured in-depth interviews. In using a semi-structured format to conduct the interview, I also acknowledged a concern raised by Jones and Buggie (2006), who believe that there is no such thing as assumption free research and therefore the researcher should have some broad questions in mind before initiating the interview. As Broom (2005) suggests, the interview guide facilitated an open environment that allowed the interviewee to reflect upon the issues that were introduced. This provided the opportunity to carry out interviews with defined areas and questions which needed to be asked to explore the childbirth experiences of the women. It also encouraged participants to raise and expand on their own ideas about the topic being discussed. Using the interview guide with open themes for the discussion during the in-depth interview provided me with the confidence to maintain the process and to

generate valuable data.

Generally, I used a flexible approach throughout the interview to explore and elaborate on various thoughts, feelings and impressions raised by participants as they identified and talked about different events, moments and incidents in their lives. Initially, I envisaged that this would take the form of a recursive interview model as set out by Minichiello et al. (1995), where questioning relies on the process of conversational interaction. Using this technique, I maintained a flexible and reflexive approach, picking up on what was being said at that moment to explore the remark further, or to redirect the participant's focus to the topic of interest. Denzin and Lincoln (2008) discuss the reflexive interview as being concurrently composed of a discursive method, a site for conversation, and a communicative format that produces social knowledge.

Taylor and Bogdan (1984) point out that the relationship between the researcher and participant is an essential component of gaining trust while collecting good data. Even though it is understood that the interviewer's perceptions can influence the discussion, so too may the participant's (Minichiello et al., 1995). Therefore, to gain the best information possible from participants, I conducted all interviews in this study engaging in the conversation, listening carefully, seeking clarification of concepts as they arose, and asking participants questions about their data.

3.6.1.1 Interview Process

Once informants were identified, they were informed about the purpose of the study and the ethical issues in relation to the study's procedure. This involved informing them that the interview may be recorded, their anonymity and confidentiality would depend on the circumstances as mentioned before and they would have the right to not answer any questions during the interview or refuse to continue with the interview at any time. After the informed verbal consent, the interview took place in a location chosen by participants, mostly in their kitchen and working area. The interview followed the natural conversation process where my role was to assist participants to explore their experiences. To give participants enough opportunity to talk about their childbirth experiences, I opened the conversation using more general questions and examples related to childbirth. Then, the conversation was continued

focusing on the areas covered in the semi-structured interview schedule.

During the interview, as suggested by Im et al. (2004), I was particularly careful to ensure that the questions were relevant to the language spoken by the people. While conversation continues in a broad theme, Berg (2007) suggests using the probe, which I did to clarify and understand particular issues. I also prepared observational notes of the factors and events noticed during the interview process to complement the interview data for analysis. Oakley (1981) suggests using an open style of interviewing in childbirth research. I also encouraged participants to share their relevant life events and experiences which had influenced their pregnancy and childbirth. Where participants experienced difficulties in being open about their experiences of giving birth, I provided examples of other women's birthing experiences to help them channel their thoughts.

I also negotiated the time with participants in which interviews were held on several occasions to fit within the demands of their daily life. I did not record the interview when participants did not want their conversation to be recorded. In these cases, I took notes and wrote up the details of the conversation immediately afterwards. The guide I used during the interview is provided in Appendix 6.

3.6.2 Field Notes and Photography

The notes in my reflexive diary contained not only descriptions of what I had seen and experienced, but also my perceptions and interpretations of the events (Liamputtong, 2009b). This reflexive note taking guided me to enquire further on going back to the participants to obtain more in-depth understanding about the socio-cultural dimensions of the women's pregnancy and childbirth experiences. Data collection also incorporated photographs (Kosteniuk, 2002), which helped me to link the interview data to understanding of the several dimensions of the women's pregnancy and childbirth experiences. I used the photographs to contextualise the related segment of data during the analysis. For example, when women were talking about the distance to the health facility, the photographs of the geographic terrain of the path provided more clarity to understand this distance.

3.6.3 Document Review

This study also incorporated information available in documents and other forms of material in the research area (Bryman, 2001), such as policy documents and relevant reports from the district. This helped me to provide background information including the related indicators of the district.

3.7 Information Processing and Analysis

Initially I reviewed the commonly used methods of analysis of qualitative data in practice: thematic analysis (Attride-Stirling, 2001, Braun and Clarke, 2006, Hayes, 2000); grounded theory (Glaser and Strauss, 1967); and the interpretive phenomenological approach (Gadamer, 1998, Heidegger, 1962). Having carefully weighed up the benefits and limitations of each one, I decided to use thematic analysis as the appropriate method of analysis. This is because thematic analysis is compatible with a constructionist approach and is a flexible and useful research tool, which can potentially provide a rich and detailed account of data within a complex and diverse context (Braun and Clarke, 2006). However, Antaki et al. (2002) criticise thematic analysis for maintaining rigor in qualitative research because of its flexibility advantages and there is no clear agreement on the thematic analysis process among researchers (Holloway and Todres, 2003). Despite these criticisms, I was satisfied to continue with the thematic analysis approach since it is widely used for analysis of qualitative data (eg Banning et al., 2009, Bayes et al., 2008, Berman and Wilson, 2009, Clarke et al., 2008, Souza et al., 2009).

Thematic analysis is a method for identifying, analysing and reporting themes within the data, which explores various aspects of the research topic (Braun and Clarke, 2006). Thematic analysis is also an appropriate method of analysing the pregnancy and childbirth experiences of women because this approach is consistent with the feminist critical approach and values a constructionist view of understanding the meaning of experiences. Emerson et al. (1995) argue that the meaning of an event is not transparent but is actively constructed by the participants. Braun and Clarke (2006) argue that any theoretical framework carries with it a number of assumptions about the nature of the data in terms of the reality, which can be made transparent through a good thematic analysis.

The themes in thematic analysis may emerge from the data as they are analysed or may have been determined before the analysis began (Hayes, 2000, p.171). These two different starting points of analysis are also known as '*inductive'* (data driven) and '*theoretical*' (theory led) thematic analysis (Braun and Clarke, 2006, Hayes, 2000). An inductive approach means that themes identified during the analysis process are strongly linked to the data themselves (Patton, 1990), and are not driven by the researcher's theoretical interest in the area (Hayes, 2000). The approach taken in this study is inductive. In doing so, I also considered the suggestion of theoretical and epistemological commitment (Braun and Clarke, 2006), which helped me to enhance the quality of the results.

In thematic analysis, there are two levels of themes: '*semantic*' and '*latent'* (Boyatzis, 1998). A semantic approach relies on the explicit and surface meaning of the data, in which the analyst does not look for anything beyond what a participant has said. In contrast, the latent approach examines the underlying ideas, assumptions, conceptualisations and ideologies that are theorised as shaping or informing the semantic content of the data. From a constructionist perspective, meaning and experiences are socially produced and reproduced, rather than inhering within individuals (Guba and Lincoln, 1985). The latent level themes provide more material to explore the socio-cultural conditions linking with individual accounts of experiences within a constructionism framework. I have focused on latent level thematic analysis in order to explore the factors that influence the pregnancy and childbirth experiences of women.

Qualitative research is aimed at providing meaningful and quality results through sophisticated analysis of data, however there is a lack of appropriate tools to facilitate this process (Denzin and Lincoln, 2008, Huberman and Miles, 1994, Lee and Fielding, 1996, Silverman, 2005). In this study, I used the analysis approach suggested by Braun and Clarke (2006), which provides a step by step process of doing thematic analysis. I will now explain how each step of the recommended analysis was undertaken in this thesis.

Stage 1: Familiarizing myself with the data

Braun and Clarke (2006) suggest that during the analysis of qualitative data, it is

vital that the researcher immerse themselves in the data to the extent that the researcher is familiar with the depth and breadth of the content. According to Hayes (2000), immersion involves repeated reading of the data and re-reading the data in an active way searching for meanings and patterns.

In this study, I started transcribing the interview data during the field work. Once I finished transcriptions of one interview, I started translating it into English. I then went back to the recording to ensure that the translation of the data was true to what the participants had shared. There were many repeated readings during the process of translating data to ensure that the meaning of the data had not been lost during transcription. Once transcriptions and translations of all interviews were completed, I spent a lot of time reading and re-reading the data. When I had the feeling of reaching the depths of the data and I was able to visualise each event and conversation without reading the transcripts, then the next level of analysis was carried out. Also, two of the interview recordings and transcriptions were sent to a Nepali academic to check the consistency in transcriptions and translations into English.

Stage 2: Generating initial codes

This stage involves the production of initial codes from the data after familiarization with the data collected (Braun and Clarke, 2006, Hayes, 2000). Codes identify a feature of the data that appears interesting to the researcher in a meaningful way regarding the phenomena (Boyatzis, 1998). I followed the data driven thematic analysis process, which aims to code the content of the entire data set. I conducted coding manually. As Braun and Clarke (2006) suggest, I coded as many potential themes as possible. I started coding the data manually. I carried out the coding systematically giving attention to each data item through the entire data set when I also highlighted the important segment of data. I used different color highlighters while coding and I used the same color highlighter to signify the repeated codes in the data set. Then, I cut out the pieces of the highlighted segments of the data and put the same coloured pieces together under each code. The following table provides an example of how codes were extracted from the dataset.

Table 1: Initial Codes

Data Extract	Coded For
I feel more comfortable staying at home than in hospital. I did not have any problems in my last 3 births at home. My mother-in-law assisted me for all childbirths.	Comfortable at home Problem free birth Mother-in-law's support Confidence in giving birth

Stage 3: Searching for the themes

At this stage, I followed Braun and Clarke's (2006) recommendation to refocus on the analysis at the broader level of themes, rather than codes which involves sorting the different codes into potential themes and collating all the relevant coded data extracts within the identified themes. As Hayes (2000) suggests, I then started thinking about the relationship between codes, between themes and between different levels of themes. I listed the repeated patterns of the data as potential themes, as I had spent a lot of time drawing and reflecting on mental maps of potential themes after the analysis of the coded data. An example of the thematic mental maps (Diagram 1) is included here to provide clarity on the process of selecting themes from the entire data set from which all potential themes were crafted in a way that demonstrated relationship and linkage to the data set and the consistently repeated codes during the earlier level of analysis.

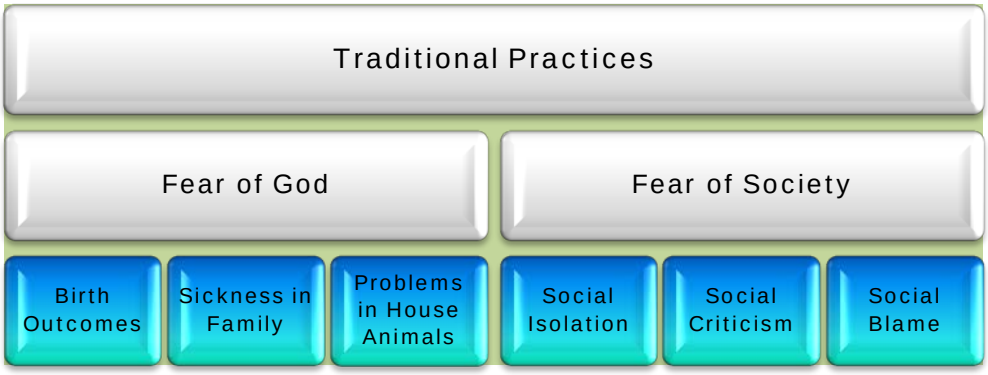


Diagram 1: Initial Thematic Map

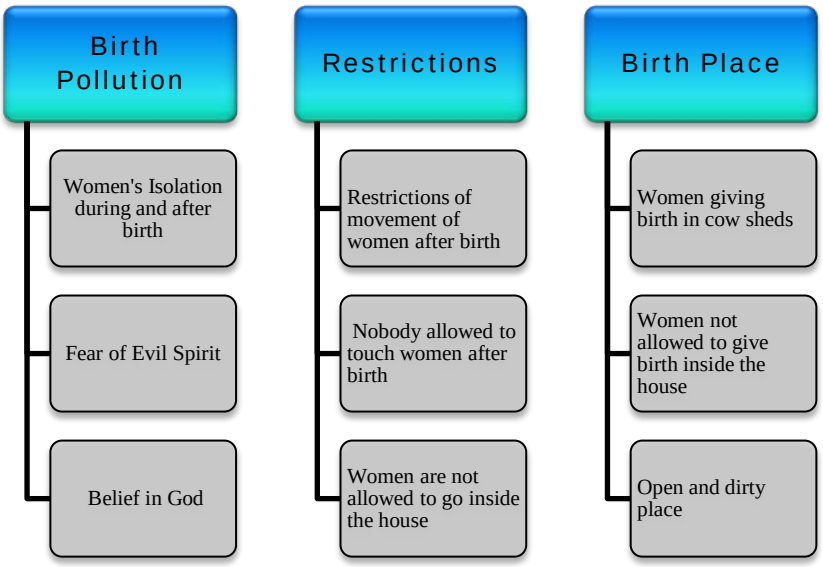


Diagram 2: Initial Thematic Exercise

In Diagrams 1 and 2, the light blue color codes were the codes which were consistently appeared in the data which was about the culture and tradition of not giving birth inside the house. In this way, I initially jotted down the thoughts, codes and understanding from the datasets to draw out the themes of the study. I made several sketches and diagrams in order to identify the potential themes emerging from the dataset during the process of analysing data. Once potential themes were identified, I then started the next level of analysis.

Stage 4: Reviewing themes

This level involved the refinement of the themes identified in the previous stage of analysis (Braun and Clarke, 2006). This stage involved two levels of reviewing and refining the themes (Braun and Clarke, 2006). In this stage, I reviewed all the potential themes by going back to the dataset to ensure that the themes were data driven and was the significant segment of entire dataset.

In this process, the place of key and sub themes were changed and modified in ways to provide insight into the data. The process was focused on examining the linkage and coherence of one theme by going through the data extracts of each sub theme of one leading theme, and ensuring for coherence and consistency. Once the first theme

was finalised, then a similar process was repeated to identify another theme from the entire dataset. For example, while reviewing the earlier themes which are presented in the previous stage of the analysis, I came up with the following thematic map (Diagram 3) in this stage of analysis.

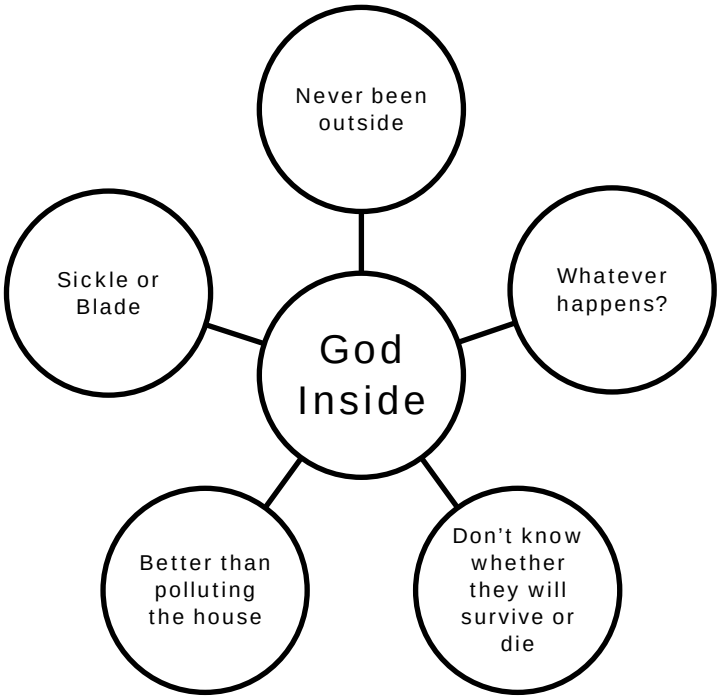


Diagram 3: Revised Thematic Map

I developed a thematic map of each theme at the end of this stage of analysis. I gave attention all the time to maintaining the relationship, coherence and linkage of each sub theme with extracted data from the entire data set to ensure that the meaning had not been lost and the theme represented the voices of participants and reflected their experiences. As Braun and Clarke (2006) suggest, I re-read the entire dataset to check whether the theme had a meaningful relationship to the entire dataset. I also coded the meaningful units of the data while identifying at this stage what was missed in the earlier stages of analysis. Once the thematic map of each leading theme was finalised, then I proceeded to the next stage of analysis.

Stage 5: Defining and Naming Themes

In this stage Braun and Clarke (2006) suggest defining and further refining the themes to present in the analysis and analysing the data within them to help identify the essence of each theme and determine the aspect of the data each theme captures.

During this process, I did not just paraphrase the content of the data extracts presented, but identified what was of interest about them and why. In this stage, I considered the individual theme and the relationship of each theme to other themes. I went through the earlier themes and revisited the dataset to give an appropriate name to each theme. I then defined each theme in relation to its meaning in the data and some subthemes were generated under the leading theme to define their relationships in dataset.

I further compiled the extracted data units under each theme and subtheme to prepare a report later on. Then I organised each theme into a coherent and internally consistent account with accompanying narratives of the women and other participants in the research. I provided detailed descriptions of each theme and subtheme with the corresponding data which was linked with the overall story of the data and the specific narrative of each theme. I identified the crucial relationship between the themes which interacted together in the women's pregnancy and childbirth experiences. This stage of analysis ended with the descriptions of final themes and subthemes including the narratives extracted from the entire dataset under each theme. Three key themes and subthemes under each key theme emerged from the data during the process of analysis and were used when writing the report.

Stage 6: Producing a report

I began this stage when I had a set of complete themes from the final analysis for writing the report. Braun and Clarke (2006) suggest that the thematic analysis report should tell the complicated story of the data in a way which convinces the reader of the merit and validity of the data analysis. Hayes (2000) alerts us to how important it is to ascertain that the analysis provides a concise, coherent, logical, non-repetitive and interesting account of the story that the data tells within and across the themes. In this stage, I wrote different chapters using the themes from stage five. I provided sufficient evidence of the themes while writing about the linking data. I consistently went back to the entire dataset to ensure that significant data had not been missed in producing the report. Each extract from the dataset was embedded within an analytic narrative that illustrated the voices that I was trying to uncover in this study. The analysis ended with a report of the data which is included in the next three chapters.

3.8 Methodological Rigor

In qualitative research, it is believed that reality is multiple and socially constructed and cannot be objectively measured (Guba, 1985, Morse, 2009, Sandelowski, 1998, Walker, 2009). The rigor in qualitative research involves the careful documentation of social relations and influences (Liamputtong, 2009b, Ratner, 1996). Leninger (1994) suggests the use of six criteria: *credibility, confirmability, meaning in context, recurrent patterning, saturation* and *transferability*. Further, Guba and Lincoln (1985) emphasise the importance of trustworthiness in naturalistic inquiry and suggest five techniques for assessing rigor in qualitative research: *prolonged engagement, persistent observation, triangulation, member checks and auditability*. I used these five criteria to maintain rigor in this study.

'Prolonged engagement' refers to the investment of sufficient time to answer the research questions. The time I spent in the field facilitated access to the wide range of actions, interactions and subjective states that were of relevance to the 'promotion of an in-depth understanding of the phenomena under study' (Laine, 1997, p.273). I also had prior knowledge of the community and the status of maternal and newborn health which contributed to the completion of the research.

'Persistent observation' adds the dimension of salience to what might otherwise appear to be little more than a 'mindless immersion' (Guba and Lincoln, 1985, p.304). The field work of this research involved persistent observation in the everyday life setting of participants living in remote mountain areas of Nepal. I lived with a family in the village which provided me with the opportunity to observe the everyday events and other happenings. This observation added value to the information collected through the in-depth interviews.

'Member checking' is an activity in which the researcher takes back the materials to the constructor of the multiple realities under inquiry. Data, analytic categories, interpretations and conclusions are tested with the members of the stakeholder groups from whom the data were originally collected (Guba and Lincoln, 1985, p.314). I offered informants the opportunity to check the audio records of the interview before its transcription and translation into English. I also re-checked the meaning of local terms asking the person in the field to confirm that the translation

maintained the meaning of the actual terms.

'Triangulation' refers to multiple sources of data, investigators, analysts, multiple ways of interpreting the same set of data or using multiple methods of data collection (Denzin and Lincoln, 2000). This study provides scope for methodological triangulation guided by multiple methods of data collection using in-depth interviews and my reflective notes of observation during the field work. Further, I conducted interviews with multiple participants about the same issue of childbirth experiences.

'Auditability' is seen as a means of demonstrating trustworthiness, which refers to the researcher's ability to show a clear decision trail of the progression of events and the researcher's rationale over the time of the study (Guba and Lincoln, 1985). A successful critique of the auditability of qualitative research is when another researcher clearly follows the decision trail used by the researcher in the study, which might be a description or explanation of a case (Laine, 1997). In the process of travelling the audit trail, the auditor might focus on field notes that contain personal information or methodological information (Hammersley, 1992). In this study, I wrote intensive field notes which demonstrated the auditability of the research process.

As Sandelowski (1998) suggests, this study offers a clear rationale for the selection of the research topic, recruitment of informants, and selection of the research site and provides details of data collection and the analysis process, which ensure auditability in determining research quality. Hammersley (1992) thinks that flexibility in adjusting to changes in circumstances while doing research in the everyday life settings of people provides meaningful understanding of the people's lives and their circumstances. Rice and Ezzy (1999) recommend taking a holistic approach to develop a rigorous understanding of the events and data in qualitative research. I tried to maintain rigor from the beginning through developing an appropriate methodology, selecting suitable data collection methods, conducting a reflexive and theoretically informed analysis and considering the ethical aspects of the research in this study.

3.9 Limitations of the Study

This study is limited for a number of reasons. Firstly, it is limited to the experiences of the women from the two remote villages in Nepal.

Secondly, I could not gather an extensive account from husbands in this study because they did not express willingness to participate. I attempted to invite all husbands to participate in the study but few husbands accepted the invitation and expressed their willingness to participate. So, this study fails to provide the perspective of those husbands who were mentioned as being unsupportive by women participants.

Thirdly, the issue of translation and maintaining the originality of the ideas became somewhat problematic during the analysis. Though I tried my best to keep the original meaning of the data, I had to negotiate with the language to make meaningful understanding and interpretations into English. Although I was able to provide the similar meaning of the data, I could not always provide the same flavor of expression when translating into English.

Fourthly, this study is also limited in its rigor because of the cost of travel and geographic remoteness of the field area; I was not able to go back to the field area after the completion of the transcription and translation of the interviews to check the meaning of translated terms with the original participants. I had to rely on the information that was made available to me during the field work and in some documents. In addition, the study is limited by the time I spent in the field. I spent only three months in the field area which was not the prolonged engagement which some authors encourage in order to increase the methodological rigor of the study.

Conclusion

This chapter has explained why the thesis adopted social constructionism and a feminist critical perspective to guide the whole research process of this study. This was because they allow me to give importance to traditional knowledge, the socio-cultural circumstances of women experiencing pregnancy and childbirth and the everyday life setting of research participants. This study used a qualitative research process in which I selected an ‘in-depth interview’ as the primary source of data

collection complemented by a reflexive diary, field notes of observation, photographs, and other documents relevant to the study. I used a thematic analysis approach to analyse the data which was consistent with the expectations of social constructionism and critical feminism.

The thesis' aim to explore the socio-cultural dimensions of women's experiences was reflected in the way the field work was conducted. I spent three months in two villages observing, exploring and documenting the everyday life of the women and their pregnancy and childbirth experiences. Most of the interviews were held in participants' houses and their working areas while they were doing their everyday work. I accepted the circumstances as they happened during the conversations with the women, deciding to either continue or discontinue the interview.

From my experience of field work with people living in remote mountain villages of Nepal, I argued for qualitative research which encourages flexibility of making decisions during the research process in order to respectfully adapt to the circumstances of the participants. I also argued that the relationship with the participants has crucial influences on gaining trust to gather insightful data. I believe that my ensuring the feeling of safety of the participants during the research has enhanced the quality of data and confirmed the research endeavours in this study.

In this chapter, I have discussed the process of conducting this research. In the next three chapters, I will discuss three key themes which emerged from the data analysis: God inside: the tradition, culture and spirituality of childbirth; women's social position, their relationships and childbirth experiences; and the complexity of the context.

Chapter 4: 'God Inside': The Tradition, Culture and Spirituality of Pregnancy and Childbirth

This chapter is the first of three chapters presenting the three key themes which emerged from the data. This chapter focuses on the tradition, culture and spirituality of childbirth as it emerged from the participants' experiences, through considering childbirth as a socio-cultural event in society. The use of social constructionism and critical feminism allowed me to use an appropriate approach in this research. The key theme of this chapter refers to the supernatural powers that participants in this study related to safety during pregnancy, childbirth and the postnatal period. Their trust in supernatural power in ensuring safety was emerged in the data. They called it God's power. There were five sub themes which emerged from the participants' experiences and they were significant for me as the researcher in understanding the women's tradition, culture and spirituality in relation to their childbirth experiences.

These sub themes were:

- 'Never been Outside': Empowering self and maintaining safety;
- 'Better than Polluting': Negotiated practice and respect for tradition;
- 'Whatever Happens': Accepting the conditions of childbirth;
- 'Will Survive or Die': Certainty and uncertainty of outcomes; and
- 'Sickle or Blade': A dilemma of ensuring safety.

I will now discuss these sub-themes in relation to participants' accounts of their experiences.

4.1 'Never Been Outside': Empowering Self and Maintaining Safety

Relating to the concept of empowerment (Wallerstein, 2002), this first theme tells about the women's feeling of being empowered during the childbirth through their capacity to give birth according to their preferred way of gaining safety. So, the data provides more evidence of the contribution of childbirth practices to achieve feelings of safety.

The practice of giving birth traditionally at the animal shed, which in the women's terms is 'Goth' (Plate 4), was the major factor for gaining safety during birth in the study villages. 'Goth' is an animal shed, a corner of which next to the cattle is used to stay in during menstruation, childbirth and the postnatal period. The Goth is normally part of the ground floor of a two storey house built from mud and stone. This is a dark space with a low ceiling, a very narrow door and no window. The entrance is directly from outside and not connected through to the rest of the house.

Some women participants who shared their birthing experiences strongly highlighted that they always give birth inside the Goth because of their cultural belief system of birth pollution and the traditional practice of untouchability. This emerged from the data as a significant and strong cultural belief.

Plate 4: Goth - Photo Credit: Author

Tradition, culture and spirituality were the key components which came out consistently in the data while analysing women's pregnancy and childbirth experiences. The cultural and spiritual beliefs had shaped the practice of giving birth in the Goth in the study villages. Most of the women participants saw this practice as showing their respect for their culture and spirituality.

Thuli shared about her childbirth practice.

> *I have given all births at Goth. Where should I give birth other than Goth? In your place, you may give birth at home, but here we give birth at Goth. We have Deuta (God) inside the house. We should not be polluting the house. If we do so, our baby might die or something wrong might happen to the family or to the animals. So, we prefer Goth to give birth. I used to live in Goth for a month after birth. You know, the next door Kanchi (referring to another woman) went inside the house on her fourth day of Chau (menstruation) and her baby fell sick. I also lost my two babies within a week in Goth. You know this is not good if God gets angry. We should be really careful about not polluting the house.* Thuli

The strong connection of tradition and spirituality as a part of safety became important for Thuli to minimise the chances of experiencing negative birth outcomes. More specifically, she indicated that the influence of spiritual belief was significant in ensuring the health and survival of the newborn babies. Thus, it was important for Thuli to follow the pollution practice during the birth and to spend her postnatal days in the Goth.

Another participant also gave preference to give birth in Goth. This is an example of gaining safety as it is defined in the thesis.

> *Both times, baby came without much trouble. I did not have any problems. It was not that hard giving birth. It is normal to have pain and discomfort while giving birth. Other women in the villages also give birth in Goth. For us, giving birth is an easy and simple task. It is common for us and we know that we can only give birth at Goth.* Toma

How childbirth is perceived in the village determines the women's ability to make culturally appropriate decisions in choosing the place of birth. Toma talks about the traditional knowledge, which is also a part of safety which she values during pregnancy and childbirth. The commonality of birthing in Goth which she refers to indicates both cultural importance and knowledge based practice. Her experiences of birth respecting the traditional knowledge and cultural practices provided a sense of

being able to maintain cultural expectations. This signifies that childbirth in Goth is regarded as a safe practice by the women and the villagers.

Manu felt a lack of safety being away from the Goth.

> *During the turn of my sixth daughter, I had problems before giving birth. They (district hospital staff) sent me to the Nepalgunj (the referral hospital). I did not have any problems when I gave birth to my other five daughters. But that time, I had to go to Nepalgunj. I was not really happy about going to the city but I went. They told me that the baby is okay. I did not feel like living in the hospital anymore. It was not the place where I wanted to give birth. Then, I went to my sister's house and gave birth at her Goth. Nothing wrong happened. I thought that I should not have come down to the city leaving children back home. I gave all births in the Goth so far. This time, I will not leave the house. I am happy being in the Goth.* Manu

Manu's preference for giving birth within the Goth was linked with the cultural connection to the place which provided safety while nothing wrong happened. The hospital setting did not provide her with the same feeling of safety and she eventually returned to give birth in the familiar environment of her village house. In Manu's case, experiencing childbirth in Goth became paramount to ensure safety.

The collective ownership of childbirth experiences was revealed in participants' narratives in this study. Most of the participants referred to 'we' during their conversation. The collectivist cultural values during childbirth contributed to achieving safety and the women in this study were exercising their agency in the continuation of this culture and tradition.

Juna mentioned how birth happened in the Goth, which indicates the contribution of culture in gaining safety during childbirth and the postnatal period.

> *We always give birth at Goth. We clean the Goth and we put straw on the floor. Then, we give birth in this straw and we stay there putting more straw for the next 20-22 days after the childbirth. This is our usual practice of giving birth. I stayed all the time in Goth for 30 days after*

childbirth. We can touch water at 30 days and are permitted to go inside the house. We will have a special purification process by Bahun (Brahman) on the 30th day. I felt so happy coming out from Goth without any problems and sickness. I think I never did the wrong thing, so God is happy to help me all the time. Juna

Juna's sense of doing the right thing according to the cultural expectation from the preparation for birth until exiting from Goth after a month contributed to gaining safety. Juna was able to make decisions according to the cultural expectation which contributed to safety.

Because of their valuing of their belief system and traditional knowledge, giving birth inside the Goth and following the childbirth pollution practices for certain days after the birth are a continuing practice in the study villages. The older generation mothers-in-law felt happy about the tradition of women giving birth and spending their postnatal time in the Goth. The voices of older generation women in this study show that the cultural importance of birth has been transferred from one generation to another.

A mother-in-law, Juneli shared her happiness about the continued practice of childbirth traditions.

I gave all my births while I was working in the field. This is not comparable these days. We stayed in Goth for several days after birth. I am happy that my oldest daughter-in-law (Jethi Buhari) living in the village is still giving birth in the Goth. The traditions are the same in the village. Juneli

Another mother-in-law, Chameli, highlighted the importance of continuing the tradition of giving birth in the Goth.

We always give birth in Goth. During our time, we did not get any cloth and any mat to put in Goth while giving birth and while staying after the birth of the baby. We slept on straw. These days they are lucky to get a mat to sleep on. We still have the same system. We should not give birth inside the house. We cannot live inside during menstruation either. We

> *have fear of bad results. So, we cannot let our daughters-in-law give birth inside the house. We must take them to the Goth. We have been following the same tradition. It is better than having problems afterwards.* Chameli

The fear of bad results signifies that there is a threat to safety which is enhanced through continuing pollution practice in the study villages. Some of the younger and older generation women participants expressed their strong determination to continue childbirth traditions and pollution beliefs for maintaining safety. Women's experiences of childbirth without bad results inside the Goth facilitated the transfer of the practice from one generation to another without making any changes. From the perspective of the women participants, coming out from the Goth to give birth would threaten their safety during and after the birth. Knowing the chances of bad things happening because of breaking the culture and tradition, they are motivated to continue giving birth inside the Goth.

However, the younger men participants (some husbands, the school teacher and the traditional faith healer) in the study had different opinions about the culture and the tradition of giving birth in the Goth. The 26-year-old male traditional faith healer considered that birthing in the Goth was sometimes associated with problems, yet the community was not keen to change the tradition.

> *Giving birth in the Goth is our tradition. We consider that women are not pure during the childbirth period. They cannot touch any people or go inside the house during and after childbirth. Traditional beliefs of society are making things difficult for women. I took my wife on the third day after birth inside the house during her second time. However, other people from the village did not like this. They complained about it and I was blamed for taking this action. So, I could not bring her inside the house afterwards. Though we wanted her to leave the Goth, it is not acceptable in society.* Traditional faith healer

There is thus a difference in how women participants view childbirth inside the Goth and how the faith healer interprets the same practice. While women emphasised their culture and spirituality contributed to them gaining safety during and after the birth,

the traditional healer considered it as creating difficulties. This shows the differences in viewing culture through two different lenses. The social value of tradition is another aspect which was revealed in the healer's account which provides an understanding of the remote mountain people's collective culture. His individual attempt at breaking the tradition was thus not acceptable to the other villagers.

Women participants shared their happiness and feeling of safety about their birth inside the Goth. However, a male local health worker spoke differently about the reasons and preference for giving birth in Goth.

> *Honestly speaking, reasons for giving birth in Goth are attached to religious stuff and also with gods and goddesses. One reason is related to untouchability in which family members should not touch childbearing women and postnatal women. Another reason might be because many people have only a common space in their home, which they cannot make impure. As a result, they have to manage at Goth as an alternative place of birth. At Goth, there is no ventilation and light but they can put the fire on to feel warm, which they cannot do if they stay inside the house because they are not allowed to go to the kitchen. I think the older generation people understand this way. The practice of giving birth in Goth is related to the lack of health education also. However, modern people [youth] are also not ready to change the tradition.* Local health worker

The health worker actually blamed women and the villagers for their ignorance of Western health concepts as they continued with their childbirth tradition. His account does not give value to the inherent culture and tradition which were a crucial part of safety for the women. Without taking their culture and spirituality into account, the health worker's comments about the lack of health education and people's preference to continue the tradition cannot be negotiated in practice. Thus, there appears to be a need for continuous dialogue among the women, other villagers and health workers to develop a shared understanding of the context of childbirth practice.

However, the medical perspective of the childbirth traditions in Goth emerged as significantly different to the socio-cultural view. Medical service providers who were

interviewed considered birth inside Goth as unsafe practice. However; women participants said that they could not find an alternative place to give birth in the village setting to minimise the medical risk.

> *We don't have a health centre or hospital nearby. We don't have other rooms in the house where we can give birth. We don't have any option. Though it is not safe as they [health workers] said, we should be giving birth in Goth. They told us to have regular check-ups, nutritious food and care during pregnancy. But we don't have a place to go for check-ups, we don't have enough food to eat and we don't have time to take a rest.* Urgen

The Government of Nepal has adopted medical discourse in their intervention strategies which views childbirth as a risk producing event and considers medical care for women experiencing complications is the only option for mitigating the risk (Wagle et al., 2004). Urgen's explanation acknowledged the power of the medical discourse and its uses of safety which are different to the concept of safety I have used in this thesis. She identified the challenge of maintaining both the cultural and the medical view in her pregnancy and childbirth experiences.

However, the medical doctor working in the district hospital saw culture and tradition as a problem and considered the birth practice at Goth as putting the mother and newborn at risk of dying.

> *Giving birth in Goth is the reality in the district. This is the tradition here. You know culture and tradition cannot be changed in a single day or in a single year. However, the trend of giving birth in health institutions is improving but it is not to the expected level. So, we are launching various programs and we are raising awareness of people about the danger of having births in Goths and about the risks of infections, neonatal tetanus and all these things.* Medical doctor

The doctor has adopted the medical risk approach and his view does not take into account the socio-cultural dimensions of safety which were expressed by the women. There is a difference in the view of how childbirth is described by women and how

the doctor attempts to minimise risk creating threats to safety during childbirth. This mutual exclusion of cultural concepts of childbirth needs to be negotiated in the medical paradigm because this is hindering the safety of women in this study. On the one side, women are not willing to leave the Goth because they believe that remaining there ensures their safety, but on the other side, the doctor wants to bring them to the hospital to give birth because this is how he believes their safety will be ensured. So, there is a difference in the way medicine focuses on lowering the risk and how the cultural perspective of birth focuses on promoting the experience of safety. In summary, giving birth in Goth is constructed as a risky practice by the medical doctor but is constructed as a culturally and spiritually safe practice by the villagers.

The female community health volunteer (FCHV) was able to articulate the perceived benefits of giving birth in the village, compared with the difficulties for women leaving the village for birth.

> *While we help women giving birth, we are not allowed to touch them after they have the baby. We consider the mother as impure. We follow the belief and practices of untouchability during the birth pollution period. If women go to the health post or hospital to give birth, they have to carry their stuff and the baby on the way back home. They don't feel like doing that. Instead they prefer staying home and going inside the Goth to give birth and to spend their postnatal days. I also gave all my births at home (Goth) and I did the same as other women do.* FCHV

The FCHV put herself in the picture and expressed the embeddedness of the tradition of impurity and birth pollution in the society. Despite the knowledge of medical risk associated with giving birth in the Goth, the FCHV went through similar experiences of giving birth without making any attempt to go beyond the social expectations. The traditional knowledge of maintaining purity for the purpose of ensuring safety became more important for her in choosing the Goth to give birth.

Similarly, there was interplay between different socio-cultural factors in shaping the childbirth tradition. More specifically, the cultural practice of pollution mediated the religious factor so that religious differences were lessened because both adopted a

similar cultural practice. The local indigenous leader spoke about this interaction of two religions and cultural groups for the continuation of birth pollution practices.

> *In Lama culture, we do not have any concept of birth pollution, in which women can't give birth inside the house. However in practice, Lama families also follow the pollution belief, which means they do not give birth inside the house. The Hindu concept of birth pollution has been mixed with Lama culture in the village which is restricting women going inside the house to give birth and for certain days after the childbirth. It is more about culture than religion. People are moving here and there but the childbirth pollution is a part which is not changing. This pollution belief has influenced the practice of Lama people.* Local indigenous leader

The local indigenous leader's view indicates the changing nature of culture and the mutual influences of factors creating these changes. It raises optimism about the changes through dialogue amongst the different groups for producing better outcomes. The difference between the two religious groups has been addressed through the acculturation process leading to the continuation of the practice of giving birth at Goth. This provides an example of the mutuality and collective culture of the village people for the continuation of the childbirth tradition. This example also provides evidence for hope that negotiation between two different perspectives of perceiving childbirth is possible.

In collectivist cultures, there are shared values and mutual understanding among the members of the particular group in which the individual often makes decisions based on the collective values and stays within the group's norms (Triandis et al., 1988). The participants in this study also gave value to their collective culture and childbirth tradition which enhanced safety in their perspective. The local high school teacher has been an observer of this collectivism in continuing the childbirth tradition for many years.

The teacher emphasised the social importance of giving birth inside the Goth in these two villages.

> *There have been no changes in the tradition since I came here [23 years ago] because they are giving more value to their cultural practices. In the village where I have been working for several years, women are allowed to touch the water tap only on the sixth day of their menstruation. As you have already been to the other villages, you would be aware of their tradition of giving birth in Goth and living in Goths after menstruation and childbirth. This tradition exists even in the family of educated members.* School teacher

The school teacher's account indicates that village people give more value to tradition than education. So, the earlier criticism of the local health worker about the ignorance of the village people and his account of their valuing tradition more than education opens a space for negotiation. The continuity of the childbirth tradition in these study villages thus provides insight into the collective value of culture and spirituality. This collective protection of the childbirth tradition for the purpose of enhancing safety is an important aspect of women's experiences in remote mountain regions of Nepal.

Further, a close interaction between culture, tradition and spirituality determined the extent of safety during childbirth in the study villages. The participants in this study made it clear that their cultural connection and spiritual beliefs had shaped the meaning of childbirth. For them, the tradition of birth at Goth had been significant in retaining safety during childbirth. These participants indicated that valuing pollution beliefs and continuing the childbirth tradition was important to ensure safety. Further, the continuation of culture and tradition provided safety and empowerment to the childbearing women in this study. This was because the pollution beliefs restricted the entry of outsiders during the birth and allowed women to experience birth according to their tradition. This enabled women to make appropriate decisions about what to do to be comfortable during the birth and who to call for help if assistance was required. Additionally, their capacity to make the right decisions allowed them to continue the childbirth tradition and to gain collective ownership of their experiences.

Rolls and Chamberlain (2004) point out the tendency in Nepalese rural communities to blame women for not maintaining the cultural practices if something wrong

happen in the house. However, women participants in this study expressed their cultural preference for giving birth in the Goth in order to maintain village cultural traditions which they are expected to adhere to and because this birthplace contributed to safety through familiarity. This component of safety was important in developing their capacity to make right judgements within the tradition and culture. Their judgement about giving birth inside the Goth for enhancing newborn survival was one aspect of safety in this study. Their empowerment, as capacity to achieve, stemmed from conforming to collective cultural practice and socio-cultural norms about childbirth pollution.

In summarising the exploration of this sub-theme, it is clear that the continuation of the childbirth tradition had become a part of the collective culture in the study villages. Participants valued the collective concept of birth pollution and untouchability and expressed their preference to continue the tradition of giving birth inside the Goth. Thus, an individual's attempt to break with the tradition was not accepted socially. This study confirms that the women's desire to continue the tradition of giving birth in the Goth is significant for ensuring the perceived collective ownership of childbirth experiences.

However, the differences in construction of risk and safety create a complexity. The medical criticism of culture and tradition as the sources of risk during pregnancy and childbirth contributes to hindering safety. There is a difference in the view and understanding of the meaning of childbirth among women participants, men participants and service providers. It seems important to bridge this gap through continuous dialogue to develop a shared understanding and shared responsibility for enhancing safety. The findings in this section provide insight into the possible negotiation between the different concepts and perspectives of the different groups of people which are significant for both villagers and service providers. Additionally, the data suggest the need for negotiation between cultural and medical practices to develop a shared understanding about safety during pregnancy and childbirth.

4.2 'Better than Polluting': Negotiated Practice and Respect for Tradition

This theme presents evidence of the negotiation that participants were able to make

with culture and tradition. Their ability to negotiate reflects that culture and tradition are not absolute and static wherein individuals have no agency, but that there is room for change. In the study villages, some participants talked about their negotiated cultural and traditional practices in relation to childbirth. Their ability to negotiate with tradition and culture creates optimism about the possibility of changing practices to produce safety. In this study, while following their culture and spirituality, some participants were able to negotiate with the tradition of birth inside the Goth by choosing other places outside the house during childbirth and the postnatal period. Nevertheless, this negotiation with the birth place occurred at the same time as a similar level of determination to follow the pollution beliefs during the birth and postnatal days. This section focuses on how the tradition of childbirth inside the Goth was negotiated in practice by some women participants in the study villages.

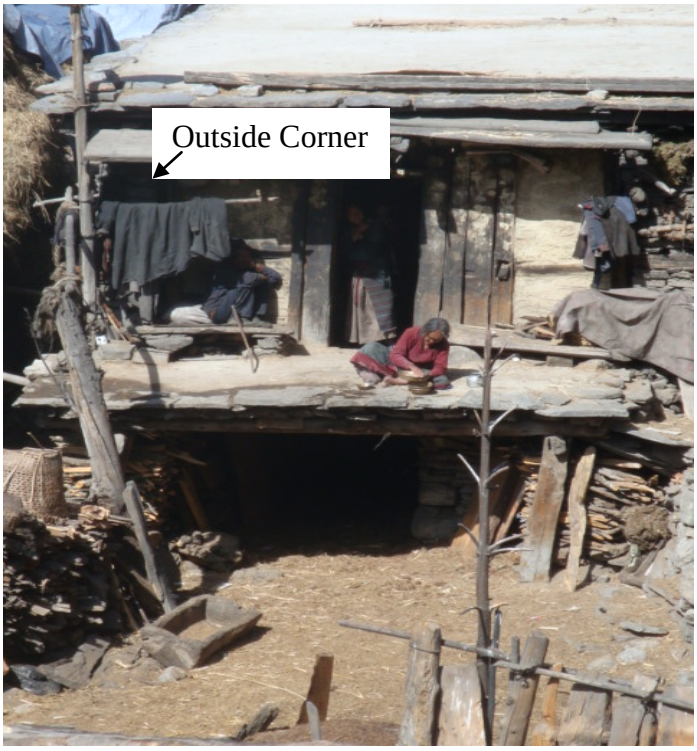


Plate 5: Outside corner of the house - Photo Credit: Author

The outside corner (Plate 5) of the house was one place that some women mentioned as their place of giving birth. Participants related that preference to a similar level of respect for their pollution beliefs and still did not go inside the house during and after the birth. This negotiation with birth place also provided confidence for the

women in keeping God's place (in the house) clean to confirm safety.

Toma's account indicates her confidence in maintaining tradition through her negotiation with birth place.

> *We have God inside the house. We are afraid of the pollution. We should not be polluting God's place. If we do so, something bad will happen either for the baby or for mother or for another member of the family. We are not allowed to go upstairs to give birth. I also don't like polluting God's place. So, I gave all my births in the corner outside.* Toma

That some women decided they could come out from the Goth to give birth provides some optimism about the possibility of negotiating with culture and tradition. Sometimes, women also gave birth inside a corner of the house (Plate 6).

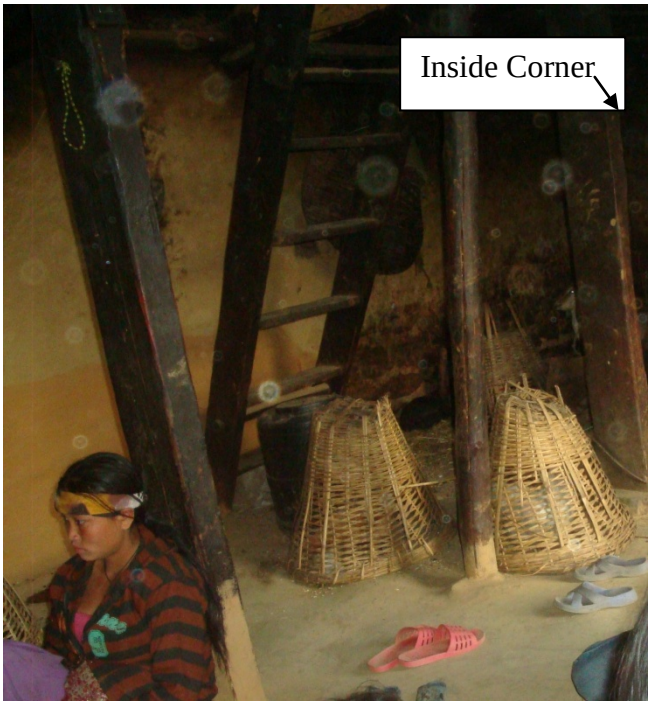


Plate 6: Inside corner of house - Photo Credit: Author

Jitu was able to give birth in an inside corner of the ground floor of her house. She described the place as better than Goth but it was still close to buffalos and cows.

> *I never went to Goth to give birth. I always give birth downstairs in the corner where the fire oven is. It is good to be downstairs as I can put on*

the fire during the winter to keep warm. It is better to stay away from God's place to give birth and during the Chau [pollution period]. Jitu

Keeping God happy and ensuring warmth from a fire were two important reasons for Jitu's preference to give birth inside her house. For her, both of these aspects were important to promote safety. Because of the fear of bad things happening, she was careful not to pollute the house. This consciousness of spirituality and cultural beliefs indicates the women's ability to understand the reasons for their preferences and continuity of tradition.

Plate 7: A separate room to give birth and to spend postnatal days - Photo Credit: Author

Similar negotiation about birth place occurred for Laxmi's. Her mother-in-law, Hira, was able to allow her daughters-in-law to remain in a room attached to the house (Plate 7). Hira recalled her birthing experiences and compared them with the current practice.

During our time, we used to give birth in Goth. I did not take my daughters-in-law in Goth. At that time, my father-in-law was a priest and we had God inside the house. We were not allowed to go inside during the Chau and not to give birth either. In the village, other women are still giving birth in Goth. In my house, as my sons became educated, they did not let their wife give birth in Goth and I took them to the room downstairs to give birth. It has made their birth better. Hira

Hira's account reflects that the culture and tradition are changing over time. She indicates the role of education in negotiation with tradition. Another form of negotiation occurred in choosing a place to spend the polluted days.

Sumi spent her postnatal days in a separate room. She accepted the isolation according to the cultural and spiritual belief system.

> *We don't have the system of giving birth in the Goth. The tradition of giving birth in the Goth has been changed in the village. I rather had the first two births in the same room outside the house. We don't give birth inside the house. It is not good to go inside during Chau [polluted time]. So I always stay outside in this room [a room made of mud and stone without windows in the downstairs of the house usually used for keeping wood] to give birth and for a month after the birth. Even my mother-in-law stays there during the Chau [menstruation] for four days.* Sumi

Being able to leave the Goth and stay in a separate room attached to the house was a negotiation in choosing birth place. This negotiation provided a sense of continuing good practice without violating the cultural expectation which then contributed to safety.

Negotiation between traditional and medical knowledge had also become possible in the study villages. Although Suntali was a professional midwife, she privileged traditional knowledge over her medical knowledge.

> *I gave birth in the hospital. But in our tradition, I was not allowed to go inside the house without doing the ritual performances to become pure. It is believed that postnatal women can pollute the house and make impure God's place. This is the reason we women are not allowed to remain inside while giving birth and during postnatal days. I went to hospital to give birth but I could not break the childbirth pollution practice. So, I did not go to the kitchen and prayer room for two weeks after the birth. Though I was aware of the medical rationale that this tradition has no connection to birth outcomes, I could not go against the tradition. What if something wrong happened to my daughter? So, I liked following the*

> *cultural values and tradition of untouchability rather than putting my baby at risk of having some bad things happen.* Suntali

Suntali was able to bring medical and cultural perspectives together so that she could maintain safety. Her account reflects that she was embracing the aspects of both that she considered important. She was more concerned about the outcomes which could result from polluting the house and not going through the purification process. This demonstrates her ability to negotiate between midwifery knowledge and cultural knowledge to promote safety.

In this section the experiences of the women participants revealed their ability to negotiate cultural, medical and other factors which were important to ensure safety in the study villages. Several forms of negotiation allowed these participants to act in a way they thought right to maintain their culture, tradition and spirituality. Some women were able to negotiate with tradition, choosing an alternate place of giving birth which was warmer and physically more comfortable than the Goth, but which at the same time still maintained their spirituality of keeping the house unpolluted and maintaining safety.

These accounts reflect that the village women have accepted the tradition with some extent of negotiation regarding the birth place to ensure safety. As in the earlier theme, the place of giving birth has cultural and spiritual significance in women's birthing experiences to ensure their safety and promote the survival of their babies after the birth. The spiritual practices have been able to protect the culture and maintain the stability of the tradition in relation to childbirth in these villages. The data demonstrates that negotiation between different perspectives is possible and beneficial in terms of birth. More importantly, the data demonstrates that negotiation between the cultural and medical view of understanding childbirth is possible and is imperative to enhance safety in these study villages.

So, summarizing this sub theme, there is interplay between women as an agency and tradition as structure in participants' experiences, as discussed in Chapter 2. Women are acting as powerful actors to determine which traditions need to be sustained and which need to be transformed. Women participants were able to see the benefit of continuing childbirth pollution practices through negotiating with the birth place.

Their act of changing the place of giving birth reflects that they were an active agency in sustaining safety.

4.3 'Whatever Happens': Accepting the Conditions of Childbirth

Castells' (2010) view about the differences of experiencing pregnancy and childbirth of women in one setting compared to another setting gives the opportunity to analyse the differences in how birth is viewed by the participants in this study. Not all the women participants had similar perceptions of childbirth. Most of the participants described childbirth as normal and as an ongoing event of their everyday life routines. In their descriptions, work, pregnancy and childbirth are the regular life routines for village women. This section demonstrates their perception and description of childbirth.

Consideration of childbirth as a part of everyday life events provided women with the opportunity to experience birth without any external medical and technological interventions. Despite the death of their newborn, some women participants accepted the spiritual notion about the control of birth and death and remained within their childbirth tradition. In their perspective, safety lay on the wishes of God which could not be interfered with by any external attempt.

Prema's account provides understanding of this perception of childbirth and related deaths.

> *I am giving birth this month. It is not long to carry like this. I lost my previous son after 9 months. You know I have three children, they are all girls. I don't know why my previous son died but we cannot live only with these three daughters. I have never been to the hospital. I feel shy to go for a check-up. I've never had any check-up. I've never had any problems in giving birth either. Who knows what happens tomorrow? It is not in our control. They will come and go. If they have to go, we cannot stop them. We have to accept whatever happens during and after the birth.* Prema

Prema indicates losing a child is an unexplained part of continuous pregnancy and childbirth. With the belief that ensuring safety during pregnancy and childbirth is not

always possible in their context, she accepted the conditions as they happened. This meant the experience of losing her baby in the previous birth did not influence her to change childbirth practice, but rather led to one pregnancy after another until her desires of having son were met.

While the death was not something that Prema felt could be prevented by external medical interventions, similarly getting pregnant and giving birth were unavoidable tasks for Dolma.

> *It is not a big deal to get pregnant and give birth. There is nothing unusual about pregnancy. We women should get pregnant and give birth. What do we do, if we don't get pregnant? I got married and I had my first baby while I was very young. The oldest son now goes to college. I have to work hard which is making me weaker. These little kids cannot work. What can I do? I need to work and cook for them. I can't avoid being pregnant and I can't avoid work because of the pregnancy. I think we women are born to work for family and to get pregnant.* Dolma

Dolma linked her status as a woman, in which her tasks involved domestic and agricultural work, getting pregnant, giving birth and taking care of children. In her circumstances, these are the social expectations which she cannot avoid. Meeting social expectations as a part of safety was fostered through the continuation of social values and collective wisdom in shaping women's lives.

Within the consideration of childbirth as a part of everyday life events, Jitu described childbirth as an ordinary event.

> *There is nothing different in getting pregnant and giving birth. The pregnancy is always the same thing. The pain during the birth is also the same every time. I did not feel any difference about being pregnant and giving birth. This is just a thing that comes and goes.* Jitu

Jitu's description of childbirth as an ordinary event is a component of safety as defined in this thesis. Within this concept of safety, Jitu sees birth as a simple and easy event. Her explanation about how her recent birth happened provided more understanding of her perception of childbirth as a simple event.

> *I did not have any difficulty in giving birth. It was not different to the previous time. The baby came easily. I did not have long pain too. It started slightly in the evening and I went to bed. When I woke up, the pain was increased. Then the pain started to increase and the baby was born in the morning. I did not have any problems. This is how I have been giving birth every time. I've never had any problem. I did not have any difficulties this time as well. For me, it is always easy giving birth at home.* Jitu

Jitu's experiences of birth without any problems signify her perception of childbirth as an easy, normal and ongoing task. This perception made her confident about the birth and contributed to gaining safety.

Laxmi described childbirth as not a difficult task and one which occurs without extraordinary things happening. However, she was concerned about the problems which had occurred this time.

> *It does not make any difference in giving birth several times. I did not know anything about giving birth the first time, so I did not have any fear. I knew about birth only after I had my first baby. I knew how difficult and easy it is giving birth. It was not that difficult giving birth to the previous babies. It just happened. But this time, I don't know why there is bleeding before giving birth. But I know that I will be fine to go back and give birth at home with my mother-in-law.* Laxmi

How Laxmi described childbirth had not changed because of the problem she had experienced in her current pregnancy. Instead, previous experiences of birth without problems in the village provided her with the confidence to trust her mother-in-law. At the same time, she saw the role of the hospital to manage bleeding before the birth. Her account envisages where both socio-cultural and medical concepts can work together in a complementary way to ensure safety during the birth. Allowing women to seek social and family support seems important to manage associated medical problems in the institutional setting.

Getting pregnant and giving birth one after another is a part of the social and cultural

expectations in these study villages. Women participants described this as a part of their role of being a woman. Juna denotes her conformity to cultural and gender expectations which vindicate her practices.

> *In our time, we get pregnant as long as it comes. We give birth as long as they come. We don't have any problems in doing so. It is not difficult to bear the baby. These days, they [the younger generation] have stopped being pregnant [She indicates the use of family planning methods to control pregnancy] and you see they are having problems during the birth. We didn't have any problems during pregnancy. I am not worried about getting pregnant and giving birth. I will bear it as long as it comes.* Juna

Juna was acting according to the expectations of society. In her view, the way she experienced childbirth contributed to gaining safety compared with the way the younger generation experienced childbirth. This indicates her valuing of the social expectations of childbirth. These women's conformity to social and cultural expectations was significant in the situation when they lost their babies. Although some women participants as mentioned before considered their newborn deaths as a spiritual event determined by God during their repeated childbirth experiences, some other women were not happy to accept the fact of the loss of their newborns.

Toli mentioned the sad part of childbirth which also seems to happen easily in her village.

> *During the cropping and harvesting season, women even give birth in the farmland. They use whatever is available during the birth. Indeed, this is not in our hands to ensure the survival of the mother and baby during the birth. But we cannot happily accept the loss of babies either.* Toli

Toli was concerned about the survival of mother and baby within these circumstances. Unlike others, she was reluctant to accept the losses as a normal part of childbirth. This indicates that culture is not all good, it also entails sadness. The sad part of the culture and spirituality opens the room to where the medical paradigm can contribute to enhance safety. So, I think culture and medicine could come

together to maximise the chances of newborn survival in these study villages because it is important for these women participants to sustain their childbirth tradition as well as to prevent the deaths of their newborns.

Eckermann (2006) and Liamputtong (2009a) provide examples of negotiation with medicine in order to continue the tradition and culture related to childbirth in the institutional setting. As women participants in this study shared their preference for giving birth in their village setting, it seems that similar negotiation is possible without making women leave their preferred settings of childbirth. The findings discussed in the previous section opened the possibility of negotiation between village people including childbearing women and service providers which seems a possible approach to create an environment in which medicine and culture can work together to enhance safety as well as to minimise risk.

Some participants shared their medical knowledge of risk which they think contradicts their traditional knowledge of safety. This gap between knowledge came from two different paradigms raised by Sani, an older generation mother-in-law. Her comparison of attitudes towards the effect of work during childbirth explored this gap in understanding.

> *Back in our days, there was not a tradition of going to hospital. We did not even think about consulting any health workers. During our time, it was said that carrying loads will help to give birth easily. These days it is said [by health workers and media] that pregnant women should not be working hard and carrying loads. It was different in our day. You know during my daughter's turn, I was carrying wood for the whole day. I did milking of five buffalo and gave birth in the evening. My husband was also not at home on that day. I was alone at home. I called my mother-in-law and gave birth. This is how we were at that time.* Sani

Sani was able to give birth without interfering with her regular working schedule, in which continuing the regular work and carrying loads facilitated easy birth. The current childbirth understanding of service providers was to minimise the work load that these women were involved in every day. This changing perception about work during pregnancy created a complexity for these women because their understanding

is that continuing work contributes to enhancing safety which they will be unable to gain if they reduce the amount of their work. This complexity highlights the need to develop negotiated understanding in order to balance women's involvement in work during pregnancy and childbirth.

How women participants constructed childbirth was linked with social values, cultural norms and tradition which provided insight into their perception of childbirth as an everyday life event as well as a socio-cultural event in these study villages. The older generation participants experienced birth in the forest while collecting fodder; some others had their babies while cropping millet in the field and others while on the way back from work in the fields. These experiences affirm the consideration of childbirth as a part of their everyday work. These participants did not make any special arrangements for childbirth. So, it was possible to easily accommodate childbirth along with all the other things women do in their daily lives. Further, participants linked their consideration of childbirth as an ongoing life event to their social expectations and cultural values.

To sum up this sub theme, the pregnancy and childbirth experiences of women participants were embedded with many socio-cultural factors in these two study villages. The interactions of culture, spirituality and tradition in determining the survival of newborns revealed that there is a possibility of both the socio-cultural and medical paradigm coming together in the process. The perception of childbirth as a continuation of the women's regular amount of work created a complexity because the women's understanding about the effect was different to what they were informed. This identified a gap in understanding and viewing childbirth between the cultural and medical paradigm. Though women valued their spiritual belief system, some were not happy about the loss of their newborns. This opens the opportunity for medicine to contribute to enhance safety while birth occurs in the community setting.

4.4 'Will survive or die': Certainty and Uncertainty of Birth Outcomes

Within the consideration of childbirth as a part of everyday life events, there were also certainties and uncertainties about the outcomes revealed in participants' experiences. On the one hand, participants were determined that birth, survival and

death are spiritual things over which they have no control. On the other hand, participants were also anxious about the outcomes which could be either survival or death. Some women and family members expressed their worries about the uncertainties because of their previous experiences of newborn losses. The term certainty in this theme refers to the safety which comes from the survival of mothers and babies during pregnancy and childbirth, where uncertainty refers to the threats to safety which lead to maternal and newborn deaths.

In the social constructionism view, experiences are a source of knowledge construction (Kolb, 1984). In this study previous experiences of birth became a source of knowledge for some participants to ensure safety. Because of the experience of loss in previous childbirth threats to safety were created and participants experienced uncertainties about survival.

The account of Pema and her husband explains the context of such uncertainties.

> *We are worried about the baby due to come this month. We lost our previous child on the ninth day of birth. You know, it was a son. This time we don't know what will happen but we hope that the birth will go in a good way unless the things turn out another way. We are hoping to have a son, but what can we do if God wants the things to happen another way?* Pema and her husband

The worry about the survival of their baby was lessened by this couple's spiritual belief and trust in God. The knowledge of possible threat and uncertainties of survival during the birth did not change the childbirth tradition but prepared them to accept the situation as it happened. Their trust in God, one aspect of safety, could not ensure the survival of mother and baby which is another aspect of ensuring safety. So, a contradiction is revealed here which creates a challenge to determining safety.

However, some other participants who had experienced the loss of their newborn in previous births decided to seek medical care to lessen their worries and to avoid a future baby dying. Toli went to the hospital to get medical help.

> *I had twins last time, but both of them died. The first one died on the ninth day of birth and the second one on the next day. You know one*

disease, they call it jaundice. They died from jaundice. I became pregnant after a few months. I am anxious about the condition of the baby. I went to the hospital for a check-up but did not get any help. I hope God will help me to go well this time. Toli

Toli opens a space of both spirituality and medical care to determine safety during the birth. This indicates that culture and medicine are not two opposites but have a complementary relationship to each other in terms of pregnancy and childbirth. Women like Toli see the significance of both paradigms working together to promote the survival of newborns in their village.

In the study villages, the social obligations of childbirth also became a reason for uncertainty about the women's safety during pregnancy and childbirth. In these villages, there was an expectation that a married woman should get pregnant and give birth, as far as possible. This expectation compelled Sunita to continue the pregnancy when she did not feel safe.

I am feeling lonely and helpless. I did not want to get pregnant that early but I could not avoid it as well. He [husband] told me I have to continue the pregnancy. I am so anxious about it. Though I live with my in-laws, I have no one to care about my discomfort and feelings. There is no one to listen to me. I am feeling sick. I have fear. I am worried about the things that can happen during and after birth. I think I will die in giving birth. But I would be happy if I die as well. I have no more wish to live this way. Sunita

Though Sunita did not have any knowledge of any problems during her pregnancy and childbirth, she experienced fear for her own survival and worried about the birth outcomes. Her account demonstrates a complex circumstance in which she had not found ways to make her childbirth a safe experience. Another complexity emerging here is about the inability of women to negotiate with the social expectations in relation to childbirth. It seems that Sunita wanted to experience childbirth when she felt herself physically and emotionally ready. She opened the room for the family's support to lessen the fear of uncertainties, which could contribute to gaining safety during pregnancy and childbirth.

The knowledge of anticipated problems during pregnancy and childbirth created worries for other participants as well. These participants did not have any experience of the previous loss of newborns. The source of their knowledge of anticipated threat was their access to information. This group of women participants were equally hopeful in God for their safety during pregnancy and childbirth.

Rita, who was aware of the possible problems during pregnancy and childbirth, shared her feelings.

> *I am so upset. I am so worried. Since he [husband] left, I am feeling helpless. I am worried about the birth. I know there is a possibility of having many problems during pregnancy and childbirth. There are many people supporting me morally and emotionally, but I am worried a lot. It would have been better if he was with me. I am just worried about so many things. I am thinking all the time how will the birth take place. Oh God, I hope everything will go well. You see, I just can't stop thinking and it is really stressful these days.* Rita

The knowledge of possible physical problems during pregnancy and childbirth did not prompt Rita to take effective action for prevention but increased the level of expectation that God could be the source of help. Both sources of knowledge, whether it came from the women's experiences or from accessing information, created fear and women sought both medical and spiritual help to minimise the possible threat to their safety. This indicates that the action of women can be instrumental in medicine making a contribution to safety, not just to risk management, because it is the women who are the central actors in their pregnancy and childbirth rather than the medical professionals.

The spiritual meaning of childbirth was significant to some participants because they thought that no other intervention could ensure safety in terms of survival of mother and babies more than the spiritual one. Experiencing problems during pregnancy created a possible threat to safety during childbirth but Kiru spoke about the control of God to determine the nature of birth outcomes within the difficult and uncertain situation in her village.

> *Who knows what happens? Who knows whether the baby will come alive or die? Who knows whether I will survive or die in giving birth? Nobody knows what will happen. There are many babies dying in the village. Who knows whether my baby will survive or die? Nobody knows what happens. Only God knows but how do we know? Last time I felt like I was going to die, but I survived. At the end, who knows, you might get your baby dead.* Kiru

Kiru linked the uncertainties of birth outcomes including the survival of mother and baby with spiritual control. With the belief that the control lies elsewhere with the God, she was prepared to accept the outcomes. Her beliefs in spiritual control signify safety but also questions about the possible threat to survival.

Some other women participants' knowledge of uncertainties of birth outcomes came from their experience of problems during pregnancy which created a possible threat to their forthcoming birth. Manu experienced weakness in her current pregnancy compared with previous pregnancies. This experience of weakness created fear about safety.

> *I am feeling very weak [kamjor] this time. I was not like this before. My belly is also very big. I don't know why it is big. Sometimes, the baby can come earlier as well. In my previous time, no baby came early though. I don't know what will happen. I did not have any fear of giving birth previously. Because of God's favour, I did not have any problem. This time, I am a bit worried.* Manu

The confidence in giving birth without experiencing any problems had been interrupted while Manu experienced the differences in her current pregnancy. Though she was not aware of the reason for these differences and the possible outcomes of birth, she expressed her worries about ensuring positive outcomes.

There is a contradiction revealed in relation to uncertainty and birth outcomes viewed in the socio-cultural and the medical perspective. In this study, while women participants linked the safety of birth outcomes with spirituality, the medical doctor saw the family as not being responsible to prevent maternal death from occurring.

> *There was one case of maternal death which was brought to the hospital. It was festival time and people were feasting in the village. She gave birth at home and had retained the placenta. She bled and bled and bled. No one noticed until she became serious. Her family members also did not bother to bring her to the hospital promptly. So, she was brought at the last minute to the hospital. She was in shock while she was brought to the hospital. There was no pulse and heart beat. We tried to resuscitate her but we could not. She died in the hospital, where we could not do anything to save her life. I felt so sad that time.* Medical doctor

The medical doctor indicates that prompt medical help might have been able to prevent the death of this woman. Within such circumstances where the doctor is placed in an extremely difficult situation, he perceived the family as neglectful of the condition of women after the birth. This indicates that there is a possibility for the contribution of the medical perspective in the process of promoting safety through minimising the risk of dying. So, if these deaths are to be prevented, it seems that the medical understanding of childbirth needs to acknowledge the contribution of a cultural understanding of pregnancy and childbirth which then could come together in the process of providing safe childbirth experiences for the women.

It emerged from the data that participants in this study often valued more their traditional healing practice than seeking medical help if they experienced any problems during pregnancy and childbirth which needed external help to manage. The account of the traditional faith healer in the village explains the preference for traditional healing including the reasons for this preference.

> *When they give birth at Goth and the placenta is stuck inside, they don't go to hospital for that as well. Instead, they consult the Dhami and Jhankri [two different types of traditional faith healer] for a spiritual healing process. Most of the time, they call me to help them to expel the placenta. I have to go and help them during such conditions. I tell them to come to the health post but they don't follow my advice. Rather, they would call another faith healer to treat the condition.* Traditional faith healer

Trust is another concept which came out strongly from the data which determined the villagers' preferences for a spiritual healing process and prevented them from seeking medical help during childbirth problems. Because of that trust, villagers value the traditional knowledge more than the medical knowledge to manage childbirth problems.

This value of traditional knowledge was explained further by a local politician.

> *Still, there is strong cultural belief and traditional practices in the village where people trust more in traditional faith healers for example Dhami and Jhankri during the sickness. There are high numbers of deaths of mothers and newborn babies in the village. Yesterday only, two newborns died in the village. It was only three or four days since they were born.* Local politician

On the one side, there are newborn babies dying in the village. On the other side, there is a hint of blaming the women for not making any effort to seek medical help and for their reliance on the traditional healing system for the survival of newborns in these villages. In this complexity, there seems a gap between medical and cultural understanding which blames tradition for causing deaths of mothers and newborns. If women value traditional knowledge more than medical knowledge, they certainly do not seek medical care. However, some women attempt to seek medical help to lessen worries about the uncertainty of survival during childbirth and this offers optimism for possible negotiation between cultural and medical practices.

This section has revealed that birthing experiences contain both certainty and uncertainty around safety during pregnancy and childbirth. The data showed the differences in medical and traditional knowledge and their consequences for safety during pregnancy and childbirth. Most of the women participants felt that there was only spiritual power which could determine safety during pregnancy and childbirth. This spiritual belief mediates the childbirth practice in which there is the consideration that births and deaths are controlled by God. In the participants' view, going against the wishes of God minimises the safety during pregnancy, birth and the postnatal period. So, there was a feeling that childbearing women were not certain about the outcomes. At the same time, there was certainty about God's control of

outcomes which cannot be changed through taking any other action.

The findings in this section indicate that the medical risk paradigm sees culture and spirituality as the cause of maternal and newborn deaths, whereas other participants see medical interventions as threats to their safety. Consequently, the trust in traditional healing has influenced the practice of seeking medical help during problems related to childbirth, by which these deaths could be prevented. Though participants experienced worries about the uncertainties in relation to their safety during pregnancy and childbirth, it did not change their spiritual beliefs and traditional practices. Instead, it raised expectations that the spiritual healing process could determine safety during childbirth to prevent deaths and promote survival. Though this trust contributed to gaining one aspect of safety, the other part of safety, to gain the survival of mother and newborn, was lacking in these experiences. This further emphasised the importance of the engagement of both the cultural and medical paradigm to create a response together which can deal with this complexity of ensuring safety through the survival of both mothers and babies in these study villages.

4.5 'Sickle or Blade': A Dilemma of Ensuring Safety

The practice of using the sickle or blade for cutting the newborn cord is common in both villages. This theme particularly focuses on newborn cord cutting practice as one example of differences in constructing risk in the medical view and safety in the socio-cultural view by research participants. Previous themes revealed that the women valued the cultural and spiritual aspects of safety more than the physical during pregnancy, childbirth and the postnatal period. A randomised controlled trial conducted in a rural area of Nepal identified the crucial time after the birth which can prevent the deaths of newborns if special care is given to the cord cutting practice (Osrin et al., 2002). This is why I am analyzing experiences of newborn cord cutting practice in terms of newborn survival and how this fits within socio-cultural circumstances.

The sickle is a common utensil for women which they have easy access to during childbirth in the villages. The sickle is a large sharp blade with a short handle generally used to cut grass but also commonly used to cut the cord of the newborn in

these villages. The use of the sickle has been replaced by a blade in some women's experiences. The blade they have found handy is the one used for shaving by men. Once men gradually started to use shaving blades in the village, women had access to it for their use after childbirth. Participants were not yet aware of the problems that can be caused for newborn survival because of the use of the sickle or blade to cut the cord of the newborn.

This cord cutting practice creates the risk of infection (Mullany et al., 2005, 2006, 2007). Pema shared how cord cutting was done during her childbirth.

> *We put the cord of the baby on timber and we cut the cord using a sickle, or whatever is available during the time. We put the mustard oil on the Navi (umbilicus) afterwards. We don't tie the cord, we always leave it open.* Pema

The cord cutting practice that Pema mentioned is consistent with the practice explained in other studies which indicates the risk of newborn infection and the potential for death (Mullany et al., 2007, Mullany et al., 2006, Mullany et al., 2005, Sreeramareddy et al., 2006).

The cord cutting practice during the recent birth of Lashi was also similar to Pema's experiences. Unfortunately, Lashi's baby fell sick on the third day after birth but she was not aware of the causes of the sickness.

> *I remember Aunty found the sickle on the ceiling and used that to cut the cord of the baby. She did not tie the cord but I don't remember whether she put anything in the baby's Navi afterwards. Nothing wrong happened during the birth to the baby, but now he is very sick. He has had fever in the last three days.* Lashi

The association between cord cutting practice and neonatal infections which contributes to a high number of neonatal deaths is regarded as a challenge in reducing newborn mortality in developing countries (Liljestrand, 1999, Stoll, 1997). There may be a possible correlation between the cord cutting practice and the newborn's fever in Lashi's case and also for other newborn deaths happening in these study villages. As this research was not intending to examine such correlations,

there was no evidence in this study to support whether their practices were contributing to high numbers of newborn deaths.

Some participants were able to replace the sickle by using a blade when cutting the cord of the baby with the thought that a blade is better than a sickle. For example, Tolma used a blade for her recent birth which she thinks was a better option.

> *This time we used a blade to cut the cord of the baby. In my previous births, we did not even have the blade. My aunty used a sickle to cut the cord. We don't use a new blade. We use whatever is available at home during the childbirth.* Tolma

The use of a new blade has been found to reduce the chance of newborn infection (Mullany et al., 2007), which was also encouraged in the newborn care training that Manu got the opportunity to go through being a FCHV of the village. However, she did not have access to a new blade during her own birth and had no help to undertake other measures even though she knew this could reduce infection.

> *I used a blade to cut the cord of my previous baby, an old blade because I could not find the new one. I tied the cord with string, the same string we use to sew the cloth. I made two knots and tied in two places. They told during the training that we should make tight two knots. I did so. They also said to use a new blade and boiled string. But I did not do that. Who will help me to do all that during the birth?* Manu

The information about risk and the way of mitigating risks was constrained by limited access to materials in Manu's case. However, the findings in the previous sections suggest that the women's construction of risk does not give importance to following safety interventions for the purpose of minimising risks.

Urgen spoke about this concept of safety to determine newborn survival.

> *They told us during the training that we need to use a delivery kit during childbirth. But they did not give any kit to us. How can we get the kit to use if they don't provide it to us? We cannot go to the district headquarters to buy it. My mother used to cut the cord by sickle. This*

time also we will do the same. If the baby has to die, we cannot prevent them from dying. It is all God's wishes. Urgen

Another study in Nepal found that the use of a birthing kit (which usually includes a sterile blade) during the cord cutting is beneficial in preventing umbilical cord infection (Rhee et al., 2008). However, Urgen revealed a contradiction about construction of risk knowledge in relation to the causes of newborn deaths. She indicates a compromised negotiation with the inaccessibility of a birthing kit believing that newborn deaths are beyond her control. It also reveals another complexity of balancing the knowledge of risk and spiritual knowledge of safety to prevent neonatal infection.

This section has provided an example of how traditional knowledge which has been transferred from one generation to another shapes women's cord cutting practice. The evidence showing their cord cutting practice as risky and the cultural perception of viewing the same practice as normal creates another complexity for ensuring survival of newborns. Nevertheless, participants provided optimism for possible changes in their practice. Participants spoke about the use of the sickle to cut the cord which was easily available to them. Their preference for availability indicates that if materials are made available, participants would be able to follow a simple, cheap and safe cord cutting practice while giving birth in their village setting.

As has emerged in previous sections, participants demonstrate their ability to negotiate with tradition to enhance safety. This provides a very important contribution to developing a negotiated health response in these remote villages. To do so, there needs to be a collaborative dialogue to take actions according to the interest of village people and birthing women. The discussion in the next section draws together some of these key issues in relation to the findings of this chapter.

4.6 Discussion

Chapter 2 explained in detail that the socio-cultural conditions in which women live influence their birthing experiences. These circumstances shaping women's lives also affect safety during pregnancy and childbirth. It was noted that the analysis of cultural dimensions of childbirth has been overshadowed universally in the current

era by the powerful domain of medicalised childbirth (Fox and Worts, 1999a). The limitations of the medical approach to ensure collective ownership of the pregnancy and childbirth experiences of women are evident in this chapter. As Labonte (1992) argues, the medical model is concerned with high risk individuals, but participants in this study also felt a lack of consideration of their socio-cultural circumstances in the hospital. So, the participants in this study strongly highlighted the value of tradition and the importance of following their cultural norms during childbirth. The participants' preference for adopting cultural and traditional ways of experiencing pregnancy and childbirth is the most important aspect of their socio-cultural dimension.

Just as Oakley (1980) highlights the importance of culture and tradition in ensuring safety during pregnancy and childbirth, some participants in this study also expressed the feeling of being safe while giving birth inside the Goth. These participants were conscious of following the traditions to enhance safety. Although they sometimes experienced the loss of newborns while giving birth in the Goth, they felt that following the practice during childbirth pollution was more important than the deaths of the newborn. In a qualitative study conducted in rural and semi-urban areas of Nepal, Regmi and Madison (2009) found that Nepalese women in rural areas experiencing childbirth in the Goth felt dehumanised. However, women in this study living in the remote areas of Nepal were accepting of the tradition of giving birth in the Goth which contributed to gaining safety and collective ownership of the childbirth experiences.

Callister et al. (1999) provide evidence of the significance of spirituality during pregnancy and childbirth; the childbirth experiences of women in this study were also highly spiritual. Women connected their practice of not giving birth inside the house and remaining outside during the childbirth pollution to their spiritual beliefs. Rice et al. (1994) describe the experiences of Hmong women's feeling of being spiritually unsafe while experiencing childbirth in the hospital setting. A few participants in this study also felt their safety was threatened when they needed to go to hospital to give birth. However, two of them were able to leave the medical service returning to the traditional way of giving birth.

Women participants in this study were acting as social actors which Giddens (1984)

discusses in his theory of structuration. These women participants were actively involved in recreating cultural values, traditional practice and spiritual beliefs as part of their social structure in their childbirth practice. In this recreation process, some women were giving continuity to the tradition of giving birth in the Goth and others were concerned more about not polluting the house after childbirth. Though Jordan (1988) and Davis Floyd (2003) consider women as the owners of their experiences while giving birth within their community in the Western context of birth, the ownership of birthing experiences in this study came through the continuation of collective tradition which contributed to gaining safety as well. As a part of the recreation process, some participants expressed strong determination to continue with the pollution belief as a part of their culture.

Kitzinger (2001) highlights the significance of giving birth in natural settings to ensure women's control of their childbirth. In this sense, the participants of this study have the opportunity to experience childbirth within their village, but they do not have control over the deaths occurring during the birth. So, the issue of survival of mothers and babies becomes complex in this cultural setting. Although there was a negotiation in practice of giving birth in the Goth in some women's experiences, their construction of knowledge about childbirth pollution did not allow them to go inside the house during the postnatal days.

In the literature, Eckermann (2006) and Rice et al. (1994) provide examples of negotiation with medical practice in the hospital setting to maintain traditions and spirituality. This form of negotiation did not occur in this study; rather, some women negotiated with the traditional practice of giving birth in their home environment, choosing either the outside corner or the adjoining room of the house and only occasionally a health institution to give birth. But all of them followed the concept of untouchability during their postnatal days. This reflects their strong agency to transform the social structure according to their knowledge of constructing safety.

In Western culture, Oakley (1996) and Kitzinger (2001) point out that the concept of childbirth as a normal socio-cultural event has been shifted to a medicalised event. Brunson (2010a) in his study among women in a semiurban area of Nepal also found a shift in the cultural construction of birth to seeking biomedical care. Unlike this shifting, participants in this study described childbirth as a normal and ongoing life

event. Women participants accepted their regular amount of work as well as continuing to bear children as a part of their life. The women participants of this study accepted their role of getting pregnant and giving birth as a normal part of their everyday life routines.

As Douglas (1992) highlights how medicine often blames culture for causing high maternal and newborn deaths, the medical doctor in this study also blamed the family for their irresponsible behaviour and highlighted the responsibility of the family to take prompt action to bring women to the hospital which could preventmaternal death. Young (1990) writes that community people do not trust people whom they do not know. Similarly, when women experienced problems during pregnancy, childbirth and the postnatal period, they preferred seeking help from traditional faith healers in the village rather than trying to get medical help, which was not available in their village. This practice and preference added to the complexity of promoting the survival of mother and newborn in these villages. Their strong connection to and faith in tradition further created a situation of certainties and uncertainties of survival of the newborn and the mother during pregnancy and childbirth.

Glifford (2010) argues that an individual's decision about their actions is based on knowledge of risk and uncertainties. In this study, women who linked their worry to the uncertainties of outcomes did not make any decisions to change their birthing practice. The feeling of uncertainty did not influence their cultural beliefs and traditional practices of giving birth within their community. Rather they expressed the same level of trust in God who could be helpful for them to deal with associated uncertainties and ensure positive outcomes. This belief in spiritual power provided them with a safe boundary to remain within their socio-cultural dimension but did not ensure the survival of themselves and their babies.

Douglas (1992) notes that an individual's understanding of circumstances influences their way of perceiving and constructing safety, which is consistent with the experiences of the women participants in this study. Most of the women were not aware of the risks; however they were aware of what contributed to gaining safety in relation to their socio-cultural circumstances in which they continued the practice of older generations. Their traditional knowledge was important and resulted in their

trust and confidence in continuing their tradition and cultural practices. As Lupton (1999) points out, types of knowledge, whether traditional or medical, influence childbirth practices. Some women, who were aware of the medical risks, expressed their interest in going to hospital or using a safe birthing kit during the birth. But others who were concerned about the problems that can arise from not following their traditions and spirituality stayed with their cultural practices. Consistent with Douglas (1992), all the women participants in this research were concerned with maintaining culture, tradition and spirituality to ensure safety, as they constructed it, during pregnancy, childbirth and the postnatal period.

Labonte (1992) argues that no particular approach is sufficient to enhance health. In the context of the pregnancy and childbirth experiences of women in this study, it seems that both culture and medicine are important to enhance safety. The differences in constructing risk by medical professionals and safety by the women may be addressed by going through the process of mediation which Young (1990) suggests. For these women, it is important to ensure their connectedness to the culture, tradition and spirituality as well as the survival of mother and babies during pregnancy and childbirth.

Conclusion

This chapter discusses the first theme which emerged from the study which uncovered how pregnancy and childbirth was viewed in the culture, tradition and spirituality of the women in the remote mountain regions of Nepal. It revealed that the women participants in this study perceived pregnancy and childbirth as a normal ongoing task of their everyday life experiences. Related cultural and spiritual beliefs and traditions were crucial aspects of determining safety for these women. Their level of trust in tradition and spirituality was high to ensure the survival of mothers and newborns. A few women were also able to negotiate even within the tradition. This negotiation opened possibilities of making differences to ensure safety during women's pregnancy, birthing and the postnatal period.

The preference for giving birth within the Goth provided collective ownership to the birth place in which women were able to experience childbirth according to their interests. Women were active agents within the tradition to gain this collective

ownership and to confirm safety during childbirth. Though there were uncertainties of survival of mothers and babies while following the childbirth tradition, there was also a strong determination that the death or survival of mothers and babies during childbirth was controlled by supernatural power. There was also a higher level of trust in the traditional faith healer than the medical care providers. This trust also created complexity to ensure the survival of mother and baby which medical services could help. Therefore, the women's trust in traditional knowledge, spiritual beliefs and cultural practices was a critical factor to ensure safety during pregnancy and childbirth in these study villages. Nevertheless, possible ways forward have been demonstrated in the way in which the data contains notions of medicine and culture working together as different resources towards safety, rather than as incompatible opposites never relating to each other.

Chapter 5: Women's Social Position, Relationships and Childbirth Experiences

It has been argued in the literature that the socio-cultural conditions in which women give birth provide in-depth understanding of the core values of society (Davis-Floyd, 2001, Oakley, 1993). Women having control during their birthing experiences has been considered as crucial for their safety (Rothman, 1996, Zadoroznyj, 1999), which is also a component of safety, as it is defined in this thesis. The previous chapter provided insight into the cultural and spiritual dimensions of childbirth in the study villages where participants expressed their collective ownership of their experiences and safety during pregnancy, birth and the postnatal period. This chapter focuses on the influences of several relationships in pregnancy and childbirth as another key socio-cultural dimension. Within the household level, the analysis focuses on the relationship of a birthing woman with her husband and mother-in-law. This section further examines the influences of various relationships outside the household level on childbirth safety.

Both social constructionism and critical feminism give importance to social norms, expectations, interactions and relationships in understanding the meaning of childbirth (Weingarten, 1991). The influences of relationships during pregnancy, birth and the postnatal period emerged from the participants' voices and are significant for understanding the meaning of the childbirth experiences of women in this study. The data about the influences of relationships is organised into four sub themes:

- Social roles and positioning of women;
- 'Being together and apart': the crucial influences of family relationships;
- 'Outside home': the stakeholders' influences; and
- 'Left uninformed': the professional's control of birth.

These sub themes cover relationships as a key component of contributing to safety during pregnancy, childbirth and the postnatal period of women in both study villages. There are several patterns of relationships in which power plays a critical role to determine safety in the women's pregnancy and childbirth experiences.

Negotiation in relationships emerged as one of the key concepts in this theme. Additionally, trust in relationships was uncovered as one of the key components of ensuring safety during pregnancy and childbirth. I will now discuss each sub theme in relation to participants' accounts of their experiences in which these concepts appear.

5.1 Social Roles and Positioning of Women

Gender is a culturally defined status marker for differences in power relationships and plays a crucial role in choices and decisions about childbirth (Cockburn, 2009, Croson and Gneezy, 2009, Scott, 1986, Stern, 1997, Unger and Crawford, 1992). Understanding gender, what it means to be a man and a woman, can often take paradoxical forms in particular socio-cultural dimensions (Martin, 1990). In Nepali society, tensions sometimes emerge as gender based understandings are adapted and renegotiated by men and women as they attempt to understand their roles (Smart and Regmi, 2008). This tension is observed in the social circumstances of remote mountain women in relation to their pregnancy and childbirth experiences. Although women accepted their birthing role as customary in their society, they also experienced differences in many aspects of their experiences. This theme focuses on the status of women within their relationship interactions in the two study villages.

Most women in Nepal hold subordinate status in families in which there are structural power differences (Watkins, 1996). Within these structural differences, men normally hold legitimate power and women perform their submissive role. Such power differences in relationships and structure emerged from the participants' voices in this study. Most of the women participants talked about their submissive status in relation to the powerful status of men.

Urgen shared her experience of this difference.

> *All men in this village ignore women's problems and do not care about the household chores. They are happy drinking the Chyang [traditional alcoholic drinks]. We are at home to cook whether the food is available or not. We can get the food ready at home while they come from outside. They can get money to entertain. Why should they worry about us? He*

> *gets money from his teaching but I am struggling to feed these children. What could I share with you? We women are always the same, same household work, taking care of children, getting pregnant and giving birth. It would be better if they understood our problem. But they never do that. You see he left home early morning; maybe he is drinking somewhere with other villagers. He often comes back in the evening. He even has no worries about the children. Not even the sick child. How can he take care of me if he does not care about the children? Women are like shoes on their feet. When I went to the health post for check-up, the local health worker told my husband to take care of me and stop having any more children. He did not listen to him. He did not go for family planning as well. Instead, he said, he will go to another country if I want him to do family planning [vasectomy]. My body is getting weaker day by day and he does not understand it. Villagers also do not understand why I have to get pregnant at this age. They just tease me. It is very hard for me.* Urgen

Urgen's account provides a potent snapshot of her life being downtrodden within her village. The gendered division of labor limits her to household responsibilities of childbearing and childrearing including domestic duties. She deplored the social tendency of viewing women as the shoes on the men's feet. The legitimate power of her husband made him not responsible for children and not responsive to her preference for not having more births.

The structural power differences at family level including the social expectations in relationships became the crucial components in defining women's role in both study villages. Thus, women were mostly involved in household chores and agricultural work in these study villages. Most of the participants gave priority to household chores.

For example, Jitu was concerned about work during her early postnatal days.

> *Our ox was sick this morning. He [husband] asked me to prepare things for the treatment of the ox. I could not get time to cook food for me. I have still too much work left to do. I have to bring fodder from another*

> *village. No one in the family will do that if I don't. Our men don't do any work. So, I have to work first and then I will do the cooking. But I don't have anyone to leave the baby with as well.* Jitu

Jitu was an example of being the lowest priority person during her immediate postnatal days. This shows the legitimacy of her husband's influence to set this priority without allowing time for the care of the baby or herself. So, Jitu followed her role as a wife according to the interests of her husband.

In this structural difference, most of the women participants introduced themselves as working women. Most of the women involved in this study accepted their working role. Generally, they were involved in bearing and rearing children, doing household chores, farming, collecting fodder, carrying food from the market, walking long distances to collect water and being involved in other daily activities. As discussed in the previous chapter, women participants considered childbirth as a routine part of everyday life within these working roles, where they and others do not have any special consideration which leads to reducing or minimizing their workload during pregnancy. Being women, they consider agricultural and domestic work as their mandatory roles in life alongside their childbearing and rearing responsibilities, on which the survival of the family also depends.

Manu explained her everyday workload including pregnancy.

> *In the village, we women need to work hard. We are the ones to manage all work, inside the house and outside as well. We will remain with an empty stomach if we don't work during the season. The men have no tensions about work. They do not have to work in the farm as we do. It is different, as we are women. I did not feel any weakness during other pregnancies. I did all the work. I had energy that time. I used to do the work until the time of birth. But these days, I don't have any strength. I cannot work these days. I have a feeling that this time I cannot give birth normally because I have not been able to work.* Manu

In this study, most of the women accepted this power difference and gendered division of labor, except it created a threat to their safety during pregnancy in some

cases. Manu's account indicates that the amount of work she was involved in during pregnancy contributed to gaining safety during childbirth. Manu's description of the role of women as workers in the family has significance at the household level.

Unlike men, women have household responsibilities which are not economically visible but have a major role in managing the family. Historically, the Hindu religion has influenced women being put into the categories of performing the household chores including the child bearing and rearing tasks (Thompson, 1983). There are certain duties prescribed for women, such as keeping the house clean, cooking for family and looking after children, including managing the household.

Rima describes household work as one of the duties of women.

> *You know we women are not like men. We are supposed to be involved in household work. It does not allow for women keeping the house unmanaged or watching television or going outside. We should maintain our Dharma (duties) being women.* Rima

Rima's knowledge of these duties made her concerned about maintaining womanly roles. However these duties are not limited within the household boundaries and do not only apply to women from the Hindu religion. Lama women from the study villages also described their role similarly. Both Chhetry and Lama women were involved in agricultural work which sometimes required several hours' walking each day during pregnancy and the early postnatal days.

Toli shared her experiences during the working season in the village.

> *I usually go to Lek [high altitude farmland] during the cropping season. I was there a week before I gave birth. It takes about seven to eight hours to walk from here to get to our farming area. Other villagers have already gone to the Lek. We haven't started yet. We will not get good potatoes if we don't crop now. If I don't go to start cropping today or tomorrow, no one else will do it.* Toli

Panter-Brick (1991) observed Nepali women in the mountain areas of Nepal and wrote that walking long distances carrying a fetus inside the womb and a baby on

their back is a common feature. Toli shared a similar experience where she was worried about the delay in cropping potatoes during her early postnatal days.

Although the women's involvement in household work is not valued as contributing economically to Nepalese society, the amount of unpaid work women do every day has a major contribution to the subsistence of the family (Panter-Brick, 1989). The routine work of women in these study villages indicates that they are working long hours every day and highlights their contribution to family subsistence.

Tolma shared her everyday routines.

> *My day starts with the rooster's first cry. I have some goats in the house. I have to take care of them as well. I cook for the children and feed them. The water tap here is not close to the house. I have to bring water for household use. I carry water four times every day; it takes about 20 minutes for each time. I go to the field after finishing the household work. In the field, I have to work according to the season. Now, it is the season for wheat and potato cropping. We all are preparing the soil in the field. During the day, I have to prepare snacks for the children and also for the people working with me in the field. It is usually a busy day every day. I usually come back home in the evening only.* Tolma

Tolma's daily routine indicates that she is busy working the whole day. She further links this work with the continuous task of getting pregnant and giving birth, which are other tasks for her to accommodate in this daily routine.

> *I think this is because I am a woman. A woman should get married, become pregnant, give birth, get older and die. We must do other work all the time. This is how our life goes.* Tolma

Tolma accepted this amount of work including childbirth as a part of being a woman. It was a part of social expectations that she continued to accept. Unlike women, men are involved in direct earning activities in the village. Thus, men have a different role to perform which does not necessarily require involvement in household and agricultural work.

Dolma mentioned the work that men are generally involved in the village which clearly shows the differences between men and women in terms of their working role.

> *Our [women's] work is different to their [men's] work. Men are more concerned with business and other earning work. They usually travel around the place for their business and other activities. But we need to be involved in household work and farming. Isn't that what a woman is supposed to be doing? Why would a husband do such household things? They are not supposed to be doing women's things.* Dolma

Traditionally defined roles of men and women in Nepalese society have influenced the current practice in which men have significantly less working hours than women (Gautam et al., 2011). Gendered social norms have shaped the views of these participants where, for example, Dolma thinks that these regular jobs are the expected tasks of women. So, these women participants do not appear to be going against the social expectations because they think that fulfilling their expected role is important.

Although there were not any differences found between the accounts of the experiences of Chhetry and Lama women in these defined working roles, the medical doctor explained the difference between the two groups in terms of managing the household.

> *In the Lama community of Mugu district, generally the male is the breadwinner and the female is the manager of the whole house. Generally males go travelling for business to various places, Surketh, Nepalgunj and sometimes even to Tibet to the market places. However the Chhetry women never get an opportunity to make any decisions because their men usually do not leave the village.* Medical doctor

The role of men as breadwinner and women as the household manager is widely written about in the literature (Kandiyoti, 1988, Lein, 1979, Treas and Drobni, 2010, Zuo and Tang, 2000). In the study villages, the work division on the basis of gender has given more responsibility for household work to women during pregnancy and

childbirth. Despite the general claim of the government about increasing gender equity in Nepal, it is undeniable that economic, social and cultural inequalities exist at the societal level (Rai, 2010). The findings of this study suggest that women are central in the subsistence of the family. However, the voices of the women participants emphasised that differences remain in the society in which women do not see themselves as equal to men in terms of their status and socially defined roles.

However, some women participants felt that their status would have been improved if they were not required to give birth one after another. Because of the power of men over women, these women participants expressed their inability to resist the interest of men in making childbirth decisions.

Hira shared the complexity of the power of men over women.

> *I think that it would be better if we didn't need to have that many births. What can I do? I must give birth one after another. If I told my husband that I didn't want to give birth, he would certainly bring another wife. I have to accept whatever happens. This is more about him than me. Our (women's) life will go like this unless they understand.* Hira

Hira's account indicates that the understanding of husbands is critical for managing the number of children and making childbirth decisions. However the legitimate power exerted by her husband, being a man, over Hira made her unable to resist. Because of the possible threat to their relationship, she followed the interest of her husband without making her own decisions.

Pema shared similar frustration relating to the future life of her daughter.

> *I wish my daughter wouldn't get married. The life of a married woman is very hard in the village. If she gets married, I will tell her not to give birth to many babies. I hope the man will listen to her.* Pema

These women participants shared how they felt being a woman. They shared the impact of unequal power relationships between men and women on their childbirth decisions. Their expectation of bringing men into the process of developing a shared understanding and shared responsibility provides an opportunity to take collaborative

action for mediating current power structures.

Urgen shared the possibility of developing such negotiation through education and awareness.

> *I think giving girls the opportunity to be educated will make their life happy and easy. That is why I am sending them (daughters and daughter-in-law) to school. I hope that they do not need to live like me. Especially in this village, men have made women's lives harder. Women can't say no to their husband when they don't want to have another birth. Women cannot ignore the husband's wishes. Unless men think that they need to limit the number of children and take care of their wife's body, the situation will remain the same. So, we need to make men aware about the need for taking care of women during pregnancy and childbirth.* Urgen

In Urgen's view, formal education could enable women to speak about their interest in making appropriate childbirth decisions. She made an important distinction between education and awareness in developing a supportive relationship between men and women, in which she focused on educating women and raising the awareness of men. This indicates that in her view awareness is a more important aspect than education to develop supportive relationships for the benefit of women. Her view is supported by Freire's (1973) approach which focuses on the contribution of education to create awareness through subjective understanding of the conditions of the world and the conditions that shape them. Urgen's view of the need for awareness among men also demands a subjective understanding of childbirth conditions. However, there were many men in the village who did not express interest in participating in this research, saying that childbirth is women's business.

Though some participants accepted their working role and the amount of work they were involved in every day, there was also a thought about equal sharing of work, mutual understanding and supportive relationships between men and women.

Kabita shared her view.

> *I think it would be better if men had equal sharing of work with women.*

> *It would be better to have understanding between a husband and wife in any issues related to their life as far as possible. It is good if they work together with mutual understanding.* Kabita

Kabita opens the possibility to promote safety through equal sharing of work at the family level in her village. Another study (Simkhada et al., 2010) found a similar possibility for reducing the amount of domestic work that Nepali women are involved in through the understanding of family members including the husband. Some other women participants in my study felt that their ability to continue their daily amount of work impacted on safety in pregnancy and childbirth as I have defined it in this thesis.

This section has explored the social positioning and role of women in the two study villages. The findings suggest that women in these villages hold subordinate status in structural power relationships. The legitimacy of men over women makes women unable to speak against the decisions of men. However, there are different domains where decision making power resides for different parties. In the case of childbirth, power resides in the supporting person and birthing women. But the decision about whether to conceive the baby or not resides with the husband because women cannot resist the men's wishes. Consequently, the tasks of getting pregnant and giving birth become a part of the everyday life routines for these women.

The women participants were able to continue the expected amount of work throughout their pregnancy. For them, work was a part of life. Similarly, getting pregnant and giving birth was also a part of their everyday life routine. In their view, their ability to continue the regular burden of work during pregnancy facilitated their childbirth without experiencing any problems, which is one component of safety in this thesis.

Nevertheless, some women participants shared optimism about improving their status through shared understanding and responsibilities between men and women. This optimism signifies the possibility of creating a dialogue to construct negotiated understanding at both family and societal level. This negotiated understanding could help women to plan pregnancy according to their preferences, which then could contribute to constructing safe childbirth experiences. The next section explores the

influences of family relationships on pregnancy and childbirth experiences.

5.2 'Being Together or Apart': The Crucial Influences of Family Relationships

The previous theme provided some insight into the social roles and positioning of women in the study villages. This theme focuses on various family relationships of a birthing woman in relation to their influences on childbirth experiences. In the study villages, there was a hierarchical family structure in which a birthing woman generally held the bottom position. In this family structure, there were some relationships which were crucial to the women in ensuring and enhancing safety. More specifically, the relationships with their mother-in-law and husband were consistently shared by women participants as the critical relationships and their influences were revealed in childbirth experiences. The influence of the father-in-law was also explored in the conversations with a few women. The influences of these family relationships were uncovered in the data where a supportive relationship contributed to safety during pregnancy, birthing and the postnatal period. This section discusses the influences of these relationships on women's childbirth experiences in the two remote villages.

5.2.1 Mother-in-law and Daughter-in-law: A Crucial Relationship

Women's status varies depending on the domain in which they are operating, where their position as a mother-in-law holds a respected and powerful status because a married woman in Nepal is supposed to be ruled by her mother-in-law within the household boundaries (Cameron, 1998). Most mothers-in-law in Nepali society endeavor to have power over their daughters-in-law in a hierarchical family structure (Simkhada et al., 2010), which is legitimate because of their status as mother-in-law. Traditionally, girls have been trained to be submissive in their status as a daughter-in-law without speaking against the family (Manandhar, 2000), which can still be observed in some rural and remote villages of Nepal. If a married girl fails to be respectful to her in-laws, her parents might be blamed, most specifically the mother.

There is a significant power dynamic in the mother-in-law and daughter-in-law relationship. Most importantly, the presence of the mother-in-law is significant in the

pregnancy and childbirth experiences of daughters-in-law. It seems generally the more powerful the mother-in-law is in the family, the less likely the daughter-in-law gets autonomy in household matters. This status gives a mother-in-law authority to exert power over her daughters-in-law. The influence of such status of the mother-in-law was revealed in daughters-in-law's childbirth experiences in this study. This study showed that the relationship between mother-in-law and daughter-in-law provided a mix of influences in women's birthing experiences, in which a supportive and understanding relationship, as a component of safety, contributed to developing a shared understanding between them.

Some relations between mother-in-law and daughter-in-law were reciprocal in which mutual understanding and shared values were established. The reciprocity in this relationship refers to mutual respect towards each other which established a shared understanding between mother-in-law and daughter-in-law.

Sumi and Maina were able to develop such a shared understanding. Sumi shared the benefits of their reciprocal relationship for her pregnancy and childbirth experiences.

> *My mother-in-law was there with me all the time. She helped me to give birth. I did not know anything about how to deal with all of these things. She did everything for me. I did not need to worry about the baby as well. This time also we were hoping to have the baby at home. It did not come and my mother-in-law said that we needed to go to hospital. It was good that she went along. She is the one who looks after me and the baby all the time, which makes me more comfortable.* Sumi

Sumi's mother-in-law was able to make decisions beyond the tradition when the birth did not occur in the village. The mother-in-law's control during the birth contributed to gaining safety. This example of the supportive contribution of power is significant to note here because it created respect for and trust in the mother-in-law. Sumi's account further explores the status of the mother-in-law as a source of knowledge. The form of knowledge that mothers-in-law hold is lay knowledge constructed through their experiences. Sumi valued the traditional knowledge of her mother-in-law, which was also a component of safety.

The relationship between Sumi and Maina was sustained through respect, trust and mutual understanding. Maina shared the essence of this trust and respect in this relationship.

> *Kanchi [the youngest daughter-in-law, Sumi] loves me and looks after me very well. I also love her and take care of her well. It is not one side of a coin. It has to be always both sided. I tried the same with the oldest daughter-in-law but she did not understand it and she ignored me totally. She is educated and doing a job [paid work]. I am happy with Sumi. We understand each other's pain and discomfort. I will let her have complete rest for a month. I will not ask her to do any hard work until two months. I did not have such rest during my time. Now, I realise that women giving birth need rest and enough food to eat. I will provide as much as I can for Kanchi.* Maina

Despite the reciprocity of relationship with one daughter-in-law, there were grievances about the relationship with another daughter-in-law. Understanding between mother-in-law and daughter-in-law was a critical factor in this relationship. For Maina, the educational achievement and involvement in paid work of her other daughter-in-law was a negative influence on sustaining a good relationship. The good relationship with one daughter-in-law indicates that a mother-in-law holding status, power and respect can mediate change. However, Maina's account also demonstrates complexities in this relationship which influenced the childbirth experiences of her daughters-in-law, making one advantaged and the other disadvantaged in gaining safety during childbirth.

Along with educational achievement, difference in age was another factor which created gaps in understanding between mother-in-law and daughter-in-law. The relationship between younger generation daughters-in-law and older generation mothers-in-law was problematic in both villages. In this case, there was power conflict and misunderstanding between them which resulted lack in safety during pregnancy and childbirth experiences of daughter-in-law.

The relationship of Hira with her daughters-in-law showed the tensions around differences in understanding.

> *During my time, I had to bear two pregnancies within a year. I took that burden. Now, I am a mother-in-law for my daughters-in-law. I tell Laxmi to do light work, to eat better food and to live with me sharing comfort. I did not get such opportunity during my time. But I feel always how important it is to provide them with support during pregnancy, childbirth and the postnatal period. I have one daughter-in-law, she does not respect me and she does not follow the things as I ask. Yesterday, my daughter-in-law would have told you that I am a good one in the village. If you talk with my youngest daughter-in-law tomorrow, I am the bad one for her. She turns the other way, if she meets me by chance. She does not speak with me. I have not treated them differently. But she reacts differently.* Hira

A good relationship between mother-in-law and daughter-in-law increased the quality of care and childbirth support. Personal experiences of pregnancy and childbirth also led Hira to be more supportive and caring of her daughter-in-law. This provided satisfaction and contributed to sustaining a good relationship between them. More importantly, her daughter-in-law, Laxmi was able to achieve safety through the better understanding and continuing care of her mother-in-law during her pregnancy and childbirth.

Laxmi shared how their relationship was being fostered.

> *My mother-in-law usually tells me to work less, eat well and maintain hygiene. I spend most of the time with my mother-in-law. We do not have any conflict and misunderstanding. She is taking care of me very well. I think it has to be two sided. Daughter-in-law should respect mother-in-law to get better care and support. A woman there just told me that the relationship between mother-in-law and daughter-in-law is like an enemy. I don't agree with her because it does not apply in our case. We have good intimacy and trust each other. She understands well, I respect her. I also trust her in the things she tells me to do.* Laxmi

Respect and trust became a core factor for developing a good relationship for Laxmi. Laxmi highlighted the importance of having understanding and mutual respect

between each other which contributed to developing trust in an enduring relationship. Laxmi articulated clearly that mothers-in-law are not the only causes of conflict situations, but the understanding of the daughter-in-law is equally crucial. The respect she offered to her mother-in-law helped her to get support and better care. However, the mother-in-law raised her concern about the role of education and changing practices in maintaining social harmony and family relationships.

The generational divide between mother-in-law and daughter-in-law has become another more transparent issue in some other relationships demonstrating an issue of power. In these cases, daughters-in-law articulated the impact of the powerful influence of their mothers-in-law during the pregnancy, which most of the time was not supportive for them. The gap in understanding between the two generations has become critical and has been influenced by two factors, first the age difference and second the educational exposure of the daughters-in-law. There was more than 30 years difference in age between Hira and Maina and their youngest daughters-in-law. Although they shared the same social environment, the mothers-in-law's perspective of pregnancy and childbirth as it was experienced in their generation did not match with the perspective of their youngest daughters-in-law, which created confusion, conflict and misunderstanding. Some daughters-in-law who were younger talked about the misunderstanding with their older generation mothers-in-law.

Rama described the view of older generation women which creates misunderstanding.

> *The older women in this village usually talk about their experiences of pregnancy and childbirth. In their time, they say that they did all the work without taking any special food or extra meals, without taking any extra rest and without consulting any health workers. They expect the same thing from us too. They ask us why we need to go to hospital during pregnancy. They even criticise us for wearing clean and new clothes, going out with other friends and for being tidy during pregnancy. This is happening this way in our village. So, you can imagine how I have been feeling and how my pregnancy is going. It is not easy. We have to accept whatever comes. That is the only thing I can expect. Nothing is certain here; this is like living in the dark night. We don't know what is likely to*

happen. We know only these things that come to us. Rama

In this situation, the expectations of the older generation mothers-in-law created problems in understanding which led to conflict in some power relationships in the study villages. Rama did not step ahead beyond the older women's expectations in making decisions about her own childbirth. The only option left for her was to follow the expectations and continue the tradition. This was the difficulty for women like Rama on one side but on the other side the older generation mothers-in-law were also worried when their daughters-in-law did not demonstrate respect for the relationship or for tradition.

The generational conflict in this relationship resulted in disappointment and created mistrust between the parties. Urgen, a mother-in-law, shared her experiences of being with two different generation women, her mother and her daughter-in-law, where she differentiated between the relationships in terms of education and understanding.

> *My mother took care of all my childbirths. But my daughter-in-law does not share things with us. She thinks we [older women] don't know anything. She thinks we are ignorant about things. We don't know about her. She does not even speak well. I am happy to be with my mother. My daughter-in-law thinks that she does not need us during her childbirth. The talk between educated and uneducated is not the same. An educated daughter-in-law does not follow the advice of an illiterate mother-in-law.* Urgen

Urgen indicated the differences in the relationship based on her expectations and the perspective of her younger generation daughter-in-law. In her experience, disruption in a respected relationship was caused by education which created differences in understanding and in the power relationship between the younger generation and older generation and in their continuing social expectations. This gap in understanding became very influential and created tensions and conflict in the power relationship; subsequently it did not benefit either of them. In this sense, education created a threat to the mother-in-law's traditional way of doing things and to the social relationships which had been continuing down the generations.

This impact on continuing relationships was revealed in the experiences of some younger age daughters-in-law and their older age mothers-in-law. Sanju talked about her relationship with her mother-in-law which was more distressing during the time of pregnancy and childbirth.

> *She [mother-in-law] used to quarrel with me. There was no specific issue but she took everything negatively. I did as much as I could. But she was never satisfied with me and with my work. She did not even ask how I am during pregnancy and childbirth time. I was restless during the night. She did not even come out from her room. My husband took me to the health post at midnight with the help of other villagers. She did not come to ask how I was after my return from the health post.* Sanju

Trust and respect in their relationship as a component of safety was missing when there was a lack of a supportive relationship between Sanju and her mother-in-law. The account of her mother-in-law, Lali, further demonstrates how a good relationship between them was lost.

> *You know she does not speak with me. I am her mother-in-law. She should respect me. Why should I go and talk with her if she does not speak with me? She gave birth in the health post. I noticed she was in labour. They did not call me, so I did not go. I heard them going to the health post. I have not seen her since they returned from the hospital. If they do not need me, why do I need them? It is more comfortable to stay apart and not speak to each other rather than quarrelling every day. Being a daughter-in-law, she has to learn to respect others and to cope with the situation. I am obviously the more respected person as I am a mother-in-law. She should not be disrespectful this way to her in-laws.* Lali

Lali expected to be respected being a mother-in-law and complained about the attitude of her daughter-in-law for not respecting her. She indicated that respect and communication are the crucial components of relationships. Lali did not receive the expected level of respect from her daughter-in-law which led her to ignore the need of her daughter-in-law for care and support during pregnancy and childbirth. On

both sides, they thought differently about the cause of the unhappy relationship and both of them found they were not able to negotiate with the conflict and misunderstanding. However, there was an expectation of getting the mother-in-law's support during childbirth. The mother-in-law's lack of support during childbirth contributed to lack of safety for Sanju. This indicates that a good relationship between mother-in-law and daughter-in-law can contribute to achieving safety during pregnancy and childbirth.

The way of thinking about and maintaining their relationship was different for mother-in-law and daughter-in-law and created conflict and a stressful situation during the ongoing pregnancy of Sunita. She felt unsupported by her mother-in-law.

> *For six months of marriage, we have had no good relationship at home with each other in the family. That was the time I thought I should not have got married. My mother-in-law usually scolds me. Though we are living together, we don't speak. She says many things to me. Most of the time, she makes unnecessary comments. She usually listens to the village people and comes back to me with unnecessary arguments. She does not care how I am. She never asks how I am feeling either. I don't even share these things with my husband. I don't think he likes hearing these things from me.* Sunita

Being together with the family members did not provide a feeling of being cared for and supported during pregnancy for Sunita. This lack of a supportive relationship threatened safety during her pregnancy. There was also misunderstanding about the causes of the conflicting relationship between them. Both mother-in-law and daughter-in-law blamed each other for not sustaining a good relationship.

Seti, Sunita's mother-in-law said that the daughter-in-law has a more important role to play in maintaining the relationship.

> *During my pregnancy and childbirth time, my mother-in-law did everything for me. I used to share my feelings, discomfort and problems with her. I have also taken care of her very well. She has also taken care of my problems and tried to make me feel comfortable. She used to tell*

me what I should be doing and what I should not be doing during the pregnancy and childbirth period. I followed her advice all the time while she was alive. Now, if I say something, she [daughter-in-law] takes it differently and she doesn't follow my advice. It has been nearly a year we have not spoken to each other. I have never told her to do the work if she is unable to do it. I just advise the good things to ensure her comfort. I also got married at a very young age and she also came to my house at about the same age. I can understand her feelings but she does not care about my advice which makes me sad. Seti

There was a dynamic of power at play where the mother-in-law was playing the role of oppressor and the daughter-in-law was being oppressed. In this case, the gap in understanding did not only influence the way the daughter-in-law experienced pregnancy and childbirth, it also influenced the way the mother-in-law perceived her status.

Chameli expressed the feeling of losing her status and respect from her younger generation daughters-in-law.

You know, these days Buhari [daughter-in-law] does not respect their Sasu [mother-in-law]. They do things from their wishes and interest. They don't even ask before doing anything. We have been working hard our whole life. Now it is our time to take a rest and live at home. But they don't take care of us. We don't like the modern practice, in which our existence becomes worthless. We don't like to see the Buhari not respecting their Sasu. During our time, we gave birth while working. Now, they have started going to hospital from two to three months of pregnancy. They go to hospital to give birth as well. It may be good for them but they should respect the traditional practice also. They don't even hesitate to talk in front of their Sasura [father-in-law]. They are shameless. Chameli

Chameli's experience revealed that being a mother-in-law provides a role in the family and in the community and not being able to play this role makes the mother-in-law feel devalued. Chameli was not ready to accept the changes in this

relationship pattern which led to the feeling of loss of her status and power. So, the gain of power by the daughter-in-law became very critical in this relationship to receiving the care and support of the mother-in-law during pregnancy and childbirth. In a general sense, the gain of power meant that they had the ability to make decisions according to their preferences. But in this study, the power shift from mother-in-law to daughter-in-law created a lack in safety through the loss of collective support during pregnancy and childbirth.

While a few mothers-in-law felt the loss of respect in their relationship and felt they were being devalued by their daughter-in-law, the modern daughters-in-law also felt difficulty in adjusting to this relationship where understandings and expectations did not match. This reveals that modernity has created threats to tradition through the disruption of the relationship between mother-in-law and daughter-in-law. Especially those mothers-in-law who had encountered problems dealing with younger generation daughters-in-law were not ready to accept the changes happening in the relationship.

Suntali fell into this category of being modern and educated in her mother-in-law's view. She shared the differences in expectations with her mother-in-law.

> *My husband was together with me during the later months of my pregnancy. He is very understanding, helpful and supportive. He did not want me to do heavy work. He helped me to carry loads and to bring water from the tap. While he was helping me in this work, my mother-in-law was jealous. She did not like him supporting my work. She did not want to see him working and me living. She wanted me to do the same amount of work as she did during her time. I did not comment to her. Instead I ignored her since I started living separately [living in a separate house]. Now, she is on her way and I am on my way. We don't have any sharing.* Suntali

Living together with the mother/father-in-law is a common feature of the joint family structure in Nepal. There is a social expectation that the daughter-in-law should take care of other members of the family (Simkhada et al., 2010). With the support of her husband, Suntali, who was trained as a midwife, went against the social expectation

and broke the mother-in-law's social power, leaving home rather than being stressed every day. The support of her husband in a situation where the in-laws were not negotiating the differences in level of understanding in the relationship helped her to ensure safety during pregnancy. Although others experienced conflicting relationships because of the power imbalance with their husband and mother-in-law, Suntali was able to make choices about living and giving birth because of the support of her husband.

On the other hand, it is also important to analyse power and respect in a situation where the husband has acted against his mother to take care of the pregnancy and childbirth of his wife. Although the earlier generation mothers-in-law had expectations of their daughters-in-law to carry on in similar ways as they did during their time, the negotiation of understanding of the younger generation daughters-in-law helped to sustain a good relationship. Where mothers-in-law complained about the behavior, some daughters-in-law understood the generational gap and became flexible in the relationship. The flexibility that daughters-in-law adopted helped to sustain a good relationship.

Rita and her mother-in-law had differences in understanding in their relationship and view of pregnancy and childbirth. Rita's mother-in-law, Fulmaya, mentioned these differences in understanding which had resulted in them withholding sharing between them.

> *I don't know anything about how her pregnancy is and where she is planning to give birth. I have not talked with her about these things and she has not told anything to me either. She was not living here with me. They were living in the district headquarters. She came here only last week. I don't know what she is doing. I don't have time to ask all of these things. She stays home and I have to go outside to do my work. I know it does not require much time to ask how she is but she should have talked to me about it. This is the difference between Sasu and Buhari. I think I am the respected person and I also think that I should not speak with her unless she comes to talk with me. She might be thinking differently, but how do I know?* Fulmaya

There was a fear of loss of status and power which restricted Fulmaya from negotiating with her daughter-in-law. However, the daughter-in-law was able to understand and negotiate with her mother in law. The daughter-in-law's ability to negotiate contributed to sustaining a good relationship.

Rita was able to understand the feelings of her mother-in-law and paid respect to her status. Her negotiation helped to bridge the gap which had resulted from generational differences.

> *You know we have problems in understanding and in relationships among the family members at home. This is really problematic as we don't have good understanding between each other. You saw that my mother-in-law is different. She is always like this. So, I don't blame them. This is happening because of the differences in understanding between us. The time is different, so their thinking is also different to our thinking. I am trying my best not to make her disappointed.* Rita

This negotiation in relationship has been beneficial for both mother-in-law and daughter-in-law. Kabita spoke of similar negotiation with her mother-in-law. Despite the difficulties of managing the social and family expectations, she did not want to disrupt the relationship by falling below expectations. Instead, she tried to balance these expectations which led to establishing a supportive relationship.

> *I have been working in the school and also managing household work. It is not easy. Not easy you know, not really easy. I cannot say no while there is work left to do. I cannot just ignore the work and run off. I cannot see my husband and mother-in-law working without me. Being a daughter-in-law, I have to fulfill the social expectations as well. In our society, a daughter-in-law cannot behave like a daughter. It is not easy, but what can I do? I should be working for comfort in the relationship. I don't want to see my mother-in-law being unhappy about me. So, I will do what she wants me to do to make her happy and comfortable.* Kabita

The obligatory role of daughter-in-law added more household responsibilities for Kabita. The acceptance of meeting her mother-in-law's expectations contributed to

sustaining a good relationship and provided a satisfying experience for Kabita.

These women participants revealed the gap in understanding where some were able to skilfully negotiate the relationship and others were not. In most cases, this gap was causing conflicting relationships between younger daughters-in-law and mothers-in-law. A reciprocal relationship had been able to be established between those where both mother-in-law and daughter-in-law had similar understandings and also in situations where they had been able to negotiate. In a few cases where the daughter-in-law was educated, there was resentment in the relationship with their mother-in-law.

There were criticisms of the younger generation where mothers-in-law felt the loss in their respected status. It had created tensions in both groups regardless of their social status and education. It was clear from these accounts that a good relationship between mother-in-law and daughter-in-law contributed to safety. Where the relationship was disrupted, women were found to be more distressed, isolated and anxious, which threatened their safety during pregnancy and childbirth. However, negotiations in understanding had been beneficial to sustaining a good relationship between mothers-in-law and daughters-in-law.

The relationship between mother-in-law and daughter-in-law is built through negotiation, trust and respect. Giddens' (1994) notion of trust supports the essence of the relationship women participants talked about in this section. In Giddens' (1994) view, trust contributes to minimising possible threats and provides safety. In the study villages, trust in the mother-in-law allowed daughters-in-law to get support and care during their pregnancy and childbirth, which contributed to safety through minimisation of possible threats. Consequently, daughters-in-law paid more respect to the status and knowledge of their mother-in-law. In this case, the mother-in-law gained power to influence their daughter-in-law as a reward for the good relationship.

The notion of power and control goes side by side here with the nature of the relationship. Where the relationship was more conflicting, the power was held by mothers-in-law. The younger daughters-in-law also had some degree of power to make decisions for better birth outcomes; however this power was minimal to the

extent that their mothers-in-law had control over influencing safety during pregnancy and childbirth. Consequently, these daughters-in-law were complying with the norms in meeting the expectations of their mother-in-law.

More specifically, how a mother-in-law treated her daughter-in-law also varied according to the way their relationship worked. In this case, the actions that the birthing woman took during her pregnancy and childbirth were found to be shaped by the influences of social relationships within the family, gendered social norms and the resources available to them. So, it is important to explore how these relationships influence the childbirth experiences of women in terms of safety during pregnancy and childbirth. The next sub theme will focus on an analysis of these influences in terms of women's action to make choices about birthing support and how these decisions influenced their birthing experiences.

5.2.2 Mother-in-law's Support during Childbirth: Respect for Knowledge, Experience and Embedded Trust

The crucial role of the support person during childbirth which contributes to promoting safety was discussed in Chapter 2 of this thesis. It was also discussed in the literature that social structures and agency have a paramount role in influencing decisions about choices and actions. The concept of this structure and agency provides a basis to analyse the relationship between mother-in-law and daughter-in-law in relation to the childbirth support of the mother-in-law in these two remote villages. The previous theme provided insight into the pattern of the relationship and embedded power between childbearing women, who were daughters-in-law, and their mothers-in-law. Most of the women found the support of their mothers-in-law during childbirth contributed to safety.

Hodnett et al. (2011) argue that continuous support of a person from the family or social network is beneficial for women to achieve satisfactory childbirth experiences. In this study as well, the support of a known and trusted person was important to gain safety during the birth. The preference for a mother-in-law's support was evident even in those relationships which were conflicting in their everyday lives. In most cases, their preference reflected the safety achieved through the trusting relationship with their mother-in-law. This section uncovers the contribution of the

mother-in-law in enabling their daughter-in-law to gain safety during pregnancy and childbirth. Most importantly, I will focus on the support of the mother-in-law during childbirth.

Indeed, mothers-in-law were the first preference of most of the women for support during pregnancy and childbirth. The presence and support of their mother-in-law during the birth was immensely valued by childbearing women. For some women, the support of their mother-in-law contributed to achieving safety.

Laxmi was in hospital because of a bleeding problem a week before her expected date of giving birth. However, she wanted to go back home from the hospital and give birth with the assistance of her mother-in-law.

> *All the time, my mother-in-law helped me to give birth. She supported all my previous births. Nothing wrong happened. I am very comfortable giving birth with my mother-in-law. I am not happy staying in hospital. I don't like giving birth here. I want to go with my mother-in-law and give birth at home. I am sure, nothing will go wrong. I really feel comfortable with my mother-in-law. I know that she can manage the problems and help me to give birth.* Laxmi

Laxmi's respect for and trust in the knowledge of her mother-in-law developed through experience contributed to her experiencing birth without any difficulties. Laxmi gave more value to the lay knowledge and skills of her mother-in-law than the medical knowledge and professional skills available in the hospital. This indicates that greater importance was given to achieving safety rather than minimizing risk.

Another participant, Sumi had recently been to the hospital to give birth because of her prolonged pain. She also wanted to be accompanied by her mother-in-law all the time while giving birth at the hospital. It had contributed to her gaining safety during the birth and afterwards.

> *My mother-in-law was there with me all the time. She helped me to give birth. I did not know anything about how to deal with all of these things. She did everything for me. I did not need to worry about the baby as well. This time also we were hoping to have the baby at home [in a room*

> *attached to the outside corner of the house]. It did not come and my mother-in-law said that we needed to go to hospital. It was good that she went along. She is the one looking after me and the baby all the time, which makes me more comfortable.* Sumi

Better understanding and a supportive relationship with her mother-in-law made pregnancy and childbirth a safer experience for Sumi. As Giddens (1994) suggests, trust in the childbirth support of the mother-in-law becomes significant in gaining safety through effective action towards minimizing the possible threats. In these daughters-in-law's experiences, they were able to gain the confidence to effectively manage threats through the support of their mothers-in-law.

The childbirth support of the mother-in-law was crucial even for those who had other supports available in the village. The trust these daughters-in-law were able to develop in the knowledge and experience of their mothers-in-law seemed not possible to gain in other relationships. This made the presence of the mother-in-law during childbirth significant to gaining safety for these women participants.

Hira explained how the absence of her mother-in-law threatened safety.

> *If my mother-in-law was alive, I would have been more comfortable about giving birth. At least, I could have shared my problems with her. I don't have anyone with whom I can share. Others have their mother-in-law [Sasu], they are confident about childbirth. For me, I have to call other women from the village, which is not easy all the time. I am not comfortable sharing things about pregnancy with men. I feel most of the time that it would have been better if there had been any woman at home. I think sometimes that I would not have lost my baby last time if my mother-in-law was alive.* Hira

The absence of her mother-in-law created a lack of trusted support during childbirth which also contributed to a lack of safety during Hira's recent birth. The trust in mothers-in-law's support during childbirth opens the opportunity to bring those mothers-in-law into the process of promoting safety during pregnancy and childbirth. As some participants shared that they wanted the involvement of their mothers-in-

law even when they required medical support, there is a possibility here of negotiating with culture to ensure safety during the childbirth of these women.

Further, the birthing support of the mother-in-law was expected even in the case where the relationship between the mother-in-law and daughter-in-law was conflicting. Sanju's relationship with her mother-in-law was not good, but she was expecting her support during her recent childbirth.

> *I wanted to give birth at home but it became difficult to remain at home because my mother-in-law did not even come to ask how I was. She was with me last time while I gave birth to my son but this time she has not even talked with me since last year. I did not feel like giving birth on my own at home, so then I had to go to the health post. I did not feel good about it when she did not come to ask me how the birth was going.* Sanju

Sanju shared her disappointment about the lack of support of her mother-in-law. This lack actually required Sanju to seek medical help in her second birth, which was not her preference. This indicates that supporting daughters-in-law during childbirth has been a part of mothers-in-law's role in these study villages. When her mother-in-law did not perform that role, Sanju felt that she lacked safety during childbirth and the postnatal period. It seems that the involvement of the mother-in-law is a part of the daughter-in-law's construction of the childbirth experience.

The women participants explained the reasons for their preference for their mother-in-law as the support person during childbirth. Toma talked about the reassurance, physical support and encouragement she got from her mother-in-law in giving birth without experiencing problems. Consequently, it had lessened her worries and physical pain during the birth.

> *She told me not to be worried about giving birth. She reassured me during the pain as well. She always told me that I will be fine and that things will go naturally. It really made me comfortable. I did not have any worries the first time as well. I saw my Aunty giving birth when I was not married. The assurance I got from my mother-in-law made me feel confident.* Toma

The reassurance of her mother-in-law made Toma confident about giving birth. This feeling of confidence was significant in her gaining ownership of her childbirth experience. Toma also indicated that the experience of being involved in a birth prior to her own brought its own advantages beyond the mother-in-law's influence.

For Kabita, the presence of her mother-in-law was desired even when she was giving birth in the hospital. Her mother-in-law had prepared her to give birth without experiencing any problems when she did not know anything about how things progressed during pregnancy and childbirth.

> *I was with my mother-in-law while I had my first baby. I did not know anything about childbirth pain and how the baby comes. She told me that I was having childbirth pain. She gave me some warm drinks and said that there should be intense pain to bring the baby out. She comforted me during the pain. She gave me an oil massage and asked me to walk around. I did so. We were expecting to have the baby at home. She called the grandma from the next home; she is also a Sudheni [Traditional Birth Attendant]. Both of them were with me. They tried to comfort me all through the night but nothing happened until the next morning. Then they took me to the hospital. It was good they did not leave me alone. It was better to be with my mother-in-law than with a man [husband] in the hospital.* Kabita

The traditional ways of reducing pain through massage and walking were believed to be beneficial while giving birth in the study villages. Even in the hospital setting, Kabita felt the need of her mother-in-law to ensure that she was safe. The way her mother-in-law helped her to identify the birthing time and to progress through the birthing pain indicated that she valued her mother-in-law's knowledge and trusted in her support to ensure safety.

Giddens (1994) relates trust to uncertainty. In Giddens' (1994) view, uncertainties arise from the lack of information and the function of trust is to reduce those uncertainties. Some daughters-in-law involved in this study were able to develop trust in the support of their mothers-in-law which helped them to reduce their fear of uncertainties during childbirth. Additionally, mothers-in-law had been able to gain

knowledge about pregnancy and childbirth. The source of their knowledge was their own experiences of childbirth. Daughters-in-law offered their respect to their mothers-in-law and valued their lay knowledge more than the medical knowledge. In this context, the power of lay knowledge was more important than the power of expert knowledge in contributing to the safety of these women participants.

The findings in this section suggest that the involvement of the mother-in-law during childbirth was not only something that a childbearing woman desired; it also helped women to gain what they considered to be a safe childbirth experience through lessening their worries about uncertainty of survival. In this relationship and childbirth support, mothers-in-law held a powerful status and this type of power actually contributed to gaining safety during the pregnancy and childbirth of their daughters-in-law.

5.2.3 When Mothers-in-law Were Not Available – Other Childbirth Support

The previous section has clearly highlighted the significant contribution of mothers-in-law's support to achieving safety during pregnancy and childbirth. This section focuses on the other preferences of childbearing women outside of their family structure when they were not able to get support from their mothers-in-law.

Mother Supporting Daughter

In Nepal, once a girl child is married, she should leave her parents' house and start living with the family of her husband. So, meetings between mother and daughter do not happen very frequently unless they live in close proximity. Those women who lived close to their mother had the opportunity to get their support during pregnancy and childbirth. In some women's experience, mothers were the next trusted person after the mother-in-law to get support from during pregnancy and childbirth which contributed to achieving safety.

Urgen's birth was supported by her mother.

> *My mother had taken care of all my childbirths. She helped me during all my births. I never called anyone from outside and I never had any problems giving birth. My mother knows how to comfort the birthing*

woman. She did an incredibly great job with me. Urgen

The involvement and continued support of her mother helped Urgen to achieve safety during pregnancy and childbirth. In Western societies, the uniqueness of the mother daughter relationship involves role development, care and support, and emotional attachment (Hirsch, 1989, Martell, 1990). But in the study villages, the relationship between mother and daughter was important in providing support during childbirth. The two relationship patterns, mother-in-law/daughter-in-law and the mother/daughter relationship are different in terms of how power resides in them. The same woman became more powerful when she acted as mother-in-law but was more caring and passionate when she acted as mother, to provide support and care during pregnancy and childbirth.

Hirsch (1989) has noted that the emotional bond between mother and daughter is more likely to increase during pregnancy even if they don't live together. In this study only a few women talked about the care and support they received from their mother during pregnancy and childbirth.

Dolma described the opportunity of being with her mother while giving birth.

> *My mother assisted me in my childbirth. We did not need to call anyone from outside. My grandmother was also there to help if my mother needed any advice or assistance. Both of them were well experienced. They knew how to handle the situation. They were skilled too. I did not have any problems in giving birth with their support. I felt comfortable to be with them all the time.* Dolma

Dolma trusted the knowledge, skill and support of her mother and grandmother in childbirth. This trust contributed to making her childbirth a safe experience. As discussed in the previous section, the notion of trust in this relationship is similar to the concept of minimizing potential social threats.

Where these women participants felt safe with the support of their mother during childbirth, Toli shared her worries because of the absence of her mother to support her forthcoming childbirth.

> *My mother-in-law died before I came to this house. So, my mother was with me during my first birth. She did everything for me. This time, she now lives in the district headquarters. Being with my own mother is the best thing I always think. I am wondering how to give birth without her this time.* Toli

Toli's mother-in-law was not alive. She expressed her worries about the possible lack of support of her mother during the birth.

Some women participants expressed their desire to be closer to their mother during pregnancy and childbirth. While Suntali was restricted from meeting with her mother during pregnancy by her mother-in-law, she could not cope with this restriction and decided to be separate from her mother-in-law.

> *While we were together, I had restrictions in going out. My parents were living about one hour away. My mum wanted me to come and see her very frequently. I also wanted to do so, though I was busy in work. When I became pregnant, I wanted to stay with my mother. I could share any feelings with my mother but I can't with other women. So, I used to complete all the work at home before going to see my parents. They [mother and father-in-law] complained about it a lot. They did not let me go. My husband told me to ask them and then decide myself whether they allowed me to go or not. This was how I had to deal with them. I would not have left school as well if they had been supportive. They did not support me in my work and I had to leave school to help them with their farming. Even during the pregnancy, my mother-in-law did not feel I needed special care. I was not able to live with them anymore. I went to live with my husband in his working areas and I regularly visited my mother. I used to share all my problems with my mother.* Suntali

Suntali's trust in the care and support of her mother contributed to her gaining safe pregnancy and childbirth experiences. It demonstrates that having a trusted person to share problems with during pregnancy was very important for the women during pregnancy and childbirth. When the trusted person was not available to seek advice and support from during pregnancy and childbirth, it created worries and contributed

to lack of safety.

Rita shared how she felt about the absence of her mother.

> *I am missing my mother too much. I felt her absence all the time, especially after my marriage. This absence became more intense after I got pregnant. When I had my daughter, I felt how my mother would have been during the time I was born. I don't feel like going to the paternal house when there is no mother. I would have been staying with her now if she was alive.* Rita

Experiencing life without the presence of her mother had been a difficult experience for Rita. Her personal account reflected the feeling of not being properly looked after without her mother with whom she could have shared her motherhood experience and her feelings. This sharing and exchange was important for gaining safety through lessening fear during pregnancy and childbirth.

Support of Other Experienced Women

When the mother or mother-in-law was not available to support birth, some women preferred the help from other experienced women during pregnancy and childbirth. In some cases, there was the presence of female relatives during the birth. In some other cases, women preferred the help of other experienced women from the village during the birth.

For example, Tolma chose her maternal aunt to help her giving birth.

> *I had given all my births at home. It was not difficult to give birth. I had my Aunty with me during the time I gave birth which went without any trouble. I feel very comfortable with my Aunty. She lives nearby and she knows how to help during the birth. We are like a single family. She is not different to my own mother. I could have died while giving birth to triplets if she was not with me to support me.* Tolma

The support of her aunt during childbirth had been a satisfying experience for Tolma. Accessibility was the first factor in choosing her aunt as a support person. Secondly, there was trust in her aunt's knowledge about childbirth which led her to consider

her as the best companion during the birth.

In the case of the unavailability of a close family member, some women preferred the support of an experienced woman from the village. For example, Kiru's birth was supported by another village woman whom she considered as a sister. The village woman she referred to during the conversation was experienced in providing childbirth support.

> *When the pain started, I did not call anyone. I went down to the Goth and tried to give birth myself. I felt exhausted and did not feel that I was going to give birth for a few hours. Then, I asked my daughter to call the next door sister because I don't have any family members or relatives in the village to come and help me. She came and stayed with me. She helped me during the birth. I usually call her if I cannot give birth on my own.* Kiru

In case of unavailability of family members and relatives support, Kiru's birth was supported by a neighboring sister. So, the availability and acceptance of other experienced women in the village to provide help during childbirth was a significant opportunity for the participants who did not have experienced women in their family to support them when needed.

Lashi found an experienced village woman to help her in giving birth. She considered her as a sister.

> *I had three days long of pain. Ani [sister] was there with me all the time to look after me. I had the baby in the evening of the third day. She did everything for me. I did not have any problems.* Lashi

Lashi was able to get childbirth support from her respected and trustworthy neighbour which helped to make her childbirth a safe experience, as I have defined it in this thesis. This indicates that childbirth support is a significant component of safety in this research.

However, the experience of Prema was different to these women. She had given birth twice by herself and her other three births were supported by her mother-in-law and

aunty. She called her aunty because of the absence of her mother-in-law while giving birth.

> *I had given birth on my own as well. When I needed help, I called my mother-in-law or next door aunty. It depends on the place where I am giving birth and how I am coping with the pain. While I was at home giving birth to my first child, my mother-in-law was with me. She helped me to bring the baby out. She was with me during the birth of my second baby as well. During the turn of my third baby, I was in Lek [mountain farmland]. I was there alone and I gave birth out there. I could not get anyone to help me that time. I wrapped the baby and came down a few hours after the birth. The youngest daughter I have was born at home. I called the next door aunty because my mother-in-law was not at home. Aunty helped me to bring the baby out. All my births occurred in different places and were supported differently.* Prema

The influence of various relations and persons within and outside the family is evident in women's pregnancy and childbirth experiences. Whether the support persons were skilled or not, their experience of childbirth was the crucial basis of establishing trust and safety in their childbirth support. On all occasions, these women did not have a male companion during the birth, not even their husband. Although a TBA was available in both villages, the use of them was not evident in these women's childbirth experiences. So, women to women's relationships seem to be working to provide positive childbirth support in these two study villages.

This subsection has described how most of the women involved in this study chose their mother-in-law as the trusted person during childbirth. The influence of the mother-in-law during pregnancy and childbirth was significant for childbearing women to ensure safety. A few women preferred their mother as the next most comfortable companion during the birth. The support of the mother during childbirth was equally significant to ensure safety.

When women could not have access to their mother or mother-in-law, then their preference went to a trustworthy and accessible person in the village whom they thought was experienced and skilled in supporting the birth. Their preferences were

based on their lay knowledge, accessibility, experience of childbirth, skill in providing support, being comfortable in the relationship and their knowledge of assisting with birth. Although the supporting person had control in helping women during the birth, there was not any issue of a power relationship because the control of the support person contributed to achieving safety during the pregnancy and childbirth.

5.2.4 Husband and Wife Relationship: Understanding and Childbirth Support

Once a woman in Nepal is married, the relationship between them is known as husband and wife, as is common in other countries. In some women's experiences, they were able to gain safety through the care and support of their husband during pregnancy and childbirth. In this thesis, the presence of the husband means having them available and accessible to the wife to take necessary action and make decisions when needed. Because of pollution beliefs, the husband is not allowed to touch his wife or go inside the birthing place in these villages. Thus, their presence is about having them around the home during childbirth. Whether the husband was present or absent made a difference to the childbirth experiences of some women. The presence of a supportive husband contributed to gaining safety. When this supportive relationship was absent, women felt they were lacking safety during pregnancy and childbirth.

For example, Lashi felt a huge absence when her husband was not with her during and after her recent birth.

> *I felt so lonely. It would have been better if he [husband] was with me. I could have told him to take the baby to the hospital once I knew he was sick. I was feeling very weak myself and I could not tell anyone to take my baby to the hospital. It took me three days to have the energy to come here. Although men do not understand all the things happening in women, it would be better for a wife to live together with her husband to manage money and other costs. They [men] are not weak [emotionally and physically] like us. And other people in the village also trust men more than women. I feel most of the time helpless and insecure. I did not*

feel this way while he was with me. Lashi

Lashi talked about the practicalities of the presence of her husband during childbirth. She highlighted how the perception of women as the physically weaker counterparts of men led to her feeling of being unsafe during the absence of her husband. Although she thought that men could not understand how pregnancy and childbirth takes place, the presence of her husband for her was important to manage things, such as arranging money, calling health workers, and going to hospital if required during the childbirth.

Rita focuses on her emotional relationship with her husband and provides a stronger picture of a very supportive husband who takes responsibility.

> *He [husband] is a good person to everyone. He is worried about me all the time. He realised that he should not have left me at this stage. He told other people as well to help me if anything happened. There are other people around but it does not feel like being with him. He used to tell me not to do any work. He is trying to send some money for my care and support. Our daughter was very small when she was born. He wants to have this baby strong and big. He calls me twice a week. He is missing his daughter too much. He is worried all the time. I don't know what to do. I tell him not to be worried about us. Life would be hard for him there as well. But I cannot do anything. I am missing him a lot.* Rita

They were an educated couple working together in a school before her husband left Nepal. Rita articulated the importance of the presence of her husband during the time of childbirth. However, their physical distance from each other had made both of them worried about the forthcoming childbirth. More specifically, it had made Rita more anxious, thinking about the hardship that her husband might experience at his work place and also the condition of her pregnancy. It indicates that safety during Rita's pregnancy and childbirth was threatened due to the lack of care and support which she was getting from her husband.

Having a supportive and responsible husband created the feeling of safety during pregnancy and childbirth for Sarita. She shared her happiness about having a caring,

understanding and supportive husband during her pregnancy and childbirth.

> *I am feeling so happy being with my husband. He is caring, supportive and understanding. He knows about things and can decide what to do. My husband is looking after me very well all the time.* Sarita

This couple was involved in the People's War called Maoist in Nepal. Their political involvement could have contributed to establishing a supportive and understanding relationship between them as husband and wife. In Sarita's understanding as well, her husband was the decision maker. But Sarita showed her trust in the knowledge of her husband in making decisions about the care required during pregnancy and childbirth.

The husband's involvement in providing care and support during pregnancy and childbirth has been beneficial in ensuring positive outcomes and the emotional well being of childbearing women in many cultural settings (Kakaire et al., 2011, Sawyer et al., 2010, Singh and Ram, 2009). A Nepalese study found that the involvement of the husband during pregnancy contributed to minimizing delays in seeking care during pregnancy and childbirth which contributed to reduced risk (Sapkota et al., 2010). The positive role of the husband in this study also contributed to minimizing risk, which is a component of safety in this thesis.

There were some related events which initiated Sarita's husband, Ramesh seeking hospital care. Ramesh shared some events he had experienced which created his fear of experiencing risk.

> *I have seen many newborn deaths in my village. I have also seen one mother in the village who had given birth seven or eight times. All of them [babies] died and only the last one survived. There was my Buhari [brother's wife] who died at home because of not being able to give birth several years ago. I was anxious about Sarita this time. I was also fearful about the birth outcomes. That is why I thought about her going to hospital to give birth from the beginning of her pregnancy and we did so.* Ramesh

The knowledge that pregnancy and childbirth can be related to the risk of mother and

baby dying enabled this couple to choose to go to the hospital to receive regular prenatal care and to give birth. The source of that knowledge about risk was their previous birth experience. Their decision to go to hospital helped to reduce the risks of experiencing miscarriage or maternal or newborn loss throughout the pregnancy, childbirth and postnatal period. This indicates that the positive relationship between husband and wife contributed to lowering the risk, which enhanced safety in their experience.

For some couples, the role of the husband was crucial to making decisions for managing pregnancy and childbirth problems in the village. The data demonstrated that where gender and power relations played out in a supportive marriage relationship and so represented safety that in turn contributed to lowering risk.

Rima shared how her life had been saved because of a good and supportive husband who made an appropriate decision to take her to the city hospital.

> *He [husband] is very good to me all the time. I think I would not be here today if he had not brought me out to the city hospital while I was giving birth to my daughter last time. I was almost dead in the district hospital after three days of pain and discomfort. He managed to fly me out to the city and I was able to give birth to this daughter. His presence and support have always been comfortable to me. This time also he brought me down [to the city] to make sure that I could give birth in good way.*
> Rima

Rima indicated that she was able to gain safety because of the support of her husband. This type of support in taking immediate and appropriate action during a childbirth problem was due to an understanding of the problems and knowledge of the care needed to manage the problems. Rabin, Rima's husband was able to gain that knowledge through his experience, education and religious orientation.

Rabin talked about the source of his knowledge and understanding in developing his supportive attitude.

> *I think the role of the husband is crucial during pregnancy and childbirth. As Rima left her family and came to live with me for the rest*

> *of her life, I should take responsibility for looking after her very well. I should be the one to be with her sharing grief and happiness. In the Bible also, it is said that when your wife leaves her family to marry, then this is your responsibility to make her happy with love, care and happiness. Another factor is that I have been in contact with educated circles since my youth. The relationship and conversations with them have made me feel differently to other village people. I have learned to respect women and to take care of Rima. During the first pregnancy as well, I did my best to make her comfortable. I think this is what we need to learn and apply in our lives.* Rabin

Religious education is considered as one way to create changes in the perspectives of people (Noddings, 2009). The knowledge of Christianity contributed to changing Rabin's perspective of valuing women's status which later transformed into care, love and support of his wife. Similarly, the combined approach of education and religion has been shown to be successful in creating positive support in women's pregnancy and childbirth experiences (Stambach, 2010), which was also evident in Rabin's experiences. The husband's knowledge and understanding not only contributed to minimizing risk during the birth, Khan et al. (2009) found that it also helps women to recover early from the emotionally stressful experiences of childbirth. The findings in this study suggest that the understanding and support of the husband was a significant factor to determine safety during pregnancy and childbirth.

However, knowledge about the need for care during pregnancy, childbirth and the postnatal period made participants more anxious when they did not have resources to manage this care and support in the village.

Pema's husband, Chiring, talked about the gap between knowing and doing.

> *I know she [wife] is weak. I also know that she needs to eat enough vegetables and she should not be working hard. She should be doing only light work during pregnancy. It does not mean that she should not be doing anything. This is also not good staying home all the time doing nothing. I know she has to take care of her pregnancy but it is not always*

possible to avoid work. We should give her good food but no vegetables are available in our village. I might need to take her to the district hospital for a check-up as we have no one available in the village to consult about problems. Honestly, I cannot take her to the city. There are the children to look after and she is going to give birth. I am wondering how to manage the work while she needs rest after the birth. Chiring

Zadoroznyj (2001) relates material circumstances to the birthing choices of women in the Australian context and argues that social class has a strong influence on the childbirth experiences of women. Though the context of women in the remote mountain villages in this study is completely different to the context of women in Australia, Chiring shared his circumstances which constrained his ability to take his wife to the city hospital, even if it became necessary. He indicated a complexity of knowing and doing which was dependent on other social and structural factors, for example, access to services, transport, good food and other resources. Although they had limited choice, Chiring's understanding and their good marital relationship contributed to Pema gaining safety while experiencing pregnancy and childbirth.

Pema shared her feelings comparing the differences between her first and second childbirth.

When I had this daughter, it was a very hard time in my life. I had to work all day and bear the physical and emotional torture of my husband during the night. I could not say no to anything. We women are born to live for men. At that time, when I was giving birth to this daughter, there was no one to support me. My husband, he was drunk. He was shouting out from inside the house to bring food and more drinks for him. I had the first birth in such difficult conditions. Now, I am so happy to be with Chiring. He loves me. I feel like heaven now compared with my time with my former husband. Although we are not rich, we share the pain and happiness together. Although I had to work the whole day this time also, I can have a sound sleep during the night. We do not have more money but we can share the pain and comfort. I love this life. I am happy whatever happens now. Pema

Pema was able to gain safety through the care of her husband which she regarded as very important during her pregnancy and childbirth. The mutual understanding and support of their husbands made pregnancy and childbirth a safer and satisfying experience for women in these villages.

Nevertheless, there were many husbands who did not want to share their experiences and views about the pregnancy and childbirth of their wives. Those husbands made decisions in line with men's traditional values and understanding of what is appropriate. In traditional Nepalese society, talking about pregnancy and childbirth is not a matter for men. So, the men's avoidance of being involved in the research was not a major issue because they were doing what a man was expected to do in the village.

More importantly, the safety that a few women were able to achieve through the care and support of their husband during pregnancy and childbirth provided an important insight into the significance of mutual understanding and a good relationship between husband and wife during childbirth. At the same time, there was also the influence of the husband in making decisions about going to hospital which contributed to managing risk. Linking this with the findings in the earlier sections, it seems that men were more concerned about lowering the medical risks and women were more concerned about their safety during childbirth. So, there is a possibility of involving both the medical and cultural paradigms to enhance safety as well as lower risk. This could contribute to promoting the survival of mothers and babies without harming their culture and tradition.

The voices of husbands revealed in this section are only the views of those husbands who were supportive in their relationship. Thus, the perspectives of many other husbands remained hidden and unexplored in this study. However this study has provided insight into the essence of having love, care and support from the husband during pregnancy and childbirth.

5.2.5 Father-in-law: A Patriarchal Influence

It has been shown in the earlier sections of this chapter that mothers-in-law and husbands were the most active agents in the pregnancy and childbirth of their

daughters-in-law and wives, which was the strongest pattern in structural relationships. However, the place of the father-in-law was also significant in a few cases where the father-in-law's presence significantly interfered with the woman's interview. A father-in-law holds legitimate power in structural family relationships in which they are on the top of the structure.

The more influential position of the father-in-law was observed in Sumi's house when each question asked of her was answered by her father-in-law. While Sumi did not make any comment about her recent hospital birth experience, her father-in-law responded instantly about why they chose the hospital to give birth.

> *We are afraid of giving birth at home these days. In hospital, there are doctors, nurses and other health workers who have knowledge and skills. They can handle the situation properly and manage the problems accordingly. We like going to the hospital for birth these days. It is safe for mother and baby. During the night, it would be hard to take them to the hospital. It is better if we take them on time. There are materials and resources as well in the hospital.* Sumi's father-in-law

In this narrative, the father-in-law spoke on behalf of women and himself. He took over the conversation with Sumi and started to respond to the questions I asked. This scenario revealed hidden power issues in relation to the limited choices of women during pregnancy and childbirth. The father-in-law's comment about the hospital birth highlighted how risks are minimised in the hospital, which could contribute to saving the lives of both mother and baby. However, it also raised the question of whether Sumi really wanted to go against the tradition of birth in the village. When I repeated the same question of Sumi regarding her experience of giving birth in the hospital, she looked down without making any comment.

Her father-in-law added the reason for the hospital birth.

> *I think she had difficult pain and also a headache. We decided to take her to the hospital. She went with her mother-in-law and I also went afterwards.* Sumi's father-in-law

The father-in-law's taking over of the response to the question reflected his powerful

influence in making the decision about going to hospital to give birth. This was another instance where safety and risk came together during childbirth of the women. When problems were seen during the birth, they felt the need for medical help to manage them. This shows that medical and cultural concepts can work together to ensure the survival of mothers and babies in these villages.

When Sumi expressed her feelings of safety in giving birth in the village setting, her father-in-law commented about the hesitation of women to go to hospital during the birth.

> *I don't know why these women are hesitating to go to hospital. These days Shamans [Dhami and Jhankri] are also telling them to go to hospital. At least, it is good to have this awareness in the community. Otherwise, they would be dying staying at home. These women cannot even think what they should do for their safety. They don't even know how to talk with other people. These women are useless. I think she is feeling shy about talking with you as well.* Sumi's father-in-law

The father-in-law's judgment about women's inability to make decisions about going to hospital during their childbirth reflects the interplay of power which influenced Sumi's birthing experiences, and again reflects the fact that women were being marginalised in the power structure. Even though women were able to act according to their preferences during births which happened in the village setting, in other instances they did not have the power to make any decisions.

Not many women during the interviews mentioned the influence of their father-in-law during pregnancy and childbirth. Laxmi and Sarita talked about the supportive role of their father-in-law in making decisions regarding hospital visits during their childbirth experiences. The father-in-law was present during the interviews with Sanju and Sunita at their homes; however these fathers-in-law preferred to stay outside until the conversation ended. The data revealed that the role of fathers-in-law during the pregnancy and childbirth experiences of daughters-in-law was hidden but significant in making decisions to bring the women out from the village setting.

This section has provided understanding about the influences of family relationships

in the pregnancy and childbirth experiences of the women in this study. The concepts of structure and agency discussed in Chapter 2 are clearly shown in this section to be shaping the childbirth experiences of women living in two remote villages in Nepal. Both social structure and human agency were found to be influencing the pregnancy and childbirth experiences of the women which made most of the women participants silent about their choices and expectations.

As Giddens (1984) points out, these social relationships which are a part of structures can also be beneficial to the women in gaining safety during pregnancy and childbirth. For example, women who talked about their feeling of safety in being with their husband or mother-in-law and getting support and care from them during pregnancy and childbirth are a positive example of structural relationships. The same structure and agency were however found to be oppressive in other women's lives. In the majority of cases, women were social actors in making decisions about the person they wanted to help them in giving birth which contributed to achieving safety.

The dynamics of relationships were found to be changing according to the circumstances of the women, but support during the birth became paramount in all instances as most important for the childbearing women. The power of the support person to control the childbirth experience actually contributed to the women taking collective ownership of their birthing experiences. In these villages, women's ability to choose a support person whom they trust during childbirth indicates safety. Their choice of support person was found to be linked to their preference for continuing traditional practices in which they were allowed to follow the way they wanted to without any external interference.

The significance of giving birth in the village and its influence on ensuring safety was explored in the previous chapter. The theme discussed in this section has added to an understanding of the socio-cultural dimension of childbirth in which family relationships were critical to constructing trust in the care, experience and knowledge of the chosen support person in order to ensure safety. This theme has also uncovered the power issue at the family level and its influence on the pregnancy and childbirth experiences of women. The next theme further explores the value of knowledge, relationships and trust in making decisions about the action to be taken

during pregnancy and childbirth. Most importantly, it explores the social structures and agencies that played a crucial role in the pregnancy and childbirth experiences of the women in the study villages.

5.3 'Outside Home': The Stakeholders' Influences

A complex array of relationships and their influences on women's childbirth experiences were observed in the study villages where people holding a respected social status had authority to exercise power. In the local term, women participants referred to the people holding social status as 'the big people [Thula Manche]'. For example, they called the chief of the school 'the head sir'. There were a few people who were able to gain a higher level of respect and trust from the village people. The respected status of these people influenced the women's childbirth experience in this study.

The analysis in this section examines the embedded influences of the highly respected people in the village on women's pregnancy and childbirth experiences. The interaction between status and power is revealed in the analysis of these influences. The respect given to the social status of a particular individual was related to their status and knowledge that had an impact on social practices. For example, the school teacher was respected highly in the village and people usually followed his advice during illness and consulted him first before the health worker. The villagers considered the school teacher to be a knowledgeable person and they expected that he would give them sound advice.

The school teacher talked about this impression.

> *If they get sick, they don't go anywhere without consulting their Lama [local religious leader] first. We know that antibiotics work better during infections. If I give them the same antibiotic capsules during their sickness, they think that these must be good because the master [the head sir] is also taking them. They trust the medicine to cure their illness, if it is given by me or by their Lama. At the same time, if a local health worker gives the same medicines, they don't trust him and they think that he is giving them tablets which have no effect on their illness. This is how*

the trust in medical care is constructed in this village. School teacher

The school teacher articulated how trust in health care is constructed in the village, where the care is mostly influenced by the trust in the person rather than the care provided by the person. Consequently, the school teacher became a more trusted person than the health worker. It is usual in Nepal to have access to antibiotics as anyone can buy them in the medical shop without a prescription. The familiarity in the relationship seemed to be important for establishing trust which health workers were not yet able to gain.

The trust in specific people in the village emerged from familiarity and shared understanding between each other. A local indigenous leader, who was also respected in the village and provided both traditional and modern medical care during illness, shared the reason for this respect and trust which had been crucial in managing problems during pregnancy and childbirth. It was revealed in his account that the health workers were not able to gain the trust and respect which the lay care providers had gained in the village.

The local indigenous leader talked about this trust.

> *In this village, people look for Lama and other local care providers rather than the health assistant who comes from outside. They are more comfortable with trustworthy persons in the village than a skilled provider coming from the district. I have never been trained to provide health care but I have been helping them for the basic treatment. I usually get medicines from the markets and keep them in my store. In the village, when they get sick, they come to me. They don't go to the health post. It may be because the health workers coming from outside complain about the hygiene of the people. They ask people first to be clean and wash their face and only then will they start to check them. I am like a doctor in this village since the last 20 years but I cannot help them all the time when they have major problems. A few women died because of the problems in giving birth in the village. I tried my best but I could not save their life. They don't go to the hospital although I usually tell them to go for a check-up. They rather come to ask me to do*

whatever I can. Local indigenous leader

The local indigenous leader held a high social status, where villagers including women consulted him during problems related to their health, including pregnancy and childbirth related problems. He was an influential person in helping women during childbirth to manage related conditions and in saving lives of mothers and babies. His explanation about the health workers' disrespectful attitude towards the village people and his status like a doctor for several years demonstrated the trust, familiarity and respect of the villagers in relation to the care provided by him. There was a two way dynamic of respect in the relationship to establish this trust. While stakeholders were able to provide good care and respect the village people, villagers also offered their respect to them and trusted consulting with them. When health workers did not demonstrate respect for the village people, there was a lack of trust in their health care and the health care providers.

The respectful status of certain individuals in the village was not only in relation to consultation during health problems. These people influenced other decisions as well. During the interview with a local politician who had been working as the district development committee chief for a few years, it came to be known that the villagers had expectations of his contribution in managing better health services to prevent the unnecessary deaths of newborn babies.

The villagers are saying that they never find the doctor in the health post. They also told to me that they could not get any medicines from the health post even if it is open. Yesterday, the father of a sick baby went to several health posts to get medicines but he could not get anything while visiting three health posts on the way to the district headquarters. Then, he bought medicines from a medical shop in the district headquarters. While he was returning home with the medicines, his baby was already dead. You can see that all the children in the village are suffering from fever at the moment without getting any medicines to manage it. This is a serious problem in the village. I want to make sure that services are available in the village but I cannot ensure the health workers' presence here. I am just listening to their problems and trying to reassure them. In this scenario, people only have the option of consulting the Lama and local care providers who are available to

them in the village. Local politician

The shared understanding between villagers and the local politician was critical to creating the trust and respect between them. The reassurance that the local politician provided to the villagers was significant in relation to their expectations of having medicines and services available in the village. However, the unavailability of services and medicines made them unable to manage their health problems without consulting traditional faith healers and lay care providers. As a local politician, he held a powerful status but he had not been able to offer services to sustain trust and respect. In terms of the role of government to ensure access to care, his account opened up several issues in relation to the quality of services at the local level.

Along with the people holding highly respected positions, there were a few other people in the village who did not hold any political or administrative position in the community but their lay knowledge, skills and experience were crucial to the women during their pregnancy and childbirth.

A female community health volunteer (FCHV) in the village talked about the preferences of women which indicated their trust in lay care providers rather than health workers.

> *Women feel comfortable to share their problems with us. They don't even share their problems with family members. They feel shy going to a health post for a check-up. There were three women who gave birth recently and I helped one of them. The family members don't want to take women to the health post. Instead, they called us at home. There are other Sudheni [traditional birth attendant] also in the village to help during the childbirth. I do Sudheni work as well.* FCHV

The FCHV mentioned the confidence of women in sharing their problems related to pregnancy and childbirth with them rather than with other health care providers. The preference of family members to choose a traditional birth attendant during problems when giving birth reveals their influential status in supporting women while giving birth discussed in other studies as well (Osrin et al., 2002, Manandhar, 2000, Rhee et al., 2008). Though women participants did not mention about the traditional birth

attendant, they were found being more comfortable to speak with FCHV than the health workers and to seek traditional help to cure the problem during pregnancy and childbirth.

In the two study villages, there was not the regular presence of a professional midwife or trained birth attendant. However, the mothers-in-law and other older women in both villages were able to support births using their traditional knowledge and skills developed through experience. This shows that the women did not have access to the services of a midwife who could have helped them to manage their pregnancy and birth related problems which required medical help while experiencing birth in the village setting.

In both study villages, another person influencing the childbirth experience of women at the village level was a traditional faith healer. The faith healers were mostly men who were known as Dhami (Shaman) in the village. Their status in the village was generally not high and respected but the healing that they provided in the village established trust in their care. The influences of traditional healing were also evident in the women's pregnancy and childbirth experiences, in which the status of the faith healer was respected.

A local traditional faith healer spoke about his practice in the village.

> *Most of the time, they call me to help them to expel the placenta. I have to go and help them during such conditions. I tell them to go to the health post but they don't follow my advice. If I disagreed to go and help them, they would call another Dhami [Shaman] to treat the condition.*
> Traditional faith healer

The faith healer mentioned people's faith in traditional healing in which the healers held a respected and trustworthy status in providing care even during the problems of giving birth. This indicated that the place of the Shaman in the village was respected when women were not seeking medical care. Their trust in traditional healing was also linked with familiarity, respect and lay knowledge.

The strong belief in the traditional healing system was evident when Sunita's mother-in-law shared her experiences. She talked about her trust in the traditional

healing system to cure her problems.

> *A few weeks ago while we were all working, I had bleeding. It continued. On the fifth day, it became serious. In the evening, I had vomiting too. I became unconscious. I did not know what they did after that. They took me to the medical shop at midnight and then to the district hospital. I had a few transfusions at the hospital. I came back home the next day. It has been 14 days since I came back home. I had too many medicines which made me very weak. It did not help me to get better. Now, I cannot even move my hand properly. These tablets did not do anything for me. I started going to the 'Dhami' [traditional faith healer] since the day before yesterday. He said this is all happening because of the 'Nepale Hawa' [Nepali Air]. I am feeling a little better since he started healing me.* Seti

Women lacked trust in the available medical care and relied on traditional healing for help during illness. But there was not a total reliance on traditional healing, which reflects that these participants offered a space for the medical paradigm to be involved and to help them to manage their conditions to ensure survival.

This section has provided insight into the influences on women's childbirth experiences of relationships outside household level persons holding a different status in the society. Although the influences of these people were not directly evident in the women's pregnancy and childbirth experiences, their social status in the village has significantly contributed to the women's childbirth experiences. This section has revealed that trust was a core factor in respect to the status and valuing of the knowledge of a particular person in the village. There were the powerful positions of the school teacher, indigenous leader and local politician who were able to gain a higher level of trust from the villagers. These people were able to maintain their respected status providing positive support, care and reassurance to the villagers.

There was shared understanding between the high status people and the villagers which contributed to increasing the level of trust. In most instances, this understanding contributed to gaining safety in women's pregnancy and childbirth

experiences. At the next level, there were female volunteers and traditional faith healers who contributed to creating safe experiences, providing support to the women during pregnancy and childbirth. The contribution of these lay care providers was traditionally respected to resolve childbirth related problems and cure associated conditions.

5.4 'Left Uninformed': The Professional's Control of Birth

The previous chapter revealed the differences between the construction of the knowledge of safety in the cultural paradigm and the knowledge of risk in the medical paradigm in relation to pregnancy and childbirth. It was also clear in the previous chapter that childbearing women in this study gave importance to safety more than reduction of risk during pregnancy and childbirth. This difference in constructing the knowledge of risk had an impact on the childbirth experiences of the women through the control of professionals in the institutional setting. This sub theme focuses on exploring the gap in understanding between service providers and women participants where women themselves were not aware of the things that were going to happen during their pregnancy and childbirth time and health providers did not explain them. This section will provide both perspectives of providers and receivers of care in relation to the control of women's childbirth experiences.

The women's accounts of their experiences exposed various aspects of the professional services. For example, some women participants talked about the uncooperative attitude of the health service providers during their prenatal consultations.

Sarita shared her prenatal consultation experiences in which she never felt that she was informed or benefitted.

> *I went to the hospital for a regular check-up. But you know the services in hospital are not that good. They do the pregnancy check every Wednesday only. There are usually many women to check on that day. They don't give enough time and attention to each pregnant woman. They didn't really tell me anything. I knew nothing about the condition of my pregnancy. I was always curious about what they were doing. But*

> *they never told me about the check up and my condition. Sometimes, they did not even answer my question. I did not feel really comfortable when I went for the check-up during pregnancy. It was meaningless to go there for a check-up.* Sarita

Sarita's experience indicated the attitude of the care provider in which they were not able to provide satisfactory care. So, there seemed to be no trust in or respect for the care providers.

A similar attitude towards care providers was evident in the experiences of other participants. Toli walked a long way for prenatal consultations in the district hospital but she did not find her experience satisfying or meaningful. Toli shared her experiences of being in the hospital.

> *I went to the hospital once. They did not check me properly. There were many women waiting outside for their check-up. I went inside when a sister called. She only palpated my abdomen. She asked me something but I could not understand what she asked. Then, she became irritated. She did not repeat the question when I told her I could not understand what she said. She remained angry and did not say anything to me after that. I did not know how my baby was after the check-up as well. I also did not know when I needed to have another check-up. I felt I should not have gone there for a check-up. It was just a waste of time and energy to go there. They did not behave well and they did not even talk with me.* Toli

The implicit conceptualisation of dominance of care providers based on their role is exposed in the experience of Toli, in which her presence and her socio-cultural status was not valued and respected. The expression of irritation and anger of the care provider in response to her request demonstrated the power and control embedded in the position and the professional role which left Toli ignorant about the condition of her baby and the care she needed. It indicated that the professional's way of viewing women's experience of pregnancy was too mechanistic and the professional did not appear to respect the socio-cultural circumstances of the women coming to receive services. The professional power created a lack of trust in the care provided in the

hospital to which the women participants did not feel attracted.

The inability of some care providers to understand several dimensions of the women coming to the prenatal clinic created mistrust and gaps between providers and pregnant women. Manu talked about the waiting in the hospital without them realising the distance she walked to get there and the expectations she had during her prenatal check-up.

> *I did not have any check-up before. I just came here for the first check-up. In fact, I came here last Friday from the village. They told me that I had to wait until the Wednesday for a check-up. As I had to walk for two days to get here, I thought I would wait until today. They checked me but did not say anything. I don't know how my pregnancy is going. They said there might be two babies, looking at my big belly [Pet]. I don't know whether there are two or one. I also don't know what I need to do to give birth.* Manu

The lack of respect for the women and the poor communication of care providers created confusion and uncertainty for Manu about the childbirth outcomes. The lack of confidence in the care providers to confirm the condition of the baby and unclear explanations created worries which threatened safety.

While these women participants felt they were not appropriately treated by the service providers during their prenatal consultation, Jitu was actually threatened by the powerful influence of a service provider during her recent pregnancy. Jitu shared her impression of the institutional care provider.

> *I heard that they [health workers] said that I must go for a check-up during the pregnancy. They also told me that they will send the police to my house if I don't go to the health post for a check-up during pregnancy. The village women who went for a check-up passed me this message when they came back from the health post. I went there once but I did not feel like going afterwards, though they told me to come regularly.* Jitu

Jitu's experiences indicate that the health worker was using coercive power to

control her pregnancy and childbirth in which she felt threatened for not consulting them during the pregnancy. However, she resisted this control and did not make another visit to the health post. This indicated the control of service providers was not acceptable to these women. Their resistance to the control of care providers was a significant achievement in gaining safety and taking ownership of their childbirth experiences.

Further, there were differences in viewing childbirth which made a few women unsafe during childbirth in the institutional setting. Rima shared her feeling of being in a completely different environment because of the medical procedure she had to follow as instructed by the professionals.

> *After several hours travel from the district, I found myself in a completely different place. It was all unusual to me. The hospital was different, people were different and the way they talked was also different. I felt a little odd to talk with them. I was in pain and discomfort. I had to wait another three days there to have my baby. They gave injections to me and a few other tablets. I did not know why these injections were required but I felt that they were going to save my life. But these injections did not help me to give birth, I felt so uncomfortable in the hospital. I did not know any of them and I also did not know what they were going to do. They were all different to me and I could not speak with them either, as I thought I should not be asking anything. It was all too different for me. I wanted to give birth on my own. But they told me that I could not give birth myself. On the third day, they decided to do the operation. It was so scary.* Rima

The institution made Rima feel powerless in which she remained silent being an 'obedient' follower of the health professional. Rima's experience demonstrates the control of service providers during childbirth within a controlled institutionalised setting in which the decisions were made by professionals. Kitzinger (2001) argues that the use of technology and medical knowledge in an institutional birth tends to dehumanise women's birthing experiences. Rima's experience of recent childbirth was consistent with that argument in that she was not aware of what was happening in her childbirth and why she needed to go through the different procedures. Most of

the time professionals make decisions based on the knowledge of physical risk during childbirth in institutional settings where childbearing women cannot resist these decisions to ensure the survival of themselves and their babies (Torres and De Vries, 2009). Rima was in a similar situation when the professionals made the decision about the operation despite her interest in having a normal birth.

In addition to the control of her birthing experience, Suntali experienced negligent practice by the professionals in a local health institution. Being a trained midwife, she noticed that she was treated unsafely which created life threatening problems during her recent birth.

> *In the birthing centre, they told me I would be fine initially. Later on, they said different things. Sometimes they told me the cord was around the baby's neck. Sometimes they told me that I had a contracted pelvis. Sometimes they told me that I won't be able to give birth normally. Their talk made me so sad. They did not behave well with me. They were not good. They even blamed me for not having a video x-ray while I was with my husband in the city. A health worker [Auxiliary Health Worker] came and started to give me oxytocins. I noticed that he gave me 10 units of oxytocins initially and did not maintain the actual drops as well. My labour progressed abnormally. I asked my husband to take me to the hospital rather than listening to them helplessly. I could have died if I did not insist my husband take me to the hospital. They were hopeless. Yes, it was really disgusting to be with them. I really had a very bad experience of giving birth. They made me really mad. I just can't believe that they do the right things for other women. It was their negligence rather than a mistake. I just can't even think that a health worker does such negligence in care, but they did. There is no way that I can trust them.* Suntali

The way service providers in the local health post controlled the birthing experience of Suntali demonstrated the inappropriate use of medical knowledge by the professional providing care in an officially sanctioned authority. It exposed the oppressive attitude of the care provider which impacted on Suntali's safety while giving birth in the institutional setting. It created mistrust in the care and their way of treating women in the health institution.

How professionals hold power and control in the pregnancy and childbirth experiences of women was further revealed in the interview with a medical doctor working in a hospital. The medical doctor differentiated his status and said that women should follow his instructions during their pregnancy and childbirth. He referred to the status of village people as the 'peasant farmers'.

> *The socio-economic condition of the people in the district is not good. Generally in the peasant family or in the farming family, they need somebody to work. So they want their son to get married and bring in someone to work in the family. This means a girl has to get married and start work very soon as a working member of the family. Then, the education or awareness of the people is another factor. Unless people are educated and aware, they don't know the risks of getting pregnant and giving birth at an early age. So, when they become educated they know the appropriate age for getting married and that they need to go for antenatal check-ups, they need to go to hospital to give birth, they need to take injections, prenatal vitamins and other nutrients. So, it is not only one dynamic or only one aspect of life which can be focused on. There is a multifactorial relationship which influences the pregnancy and childbirth experience of women in this district. I think this is the best approach to address these issues in order to make the experiences of women better.* Medical doctor

The way the medical doctor viewed the status of people and pregnancy contradicted the way the women talked about their interests in giving birth in the previous themes. The doctor was trying to make people go through medicalised experiences of birth with vitamins and injections. His narrative indicated his attempt to have women come to the health institution for prenatal consultations. He argued that the health institution's approach possibly helped to save the lives of women during childbirth.

> *At least if the people come to the hospital, they don't have to lose their life for a trivial reason. We are trying to manage and we have been managing the various complications in the district hospital setting as well.* Medical doctor

The medical doctor considered the increasing number of births in the hospital as good progress in reducing the number of deaths associated with childbirth. He referred to the culture and tradition of childbirth as causing deaths in the village. Compared with the women's experiences we have heard about in the previous sections, that they feel safe and well supported during childbirth in the village, the comments of the medical doctor about institutionalised birth create a contradiction between the cultural and medical paradigm.

However, the local midwife commented differently about the increasing trend of women coming to the hospital to give birth.

> *Women started to come to the hospital only after they knew that they will get money from the hospital. There were only five women who came to the hospital to give birth in the first year. Now, there are more than 30 women coming to give birth every month. They come to the hospital on a stretcher, most of the time. Some of them give birth at home and come to the hospital after their bleeding does not stop at home. Some of them come because of the retained placenta. Although we are telling them to come to the hospital for a check-up and to give birth, it has not been happening. Most of them are coming from the surrounding villages of the hospital only because they are aware of the incentive they are entitled to get. This has made a really positive impact on the safe childbirth programme here. It is very good now, but still there are many who have not been able to come to the hospital.* Local midwife

The policy introduced by the government had become dominant for the women who went to the hospital. However, no woman in this study mentioned such an incentive as their reason for going to hospital. Rather, they said their reason for going to hospital was because of problems in giving birth in the village setting which were not able to be managed by traditional help. This indicates that the service providers' intentions of bringing women into the medicalised setting of birth was not welcomed by the majority of women and only a few women living around the hospital were using the hospital services.

The local male health worker's account demonstrates a form of denial of the culture

and childbirth tradition. It also highlights the women's resistance to going to hospital to give birth.

> *The women in the village do not know their age also. They do not know the responsibilities of being parents and the way of giving safe birth. People here are like 16th century people. They are neither better nor worse. Though several organizations are working here to change their lifestyle the impact is very low. I have been telling them to come to the health post and have also reminded them many times about the risks of giving birth in the Goth. They don't come. They are so different.* Local health worker

The local health worker placed the women back in the 16th century and blamed them for not coming to the health institution to use the medical services. He criticised the traditional practice of giving birth in the village and the resistance of the people to adopting the medical way of viewing pregnancy and childbirth. However, the approach of making people aware of the medical risks did not bring any changes in how pregnancy and childbirth were viewed as a socio-cultural event in the village.

This section has provided insight into external service providers' influences on women's experiences of pregnancy and childbirth in remote areas of Nepal. The narratives of a number of women in this study have reflected the powerful influences of service providers within institutional settings where women felt they were treated mechanically and in one case, inappropriately. The differences perceived by the women participants in institutional settings are consistent with what Young (1990) highlights in 'Politics of Difference'. These service providers were like strangers for the women and there was no respect or trust established between them.

A few women who went to the health service institutions during pregnancy and childbirth felt that they were being controlled by the service providers while they were left confused and uninformed about their condition which created limited trust in the care and care providers. The interviews with a number of service providers exposed the influence of their position, power and control over women's experiences of pregnancy and childbirth. However, the resistance of the people which was revealed in the service providers' narratives reflected the autonomy of the village

women in choosing a safe way of experiencing pregnancy and childbirth.

5.6 Discussion

Childbirth is considered to be a powerful and overwhelming experience for women which provides clues for understanding our nature as women, our relationship to ourselves and others, and our attachment to people and place in our everyday lives (Kelpin, 1992). As discussed in Chapter 2, women's birthing experiences in the study villages were influenced by social structures and different human agencies. More importantly, various forms of relationships that existed in the society were influential in relation to safety during pregnancy and childbirth. Different forms of relationships as agency influenced the childbirth experiences of women either in gaining or hindering safety. Similarly, there were social norms, roles, expectations, tradition and knowledge which built structures to interact with these relationships. The interplay between the structures and agency indicated that the status of women and their relationships within and outside the household were crucial to their safety during pregnancy and childbirth in the study villages. This demonstrated that despite the submissive status of the women participants in the society, women to women relationships were the most crucial during pregnancy and childbirth.

Within this structure/agency relationship, there were different forms of power at play which influenced the childbirth experiences of women. Participants' accounts revealed the interplay of legitimate, referent, coercive and expert power during pregnancy and childbirth. The legitimacy of men in these villages restricted women in making decisions about pregnancy. However, where the relationship was mutual between men and women, a similar form of power contributed to gaining safety and to lowering risk. When the power became coercive, some women participants felt a threat to their pregnancy and childbirth. Some women participants said that the coercive power of their husband made them unable to speak against his decisions. Similarly, the coercion of mothers-in-law was found in some daughters-in-law's experiences to have created conflict and misunderstanding in their relationship.

More specifically, the mothers-in-law held a powerful status during the pregnancy and childbirth of their daughters-in-law. Most of the mothers-in-law were able to gain power through the trust and respect of their daughters-in-law. This was because

daughters-in-law admired the knowledge, skills and experience of their mothers-in-law in getting their support during childbirth. When the support of mothers-in-law contributed to gaining safety, daughters-in-law accepted the power and control of their mothers-in-law. Even when there was a conflict in this relationship, the mother-in-law's support was expected to ensure safety. The changing nature of power revealed in this study opens the opportunity for negotiation in relationship patterns. The relationship between mother-in-law and daughter-in-law provided insight into how negotiation was possible in the case of the gap in understanding between generations.

As Giddens (1984) highlights, structures can constrain or enable certain forms of behaviour. In this study the relationship pattern of some women participants with their husband or mother-in-law confirmed safety during their pregnancy and childbirth experiences. The narratives of the childbearing women, their husbands and their mothers-in-law revealed the complexity of relationships within the family influencing safety during pregnancy and childbirth. The relationship between mother-in-law and daughter-in-law was complex because of the generational divide and gaps in understanding; however the mother-in-law's support during childbirth was satisfying for some women. Although women's submissive status to men in the village was not surprising, their preference to have trustworthy and experienced women rather than their husband with them during childbirth was the key insight to take into account in ensuring the safety of the women during pregnancy and childbirth.

Giddens (1991) also argues that human behaviour is determined by external forces and social actions are influenced by power relationships. The findings in this chapter revealed the crucial influence of power relationships in both villages. As in family relationships, different forms of power were changing depending on the role they played in the study villages. The nature of power the individual held at the societal level was linked to the trust and respect extended to them on the basis of their skills, knowledge, position and experience. Most of the stakeholders and service providers held both expert power and legitimate power because of their position and knowledge. The power of knowledge expressed as expert power within the culture created positive experiences and contributed to safety. For example, the school

teacher and local indigenous leader were able to gain respect for their knowledge and status from the village people. As Young (1990) highlights the power differences existed in society, when this form of power was external to the culture, villagers did not respect and trust it. For example, health workers who came from outside into the village were not able to gain respect and establish trust with the village people.

Labonte (1992) argues for shared understanding and collective action to enhance health. More importantly, in this study the villagers valued a person from their village to share their problems with in order to find a solution. A local indigenous leader, local politician and school teacher were able to gain both respect and trust, which meant they were able to gain power. Young (1990) emphasises in relation to reciprocity of understanding, the trust and respect for the social relations in the village led to the establishment of reciprocity in this study.

As Heath (2007) argues, the reciprocity and symmetry evident in the relationships meant that power was able to be negotiated through shared understanding. Similarly, Heath's (2007) argument about the contribution of dialogue among stakeholders to produce creative and innovative outcomes was evident in the findings discussed in this chapter where some forms of power exerted by some people in the village helped women to feel confident to manage problems during pregnancy and childbirth. It ultimately created trust and more respect, which was one of the components of safety in this thesis. This highlights the significance of these powerful people in the village and their crucial role in gaining safety.

The function of trust as defined by Luhmann (1979, p.8) is the 'reduction of complexity'. The participants' accounts in this study demonstrated the function of trust in reducing fear and uncertainties and in resolving the problems associated with pregnancy and childbirth. As explored so far, the pregnancy and childbirth experiences of women in the remote mountain villages were complex and the trust that emerged from the data contributed to reducing the complexities and to gaining safety. Consistent with Luhmann (1979), participants made decisions about the person to consult when they experienced problems during pregnancy and childbirth with the expectation that these problems would be dealt with effectively. So, in this research trust plays a significant role in enhancing safety through the reduction of uncertainties and complexities related to pregnancy and childbirth.

However, the power relationship between service providers outside the village and women participants revealed that women had limited choices when their birthing was controlled in an institutional setting. This control contributed to hindering safety and consequently, some women felt they were being marginalised during childbirth because of the coercive power and control of the service providers. In the case of relationships among women, family members, local stakeholders and service providers, there was a gap in understanding about the issues and what was needed by the women to help them during pregnancy and childbirth. This suggests that there is a need for collaborative dialogue among them to establish trust and reciprocity which could contribute to achieving safety during pregnancy and childbirth.

As Lupton (1999) identifies, women's experience of childbirth is highly influenced by the power of expert knowledge and the legitimacy of service providers in the institutional setting. For example in this study, a few women who went to the hospital felt that the service providers did not respect their socio-cultural background. Such lack of respect created mistrust in the care provided in the hospital. In some instances, women participants demonstrated their resistance to the medical control.

Young's (1990) concept of differences was evident in these women's experiences when they felt completely different to others in the institutional environment. Similarly, service providers considered these women as being different in relation to their understanding and knowledge. While the experiences of the women reflected their perception of being treated mechanically by the service providers without their interests, knowledge and social background being valued, the use of language in few service providers' narratives further revealed their dominating attitude towards women. So, there appears to be an oppressor and oppressive dynamics as Freire (2000) and Young (1990) have described. As Labonte (1992) highlights the insufficiency of the medical approach in enhancing health, the narratives of the service providers revealed the medical oppression in some of the women's pregnancy and childbirth experiences which was one of the significant limitations to enhancing safety.

Further, it was revealed in this study that the villages contained a multiplicity of relations which had complexities, contradictions and negotiations and could serve as

the basis for providing safety in women's birthing experiences. Nilsen and Brannen (2002) highlight the influence of gender, caste, lifestyle and other contextual factors in social actions. This influence became evident in this chapter in that various forms of these social relations in which the ideological and material conditions of gender, knowledge, status, and social position are at work influenced the women's experiences and ultimately the birth outcomes. As with the support of family, friends and relatives during childbirth discussed in Chapter 2 (Kitzinger, 2001, Mead and Newton, 1967, Oakley, 1983), women participants in this study also valued the support available in the village. As Hodnett et al. (2007, 2011) found that the continuing support of family members and other familiar persons was beneficial to women during pregnancy and childbirth, the traditional support of female family members and other female relatives or other experienced women from the village provided necessary care and support during pregnancy and childbirth and contributed to safety in this study.

The childbirth experiences of women in the villages were found to be a part of their complex socio-cultural system, and there was also the influence of political processes in accessing services in the village. Riessman's (1992) focus on understanding childbirth experiences within a complex socio-political process is relevant to this analysis where the relationships and influences within and outside the household level were at play in shaping women's experiences in terms of safety and nature of birth outcomes. From the perspective of gender and power relationships as they are defined in the Western paradigm, it can be seen that these women had an oppressed status within the family and society. However, participants' experiences did not reflect this oppressed status as they seemed to be able to negotiate with the situation and resist the control of outsiders which provided a threat to their safety. Although there was the influence of gendered norms within their social circumstances, the women had accepted these feminine roles valuing the traditional social system where the domination of men over women was considered as the common way of maintaining relationships and social norms.

Conclusion

The overall analysis in this chapter has revealed a complex array of relationships and

their influences in which the involvement of different members of the family and society became crucial in women's childbirth experiences. Although there were differences in gender, forms of relationship and status among the people which created gaps in understanding between each other and demonstrated a visible power imbalance in the society, the majority of women valued the trusting and supportive relationships which became a part of safety during pregnancy and childbirth. Despite the fact that these women were continuing with their regular amount of work and responsibilities within the household boundaries, they accepted their reality in a way that was socially endorsed in which their only option was to go through with the experiences rather than contesting them. Because of the lack of trust in external service providers, the women were reluctant to seek medical care during pregnancy and childbirth.

Consistent with the earlier theme in the previous chapter, women's preference for giving birth without external interference within their community reemerged with their preference for having support from their mother-in-law or other experienced female relatives during the birth. Their resistance to professional and medical control over birth reemphasised the importance of their owning their childbirth experiences within their social and cultural setting. Although the influence of social structure and agency were very influential in their childbirth experiences, the involvement of these structural relationships and actions were found to be most supportive for women in developing a sense of safe and satisfying experiences, which was important to enable them to take control of their childbirth.

Chapter 6: The Complexity of the Context: Looking Through the Safety Lens

The previous two chapters have examined the influences and interrelationships of cultures, traditions, social values and different forms of gender and power relationships in women's pregnancy and childbirth experiences. It has been evident in the earlier themes that participants in this study internalised the importance of their safety and generational transfer of the traditional knowledge about childbirth. It has also been clear from the previous accounts of the participants that they preferred giving birth in the village setting despite the risk to the survival of mothers and babies during childbirth. This chapter now focuses on the reasons for women's preference to birth in the village setting as opposed to in a health institution.

Institutionalisation of childbirth is one of the government's current focuses in Nepal, as explained previously in Chapter 2. Institutionalisation in their view refers to the utilisation of prenatal care and giving birth in a health care centre with the help of a trained midwife or medical personnel for the purpose of identifying the risks and taking interventions to mitigate those risks. The experiences of the research participants revealed the complexity of reducing these risks and ensuring safety during the pregnancy and childbirth of women living in two remote mountain villages. The analysis of the participants' narratives demonstrated complexities which need consideration at both policy and service provision levels.

As indicated in the previous chapters there are complexities in ensuring safety during the pregnancy and childbirth of the remote mountain women. The participants revealed just how complex are their childbirth experiences and how complex are the array of factors that provide safety. This chapter focuses on the related issues which contribute to safety of women in terms of the accessibility, acceptance and appropriateness of care. The challenges of managing risk and ensuring safety during pregnancy and childbirth will be analysed in relation to the pregnancy and childbirth experiences of the women in this study. More specifically, the relevance of medicalisation and institutionalisation of pregnancy and childbirth will be examined considering the socio-cultural dimensions of the women living in the remote

mountain villages. This chapter will further discuss some of the possible implications which emerge from the participants' voices in order to address the complexity of ensuring safety during pregnancy and childbirth of women living in the two remote villages.

Participants' accounts of their experiences uncovered some important issues in relation to the challenges of ensuring safety during pregnancy and childbirth which are organised into the following subthemes:

- Traditional childbirth practice and place of institutional birth;
- Socioeconomic circumstances of women – Challenging safety; and
- Whose responsibility? - The tendency to blame.

.

6.1 Traditional Childbirth Practice and Place of Institutional Birth

This section focuses on why women prefer to give birth in the village setting to enhance safety rather than choosing the hospital to minimise risk during birth. Some participants raised the question of how the institutionalised approach to pregnancy and childbirth fits within a context where childbirth is a socio-cultural process. The attempt of the government to encourage women to give birth in hospital had not been welcomed by the participants of this study.

Juna raised her concerns about the initiative of bringing women to the hospital to give birth when she felt safe staying in the community and giving birth traditionally.

> *It is not that we like going to the hospital. We need to go to the hospital if we cannot give birth at home. The pain is the same wherever we give birth. Wherever we go, we have to give birth ourselves. So, why do we need to go to hospital? I don't see any point going there if there is no problem. We will have our things around us at home. We will also have our people around when needed. We can do things as we like. We can get hot foods and the fire to feel warm. This is far better than walking many hours to the hospital and coming back holding the baby. Why do they want us to go to hospital just to give birth if there is nothing wrong?* Juna

Juna's preference to give birth in the village setting provided her with the opportunity to make decisions in terms of availability of food, warmth and low cost of care to determine safe childbirth experiences. The benefits of giving birth in the village contributed to Juna gaining ownership of the place where she gave birth and her childbirth experiences. Consequently, giving birth was closely bound up with her chosen place of birth. She also allowed for the possibility of going to hospital when things went wrong. Her valuing of both cultural and medical care opens the possibility of negotiation between hospital and village people to work together in the process of enhancing the safety of women during pregnancy and childbirth in these villages.

As discussed in Chapter 4, giving birth in the village setting signified the cultural importance of birth which led to safer experiences for some women participants than when birth occurred in institutional setting. It was also noted that birth in the village setting allowed women to claim collective ownership and gain safety during childbirth. When birth occurred in hospital, women were not able to gain safety and ownership.

Sumi shared her recent hospital birth experience comparing it with her previous birthing experiences.

> *When I was giving birth at home, I was able to ask for the things I wanted to have. I was also able to do the things my mother-in-law asked me to do and I wanted to do as well. She never hassled me during the birth. Instead, she helped me all the time. In the hospital this time, they never asked me if I wanted something. They used to come and check unnecessarily. Sometimes, they said that the baby's heart is a bit slow and sometimes it is fast. Sometimes, they said that the labor is progressing and sometimes they asked me to stop yelling. I had to follow whatever they asked me to do. I had to be completely dependent on them. Though my mother-in-law was there with me, they did not even let her massage my back during the pain. They gave me saline and a few injections which I think was not necessary. I thought I would have been better off if I did not go to the hospital.* Sumi

Sumi's account exposed the different focus of the mother-in-law and the health professional, the latter on the physical progression of the medical event and the former on how Sumi was feeling. There was control of the birth in the hospital which prevented Sumi from using the traditional knowledge of easing pain and progressing the birthing process. The professional power controlled her birth in which she did not get the opportunity to accommodate traditional practices. This demonstrated a significant difference between gaining ownership and safety of the birthing experiences in the village and hospital settings. This also opens the opportunity for allowing traditional support and involving mothers-in-law during the birth to enhance safety for women who come to give birth in the institutional setting.

Similarly, Laxmi did not feel safe when her pregnancy was considered risky because of the bleeding she had while she was brought to the hospital. She willingly followed her mother-in-law's advice and was admitted to the hospital.

> *I feel more comfortable staying at home than in this hospital. I did not have any problems while having my previous three births at home. I had bleeding yesterday and my mother-in-law brought me here for a check-up. They said it is a big risk to have bleeding during pregnancy and they admitted me. I had nothing happen afterwards. I am sure I can give birth normally at home. But they said there is a high risk of having adverse outcomes. I really don't like staying here. I am sure that I can give birth at home.* Laxmi

Laxmi's experience of giving birth in the village setting was threatened by the medical view of risk during her visit to the hospital, where she was treated as a high risk mother. Medically, there was risk which threatened the survival of mother and baby. Culturally, her determination to give birth without problems in the village setting indicated her indirect resistance to the care and control of the care providers in the hospital. So, the lack of knowledge about the consequences of these risks enabled her to trust in her mother-in-law's knowledge, skills and experience.

A few participants shared their negative impression of the treatment in the hospital which created mistrust and increased their preference for giving birth in the community. A man from the village who was looking after the pregnancy of his wife

shared his experiences when he brought his wife to the hospital.

> *No, she did not have any check-up this time. I took her to the hospital during her fourth pregnancy. The baby was moving around. She was feeling the movement of the baby. They [nurses] told her that the baby was dead inside. Then, I brought her back and she gave birth. The baby was alive and still very healthy. I think they do not know anything. They made us more anxious about the situation that time. Then I decided not to bring her again to the hospital. The hospital is not good.* A village man

A village man commented about the knowledge and clinical skills of the nurses. When the baby was born alive in the village, this created mistrust in the care provided by service providers in the hospital. As in the previous chapters, trust became a core factor in participants' preference to give birth in the village setting. In the women's experiences, trust in the care providers whether in the village or hospital contributed to gaining safety and lacking trust created threats to safety.

When women experienced risk, it created fear and threatened the survival of the mother and unborn baby in some participants' experiences. Rima was considered high risk in both pregnancies and was sent to the city hospital to give birth.

Rima's husband, Rabin explained how Rima's pregnancies were considered in the district hospital.

> *Rima's height is short and she is very young. This is what the doctor told us last time and said that she is at risk of giving birth normally. She had a problem in giving birth last time and had to go through with the operation. We had experienced difficulties bringing her down to the city hospital during the problems of giving birth when they said she needed an operation. The nurse in the district hospital told us that she is at high-risk and they cannot keep her safe. This was why I decided to bring her into the city hospital early this time. They are saying that Rima needs to go for an operation to give birth. Though I have seen women giving birth normally after they had an operation the first time, I think this is not*

possible for Rima. The doctor we visited last week said that she needs to be in the operation list. Rabin

The consideration of pregnancy as risky by the doctor and nurses in the hospital took away Rima's power to make a decision about the place and process of birth. This form of power and control is consistent with Kitzinger's (2000) critique of medicalised birth which puts women in the risk category of having complications and treats them through the continued monitoring of medical professionals. Although the possibility of having a normal birth after the first caesarean section, depending on the causes, is well recognised in the Western literature (Carroll, 2003, Chen and Hancock, 2011), Rima did not get the opportunity to discuss the possibility of having a vaginal birth experience when the doctor made the decision about the birth being through caesarean section.

The essence of childbirth which happened in the village setting surrounded by family members was a satisfying experience for most of the women participants of this study. The narratives of the women participants reflected that they did not want to be transferred to the hospital to experience childbirth for a number of reasons: cultural values; childbirth tradition; the financial burden; travel distance; and so on. Therefore, the survival of mother and newborns during childbirth is critical in these study villages where there are several challenges to managing birth related problems.

Davis Floyd's (1994) critique of medicalised birth in which women's bodies are considered as a machine operated by the interests of health professionals is evident in the participants' narratives in this section. Participants in this study strongly opposed the way they were treated by care providers in the institutional setting which created a threat to their safety. Participants disagreed with the medical construction of risk and preferred to continue their traditional birth practice which contributed to gaining safety within their village setting. This indicates that the Westernised techno-medicalisation of childbirth at present does not address safety issues within the village culture, which were valued highly by the participants. The next section will explore the major social issues which influenced the women's access to institutional care in the study villages.

6.2 Socio-economic Circumstances of Women – Challenging Safety

The previous section explored the preference of some women to give birth in their village. They were rejecting the medical construction of risk during pregnancy and childbirth and expressed their concern about their safety while giving birth in the institutional setting. From the experiences of participants, it was clear that they didn't see any need to approach the health institution during pregnancy and childbirth unless there were serious threats to their safety. This section focuses on the socio-economic circumstances of the participants in relation to their age at marriage, ethnicity, economic status and place of residence and their influences on the women's ability to access care and care providers.

It was revealed in the previous chapter that age was one of the aspects of power relationships at the household level. While looking at the age of mothers who shared their childbirth experiences, most of them had experienced their first birth before the age of 16. A few women were married as young as age 10. On average, women were married by the age of 16 in the villages. The average number of pregnancies that these women had experienced was nearly five, from which they had only three live babies on average. Chapter 4 uncovered the complexity of social and cultural acceptance of continuing pregnancy and childbirth including related losses and the medical view of minimizing risks of death. Nevertheless, some women participants did express their unhappiness about the loss of their newborns. This indicates that dealing with these complexities requires a broader understanding of the socio-cultural dimensions of childbirth.

Women participants and their family members never felt that the age of marriage was a problem. Most of the older generation women did not know their age and could not remember their age of marriage. The only way of guessing their age at marriage was asking them about their menstruation, whether they had their first period before marriage or after marriage. Most of them did not even notice their first period. Considering their life expectancy and the number of pregnancies they had experienced so far, it could be argued that young age marriage practice is still common in these villages. Only a few stakeholders, the politician, journalist and medical doctor were concerned about the early marriage practices.

The local politician confirmed the commonness of young age marriage in the village, which mostly applied for girls.

> *In the village, girls usually marry very early. If they don't do that, other people criticise them for being unable to find a boy to marry. When a girl passes the age of 15, then people talk about her saying that she is not good as she is still living in her paternal house. How can we expect change in this context? [He laughed]*. Local politician

Early age marriage of girls was one of the valued social practices in these two villages. The politician's critique reflects the more nuanced tensions that arise between cultural practices and more universal views of human rights and women's rights to which people like the politician are exposed.

The journalist recognised the power of social values which overrides politico-legal power in relation to the social practice of girl children marrying at a very early age. He thought that the legalised age had no effect on changing social norms and practices in these villages.

> *In Karnali, a girl becomes old without experiencing their young age. They get married between 8-12 years of age. The trend of early marriage is affecting their reproductive health. It also influences seriously the health of the mother and her newborn baby. Not being able to prevent early marriage is the main problem here if we talk about women's health in this district. I know there is a legal age of marriage, but enforcing the law does not really do anything to social practice. The change should come socially in practice. This is the major problem in the whole Karnali region. The other correlation I found in this area is that the early marriage is increasing because of the food scarcity in this district. What I found during my visit to the village is that most of the women are giving birth expecting a son. They want to send their daughter to her marital home as early as possible so they don't need to feed their daughter. This is a really serious issue needing attention by all sectors. I did not see the law working in this situation. It has to be dealt with by addressing the issues behind the situation to prevent early marriage.* Journalist

There are many crucial structural issues that the journalist names here in relation to the social practice. Although the legal age of marriage for girls in Nepal is 18 years, it does not have any effect on bringing changes to social practice. Though their chronological age was young, the social age of these girls was higher because they were performing their responsibilities being a wife, a daughter-in-law and a mother of a baby because of socially imposed values. The politician's and journalist's accounts exposed the issue of structural oppression and disadvantage and the way these are perpetuated by imposing external values upon the women without any dialogue or exploration of the way that these issues can be resolved.

The medical doctor, through his biomedical lens, further commented on the impact of the early marriage social practice on creating risk during pregnancy and childbirth.

> *The situation of pregnancy and childbirth in the district is like a complex wave of the ocean. Because of ignorance and various socioeconomic constraints, girls are getting married at a young age, like the age of 12, 13 or 15 years. They become pregnant at a very young age. Teenage pregnancy itself is a very high risk pregnancy. There are lots of problems associated with teenage pregnancy. Unless the girls get married at an appropriate age when they are physically and mentally mature, the risk of maternal and newborn deaths continues.* Medical doctor

This is another example of looking through the lens of risk and not including the lens of safety. The doctor's biomedical lens was not able to see the issue beyond the risks and could not explore other possibilities of negotiating to promote the safety of women in these study villages. Though these three participants shared their views differently, the main factor coming out from their narratives was the structural constraints which must be addressed to ensure the safety of these women.

It has been revealed so far that the women participants in this study were concerned about their safety during pregnancy and childbirth. Their concern was heightened when they gave birth in an institutional setting. Some participants' experiences of discrimination against their caste and ethnicity were one example of threats to their safety.

Lashi talked about the possible discrimination and raised the issue of disparities.

> *It would have been better if I had the opportunity to give birth at the hospital. I would have gone to the hospital if my husband was with me. How could I go though even if I wanted to? I don't have any relatives at district headquarters. Even the hotel treats lower caste people differently. The same thing might happen in the hospital. Improvement is not possible in our life. This village is our complete world. We will be living in the same way as we were before and we are now. Nobody can change this world for the favor of a lower caste woman. Rich people are always rich, poor people are always poor. We women are always oppressed. I don't expect any change in the way we are living.* Lashi

Lashi's account explored the issue of relationship, power and status differences in her village context. These issues created a challenge to maintaining safety and minimizing the possible risk during childbirth. Lashi was concerned about protecting herself from the threats to safety. Though she wanted to experience a hospital birth, she decided to stay away from the possible discrimination which might impact on safety. Another issue which emerged from Lashi's account was poor/rich variations which indicated that lower caste women were more likely to be oppressed in the remote villages.

The issue of power and discrimination because of ethnicity and geographic background was exposed in another male participant's experience. Toli's husband shared his experience of being discriminated against in administrative decisions and service provision.

> *We indigenous people are not treated well. Although the government is saying that the indigenous people should be the priority in any interventions, we are highly dominated by other caste people. Brahman, Chhetry and Thakuri people are in administrative positions and they hold the power in the district. They are using their power and indigenous people are discriminated against and disadvantaged in access to the resources and facilities. Even in the hospital, we don't get better treatment. They don't respect the needs of indigenous people. Yesterday,*

> *I saw a hoarding where it was written that all people are equal regardless of ethnicity and place. All people from Tarai, Hill and the mountains are equal but it is never reflected in practice. So, it is better for our women to live in the village while giving birth. We can help each other and we can share whatever we have in the village.* Toli's husband

The discrimination against the village people's ethnicity put them in a position of limited access to resources, opportunities and services. Toli's husband's account indicated that their involvement was not realised at a policy and practice level and their issues had not been effectively heard. The practice of helping each other in the community contributed to the safety of women during childbirth in these villages. However, their risk management during childbirth became a critical issue because of not having services available in the village setting which created possible threats to their safety.

While ethnicity was influencing access to services on the one hand, on the other hand there was an impression that hospital services were not targeted at them. Jitu had all her births in the village setting. She thought that the hospital was for the rich and others living closer to it.

> *Those people who are living around the hospital will be able to go there to give birth but this is not possible for us. They [people who often use hospital services] are either rich or close to hospital. So, they can go there. For us, it is too far and we have to work every day. We cannot even think about the birth in the hospital.* Jitu

Women's working responsibilities at home and the distance of several hours' walk over steep terrain to the hospital made it impossible for Jitu to give birth in the hospital. She intimated that facilities were built based on where the privileged people lived which did not provide physical and social access to services for the people of her village. She indicated her status as a poor and remote woman compared with those who had access to and could afford services. Though there was no direct cost to pay for services at the hospital, the women's absence from the regular work in the village, the cost of reaching hospital and the psychological impact of leaving the community were serious factors needed consideration. Though other studies report

the issue of rural women's physical access to services as a challenge in reducing maternal and newborn mortality in Nepal (Regmi et al., 2010a, Bhandari et al., 2011), Jitu's account explored additional issues as well as physical access which were more critical to accessing hospital services.

The issue of financial poverty and its influences on accessing services was highlighted by other participants as well. Pema and her husband talked about their inability to access the hospital services because of the cost factor.

> *The mothers and children are dying in the village. We think this is happening because we are poor. We do not have money to go to the hospital on time and wait for the baby to come. We would have gone to the hospital if we had enough money. You know that the doctor [health worker] comes to the village and tells you things. They say you should do this and that. They don't provide anything. I know that you also don't do anything for us. All people come to say their things and ask their questions. It does not help us. It does not change our situation. The health staff only earn money. They do not work for the people in the village.* Pema and her husband

Pema and her husband's narrative indicated outsiders' inability to understand the socio-cultural conditions of the people which they thought limited their choices. The data indicated that the village people's ability to exercise their rights to health and quality of life had not become the reality. In the study villages, the physical, social and financial inability to access services, was one of the causes of lacking safety. An association of poverty and adverse birth outcomes is reported in the international literature (Janevic et al., 2010, Yang and Walker, 2010). This couple related their poverty to the higher numbers of deaths of mothers and babies in the village, which is a significant human rights issue.

Another participant, Sonam, had to walk for three days to access services when she recently had problems giving birth. When she found that giving birth in the village was not possible because of the problems she was experiencing, she needed medical help to manage the risk of dying. In this situation, Sonam acknowledged the need for medical help and blamed herself for her ignorance and remoteness.

> *We are living in very remote areas. We don't know anything. We don't know why our children died. They were sick. They did not get treatment as we did not have a doctor here. We tried our best using Lama and Dhami but it did not help. I had a difficult time giving birth. We did not have anyone to ask for help while I had problems in giving birth. I had to walk for three days with pain and discomfort to get to the district hospital. We thought this is just what we have got to experience being in a remote village.* Sonam

Sonam's account reflected that she was prepared to take some responsibility for her health. The lack of medical knowledge about the causes of deaths and lack of access to medical services in the village increased her reliance on the traditional healing system but it could not manage the risks associated with childbirth. So, providing access to services is not the only solution to these villagers' problems, the issue of access to food and other basic resources for living are equally important to ensure safety in pregnancy and childbirth in these villages.

When a number of women went through the experience of loss of their newborns, they realised the importance of medical care which could have prevented these deaths. Participants' views about the contribution of medical care to managing risk during pregnancy and childbirth indicates that culture and medicine can both make a contribution to promoting the survival of mothers and babies in these remote villages.

Toli talked about this possibility in relation to when she experienced the recent loss of her triplets in the village which she thought could have been prevented if she was in the city hospital.

> *I think that if I was in the city, my babies would have survived. I heard this type of babies can survive in city hospitals. Nothing is available in the village. No one thinks about us. But you know thinking about the better hospital can be only a dream for us. It is not possible to go to the city from here to give birth.* Toli

Envisioning the birth in a well resourced city hospital was not practical for Toli in

her current circumstances. The participants in this study thought that their socio-economic circumstances were an issue in relation to accessing services during pregnancy and childbirth in the village.

Some participants raised the issue of mismatch between what health workers were saying and doing. The things that health workers were asking women to do during pregnancy and childbirth were not possible.

Tolma described why it was not possible.

> *They said we should eat better food. We should take enough rest. We should go for regular check-ups. But this does not apply to our village. We could not do that because we don't get enough food to eat and we don't have services in the village. Tolma*

Informing people about the required care without ensuring their access to basic resources and services was not a practical solution. Accessing medical care was the last option the women used during problems of giving birth in the village and they generally did not see the need for medical care while the birth progressed normally. However, there is a significant role for medical care to prevent childbirth related deaths which traditional healing cannot provide for these women.

Toma added to her view by asking several questions about the practicalities of reaching hospital.

> *I know that I should go for check-ups and I should not be doing heavy work during pregnancy. They [health workers] told us that we should give birth in hospital. But it is not possible for us. How can we go to the hospital? How can we avoid work? How can we go for the check-up? This is all impossible.* Toma

In Toma's view, accessing medical services for the management of risk was not possible for women of her village. In this case, it may be possible for health care providers to come to the village and provide basic care to the women rather than the women making a long walk to reach the care located in the district hospital.

As discussed in Chapter 2, unequal access to safe childbirth services is considered in

public health literature as one of the main reasons for socioeconomic disparities in maternal and newborn health. But in the context of this research, the issue is not as simple as physical access, but is also about the ability of the services to appreciate cultural issues, which is a major lack in the current health care system.

In the research setting, the only service institution that was located in the village was a health post. But this health post was not able to provide basic services because of the absence of service providers. Some participants were aware of the government's attempt to provide regular medical supplies in the village health post. But they were not getting services or medicine when visiting the health post.

Toli explained the situation of the local health post.

> *We have a health post only in name. It is all useless. It never opens and health workers never come. We have to go to the medical shop to buy medicines, though we heard that the government has a regular supply.* Toli

This indicates that participants in this study suffered from the regular unavailability of basic services and service providers in the village setting. This unavailability created difficulties in managing childbirth problems when the women needed medical help.

Chiring shared the difficulties of finding medical help in the village when his wife experienced problems during a recent pregnancy.

> *We don't have any health workers available in the village. This is the problem in our village. I told to the Madam [MCH worker] the other day when I met her in the district if she could come and check my wife. She told me to bring her to the hospital. Honestly, I can't take her to the hospital to give birth. We will stay home and wait for the baby to come. We cannot leave our other children at home and go to the hospital. Who will look after these children if we go to the district hospital? So, we don't believe in health workers any more. They don't come to the village. We only have the option of going to Lama and then Dhami for the problems. We always think that women might die in giving birth.* Chiring

On the one side, health workers were reluctant to come to the village, though it was a part of their job. On the other side, villagers were unable to access services located in the hospital because of social, cultural and physical distance. Though there has been an ongoing attempt to improve coverage of community based maternal and newborn care services in Nepal (Bhandari et al., 2011), villagers in this study experienced consistent lack of services, service providers and basic medicines in the local health post. Additionally, participants' accounts indicated that the villagers appreciated that there is a place for medical services and risk management in their culture.

The significant place of medical services for risk management was evident in Sonam's experiences. But accessing the medical services was a difficult experience for her.

Sonam's husband shared his recent experience.

> *We don't have any health post in the village. There is one in Pulu [adjoining village which is also three hours' walking distance], but there were no doctors [health workers]. I went there but could not find any one. I could not even find a stretcher there. Sonam was able to walk slowly for two days but later, she could not walk. I found the stretcher in the Lumsa [health post near district headquarters] and brought her to the hospital. I had complained to the health post people here in the district. They told me that they will allocate some money for stretchers through the Village Development Committee (VDC) council. The situation in the village is hard to manage without having doctors in the health post which we could have accessed. Now, I don't know how I can take her back home. It has been very costly to live here [district headquarters] and there is work left to do in the village. We cannot live here in this season.* Sonam's husband

In a situation when they needed to bring childbearing women from the village to the hospital, transfer was difficult due to the lack of resources and long walking hours. Sonam's husband indicated that the cost of taking childbearing women to the district hospital was beyond their ability to manage. Though several attempts have been made by non-government organizations in collaboration with government to create a

maternal and child health fund to manage the cost of transport during emergency referral to hospital in Nepal (Morrison et al., 2010), no evidence of such an initiative was found in the study area where participants mentioned the lack of stretchers to transfer women from the community to the hospital.

Low socio-economic status and the long distance to the hospital have been found to be the key barriers for women going to the hospital to give birth in rural areas of Nepal (Wagle et al., 2004). Participants in this study also raised the issues of geographic distance to the hospital, social distance between them and health care staff and their socio-economic conditions as the barriers to accessing services. As explored in earlier chapters, their preference for giving birth in the village setting was highly significant but they also saw the importance of medical care to ensure safety when giving birth. Thus, the participants' expectations of making services available to them at the village level is important to take into account at both policy and practice level to promote the survival of mothers and newborns in the villages.

Marmot (2010) wrote about the social inequity in maternal health in which he highlighted the social, economic and political factors influencing the higher burden of deaths in developing countries. The WHO and UNICEF (2010) report, *Countdown to 2015* emphasises the influence of political, social, economic, technological and environmental factors in reducing mortality and promoting maternal and newborn survival. In this study social, structural and economic factors influenced women's pregnancy and childbirth experiences. Distance became another issue where social, cultural and physical distance to access care was raised by most of the participants in this study.

So far, this section has explored various types of access issues in getting medical care and services from the villages. There were issues of social, cultural, physical and financial access to reach hospital services. Discrimination against caste and ethnicity, long walking distance to hospital, service providers' reluctance to come to the village, unavailability of services at village level, the cost of reaching hospital, and unfamiliarity of medical services were some of the factors explored relating to these issues of accessing medical care during pregnancy and childbirth. Participants also raised some other critical issues about their access to food and basic health services at the village level. Participants in this study acknowledged that there was

risk involved in pregnancy and childbirth and so there is a place for medical help to contribute to safety.

Toma reflected on some of the practicalities of making medical services available in the village if they were required during pregnancy and childbirth.

> *Though we like our tradition and we are happy how we are in our village, it would be better if we didn't need to go that far if anything goes wrong during birth. Reaching hospital services is not easy for us. So, we need a place in our village where we can go and get childbirth services whenever required. The government should ask their staff to come to the village and to serve regularly.* Toma

Participants' accounts indicated that the cultural significance of childbirth is higher because culture and tradition are the only source of knowledge and help available in the village to manage childbirth related problems. So, Toma's emphasis on bringing the services to the community rather than having to reach services from the community was a very important aspect of enhancing both safety and reducing risk during pregnancy and childbirth of these women. If people can't even get to services, it seems that these women will continue to give birth traditionally in their village with both themselves and others blaming them for the cause of deaths occurring during pregnancy and childbirth.

The findings in this section have exposed various structural constraints to gaining safety during pregnancy and childbirth. These structural constraints continuously disadvantaged women in the villages which created complexities for maintaining safety. Consistently, the politician and medical doctor blamed village people for their poverty, remoteness and ignorance about the risks. On the other side, village people blamed them for not providing services in the village. So, there was a circular chain of blaming each other. As Young (1990) suggests, mediation processes can be used to address the differences existing in society, so participants' experiences could be transformed through mediating with the people to develop reciprocity in understanding and shared responsibility for safety during pregnancy and childbirth.

As in Labonte's (1992) socio-environmental approach which demands the

involvement of other sectors to enhance health, the local indigenous leader and the journalist opened possibilities of involving various sectors to address the complexities related to the socio-cultural circumstances of the women. Consistent with Labonte's (1992) argument about the insufficiency of any single approach, the women and other participants acknowledged that there was risk involved during pregnancy and childbirth which could be managed by medical help, while at the same time they preferred continuing their culture and tradition and ensuring collective ownership of their experiences.

Petchesky (2003) highlights that critical feminist practice needs to focus on women's rights and circumstances. Relating this to the circumstances of participants in this study, women were informed that their traditional childbirth practice was risky but they did not have access to safe maternity care to give birth in the village. This reflects the contradiction of ensuring safety and managing risk. This study has further explored the complexity of balancing both through sustaining their childbirth tradition and managing associated risk during pregnancy and childbirth. Although the feminist critical approach affirms that women's health and empowerment must be treated as an end in itself, not merely as the means towards other social goals (Correa, 1994), analyzing many dimensions of the lives of the participants in this study demonstrates that there were no such services available in the village to ensure women's right to survival during pregnancy and childbirth. Participants did not aspire to having a clinician or specialised clinic in the village, their expectation was only that basic services be made available at the village level, which is a possible, cost effective and justifiable demand. Participants also offered some possibilities of negotiation between the medical and cultural paradigms. The next section focuses on the issue of responsibility to ensure safety during pregnancy and childbirth of remote mountain women of Nepal.

6.3 Whose Responsibility? - The Tendency to Blame

The previous two sections in this chapter have explored the social, geographic and financial constraints, including the limitations of the health care system, to providing access to pregnancy and childbirth services for the women in the study villages. This section more specifically focuses on the political factors that participants raised in

this study. A few stakeholders took a wider perspective of the issues. There was also the situation where no one was claiming responsibility for the current state of childbirth in these villages, rather there was a tendency to blame each other.

It was identified in the previous section that lack of health services in the village was one of the ongoing issues. The local indigenous leader shared his perspective which was consistent with the comments made by women participants in the village. He mentioned that the issue of lack of services was highly influenced by the interests of certain political groups using their power rather than providing access to services for the larger group of people in his village.

> *We knew that there should be services available to women during pregnancy and childbirth. We are also aware that there should be awareness raising programmes at community level to make women aware of childbirth care. However, both of these services are not available in the village. The birthing centre [a centre in which there is a midwife providing 24 hours normal birth services] which is planned is also not in an appropriate place. Our village is the centre for all surrounding villages but they [political leaders] decided to establish the birthing centre in another village. Only a few people from that village will be able to access services from there. Most of the villages will still have no access to it including this village. This is not a good effort. You might have seen that this health post always has a scarcity of medicines. In another health post, the medicines are being expired. I don't blame the government for all of these things. This is the monopoly of local politicians also who ignore the need of the wider community. The government has given the choice to the local community to make the best decision but the local representative has thought for their single village rather than the whole area. This is because of politics.* Local indigenous leader

Political power had become an issue in which the choices given to the local community were made by the politicians and decisions were made against their interest. In Nepal, the government is unstable and so the power of a political party also changes according to their access to central government. The actions are taken

according to the interest of the political party rather than the priorities of the policy. Thus, priorities also change, once the government changes. So, the local indigenous leader blamed the political manipulation of decision making which constrained the women of his village from accessing childbirth services. This indicates that the politicians are not taking responsibility for women's access to childbirth services. Although promoting maternal and newborn survival has been a political priority in Nepal (Smith and Neupane, 2010), it has not been translated into practice yet.

Consistent with the comment of the local indigenous leader about political influences in the decision making processes, the local politician, who was from the opposition party highlighted how people with political power failed to consider the needs of village women during pregnancy and childbirth.

> *In all mountain districts, there is the lack of health services and people are not educated. There is therefore lack of appropriate advice. Still, there are strong cultural beliefs and traditional practices in the village where people trust more in traditional faith healers for example Dhami and Jhankri during sickness. There has been little improvement in the health status of children through immunization programmes; and the childbirth experiences of women have shown no significant improvement compared with before. Mainly, the health of mothers and children has remained a serious problem in the district and especially in our village. In urban areas, we do take care of women offering good food, rest and special attention during pregnancy. We don't have such traditions here. This may be causing the death of mothers and newborns. Another factor which is causing the death of birthing mothers is because of the problems related to the uterus. Most of the women in this village are suffering from uterus related problems. I was requesting to run a gynaecology camp in the district but the Department of Health Services did not approve my request. Instead, they ran an orthopaedic camp.* Local politician

The local politician highlighted the issues of power, access to services and health care practices in the community. In his view, the centralised power dynamics led to inappropriate interventions without considering the needs of the district. He linked the poor status of maternal and newborn health of the community with the lack of

health services and education of the people. He identified education as one of the determinants of health in the community. Being a local politician, he did not claim it as his responsibility to facilitate the process of improving childbirth status in the village. He rather blamed the women for being uneducated and for their use of the traditional healing system. Changing people's practice through education may be possible; however, allowing them to follow traditional practices as a part of safety is equally important during pregnancy and childbirth for women living in remote mountain villages.

Another participant, a local husband who was a university graduate, Rabin, spoke about the value of education for developing understanding and supportive roles for men during childbirth.

> *Without being educated, they [men] can't understand the pain of women in giving birth. They [men] cannot understand the pain and discomfort of women. They also don't know how childbirth takes place and what type of care needs to be provided to them [birthing women]. Educated men can understand this. They do value the women and their childbirth event. But you know in our village [he laughs], it does not even matter for them losing their newborns. They take it easily as though nothing has happened.* Rabin

Rabin acknowledged the role of education and its contribution to promoting safety. In his view, the lack of knowledge about the possible risks involved during pregnancy and childbirth caused the deaths of newborn in the village. He highlighted the responsibility of men to contribute to preventing childbirth related deaths and also blamed village people for not being able to do so.

Another participant, Ramesh, believed that education could contribute to bringing positive changes.

> *This is a remote area, education is really important for change. The social, economic and educational status of people living in this area is very poor, which makes things hard to achieve. Personally, I have not been able to do the things as I wanted. Other people also have not been*

> *able to bring changes in the social practice. So, I think we can expect some changes through education.* Ramesh

Ramesh had developed optimism for bringing some changes through education. It has been agreed internationally that educating people can be the means of changing social practice (Jordan, 2009). So, Ramesh opens the space for education to come and help the villagers to gain safety during pregnancy and childbirth.

The local journalist made a distinction between education and awareness. In his view, creating awareness was more important than giving core education.

> *The poor status of women's health in the district is related to education. The Karnali region is far behind in literacy levels as well. The relationship of education here is linked with the awareness of people. There is a possibility that people would have been aware about health if they were educated. But I feel being aware is more important than being educated for this district. The problem of polygamy and early marriage would no longer be in practice if people were aware of the issues. Most of the women in this region are illiterate. Generally, there is no practice of girl's education. Unless both men and women are aware about the risk of early pregnancy in their reproductive health, the situation of maternal and newborn deaths in this village will continue. This is not only the case of this district; many remote areas of the country including Karnali have such problems. Most of the mountain districts have the same problems.* Journalist

The journalist made a clear distinction between education and awareness. Freire's conscientisation process also emphasises the need for education through the involvement of community people (Freire, 2000, Freire and Freire, 2004), which is liberating and empowering rather than subtly imposing conformity to another set of values and practices. Freire's (2000) approach to education is focused more on enabling the social transformation of oppressed groups of people through dialogical cultural actions. In his approach, individuals can construct their own set of values and knowledge and so, there is room for the people to decide which knowledge they want to construct for their benefit rather than it being imposed by external

knowledge. Considering the culture and tradition in these villages, Freire's (2000) approach could offer more possibilities for protecting lay knowledge and sustaining traditional practices while gaining new knowledge of risk.

The local high school teacher explored the need for continuing religious forms of education and needs based education.

> *I think the situation of having high maternal and newborn deaths in the village is because of the lack of awareness among the people. If the people migrate to the urban area, they send their children to the school. Thirty years back when I first came here, they were more interested to send their sons to become Lama [Chumba] than sending them to the school. They were thinking that their son would be able to live his life doing Gyan [ritual performance] if he could not do any other work. That was the tradition here. This tradition is still in practice. If I tell them to send their children to school, they start giving me examples of other educated persons who did the wrong thing in the village. 'What did that person do after being educated? He married three wives and did not look after his parents. This is how they link education to their reality. So, it is not easy to convince them within the context where educated people are not being a good example. I think it is more about awareness than education.* High school teacher

Awareness was seen as an important concept as well as formal education. In these villages, Lama education (a religious form of education in Buddism) was a more effective tool in building awareness. In the Lama village, villagers were attracted to the Lama Education rather than going to school to get a formal education. This opens the opportunity of involving both culture and education to contribute to enhancing safety during the pregnancy and childbirth of women in the remote villages.

While earlier participants were focusing on education as their concern, the medical doctor saw culture and tradition as problems which in his view were risk producers during pregnancy and childbirth.

> *The first and foremost thing starts with the culture and tradition of the*

> *society. Unless the girls get married at an appropriate age when they are physically and mentally mature, teenage pregnancy cannot be avoided. Similarly, the villagers are producing risks themselves because of their traditions related to childbirth. So, the change in such traditions is essential. The next thing is the socioeconomic condition of the people. They are poor and uneducated. Unless people are educated, they don't know the risk of getting pregnant and giving birth at an early age. So, it is not only one dynamic or only one aspect of life which can be focused on. This is a multifactorial relationship which is influencing the pregnancy and childbirth of women. I think an integrated approach needs to be applied to address these issues in relation to the pregnancy and childbirth of women.* Medical doctor

The participants' perspectives of education in this section indicates a blaming tendency which considered villagers as uneducated, poor, traditional and unaware of the need to develop health promoting behaviour. The medical doctor emphasised educating people about the risk of the early marriage system. It seems that informing people about the risks is important to let villagers figure out the place of both cultural and medical knowledge. The medical doctor acknowledged the interactions and relationships of many socio-cultural factors producing risks during pregnancy and childbirth and suggested an integrated approach to address these factors. The integrated approach he refers to is about bringing other development sectors to health. His idea included the key concept of multi-sectoral involvement in comprehensive primary health care (Keleher, 2001).

In contrast, Rabin gave the responsibility of promoting the safety of women to the health care providers.

> *I think the district health staff should be responsible to mobilise FCHV at village level to make sure that women are able to get required care, diet and rest during pregnancy and after childbirth. They should be aware of the conditions at village level. The district hospital should be able to manage the resources and materials required to manage the common conditions and complications during pregnancy and childbirth. In my opinion, pregnancy and childbirth is the most*

> *complicated issue in Mugu, which needs to be considered as a priority issue at district level. They have to pay attention to managing services accordingly. I think this is really important to keep in mind that many women and newborn babies are having a premature death. We could have prevented those deaths.* Rabin

Rabin shared a very important perspective about awareness which indicates that awareness is everyone's responsibility, not just women and men in the community. So, rather than blaming each other, there is a need for shared responsibility where both service providers and village people can work together in a process of change.

Shor and Freire (1987) demonstrate the effectiveness of dialogue in action as a practical means of liberating people and transforming society. Their concept of dialogue offers an opportunity to create a dialogue among service providers, villagers, politicians and other social leaders in order to develop a shared understanding about the issues relating to pregnancy and childbirth experiences of women in the remote villages. Without developing a shared understanding, the tendency to blame may continue and developing a shared responsibility for promoting safety may not be achieved.

Consistently, the politician and medical doctor blamed village people for their poverty, remoteness and ignorance about the risks. On the other side, village people blamed them for not providing services in the village. So, there was a circular chain of blaming each other. As Young (1990) proposes the mediation process to address the differences existing in society, participants' experiences could be transformed through mediation among the people to develop reciprocity in understanding and shared responsibility for safety during pregnancy and childbirth. Further, Heath's (2007) concept of collaborative dialogue offers the opportunity to create dialogue among the people in the village including service providers and stakeholders which could contribute further to negotiating power and relationships through innovative and creative approaches.

Apart from the issues of access to health services and education, there are other critical issues related to everyday survival which need to be brought into the dialogue of politicians, stakeholders, service providers and policy makers. There

were some participants who blamed the government for not addressing the factors contributing to the health and status of women in the villages.

The local journalist highlighted the basic survival need of the people to promote their general health status and emphasised the government's inability to ensure the fulfillment of the basic needs of the people in the study villages.

> *The main issue of women's health in Nepal and more specifically in Karnali districts depends on the other aspects of development. Mugu district was the lowest ranking in the human development index last year. In this place there is always scarcity of food. The life expectancy of people in Mugu was only 34 years in last year's report. It means that people living in this district simply do not have access to food, shelter and other services. I think unless the government manages to give access to food, shelter and other services to the people living here, we cannot expect their good health. Regarding the situation of the health of mother and baby, I think it is important to meet their basic needs for the purpose of improving their health status. In the current scenario, the government has not been able to fulfill the basic needs of the population. This is the number one issue here. The government should be accountable to address the basic rights of the people of fulfilling their basic needs of survival and ensuring their access to basic health services, resources and opportunities.* Journalist

The journalist considered health as a human right issue. However, people in his village were not getting the opportunity to exercise their right to health. He noted the issue of the scarcity of food that people in the villages have been experiencing which is a critical health issue and also influences the safety of women during pregnancy and childbirth. The journalist took a broader perspective to analyse the situation of women and to address the factors that were influencing their pregnancy and childbirth experiences. While the local politician and the medical doctor blamed the people for their poverty and lack of medical knowledge, the local journalist offered a critical analysis of the socio-economic status of the village people. His argument about the commitment of the government to fulfill the basic rights of people is significant to this research because the fulfilment of basic survival needs is crucial to

ensuring safety during pregnancy and childbirth.

The medical doctor, who was also a part of the government's health authority of the district, mentioned the policy initiatives that the government had made to address the economic issues and to increase the access to services. He talked about the new policy initiative of establishing birthing centres in the peripheral areas and providing financial incentives to the expectant mothers coming to the health institution to give birth.

In the medical doctor's view, the incentive programme could bring significant improvement in health care utilisation during pregnancy and childbirth.

> *Indeed, Mugu is one of the unfortunate districts of Nepal, which is yet to be connected to road networks. Even intra-district transportation is also not easy. However, the government policy of giving incentives to those pregnant women coming to the hospital or birthing centre for delivery indeed has increased the rate of hospital delivery quite significantly. We give 1500 rupees (about 20$) to the women who come to hospital for delivery as an incentive For example, this incentive is supposed to cover the cost of people carrying a patient in a stretcher to the hospital, which generally requires four to five people in the mountain district. This is a very difficult task. Whenever they get this money, they can at least feed those people on the way. Recently, our policy of giving incentives to those pregnant women, who completed their fourth ANC visit, has also been put forward by the government. I believe that this policy will also increase our ANC check-up rate so that risky and very dangerous pregnancies can be sorted out on time and necessary action can be taken.* Medical doctor

The medical doctor sees money as the solution to the issue of accessing services from the two remote villages but linking back to other participants' comments about the issue of other costs involved when accessing the services located in the district hospital such as the cost of food and living on the way; we cannot say that the incentive scheme was able to influence the practice of these groups. The expectation of the medical doctor is justified in the light of the evidence of the effectiveness of

maternity incentive schemes in increasing utilisation of maternity services which is reported elsewhere in Nepal (Malla et al., 2011, Powell-Jackson and Hanson, 2011, Witter et al., 2011). However, giving incentives to motivate people to use the services which they do not see as culturally appropriate may not be a solution to the problem in the study villages.

Another participant, who was a female Constitution Assembly member nominated from the research area of the district, questioned the practicality of the incentive scheme and the free maternity service policy of the government.

> *The government has announced free childbirth services in the health post. There is also an incentive programme for childbirth service users. But this does not mean anything for people living in these remote villages. This is not practical for the people of Mugu since the health services are far from many villages. The government needs to spend money on awareness and education, building more health posts, increasing numbers of midwives, improving quality of services in the hospital and ensuring availability of doctors in the hospital.* Female constitution assembly member

The female Constitution Assembly member was from the opposition party and talked about the need for providing access to services to promote safety during pregnancy and childbirth. She acknowledged the gap between policy and practice and highlighted the need for services to help women living in the two remote villages.

Socio-cultural conditions and geographic constraints are not the only issues related to accessing services in the study villages. The journalist said that the government is trying to escape from their responsibility by blaming the people and their socio-cultural context rather than claiming their responsibility for ensuring access to services and resources.

The local journalist shared his disagreement with the government and opposed the government tendency of blaming people and their conditions.

> *I don't think the geographic remoteness is the big problem here. If the government takes responsibility for the citizens, remoteness is not a*

major problem for this country. Yes, this district has not been connected to road networks yet, but this is not far from the road network. So, it is not hard to connect this district with the road network if the government feels accountable to the people. There are many possibilities. People are blaming remoteness for not having better health status, this is just a way of ignoring the issue. This is not the people's fault to be born in the mountains and to live in mountain areas. This is the government's weakness for not being able to provide resources and services to the people of the nation. We can't blame the place and the people. It is really an unjustified blame that the government is making. Journalist

The journalist's account exposed the tendency of the government to blame people and escape from responsibility. The journalist's perspective of possibilities creates hope and respects what people have in the village. It reflects the potential involvement of village people to identify their resources, skills, knowledge, values and to participate in the process of making both traditional and medical care available in the village.

Another participant, Ramesh further highlighted the responsibility of government to address the issues related to safety.

I think all of the issues related to safe birth are also related to the state management system as well. This is not only a local issue; the state should take responsibility and give women respected status. They should give special place and opportunity for women. Ramesh

The state Ramesh is referring to is the central government. His view about respecting the status of women adds further potential for creating change through women's involvement. More specifically, Ramesh provides hope for creating opportunities for women through proper state management systems.

This section has explored further complexities in relation to promoting safety during pregnancy and childbirth where there is a contradiction in claiming responsibility. None of the participants holding political and authoritative power talked about claiming responsibility for addressing the many socio-cultural issues related to

childbirth. Rather, they passed on blame. More importantly, they were developing an attitude of domination and oppression. Their views were likely to be heard by others because they have access to the arenas where they can promulgate their views, where villagers' views are not likely to be heard in the same places.

The people with political and authoritative power considered village people as uneducated, poor and lacking the knowledge of medical risk and they blamed them for not using medical services to manage associated risk. Likewise, villagers blamed the government for not meeting their needs. Without being accountable to address the basic needs of the village people, it seems that the health system authority was imposing policy to increase institutional care utilisation during pregnancy and childbirth. Though it has been realised that good maternal and newborn health is dependent on access to food, prenatal care and other support (Filippi et al., 2006), most of the participants in this study were lacking these supports during pregnancy and childbirth. It is therefore important to address these basic needs which have a critical impact on safety during pregnancy and childbirth of remote mountain women.

Maternal and newborn health is a public health priority in the current health care system of both developed and developing countries, however, women in low resource settings are still a long way behind in getting access to primary health care (Adam et al., 2005). It is not that the villagers did not care about mothers and babies dying in the village. They actually saw the need for both medical and cultural care to enhance safety during pregnancy and childbirth. Thus, participants highlighted the shortcomings of the health care system where women's access to services at the local level had been influenced by socio-economic, political, structural and cultural factors. Continuing to blame women and village people only perpetuates the problem and does not alleviate anything in terms of safety. Nevertheless, there were also emancipating possibilities that participants proposed in order to enhance safety in the two remote villages.

6.4 Discussion

This chapter has revealed many forces outside of as well as within the control of community people which had major influences on women's childbirth experiences in

two remote mountain villages in Nepal. It has explored the influences of structural, social and political factors which were critical in the village to ensure women's safety during pregnancy and childbirth. These factors are considered as the key determinants of health in public health literature (Bhutta et al., 2010, Bhutta et al., 2004, Wilkinson and Marmot, 2003, Marmot and Wilkinson, 2005). Recently, maternal health has been a major focus in new public health initiatives (Blas and Kurup, 2010, David and Messer, 2011, Friel and Marmot, 2011). Structural factors are identified as the barrier to ensuring equity in utilisation of health services (Rasanathan et al., 2011), and these were also identified as a key barrier to accessing maternal and newborn health services in this study.

Overcoming geographic inequity in the utilisation of maternity care has been a crucial barrier in promoting maternal and newborn health in developing countries (Ahmed and Khan, 2011, Zere et al., 2010). This study raised the issue of access to medical services when women experience problems requiring medical help during childbirth. Access is necessary but not sufficient by itself and getting the cultural and medical paradigm into a more synergistic, mutually supportive and complementary relationship is also necessary. The geographic context of the people in this study not only restricted them to access the services when needed (Kornelsen et al., 2009), but also limited the access to basic resources and opportunities. People in the research setting normally had limited access to food and other basic resources which were crucial for their overall health including the health of mother and baby.

People holding political and authoritative power, the local politician and doctor, blamed the village people for not being educated and not using medical services. But the issue of women in relation to their safety during pregnancy and childbirth in these villages was beyond medical considerations. The journalist and local indigenous leader spoke from the people's side blaming the government for not being accountable to the needs of the people or responsible for fulfilling the people's basic rights to health and survival. The politician and doctor did recognise the issues but their view represented a victim blaming approach rather than considering the possibilities of addressing the complexities of ensuring the safety of women in these study villages. However, many participants made it clear that going to hospital to give birth and increasing access to services in the village were not the solution to

addressing the complexity of both ensuring safety and managing risks during their pregnancy and childbirth. It became evident that structural determinants must be addressed if change in maternal and newborn health is to happen in these remote villages.

The responsibility of the government is linked to their perceived failure to consider social, structural and political factors which are critical to promoting safety during pregnancy and childbirth in remote villages in Nepal. There were consistent shortages of food, several hours' walk required to access basic health care, the ongoing unavailability of health workers in the village and the burden of the cost of travel to access the services which were all considered as major barriers to maternal and newborn health. Previous studies conducted in rural Nepal have also identified the government's failure to address these barriers in order to ensure access to health facility based childbirth services for rural and remote women (Neupane and Gulis, 2010, Regmi and Madison, 2009). The continued absence of health workers and lack of quality services in the hospital were also issues that participants raised. There was no consensus among service providers, politicians, other stakeholders and village people; rather there was a tendency to blame each other where no one was ready to claim the responsibility.

In this counter blame scenario, there was no evidence of shared understanding, responsibility and accountability. Service providers thought that it was the individual's, families' and community's responsibility to change their traditions and become aware of the need for care during pregnancy and childbirth. The politician thought similarly that the community people should be able to change their practices in order to promote safety. However, other local stakeholders and family members thought that it was the government's responsibility to ensure access to resources and services that were required for maternal and newborn survival in the village. In this scenario, women participants developed an attitude of self resignation and accepted the circumstances as they were in their village. So, it is critical in this context to establish who should take responsibility and how collective responsibility can be developed to address the corresponding issues. Indeed, this is everyone's responsibility.

There has been ongoing debate in public health about who is responsible for health.

The focus of medicine is on risk factors with the view that health is an individual's responsibility (Wikler, 2002). The view of service providers in this study was influenced by the medical concept of responsibility for health, in which they blamed village people and their childbirth tradition for poor health outcomes. Historically, even public health has focused on averting the risk factors rather than identifying the origin of the risk (Crawford, 1986). The medical doctor's view in this study was also influenced by the approach of addressing the risk factors. Comprehensive PHC however emphasises that government has the responsibility for the health of the people which can be fulfilled only by the provision of adequate health and social measures (World Health Organization, 2008). Most of the participants in this study also thought that the government should take responsibility for maternal and newborn health through the provision of resources and services at the community level.

Labonte's (1992) socio-environmental approach highlights that the individual and community have the ability to do what is important and meaningful to their health. Participants in this study saw their culture and tradition related to pregnancy and childbirth as important contributors to enhancing safety. Young (1990) highlights the significance of social relationships to eliminating oppression, and participants were able to identify the relationships and influences that were beneficial to them; however the medical oppression and structural disadvantages were beyond the control of the village people.

Young (1990) argues that creating a shared responsibility to address structural differences is possible. In line with Young, Heath (2007) argues that collaborative dialogue allows the conditions to be built that can fight against actions that silence people and can address the social, economic and political conditions that create differences in people's lives. This means that creating a supportive environment to achieve safety during pregnancy and childbirth is possible for women living in the remote villages through initiating the dialogical process.

The new public health sees health as being beyond personal and government responsibility and the *1997 Jakarta Declaration on Health Promotion into the 21st Century* placed a high priority on promoting social responsibility for health (Mittelmark, 2001). Most public health initiatives are moving forward with the

consensus that health is everyone's responsibility in which there is a role for the individual, family, community, and national and international governments. There is therefore a need for negotiation within the study villages to develop a sense of collective responsibility for addressing the range of socio-cultural and structural determinants rather than throwing responsibility back to another level. This understanding and collective effort would contribute to ensuring women's right to health and survival during pregnancy and childbirth.

The right to health is expressed in the *International Bill of Human Rights* as, 'the right to the highest attainable standard of physical and mental health' (Mann, 1999). This right imposes a duty upon states and nations to promote and protect the health of individuals and the community and ensure quality of care. Maternal and newborn survival is also one of the human rights issues in the global public health initiative (Gruskin et al., 2008). However, this study revealed that the right to maternal and newborn survival in the two remote villages was affected by many factors which the nation was not managing to address effectively. This study raised serious human rights concerns about the availability of basic resources and services in the village to ensure women's right to health and survival during pregnancy and childbirth.

Nevertheless, participants in this study also offered some emancipating possibilities to promote the safety of women in their villages. As Labonte (1992) argues, the medical approach is important but insufficient, and participants in this study acknowledged the possible risks during pregnancy and childbirth and appreciated the importance of medical help to manage these risks. But they did not accept the medical control of pregnancy and childbirth. From the community side, women and their family members saw the possibility of collaboration between culture and medicine for promoting the safety of women in the village setting. Young (1990) argues that community people often do not trust outsiders which create differences in understanding and relationships and it is thus important to strive for reciprocity, mutual relationships and shared understanding. Participants in this study also highlighted the need for shared understanding, responsibility and reciprocal relationships within the family, village and with outsiders.

This concept of shared understanding and shared responsibility seems very important not only between men and women but at all levels of relationships. However, the

related power issues create a gap which it is possible to address through a dialogical approach as suggested by Freire (2000) and Heath (2007) and through mediation processes as suggested by Young (1990). Among the participants in this study, there is a hope of creating safe childbirth experiences without distorting their culture and tradition. Freire and Freire (2004) see hope as signifying the possibility and potentiality of creating positive change. Labonte (1992) offers the possibility of using multiple approaches to work for enhancing health; the hope of participants in this study indicates that there is the possibility of cultural and medical approaches working together to promote safety during pregnancy and childbirth in the two remote mountain villages of Nepal. This demands collective action through developing a shared understanding, mutual relationships and reciprocity.

Conclusion

This chapter has explored the crucial influences of structural, social and political factors in promoting safety during pregnancy and childbirth. These factors were found as being critical to providing access to basic resources for women's everyday living and services to ensure safety during pregnancy and childbirth in the study villages. Many problems and constraints were identified by the participants to accessing basic care in the village, however the problems were not seen as shared which created a culture of blaming each other. There was also no sharing of responsibility to address these issues and constraints in order to ensure safety during pregnancy and childbirth. This reflects that there was a sense of unwillingness to compromise or negotiate in which no one accepted their responsibility to ensure the availability of basic resources and services in the village. This situation raises a serious concern about women's right to experience safety including their right to health and survival during pregnancy and childbirth.

The new public health initiative focuses on addressing the structural, social and political determinants of health outcomes, creating a collective responsibility for health. This initiative could contribute to fulfilling the interests of participants in this study to ensure their access to health and basic resources which would ultimately help to promote safety during pregnancy and childbirth in the remote villages. So, there are some possibilities which need to be explored through a dialogical approach

for creating shared understanding among different levels of relationships and power influences. In Chapters 4, 5 and 6, I have discussed the key themes which emerged from the data in this study. The next chapter is the final chapter of this thesis which draws together the key findings of this research, discusses some possible implications and concludes the thesis.

Chapter 7: Discussion, Possible Implications and Conclusion

Childbirth is a part of ongoing everyday life for women living in remote mountain villages of Nepal. This research aimed to address a gap in the research to date and to uncover local voices to more fully understand the factors which have an impact on women's experiences of pregnancy and childbirth in remote mountainous Nepal. This research also aimed to gain insight into what may contribute to reducing the unacceptably high numbers of maternal and newborn deaths in the region. This study identified a wide range of diverging but intertwining factors which influenced women's pregnancy and childbirth experiences. These factors impacted on women's safety during pregnancy and childbirth in two remote mountain villages of Nepal.

This thesis concerned itself with the particular socio-cultural dimensions of women living in remote mountain villages of Nepal, which may not be applicable to women living in other socio-cultural settings. The thesis was shaped within social constructionism and critical feminism and, as its focus was a public health issue, within a broad socio-cultural view of understanding pregnancy and childbirth experiences. The core concern of the research was to value the lay knowledge and collective experiences of the participants.

The research question designed for this study demanded exploration of various factors that influenced the pregnancy and childbirth experiences of women living in remote mountain villages of Nepal. My attempt to provide an answer to the question, "What factors influence the pregnancy and childbirth experiences of women living in remote mountain areas of Nepal and how do these factors interrelate?" revealed many complexities that influenced the safety of women during pregnancy and childbirth. Involving women, their family members, service providers and local stakeholders offered me the opportunity to examine the nature of these complexities in the women's pregnancy and childbirth experiences.

This research had three objectives, each of which has been addressed in the previous three chapters. The first objective was to examine the pregnancy and childbirth experiences of women living in remote mountain villages of Nepal. The second

objective was to explore the socio-cultural factors that influence the pregnancy and childbirth experiences of the women. The third objective was to examine the relationships among the many socio-cultural factors that influence safety during childbirth.

I will begin this chapter by summarising the relationships and influences of the many socio-cultural factors identified in this research. I will then discuss the possible implications of the research which provide potential ways forward to address these socio-cultural factors in order to ensure safety during pregnancy and childbirth of women living in remote mountain villages of Nepal. Finally, I will provide the conclusion of this thesis.

7.1 A Complex Array of Relationships and Influences – Socio-cultural Dimensions of Pregnancy and Childbirth

This study has shown that safety during pregnancy and childbirth is significantly influenced by socio-cultural factors in which management of risk can contribute to ensuring the survival of mothers and babies in the context of women living in remote mountain villages of Nepal. This study has revealed the significant influences of culture, tradition and spirituality in shaping childbirth knowledge and practices of women, which was covered in Chapter 4. More specifically, safety during pregnancy, childbirth and the postnatal period in the villages was linked with their culture of considering childbirth as a polluted event, the tradition of giving birth in the Goth and their belief in supernatural powers to ensure the survival of mother and newborn. Their cultural values, beliefs and knowledge were embedded in many other aspects of their experiences.

Previous researchers have argued that women in remote Nepalese villages were traditionally confined to the Goth to give birth and spend their polluted postnatal days which created the risk of infection contributing to neonatal deaths (Ahmed et al., 2010, Regmi et al., 2010a, Thapa et al., 2001). However, most of the women in this study willingly accepted their tradition and prepared themselves to be in Goth to give birth and to spend their postnatal days. Their experiences demonstrated their collective ownership of the birthing process which occurred in Goth and which was a strong part of their safety. Similarly, their trust in supernatural powers to determine

the survival of the newborn baby was another aspect of safety during pregnancy and childbirth. Although people's belief in supernatural powers during pregnancy and childbirth is not often discussed the literature of other cultures (eg Belousova, 2010, Lori and Boyle, 2011, Marak, 2010), the cultural construction of childbirth was a significant factor contributing to safety in this study. In the participants' perspective, even medicine and technology did not supersede their belief in the power of God to ensure the survival of mother and baby during the birth. In this situation, breaking their connection to this relationship created a threat to their safety.

There were strong tensions shown in the study between the medical construction of risk and the cultural construction of safety during pregnancy and childbirth. Medically, there was a risk while giving birth in the Goth. Therefore, it was preferable to bring women out of Goth to avert the associated risks. Women were therefore asked to go to the hospital to give birth. However, the cultural construction of safety was counter to women leaving Goth. Nevertheless, the potential contribution of medical help to manage risk involved during pregnancy and childbirth was also acknowledged in this study, which women were lacking in the villages.

This study further revealed a complex array of relationships which was crucial to ensuring safety of the women, and which was discussed in Chapter 5 of this thesis. There were several patterns of relationships at the family and societal level. In these relationships, there was a strong influence of power on the pregnancy and childbirth experiences of the women. Where the relationship was supportive, women were more likely to experience safety during childbirth. As in other studies (Acharya and Rimal, 2009, Brunson, 2010a, Basnyat, 2011, Dhakal et al., 2011, Regmi et al., 2010a, Simkhada et al., 2010), the role of the mother-in-law and husband was crucial in the women's pregnancy and childbirth experiences. Despite the presence of power, trust and respect were significant aspects in these relationships. Women trusted the traditional knowledge and support of lay care providers which was available in the village setting more than the medical knowledge and professionals' care in the hospital. This reflects that the power of lay knowledge is important to consider in ensuring safety during pregnancy and childbirth.

Women's trust of lay knowledge and lay care providers was supported and continued

through familiarity, respect and understanding. Lay care providers in the village were able to develop shared understanding and were respectful towards the women. So, they were able to gain respect and trust from the women to help them during pregnancy and childbirth. Health professionals were lacking that trust and respect from the women because they did not show respect towards the women and their socio-cultural background. Where there was trust and respect, the power was given by the women to make decisions which contributed to achieving safety during pregnancy and childbirth. When trust was not established, power was exercised over women and created a threat to safety during pregnancy and childbirth. This provides the very important insight into health care practice that medical care is still limited in gaining the trust and respect of remote village women.

Labonte's (1992) socio-environmental approach which addresses both individual risk factors and social conditions, is supported by the women in this study who felt the need for the contribution of both medical care and traditional community support to ensure survival during pregnancy and childbirth. Their limited trust and respect in the medical care challenged the management of associated risks. But the findings suggest that it is possible for there to be safety, even when there are power differentials, because trust serves to mediate the influence of power. Thus, the important factors in both family and social relationships were trust and respect which contributed to balancing power and to gaining collective ownership of the experiences. The childbirth support of a person who was trusted and respected by the birthing women contributed to gaining safety.

Despite the continuing efforts of government and non-governmental organisations to increase access to care and resources for rural, remote and marginalised groups in Nepal (Morrison et al., 2010), people in the study villages still experienced many structural constraints, which were explored in Chapter 6. More importantly, the inadequate supply of food from the district to the village where production was hardly possible because of adverse climatic conditions made the situation more critical. The villagers also talked about their difficulty accessing basic medicine and basic health care in the village. For them, reaching hospital services was not a practical option when they needed medical help. Additionally, there were policy and practice issues which disadvantaged women's access to resources, opportunities and

services in the remote villages.

So, returning to the original aim of this thesis, which was to uncover local voices in order to understand the factors which have an impact on women's experiences of pregnancy and childbirth in remote mountainous Nepal, the study found that there were multiple interacting issues, factors and relationships which impacted on the pregnancy and childbirth experiences of the women. The relationships between these factors were complex. Within this complexity, ensuring the safety of women during pregnancy and childbirth was challenging. This study recommends shared understandings, mutual relationships and collective action to address the many socio-cultural constraints to enhancing safety of women during pregnancy and childbirth. So, there are some emancipating possibilities for dealing with these complexities, controversies and contradictions which I will discuss in the next section.

7.2 Possible Implications

The findings of this study suggest both cultural practices and a medical approach have contributions to make to enhance safety during pregnancy and childbirth in remote regions of Nepal. If this is indeed the case, then those who hold knowledge about culture and those who hold knowledge about medicine need to come together collaboratively to negotiate a relationship which is complementary and which enables both to play appropriate roles which contribute to the safety of women during their experience of pregnancy and childbirth.

However, this collaboration is not possible without shared understanding of each other's contributions and without shared responsibility for safety of women in the remote villages. Though it is a challenging task to create an environment in which different ways of thinking come together to each contribute their particular strengths to enhance safety during pregnancy and childbirth, the role of facilitating the involvement of all these people in the process of dialogue to develop shared roles and responsibility becomes a crucial role.

Freire (1994) and Heath's (2007) dialogical concept offers some possible direction in this regard. Their concept of dialogue offers the opportunity to invite all people: women, family members, stakeholders, service providers, politicians and other

villagers into a dialogue to discuss the issues, constraints and possibilities to take collaborative action in relation to enhancing maternal and newborn survival in remote villages. This suggests the opportunity for the health sector to lead the process inviting these people into a dialogue. Freire (1994) argues that in this way, individuals come together in a transformative and empowering process which is aimed at exploring together the possibilities to solve the problems that individuals are experiencing. The involvement of concerned people in such a transformative process of enhancing safety during pregnancy and childbirth would contribute to developing a shared understanding, relationship mutuality and more shared power and to initiating collective and collaborative action for enhancing safe pregnancy and childbirth experiences for women.

While developing a process of collaboration, it is important to acknowledge and address the imbalances of power between service providers and women, and between politicians and village people. The concept of comprehensive primary health care (CPHC) discussed earlier in this thesis offers a participatory and collaborative process which may contribute to balancing the power through the involvement of village people in decision making and in the process of bringing both the cultural and medical paradigm to contribute to enhancing safety during pregnancy and childbirth. It has been acknowledged that empowering community people, including women, has a better impact on addressing a wide range of determinants of health in low resource settings (Blas et al., 2011b, Freeman et.al., 2011), which is a core principle of primary health care. The principle in CPHC of involvement of community people provides the opportunity to develop the capacity of women and other village people to engage in a transformative dialogue because here, they can identify their needs and explore the resources available to them in order to fulfill their needs. The notion of the local community having a voice both in structures and services (Gargioni and Raviglione, 2009) is important in the context of the women in this research because their involvement in any such collaborative and collective decision making had not yet been established.

The concept of people's participation or involvement in health is concerned with structural relationships and the importance of developing people's capacities and skills to negotiate for and to seek the resources and changes they require to improve

their lives and to communicate how they would like to be involved in the process of change (Kahssay and Oakley, 1999). Labonte's (1992) socio-environmental model predicts that some of these improvements would include: improved personal perception of health and safety; improved social networks and social support; a more supportive health care system; improved ability for the community and women to play a role by participating in an ongoing way in decisions about how resources are used and distributed; and shifts in equity and power that lead to better outcomes.

This offers some possibility for creating change to enhance the safety of women living in remote villages. This study and its implications for collaboration demand the participation of women, their family members, village people and local stakeholders including service providers and politicians to develop their capacity to initiate transformation required to ensure safety. Young's (1990) concept of mediation offers the possibility of negotiation between the different views and meanings of pregnancy and childbirth. Young argues that coming together in this way enables each different view to become a rich resource in moving towards wiser outcomes. For the women in this study, this could lead to pregnancy and childbirth experiences which are both safer and less risky.

Labonte (1992) argues that cultural and medical approaches have strengths and limitations. So, both culture and medicine have distinctive contributions to make to the pregnancy and childbirth experiences of women. The argument here is not about either birth in the village or in an institution. The argument is for safe birth in which women have the opportunity to use both traditional and medical services. This is because it was important for women in this study to sustain their childbirth tradition as well as to ensure the survival of both mothers and babies. This means they need access to both cultural and medical care during pregnancy and childbirth. Therefore, service providers need to develop their understanding about the preference of women to give birth in the village setting and to make themselves available to the women when they seek help. Indeed, ensuring safety during pregnancy and childbirth and the postnatal period is not only the responsibility of service providers and childbearing women, this is everyone's responsibility.

As some women participants in this study have already demonstrated their negotiation skills in sustaining good relationships and balancing both medical and

traditional knowledge, it thus seems possible to develop Young's (1990) wisdom through continuous dialogue and participation. Rather than pregnancy and childbirth experiences being either safe but risky, or less risky but less safe, the possibility is opened up for pregnancy and childbirth experiences to be safe and less risky. However, as well as improved outcomes, Freire (1994, 2000) and Heath's (2007) notion of dialogue opens up the possibility for transformed relationships which then become transformed structures in which agency can be more powerfully exercised by all participants.

Additionally, the concept of the social determinants of health provides an appreciation of the complexities of structural determinants of health, including social, political, economic, environmental, and cultural factors that have a strong impact on childbirth safety of women. This concept therefore contributes to an understanding of the factors that need to be addressed in any dialogue and in any collaborative relationship if positive health outcomes are to be achieved.

One major implication of this study is for a necessary transformation in practice to occur because involving women and community people in the process enables them to plan the action required to make necessary changes in their practice. In this study, the implications are specific to the socio-cultural circumstances of women living in the two study villages and the implications may or may not be applicable to women from other areas. However, despite the source of data being two remote villages, this study does shed light on the need for understanding the socio-cultural dimensions of women, their experiences, and preferences in order to design specific policy and practice for the reduction of maternal and newborn mortality.

In Nepal, given the fact of stagnant newborn mortality rates in recent years, there is an imminent need for more qualitative research with a specific focus on understanding the childbirth experiences of women living in difficult social, cultural and structural circumstances. This study has only exposed the circumstances of women in relation to their pregnancy and childbirth experiences. In this research, I did not intend to develop a model of care to ensure women's safety during pregnancy and childbirth. Nor should I have developed such a model. Rather the voices of the research participants and the lens through which I have made meaning of their voices have identified the participants' potential ability to devise, collaboratively, the

approach to care that best suits their context.

7.3 Conclusion

Coming to the end of the thesis, I have identified that there were many complexities, controversies and contradictions in the pregnancy and childbirth experiences of the women in this study. In order to ensure the safety during pregnancy and childbirth of women living in remote mountain villages of Nepal, the contribution of both socio-cultural and medical approaches is imperative. Both approaches need to come together and identify their possible areas of contribution to ensure the survival of mothers and babies. However, survival is not the only factor that determines safety during pregnancy and childbirth. As defined in this thesis, safety encompasses many other components including the survival of mothers and babies which need the attention of both practitioners and policy makers. There is a need for understanding the socio-cultural context of these women at both policy and practice level in order to ensure their safety during pregnancy and childbirth.

Above all, women's childbirth support needs to be trusted and the socio-cultural dimension of women needs to be respected. So, the argument is not about whether birth occurs in the cowshed or in a health institution. The argument is for establishing trust and respect, developing shared understanding and ensuring collective ownership of the experiences. The argument is for respecting the preferences of women and enabling them to make decisions about their pregnancy and childbirth while following their collective norms and practices. It seems possible to ensure the safety of pregnancy and childbirth for these women through the involvement of various people in a collaborative dialogue. Similarly, the involvement of both health and non-health sectors seems important to address the structural constraints to safety during the pregnancy and childbirth experiences of these women.

Thus, the collaborative effort of both the socio-cultural and medical paradigm could help these women to experience safe pregnancy and childbirth, ensuring the survival of both mothers and babies. Indeed, it is not only the women who need to be concerned about the losses during pregnancy and childbirth, this needs to be everyone's concern. So, it is not only the responsibility of women or their family

members or medical professionals to save the lives of mothers and babies in remote villages. This needs to be everyone's responsibility to contribute according to their capacity to make the pregnancy and childbirth of remote Nepalese women a safe and satisfying experience.

References

ACHARYA, L. B. & CLELAND, J. 2000. Maternal and child health services in rural Nepal: does access or quality matter more? *Health Policy Plan,* 15**,** 223-29.

ACHARYA, P. P. & RIMAL, D. 2009. Pregnancy and Chioldbirth in Nepal: Women's Role and Decision Making Power. *In:* SELIN, H. (ed.) *Childbirth Across the Culture: The History of Non-Western Science.* Australia: Springer Science.

ACHARYA, S., YOSHINO, E., JIMBA, M. & WAKAI, S. 2007. Empowering rural women through a community development approach in Nepal. *Community Development Journal,* 42**,** 34-36.

ADAM, T., LIM, S. S., MEHTA, S., BHUTTA, Z. A., FOGSTAD, H., MATHAI, M., ZUPAN, J. & DARMSTADT, G. L. 2005. Cost effectiveness analysis of strategies for maternal and neonatal health in developing countries. *British Medical Journal,* 331**,** 1107-1110.

ADHIKARI, R. & SAWANGDEE, Y. 2011. Influence of women's autonomy on infant mortality in Nepal. *Reproductive Health,* 8**,** 7-12.

ADHIKARI, R. 2010. Demographic, socio-economic, and cultural factors affecting fertility differentials in Nepal. *BMC Pregnancy and Childbirth,* 10**,** 19-23.

AFSANA, K. & RASHID, S. F. 2009. Construction of Birth in Bangladesh. *In:* SELIN, H. (ed.) *Childbirth Across the Culture: The History of Non-Western Science.* Australia: Springer Science.

AGGER, B. 2006. *Critical Social Theories* London, Paradigm Publishers.

AHMED, M., DEVKOTA, B., SATHIAN, B. & DIXIT, S. 2010a. Utilization of rural maternity delivery services in Nawalparasi and Kapilvastu District: A Qualitative Study. *Journal of College of Medical Sciences Nepal,* 6**,** 29-36.

AHMED, S. & KHAN, M. M. 2011. Is demand-side financing equity enhancing? Lessons from a maternal health voucher scheme in Bangladesh. *Social Science and Medicine,* 72**,** 1704 -1710.

AHMED, S., CREANGA, A. A., GILLESPIE, D. G. & TSUI, A. O. 2010b. Economic status, education and empowerment: implications for maternal health service utilization in developing countries. *PLoS ONE,* 5**,** e11190.

ALP, K. O. & OZDEMIR, M. 2010. The Tradition of Presenting Gold Gifts after Giving Birth in Anatolia. *Journal of Ethnological Studies,* 48**,** 35-47.

ANDERSON, G. 1999. Nondirectiveness in prenatal genetics: patients read between the lines. *Nursing Ethics,* 6**,** 126-36.

ANTAKI, C., BILLIG, M., EDWARDS, D. & POTTER, J. 2003. Discourse analysis means doing analysis: a critique of six analytic shortcomings. *Discourse Analysis Online,* 1**,** 1-29.

ARMSTRONG, R., WATERS, E., ROBERTS, H., OLIVER, S. & POPAY, J. 2006. The role and theoretical evolution of knowledge translation and exchange in public health. *Journal of Public Health (Oxf),* 28**,** 384-9.

ATTRIDE-STIRLING, J. 2001. Thematic networks: an analytic tool for qualitative research. *Qualitative Research,* 1**,** 385-405.

B PERRY, H., S SHANKLIN, D. & G SCHROEDER, D. 2011. Impact of a community-based comprehensive primary healthcare programme on infant and child mortality in Bolivia. *Journal of Health, Population and Nutrition,* 21**,** 383-395.

BAKKER, R., STEEGERS, E. A. P., BIHARIE, A. A., MACKENBACH, J. P., HOFMAN, A. & JADDOE, V. W. V. 2011. Differences in birth outcomes in relation to maternal age. *British Journal of Obstetric and Gynocology***,** 118*,* 500-509.

BALL, T. 1992. New Faces of Power. *In:* WARTENBERG, T. (ed.) *Rethinking Power.* Albany: SUNY Press.

BAMBRA, C., GIBSON, M., SOWDEN, A., WRIGHT, K., WHITEHEAD, M. & PETTICREW, M. 2010. Tackling the wider social determinants of health and health inequalities: evidence from systematic reviews. *Journal of epidemiology and community health,* 64**,** 284-291.

BANDYOPADHYAY, M. 2011. Tackling complexities in understanding the social determinants of health: the contribution of ethnographic research. *BMC Public Health,* 11**:**S5, 1-9.

BANKS, M., LOVATT, A., O'CONNOR, J. & RAFFO, C. 2000. Risk and trust in the cultural industries. *Geoforum,* 31**,** 453-464.

BANNING, M., HAFEEZ, H., FAISAL, S., HASSAN, M. & ZAFAR, A. 2009. The impact of culture and sociological and psychological issues on Muslim patients with breast cancer in Pakistan. *Cancer Nursing,* 32**,** 317-24.

BARKER, C. E., BIRD, C. E., PRADHAN, A. & SHAKYA, G. 2007. Support to the Safe Motherhood Programme in Nepal: an integrated approach. *Reproductive Health Matters,* 15**,** 81-90.

BARKER, K. K. 2010a. The Social Construction of Illness. *In:* BIRD, C. E., CONRAD, K. P., FREMONT, A. M. & TIMMERMAN, G. M. (eds.) *Handbook of Medical Sociology.* Nashville, USA: Venderbilt University Press.

BASNYAT, I. 2011. Beyond biomedicine: health through social and cultural understanding. *Nursing Inquiry,* 18**,** 123-134.

BAUM, F. 2008. *The New Public Health,* Australia, Oxford University Press

BAYES, S., FENWICK, J. & HAUCK, Y. 2008. A qualitative analysis of women's short accounts of labour and birth in a Western Australian public tertiary hospital. *Journal of Midwifery and Womens Health,* 53**,** 53-61.

BECK, S., WOJDYLA, D., SAY, L., BETRAN, A. P., MERIALDI, M., REQUEJO, J. H., RUBENS, C., MENON, R. & LOOK, P. F. A. V. 2010. The worldwide incidence of preterm birth: a systematic review of maternal mortality and morbidity. *Bulletin of the World Health Organization,* 88**,** 31-38.

BECK, U. 1992. *Risk society: towards a new modernity,* Sage publications.

BECK, U., GIDDENSS, A. & LASH, S. 1994. *Reflexive modernization: politics, tradition and aesthetics in the modern social order,* Stanford University Press.

BECK, U., RITTER, M., LASH, S. & WYNNE, B. 1993. *Risk society,* SAGE publications.

BELOUSOVA, E. 2010. The Preservation of National Childbirth Traditions in the Russian Homebirth Community. *Folklorica,* 7-17.

BENNETT, L. 2005. Gender, caste and ethnic exclusion in Nepal: Following the policy process from analysis to action. *Washington, DC: World Bank (http://siteresources. worldbank. org/INTRANETSOCIALDEVELOPMENT/Resources/Bennett. rev. pdf).*

BENNETT, L., DAHAL, D. R., GOVINDASAMY, P., MEASURE, D., HEALTH, N. M. O., DIVISION, P. P. & INTERNATIONAL, M. 2008. *Caste, Ethnic, and Regional Identity in Nepal: Further Analysis of the 2006 Nepal Demographic and Health Survey,* Population Division, Ministry of Health and Population, Govt. of Nepal.

BENOIT, C., ZADOROZNYJ, M., HALLGRIMSDOTTIR, H., TRELOAR, A. & TAYLOR, K. 2010. Medical dominance and neoliberalisation in maternal care provision: The evidence from Canada and Australia. *Social Science and Medicine,* 71**,** 475-481.

BENSON, J., MALDARI, T., WILLIAMS, J. & HANIFI, H. 2010. The impact of culture and ethnicity on women's perceived role in society and their attendant health beliefs. *InnovAiT,* 3**,** 358-365.

BERG, B. L. 2007. *Qualitative Research Methods for the Social Science,* Boston, Pearson Education Inc.

BERMAN, R. C. & WILSON, L. 2009. Pathologizing or validating: intake workers' discursive constructions of mothers. *Qualitative Health Research,* 19**,** 444-53.

BEUN, M. H. & WOOD, S. K. 2011. Acceptability and use of clean home delivery kits in Nepal: a qualitative study. *JHPN,* 21**,** 367-373.

BHANDARI, A., GORDON, M. & SHAKYA, G. 2011. Reducing maternal mortality in Nepal. *BJOG: An International Journal of Obstetrics and Gynaecology,* 118**,** 26-30.

BHANDARI, K. P. 2011. The Otherness on" The Telegram on the Table. *CET,* 96.

BHUTTA, Z. A., CHOPRA, M., AXELSON, H., BERMAN, P., BOERMA, T., BRYCE, J., BUSTREO, F., CAVAGNERO, E., COMETTO, G. & DAELMANS, B. 2010. Countdown to 2015 decade report (2000-10): taking stock of maternal, newborn, and child survival. *The Lancet,* 375**,** 2032-2044.

BHUTTA, Z. A., GUPTA, I., DE'SILVA, H., MANANDHAR, D., AWASTHI, S., HOSSAIN, S. & SALAM, M. 2004. Maternal and child health: is South Asia ready for change? *British Medical Journal,* 328**,** 816-819.

BISTA, D. B. 1972. *People of Nepal,* Ratna Pustak Bhandar Kathmandu.

BLACK, R. E., COUSENS, S., JOHNSON, H. L., LAWN, J. E., RUDAN, I., BASSANI, D. G., JHA, P., CAMPBELL, H., WALKER, C. F. & CIBULSKIS, R. 2010. Global, regional, and national causes of child mortality in 2008: a systematic analysis. *The Lancet,* 375**,** 1969-1987.

BLAS, E. & KURUP, A. S. 2010. *Equity, social determinants and public health programmes,* Geneva, World Health Organization.

BLAS, E., SOMMERFELD, J. & KURUP, A. S. (eds.) 2011. *Social determinants approaches to public health: from concept to practice* Geneva: World Health Organization

BLUMENSHINE, P., EGERTER, S., BARCLAY, C. J., CUBBIN, C. & BRAVEMAN, P. A. 2010. Socioeconomic Disparities in Adverse Birth Outcomes: A Systematic Review. *American Journal of Preventive Medicine,* 39**,** 263-272.

BLUMER, H. 1969 *Symbolic Interactionism - perspective and method,* New Jersey, Prentice Hall.

BOLAM, A., MANANDHAR, D. S., SHRESTHA, P., ELLIS, M., MALLA, K. & COSTELLO, A. M. 1998. Factors affecting home delivery in the Kathmandu Valley, Nepal. *Health Policy Plan,* 13**,** 152-8.

BORGHI, J., ENSOR, T., NEUPANE, B. D. & TIWARI, S. 2006. Financial implications of skilled attendance at delivery in Nepal. *Tropical Medicine and International Health,* 11**,** 228-37.

BOUCHER, D., BENNETT, C., MCFARLIN, B. & FREEZE, R. 2009. Staying home to give birth: why women in the United States choose home birth. *The Journal of Midwifery and Women's Health,* 54**,** 119-126.

BOYATZIS, R. E. 1998. *Transforming Qualitative Information: thematic analysis and code development,* London, Sage Publications.

BRAUN, V. & CLARKE, V. 2006. Using thematic analysis in psychology. *Qualitative Research in Psychology,* 3**,** 77-101.

BROOM, A. 2005. Using qualitative interviews in CAM research: a guide to study design, data collection and data analysis. *Complement Therrapy in Medicine,* 13**,** 65-73.

BROWN, S. & LUMLEY, J. 1998. Changing childbirth: lessons from an Australian survey of 1336 women. *British Journal of Obstetric and Gynaecology,* 105**,** 143-55.

BROWN, S., YELLAND, J., SUTHERLAND, G., BAGHURST, P. & ROBINSON, J. 2011. Stressful life events, social health issues and low birthweight in an Australian population-based birth cohort: challenges and opportunities in antenatal care. *BMC Public Health,* 11**,** 196-108.

BRUNSON, J. 2010a. Confronting maternal mortality, controlling birth in Nepal: the gendered politics of receiving biomedical care at birth. *Social Science and Medicine,* 71**,** 1719-27.

BRUNSON, J. 2010b. Son Preference in the Context of Fertility Decline: Limits to New Constructions of Gender and Kinship in Nepal. *Studies in Family Planning,* 41**,** 89-98.

BRYMAN, A. 2001. *Social Research Methods,* New York, Oxford University Press.

BUCHMANN, W. F. 1997. Adherence: a matter of self-efficacy and power. *Journal of Advanced Nursing,* 26**,** 132-137.

BURGESS, R. G. 1984. *In the Field: An Introduction to Field Research,* London and New York, Routledge.

CALLISTER, L. C. & KHALAF, I. 2009. Culturally diverse women giving birth: their stories. *In:* SELIN, H. (ed.) *Childbirth Across Cultures.* London: Springer.

CALLISTER, L. C. & KHALAF, I. 2010. Spirituality in childbearing women. *The Journal of Perinatal Education,* 19**,** 16-24.

CALLISTER, L. C. 1995. Cultural meanings of childbirth. *Journal of Obstetric, Gynecology and Neonatal Nursing,* 24**,** 327-334.

CALLISTER, L. C., SEMENIC, S. & FOSTER, J. C. 1999. Cultural and spiritual meanings of childbirth. *Journal of Holistic Nursing,* 17**,** 280-295.

CALLISTER, L. C., VEHVILAINEN-JULKUNEN, K. & LAURI, S. 1996. Cultural Perceptions of Childbirth. *Journal of Holistic Nursing,* 14**,** 66-78.

CAMERON, M. M. 1998. *On the Edge of the Auspicious - Gender and Caste in Nepal,* Chiacago, University of Illnois Press.

CARLO, W. A., GOUDAR, S. S., JEHAN, I., CHOMBA, E., TSHEFU, A., GARCES, A., PARIDA, S., ALTHABE, F., MCCLURE, E. M. & DERMAN, R. J. 2010a. High mortality rates for very low birth weight infants in developing countries despite training. *Pediatrics***,** 126, 1259-1260.

CARLO, W. A., JEHAN, I., CHOMBA, E., TSHEFU, A., GARCES, A., PARIDA, A., ALTHABE, F., MCCLURE, E. M., DERMAN, R. J. & GOLDENBERG, R. L. 2010b. Newborn-care training and perinatal mortality in developing countries. *New England Journal of Medicine,* 362**,** 614-623.

CARLOUGH, M. 1997. More than hospitals are needed in Nepal. *Safe Mother***,** 24, 9-10.

CARPENTER, M. 2009. *The birthing experience: towards an ecosystem approach.* PhD, University of South Australia.

CARROLL, C. S. 2003. Vaginal birth after cesarean section versus elective repeat cesarean delivery: Weight-based outcomes. *American journal of obstetrics and gynecology,* 188**,** 1516-1522.

CARSON, D., ENSIGN, P., RASMUSSEN, R., & TAYLOR, A. (2011). Perspectives on 'demography at the edge'. In D. CARSON, R. RASMUSSEN, P. ENSIGN, L. HUSKEY & A. TAYLOR (Eds.), *Demography at the Edge: Remote human populations in developed nations* (pp. 3-20). Farnham, United Kingdom: Ashgate Publishing Ltd.

CARTER, S. K. 2009. Gender performances during labor and birth in the midwives model of care. *Gender Issues,* 26**,** 205-223.

CASTELLS, M. 2010. *End of Millennium: The Information Age: Economy, Society, and Culture,* Wiley-Blackwell.

CEDERCREUTZ, S. 1999. Every infant is born with its' younger sibling': childbirth and care among Amurang fishermen. London School of Economic Monographs on Social Anthropology, 68**,** 89-112.

CHAPAGAIN, B. 2010. *RE: MNH Status of District* Type to KAPHLE, S.

CHARON, J. M. 2004. *Symbolic Interactionism: an introduction, an interpretation, an integration,* New Jersey, Prentice Hall.

CHEN, M. M. & HANCOCK, H. 2011. Women's knowledge of options for birth after Caesarean Section. *Women and Birth*. Available: http://www.sciencedirect.com/science/article/pii/S1871519211002046 [Accessed 10th January, 2012]

CHOUDHRY, U. K. 1997. Traditional practices of women from India: pregnancy, childbirth, and newborn care. *Journal of Obstetric, Gynecologic, and Neonatal Nursing,* 26**,** 533-539.

CHRISTIE, M. E. & GIRI, K. 2011. Challenges and experiences of women in the forestry sector in Nepal. *International Journal of Sociology and Anthropology,* 3**,** 139-146.

CINDOGLU, D. & SAYAN-CENGIZ, F. 2010. Medicalization Discourse and Modernity: Contested Meanings Over Childbirth in Contemporary Turkey. *Health Care for Women International,* 31**,** 221-243.

CLARKE, S. A., SHEPPARD, L. & EISER, C. 2008. Mothers' explanations of communicating past health and future risks to survivors of childhood cancer. *Clinical Child Psychology and Psychiatry,* 13**,** 157-70.

COCKBURN, C. 2009. On the machinery of dominance: women, men, and technical know-how. *WSQ: Women's Studies Quarterly,* 37**,** 269-273.

COFFEY, A. 1999. *The ethnographic self: Fieldwork and the representation of identity,* London, SAGE.

COMMISSIONS ON THE SOCIAL DETERMINANTS OF HEALTH 2008. Closing the gap in a generation: health equity through actions on social determinants of health. Geneva: World Health Organization.

CONNELL, R. 1987. *Gender and power: Society, the person, and sexual politics,* Stanford University Press.

CONRAD, P. & BARKER, K. K. 2010. The Social Construction of Illness. *Journal of Health and Social Behavior,* 51**,** S67-S79.

COOPER, K. K. B. M. A. 2009. The social context of childbirth and motherhood.*Myles textbook for midwives***,** Churchill Living-Stone.

COUSENS, S., BLENCOWE, H., STANTON, C., CHOU, D., AHMED, S., STEINHARDT, L., CREANGA, A. A., TUNÇALP, Ö., BALSARA, Z. P. & GUPTA, S. 2011. National, regional, and worldwide estimates of stillbirth rates in 2009 with trends since 1995: a systematic analysis. *The Lancet,* 377**,** 1319-1330.

CRAWFORD, R. 1986. Individual responsibility and health politics. *The Sociology of Health and Illness, 2nd ed.(pp. 369Á/377). New York: St Martin's.*

CROSON, R. & GNEEZY, U. 2009. Gender differences in preferences. *Journal of Economic Literature,* 47**,** 448-474.

CROSSLEY, M. L. 2007. Childbirth, complications and the illusion of choice: A case study. *Feminism and Psychology,* 17**,** 543-563.

CROTTY, M. 1998. *The Foundation of Social Research,* NSW, Australia, ALLEN & UNWIN.

CULHANE, J. F. & GOLDENBERG, R. L. 2011. Racial Disparities in Preterm Birth. *Seminar in Perinatology,* 35**,** 234-239.

DAHAL, D. R. 1996. Socio-cultural and demographic perspectives of Nepalese women: problems and issues. *Population Development in Nepal,* 4**,** 145-155.

DAHAL, K. 2008. Nepalese woman dies after banishment to shed during menstruation. *British Medical Journal,* 337, 2520.

DAHLBERG, K., BERG, M. & LUNDGREN, I. 1999. Commentary: studying maternal experiences of childbirth. *Birth,* 26**,** 215-7.

DAHLEN, H. G., BARCLAY, L. M. & HOMER, C. S. E. 2010a. The novice birthing: Theorising first-time mothers' experiences of birth at home and in hospital in Australia. *Midwifery,* 26**,** 53-63.

DAHLEN, H. G., BARCLAY, L. M. & HOMER, C. S. E. 2010b. Processing the first birth: journeying into 'motherland'. *Journal of Clinical Nursing,* 19**,** 1977-1985.

DAVID, R. & MESSER, L. 2011. Reducing Disparities: Race, Class and the Social Determinants of Health. *Maternal and child health journal,* 15, 1-3.

DAVIS, D. L. & WALKER, K. 2010. Re-discovering the material body in midwifery through an exploration of theories of embodiment. *Midwifery,* 26**,** 457-462.

DAVIS-FLOYD, R. & SARGENT, C. F. 1997. *Childbirth and authoritative knowledge: Cross-cultural perspectives,* University of California Press.

DAVIS-FLOYD, R. 2001. The technocratic, humanistic, and holistic paradigms of childbirth. *International Journal of Gynecology and Obstetrics,* 75**,** S5-S23.

DAVIS-FLOYD, R. 2003. *Birth as an American rite of passage,* University of California Press.

DAWSON, P., PRADHAN, Y., HOUSTON, R., KARKI, S., POUDEL, D. & HODGINS, S. 2008. From research to national expansion: 20 years' experience of community-based management of childhood pneumonia in Nepal. *Bulletin of the World Health Organization,* 86**,** 339-343.

DE BROUWERE, V., RICHARD, F. & WITTER, S. 2010. Access to maternal and perinatal health services: lessons from successful and less successful examples of improving access to safe delivery and care of the newborn. *Tropical Medicine and International Health,* 15**,** 901-9.

DE CAMARGO JR, K. R. 2011. Closing the gap in a generation: Health equity through action on the social determinants of health. *Global public health,* 6**,** 102-105.

DE HOOG, M., VAN EIJSDEN, M., STRONKS, K., GEMKE, R. & VRIJKOTTE, T. 2011. Overweight at age two years in a multi-ethnic cohort (ABCD study):

the role of prenatal factors, birth outcomes and postnatal factors. *BMC Public Health,* 11**,** 611-619.

DENZIN, N. K. & LINCOLN, Y. S. 2000. *Handbook of Qualitative Research,* London, Sage Publications.

DENZIN, N. K. & LINCOLN, Y. S. 2008. *The Landscape of Qualitative Research,* California, SAGE Publications.

DESAI, S. & ALVA, S. 1998. Maternal education and child health: Is there a strong causal relationship? *Demography,* 35**,** 71-81.

DHAKAL, S., VAN TEIJLINGEN, E., RAJA, E. A. & DHAKAL, K. B. 2011. Skilled Care at Birth among Rural Women in Nepal: Practice and Challenges. *Journal of Health Population and Nutrition,* 29**,** 371-378.

DI CIANO, T., ROONEY, R., WRIGHT, B., HAY, D. & ROBINSON, L. 2010. Postnatal social support group needs and explanatory models of Iraqi Arabic speaking women in the year following the birth of their baby in Perth, Western Australia. *Advances in Mental Health,* 9**,** 162-176.

DICK-READ, G. 2005. *Childbirth without fear: the principles and practice of natural childbirth,* Printer & Martin Ltd.

DIENER, E. 2009. Introduction–Culture and Well-Being Works by Ed Diener. *Culture and Well-Being***,** 38, 1-8.

DISTRICT DEVELOPMENT COMMITTEE 2008. Mugu Baseline Survey Mugu DDC, Mugu

DISTRICT DEVELOPMENT COMMITTEE 2009. District Profile. *In:* CENTRE, D. I. A. D. (ed.). Mugu: District Development Committee.

DOUGLAS, M. & WILDAVSKY, A. 1983. *Risk and culture: An essay on the selection of technical and environmental dangers,* University of California Press on Demand

DOUGLAS, M. 1966. *Purity and danger: an analysis of concepts of pollution and taboo,* Penguin Books.

DOUGLAS, M. 1991. *Purity and danger,* London, Routledge.

DOUGLAS, M. 1992. *Risk and blame,* Routledge and Kegan Paul.

DOUGLAS, M. 2002. *Risk and blame: essays in cultural theory,* Psychology Press.

DOUGLAS, V. K. 2006. Childbirth among the Canadian Inuit: a review of the clinical and cultural literature. *International Journal of Circumpolar Health,* 65**,** 117-32.

DOUGLAS, V. K. 2011. The Rankin Inlet Birthing Centre: community midwifery in the Inuit context. *International Journal of Circumpolar Health,* 70**,** 178-185.

DOWNE, S. & MCCOURT, C. 2004. From being to becoming: reconstructing childbirth. *In:* DOWNE, S. (ed.) *Normal childbirth: Evidence and debate.* Oxford: Elsevier.

DOWNE, S. 2007. Campaign for normal birth. Trust and expertise. *RCM Midwives,* 10**,** 66.

DOWSWELL, T., CARROLI, G., DULEY, L., GATES, S., GÜLMEZOGLU, A. M., KHAN-NEELOFUR, D. & PIAGGIO, G. G. P. 2010. Alternative versus standard packages of antenatal care for low-risk pregnancy. *The Cochrane Database of Systematic Review,* 10.

DRUMMOND, P. D., MIZAN, A., BROCX, K. & WRIGHT, B. 2011. Barriers to Accessing Health Care Services for West African Refugee Women Living in Western Australia. *Health Care for Women International,* 32, 206-224.

ECKERMANN, L. 2006. Finding a 'safe' place on the risk continuum: a case study of childbirth in Lao PDR. *Health Sociology Review,* 15**,** 374-386.

EDSON, G. 2009. *Shamanism: a cross-cultural study of beliefs and practices,* McFarland & Company.

EDWARDS, R. 1990. Connecting method and epistemology: A white woman interviewing black women. *Women's Studies International Forum,* 13**,** 477-490.

EIGNER, D. Year. Social and Cultural Dynamics of Traditional Healing. *In:* International Military Mental Health Conference 2010 Vienna. Institute of Human and Social Science

ELO, I. T. 1992. Utilization of maternal health-care services in Peru: the role of women's education. *Health Transition Review,* 2**,** 49-69.

EMERSON, R. M., FRETZ, R. I. & SHAW, L. L. 1995. *Writing Ethnographic Fieldnotes,* Chicago, University of Chicago Press.

ENSOR, T., CLAPHAM, S. & PRASAI, D. P. 2009. What drives health policy formulation: Insights from the Nepal maternity incentive scheme? *Health Policy,* 90**,** 247-253.

FALLE, T. Y., MULLANY, L. C., THATTE, N., KHATRY, S. K., LECLERQ, S. C., DARMSTADT, G. L., KATZ, J. & TIELSCH, J. M. 2009. Potential role of traditional birth attendants in neonatal healthcare in rural southern Nepal. *Journal of health, population, and nutrition,* 27**,** 53-61.

FAMILY HEALTH DIVISION 2009. Ama Surakshaya Karyakram Implementation Guidelines Kathmandu

FAMILY HEALTH DIVISION 2010. Nepal Maternal Mortality and Morbidity Study. Kathmandu.

FILIPPI, V., RONSMANS, C., CAMPBELL, O. M. R., GRAHAM, W. J., MILLS, A., BORGHI, J., KOBLINSKY, M. & OSRIN, D. 2006. Maternal health in poor countries: the broader context and a call for action. *The Lancet,* 368**,** 1535-1541.

FIVUSH, R. 2010. Speaking silence: The social construction of silence in autobiographical and cultural narratives. *Memory,* 18**,** 88-98.

FOTSO, J. C., EZEH, A., MADISE, N., ZIRABA, A. & OGOLLAH, R. 2009. What does access to maternal care mean among the urban poor? Factors associated with use of appropriate maternal health services in the slum settlements of Nairobi, Kenya. *Maternal an Child Health Journal,* 13**,** 130-137.

FOUCAULT, M. 1979. *Michel Foucault: power, truth, strategy,* Feral Publications.

FOX KELLER, E. 1986. *Reflections on gender and science,* Yale College.

FOX, B. & WORTS, D. 1999. Revisiting the Critique of Medicalised Childbirth. *Gender and Society,* 13**,** 326-346.

FREEMAN, T., BAUM, F., LAWLESS, A., JOLLEY, G., LABONTE, R., BENTLEY, M. & BOFFA, J. 2011. Reaching those with greatest need: how Australian primary health care service managers, practitioners and funders understand and respond to health inequity. *Australian journal of primary health,* 17**,** 355-361.

FREIRE, P. & FREIRE, A. M. A. 2004. *Pedagogy of hope: Reliving pedagogy of the oppressed,* New York, Continuum International Publication Group.

FREIRE, P. 1973. *Education for critical consciousness,* New York, Continuum International Publication Group.

FREIRE, P. 1994. *Pedagogy of the oppressed (Rev. ed.).* New York, Continuum International Publication Group.

FREIRE, P. 2000. *Pedagogy of the oppressed (Rev. ed.),* New York, Continuum International Publication Group.

FRIBERG, I. K., BHUTTA, Z. A., DARMSTADT, G. L., BANG, A., COUSENS, S., BAQUI, A. H., KUMAR, V., WALKER, N. & LAWN, J. E. 2010. Comparing modelled predictions of neonatal mortality impacts using LiST with observed results of community-based intervention trials in South Asia. *International journal of epidemiology,* 39**,** 11-20.

FRIEL, S. & MARMOT, M. G. 2011. Action on the Social Determinants of Health and Health Inequities Goes Global. *Annual Review of Public Health,* 32**,** 225-36.

GABRYSCH, S. & CAMPBELL, O. 2009. Still too far to walk: Literature review of the determinants of delivery service use. *BMC Pregnancy and Childbirth,* 9**,** 34-52.

GADAMER, H. G. 1998. *Truth and Method,* New York, Continuum International Publication Group.

GAGNON, A., WILSON, R. D., AUDIBERT, F., ALLEN, V. M., BLIGHT, C., BROCK, J. A., DESILETS, V. A., JOHNSON, J. A., LANGLOIS, S., SUMMERS, A. & WYATT, P. 2008. Obstetrical complications associated with abnormal maternal serum markers analytes. *J Obstet Gynaecol Can,* 30**,** 918-49.

GARGIONI, G. & RAVIGLIONE, M. 2009. The principles of primary health care and social justice. *Journal of Medicine and the Person,* 7**,** 103-105.

GAUTAM, S., BANSKOTA, A. & MANCHANDA, R. 2011. Where there are no men: women in the Maoist insurgency in Nepal. *In:* VIESWEARAN, K. (ed.) *Perspectives on Modern South Asia: A Reader in Culture, History, and Representation.* John Wiley and Sons.

GEORGE, K., PRASAD, J., SINGH, D., MINZ, S., ALBERT, D., MULIYIL, J., JOSEPH, K., JAYARAMAN, J. & KRAMER, M. 2009. Perinatal outcomes in a South Asian setting with high rates of low birth weight. *BMC Pregnancy and Childbirth,* 9**,** 5-13.

GHIMIRE, D. J., CHARDOUL, S., KESSLER, R. C., AXINN, W. G. & ADHIKARI, B. P. 2010. Strategies for Translating, Validating and Adapting Mental Health Measures for General Population Research in Non-Western Setting. *Research Report.*Population Studies Centre, Harvard Medical School.

GHIMIRE, K. & BASTAKOTI, R. R. 2009. Ethnomedicinal knowledge and healthcare practices among the Tharus of Nawalparasi district in central Nepal. *Forest Ecology and Management,* 257**,** 2066-2072.

GIDDENS, A. 1984. *The constitution of society: Outline of the theory of structuration,* Californina, University of California Press.

GIDDENS, A. 1991. *Modernity and self-identity: Self and society in the late modern age,* Californina, Stanford University Press.

GIDDENS, A. 1994. Risk, trust, reflexivity. *In:* GIDDENS, A. (ed.) *Reflexive modernization.* London, Polity Press.

GIDDENS, A. 1999. Risk and responsibility. *The Modern Law Review,* 62**,** 1-10.

GIFFORD, S. 2010. Risk and uncertainty. *Handbook of entrepreneurship research***,** 5, 303-318.

GJERDINGEN, D., FROBERG, D. & FONTAINE, P. 1991. The effects of social support on women's health during pregnancy, labor and delivery, and the postpartum period. *Family Medicine,* 23**,** 370-375.

GLASER, B. & STRAUSS, A. 1967. *The Discovery of Grounded Theory: Strategies for Qualitative Research,* New York, Aldine Publishing.

GLENTON, C., SCHEEL, I. B., PRADHAN, S., LEWIN, S., HODGINS, S. & SHRESTHA, V. 2010. The female community health volunteer programme in Nepal: Decision makers' perceptions of volunteerism, payment and other incentives. *Social Science and Medicine,* 70**,** 1920-1927.

GOFFMAN, E. 1974. *Frame Analysis,* Harmondsworth, Penguin.

GOODBURN, E. A., GAZI, R. & CHOWDHURY, M. 1995. Beliefs and practices regarding delivery and postpartum maternal morbidity in rural Bangladesh. *Studies in Family Planning***,** 26, 22-32.

GOVERNMENT OF NEPAL 2006. National Safe Motherhood and Newborn Health Long Term Plan (2006-2017). *In:* DIVISION, F. H. (ed.). Kathmandu Department of Health Services

GRUSKIN, S., COTTINGHAM, J., HILBER, A. M., KISMODI, E., LINCETTO, O. & ROSEMAN, M. J. 2008. Using human rights to improve maternal and neonatal health: history, connections and a proposed practical approach. *Bulletin of the World Health Organization,* 86**,** 589-593.

GUBA, E. G. & LINCOLN, Y. S. 1985. *Naturalist Inquiry,* London, SAGE Publications.

GUNEW, S. M. 1990. *Feminist knowledge: Critique and construct*, Psychology Press.

GUNEW, S. M. 1991. *A reader in feminist knowledge*, Routledge.

GWATKIN, D., WAGSTAFF, A. & YAZBECK, A. 2005. *Reaching the poor with health, nutrition, and population services: What works, what doesn't, and why*, World Bank Publications.

HADJIGEORGIOU, E., KOUTA, C., PAPASTAVROU, E., PAPADOPOULOS, I. & MARTENSON, L. 2011. Women's perceptions of their right to choose the place of childbirth: an integrative review. *Midwifery*. Available: http://www.sciencedirect.com/science/article/pii/S0266613811000660 [Accessed 12th December, 2011]

HAINES, H., PALLANT, J. F., KARLSTRÖM, A. & HILDINGSSON, I. 2010. Cross-cultural comparison of levels of childbirth-related fear in an Australian and Swedish sample. *Midwifery*.Available: http://www.sciencedirect.com/science/article/pii/S0266613810000707 [Accessed 11th November, 2011]

HALIM, N., BOHARA, A. K. & RUAN, X. 2011. Healthy mothers, healthy children: does maternal demand for antenatal care matter for child health in Nepal? *Health Policy and Planning*, 26**,** 242-256.

HALL, J. 2009. Spirituality and labor care. *Essential Midwifery Practice: Intra-partum Care.* Black Well Publishing

HAMMERSLEY, M. & ATKINSON, P. 1983. *Ethnography: Principle in Practice,* London and New York, Routledge.

HAMMERSLEY, M. 1992. *What's wrong with Ethnography?,* London and New York, Routledge.

HANSEN, E. C. 2006. *Successful Qualitative Health Research,* NSW, Australia, Allen and Unwim.

HARRIS, A., ZHOU, Y., LIAO, H., BARCLAY, L., ZENG, W. & GAO, Y. 2010. Challenges to maternal health care utilization among ethnic minority women in a resource-poor region of Sichuan Province, China. *Health Policy and Planning,* 25**,** 311-318.

HAYES, N. 2000. *Doing Psychological Research,* Buckingham, Open University Press.

HEATH, R. G. 2007. Rethinking Community Collaboration through a Dialogic Lens. *Management Communication Quarterly,* 21**,** 145-171.

HEIDEGGER, M. 1962. *Being and Time,* New York, Harper.

HEILEMANN, M. S. V., LEE, K. A., STINSON, J., KOSHAR, J. H. & GOSS, G. 2000. Acculturation and perinatal health outcomes among rural women of Mexican descent. *Research in Nursing and Health,* 23**,** 118-125.

HENDERSON, J. 2010. Expert and lay knowledge: A sociological perspective. *Nutrition and Dietetics,* 67**,** 4-5.

HIRSCH, M. 1989. *The mother/daughter plot: Narrative, psychoanalysis, feminism,* Indiana University Press.

HODNETT, E. D., GATES, S., HOFMEYR, G. J., SAKALA, C. & WESTON, J. 2011. Continuous support for women during childbirth. *Cochrane Database of Systematic Reviews,* 2.

HODNETT, E., DOWNE, S., WALSH, D. & WESTON, J. 2010. Alternative versus conventional institutional settings for birth.*Cochrane Database Systematic Review,* 3.

HODNETT, E., GATES, S., HOFMEYR, G. & SAKALA, C. 2007. Continuous support for women during childbirth. *Cochrane Database Systematic Review,* 3.

HOLLOWAY, I. & TODRES, L. 2003. The status of method: flexibility, consistancy and coherence. *Qualitative Research,* 3**,** 345-57.

HOMSY, J., KING, R., BALABA, D. & KABATESI, D. 2004. Traditional health practitioners are key to scaling up comprehensive care for HIV/AIDS in sub-Saharan Africa. *AIDS,* 18**,** 1723-1725.

HORTON-SALWAY, M. & LOCKE, A. 2010. 'But you might be damaging your baby': Constructing choice and risk in labour and childbirth. *Feminism and Psychology,* 20**,** 435-453.

HOUWELING, T. A. J., COSTELLO, A. & OSRIN, D. 2011. Improving maternal and newborn survival through community intervention. *In:* PARKER, R. & SOMMER, M. (eds.) *Routledge Handbook of Global Public Health.* ROUTLEDGE.

HUBERMAN, A. M. & MILES, M. 1994. Data Management and Analysis Method. *In:* DENZIN, N. K. & LINCOLN, Y. S. (eds.) *Handbook of Qualitative Research.* London: Sage.

HUGHES, K. P. 1995. Feminist pedagogy and feminist epistemology: An overview. *International Journal of Lifelong Education,* 14**,** 214-230

HUNT, S. 1995. 15th Dame Rosalind Paget Memorial Lecture. The social meaning of midwifery. *Midwives,* 108**,** 283-8.

HUNTER, L. P. 2006. Women give birth and pizzas are delivered: language and western childbirth paradigms. *The Journal of Midwifery and Women's Health,* 51**,** 119-124.

HURLEY, C., BAUM, F., JOHNS, J. & LABONTE, R. 2010. Comprehensive Primary Health Care in Australia: findings from a narrative review of the literature. *Australasian Medical Journal,* 1**,** 147-52.

IM, E. O., PAGE, R., LIN, L. C., TSAI, H. M. & CHENG, C. Y. 2004. Rigor in Cross-cultural Nursing Research. *International Journal of Nursing Studies,* 41, 891-899.

IRONSIDE, P. M. 2001. Creating a research base for nursing education: An interpretive review of conventional, critical, feminist, postmodern, and phenomenological pedagogies. *Advances in Nursing Science,* 23**,** 72-87.

IRWIN, A., SOLAR, O. & VEGA, J. 2008. Social Determinants of Health, the United Nations Commission of. *In:* KRIS, H. (ed.) *International Encyclopedia of Public Health.* Oxford: Academic Press.

ISRAEL, B. A., CHECKOWAY, B., SCHULZ, A. & ZIMMERMAN, M. 1994. Health education and community empowerment: conceptualizing and measuring perceptions of individual, organizational, and community control. *Health Education & Behavior,* 21**,** 149-170.

JACKSON, M. A. 2010. *Empowering Women of Nepal: An experience of empowerment in the land of the Himalaya.* PRESCOTT COLLEGE.

JANEVIC, T., SAVITZ, D. & JANEVIC, M. 2011. Maternal education and adverse birth outcomes among immigrant women to the United States from Eastern Europe: A test of the healthy migrant hypothesis. *Social Science and Medicine,* 73**,** 429-435.

JANEVIC, T., STEIN, C., SAVITZ, D., KAUFMAN, J., MASON, S. & HERRING, A. 2010. Neighborhood deprivation and adverse birth outcomes among diverse ethnic groups. *Annals of Epidemiology,* 20**,** 445-451.

JEFFERY, P. & JEFFERY, R. 2010. Only when the boat has started sinking: A maternal death in rural north India. *Social Science and Medicine,* 71**,** 1711-1718.

JOHANSON, R., NEWBURN, M. & MACFARLANE, A. 2002. Has the medicalisation of childbirth gone too far? *British Medical Journal,* 324**,** 892.

JOHNSON, K. & BRADLEY, S. E. K. 2008. Trends in Economic Differentials in Population and Health Outcomes: Further Analysis of the 2006 Nepal Demographic and Health Survey. Calverton, Meryland, USA: Macro International Inc.

JONES, A. & BUGGE, C. 2006. Improving understanding and rigour through triangulation: an exemplar based on patient participation in interaction. *Journal of Advance Nursing,* 55**,** 612-21.

JORDAN, B. & DAVIS-FLOYD, R. 1980. *Birth in four cultures: A crosscultural investigation of childbirth in Yucatan, Holland, Sweden, and the United States,* Eden Press Women's Publications.

JORDAN, S. 2009. *Education, participatory action research, and social change: international perspectives,* Palgrave Macmillan.

JOSEPH, K., LISTON, R. M., DODDS, L., DAHLGREN, L. & ALLEN, A. C. 2007. Socioeconomic status and perinatal outcomes in a setting with universal access to essential health care services. *Canadian Medical Association Journal,* 177**,** 583-590.

JOSEPH, N. 2011. Incidence, correlates and outcomes of Low Birth Weight–A one year longitudinal study. *Indian Journal of Public Health Research and Development,* 2, 56-62.

JUDGE, K. 2009. Inequalities in infant mortality: Patterns, trends, policy responses and emerging issues in Canada, Chile, Sweden and the United Kingdom. *Health Sociology Review,* 18**,** 12-24.

KAHSSAY, H. M. & OAKLEY, P. 1999. *Community involvement in health development: a review of the concept and practice,* World Health Organization Geneva.

KAKAIRE, O., KAYE, D. K. & OSINDE, M. O. 2011. Male involvement in birth preparedness and complication readiness for emergency obstetric referrals in rural Uganda. *Reproductive Health,* 8**,** 12-19.

KAMAL, I. 1998. The traditional birth attendant: a reality and a challenge. *International Journal of Gynecology and Obstetrics*, 63**,** S43-S52.

KANDIYOTI, D. 1988. Bargaining with patriarchy. *Gender and Society,* 2**,** 274-290.

KARAS, D. J., MULLANY, L. C., KATZ, J., KHATRY, S. K., LECLERQ, S. C., DARMSTADT, G. L. & TIELSCH, J. M. 2011. Home Care Practices for Newborns in Rural Southern Nepal During the First 2 weeks of Life. *Journal of tropical pediatrics*. Available: http://tropej.oxfordjournals.org/content/early/2011/06/24/tropej.fmr057.short [Accessed 11th January, 2011]

KASS, J. D., FRIEDMAN, R., LESERMAN, J., ZUTTERMEISTER, P. C. & BENSON, H. 1991. Health outcomes and a new index of spiritual experience. *Journal for the Scientific Study of Religion,* 30**,** 203-211.

KAUFMAN, M. R. & CRAWFORD, M. 2011. Research and Activism Review: Sex Trafficking in Nepal: A Review of Intervention and Prevention Programs. *Violence Against Women,* 17**,** 651-665.

KELEHER, H. 2001. Why primary health care offers a more comprehensive approach to tackling health inequities than primary care. *Australian journal of primary health,* 7**,** 57-61.

KELPIN, V. 1992. Birthing Pain. *In:* MORSE, J. M. (ed.) *Qualitative Health Research.* London: SAGE Publications.

KHALAF, I. & CALLISTER, L. C. 1997. Cultural Meanings of Childbirth. *Journal of Holistic Nursing,* 15**,** 373-388.

KHAN, T. M., ARIF, N. H. B., TAHIR, H. & ANWAR, M. 2009. Role of the husband's knowledge and behaviour in postnatal depression: a case study of an immigrant Pakistani woman. *Mental Health in Family Medicine,* 6**,** 195-201.

KILDEA, S., KRUSKE, S., BARCLAY, L., TRACY, S. & BARCLAY, S. K. S. K. L. 2010. 'Closing the Gap': How maternity services can contribute to reducing poor maternal infant health outcomes for Aboriginal and Torres Strait Islander women. *Rural and Remote Health,* 10:1383. Available: http://www.rrh.org.au/articles/subviewaust.asp?ArticleID=1383 [Accessed 17th November, 2011]

KITZINGER, S. 1972. *The experience of childbirth*, Penguin.

KITZINGER, S. 1997. *Authoritative touch in childbirth: a cross cultural approach.* University of California Press.

KITZINGER, S. 2000. *Rediscovering Birth,* New York, Pocket Books.

KITZINGER, S. 2001. *Rediscovering birth,* Atria.

KITZINGER, S. 2011. *Birth Your Way-Choosing Birth at Home Or in a Birth Centre: A Guide for Pregnant Women,* Fresh Heart Publishing.

KLEINSASSER, A. M. 2000. Researchers, reflexivity, and good data: Writing to unlearn. *Theory into practice,* 39**,** 155-162.

KOHRT, B. A. & HRUSCHKA, D. J. 2010. Nepali concepts of psychological trauma: The role of idioms of distress, ethnopsychology and ethnophysiology in alleviating suffering and preventing stigma. *Culture, Medicine and Psychiatry,* 34**,** 322-352.

KOHRT, B. A., SPECKMAN, R. A., KUNZ, R. D., BALDWIN, J. L., UPADHAYA, N., ACHARYA, N. R., SHARMA, V. D., NEPAL, M. K. & WORTHMAN, C. M. 2009. Culture in psychiatric epidemiology: Using ethnography and multiple mediator models to assess the relationship of caste with depression and anxiety in Nepal. *Annals of Human Biology,* 36**,** 261-280.

KOLB, D. A. 1984. *Experiential learning: Experience as the source of learning and development,* Prentice-Hall Englewood Cliffs, NJ.

KONTOS, N. 2011. Perspective: Biomedicine—Menace or Straw Man? Reexamining the Biopsychosocial Argument. *Academic Medicine,* 86**,** 509-515.

KORNELSEN, J., MOOLA, S. & GRZYBOWSKI, S. 2009. Does distance matter? Increased induction rates for rural women who have to travel for intrapartum care. *Journal of Obstetric and Gynaecology Canada,* 31**,** 21-7.

KOSTENIUK, J. 2002. The Social Determinants of Health: Michael Marmot and Richard G. Wilkinson (Eds.); Oxford University Press, Oxford, 1999, 306 pp., price £26.50 (paper), ISBN 0-19-263063-5. *Social Science and Medicine,* 55**,** 348-349.

KRINGELAND, T., DALTVEIT, A. K. & MØLLER, A. 2010. How Does Preference for Natural Childbirth Relate to the Actual Mode of Delivery? A Population based Cohort Study from Norway. *Birth,* 37**,** 21-27.

KROKER, A. 2004. *The will to technology and the culture of nihilism: Heidegger, Nietzsche and Marx,* University of Toronto Press.

KRUK, M. E., PRESCOTT, M. R. & GALEA, S. 2008. Equity of skilled birth attendant utilization in developing countries: financing and policy determinants. *American Journal of Public Health,* 98**,** 142-147.

KRUSKE, S., KILDEA, S. & BARCLAY, L. 2006. Cultural safety and maternity care for Aboriginal and Torres Strait Islander Australians. *Women and Birth,* 19**,** 73-77.

KUNWAR, R. M., SHRESTHA, K. P. & BUSSMANN, R. W. 2010. Traditional herbal medicine in Far-west Nepal: a pharmacological appraisal. *Journal of Ethnobiology and Ethnomedicine,* 6**,** 1-18.

KUOKKANEN, L. & LEINO-KILPI, H. 2000. Power and empowerment in nursing: three theoretical approaches. *Journal of Advanced Nursing,* 31**,** 235-241.

LABONTE, R. & WILLIAMS, L. 2003. Changing health determinants through community action: power, participation and policy. *Promotion and Education,* 10**,** 65-71.

LABONTE, R. 1992. Heart health inequalities in Canada: modules, theory and planning. *Health promotion international,* 7**,** 119-128.

LABONTE, R. N. 2009. *Globalization and health: pathways, evidence and policy,* Taylor & Francis.

LABONTÉ, R., MOHINDRA, K. & SCHRECKER, T. 2011. The growing impact of globalization for health and public health practice. *Annual Review of Public Health,* 32**,** 263-83.

LADHANI, N. N. N., SHAH, P. S. & MURPHY, K. 2011. Prenatal amphetamine exposure and birth outcomes: A systematic review and meta-analyses. *American journal of obstetrics and gynecology*, 205, 219e1-219e7.

LAINE, M. 1997. *Ethnography,* Sydney, Maclennan and Petty Pty Ltd.

LANG, J. B. & ELKIN, E. D. 1997. A study of the beliefs and birthing practices of traditional midwives in rural Guatemala. *The Journal of Midwifery and Women's Health,* 42**,** 25-31.

LANSAKARA, N., BROWN, S. J. & GARTLAND, D. 2010. Birth Outcomes, Postpartum Health and Primary Care Contacts of Immigrant Mothers in an Australian Nulliparous Pregnancy Cohort Study. *Maternal and child health journal***,** 14, 807-816.

LARKIN, P., BEGLEY, C. M. & DEVANE, D. 2009. Women's experiences of labour and birth: an evolutionary concept analysis. *Midwifery,* 25**,** e49-e59.

LAVERACK, G. & LABONTE, R. 2000. A planning framework for community empowerment goals within health promotion. *Health Policy and Planning,* 15**,** 255-262.

LAVERACK, G. 2004. *Health promotion practice: power and empowerment,* Sage Publications Ltd.

LAVERACK, G. 2011. Improving health outcomes through community empowerment: a review of the literature. *Journal of Health, Population and Nutrition,* 24**,** 113-120.

LAWN, J. 2010. Maternal and child health—now, then, or when? *The Lancet,* 375**,** 1957-1958.

LAZARUS, E. S. 1994. What do women want?: Issues of choice, control, and class in pregnancy and childbirth. *Medical Anthropology Quarterly,* 8**,** 25-46.

LECOMPTE, M. D. & SCHENSUL, J. J. 1999. *Analysing and Interpreting Ethnographic Data,* Walnut Creek, Alta Mira Press.

LEE, A. C., MULLANY, L. C., TIELSCH, J. M., KATZ, J., KHATRY, S. K., LECLERQ, S. C., ADHIKARI, R. K. & DARMSTADT, G. L. 2011. Community-based stillbirth rates and risk factors in rural Sarlahi, Nepal. *International Journal of Gynecology and Obstetrics*, 113, 199-204.

LEE, M. & FIELDING, N. 1996. Qualitative Data Analysis: Representation of a technology - A comment on Coffey, Holbrook and Atkinson. *Sociological Research Online,* 1**,** <http://www.socresonline.org.uk/socresonline/1/4/1.html>.

LEEDAM, E. 1985. Traditional birth attendants. *International Journal of Gynecology and Obstetrics,* 23**,** 249-274.

LEE-RIFE, S. M. 2010. Women's empowerment and reproductive experiences over the lifecourse. *Social Science and Medicine,* 71**,** 634-642.

LEFEBER, Y. & VOORHOEVE, H. W. A. 1998. *Indigenous customs in childbirth and child care,* Uitgeverij Van Gorcum.

LEIN, L. 1979. Male participation in home life: Impact of social supports and breadwinner responsibility on the allocation of tasks. *Family Coordinator***,** 28, 489-495.

LEMAY, C. 2011. Reclaiming meanings for birth, pain and risk within the home setting. *In:* DONNA, S. (ed.) *Promoting Normal Birth-Research, Reflections and Guidelines.* United Kingdom: Fresh Heart Publishing

LETHERBY, G. (ed.) 2011. *Feminist Methodology: The SAGE Handbook of Innovation in Social Research Methods,* Thousands Oaks, California: SAGE Publications Ltd.

LEVESQUE, L. T. 1980. *Being Pregnant: There Is More to Childbirth Than Having a Baby*, Diliton.

LEWALLEN, L. P. 2011. The Importance of Culture in Childbearing. *Journal of Obstetric, Gynecology and Neonatal Nursing,* 40**,** 4-8.

LEWIN, S., LAVIS, J. N., OXMAN, A. D., BASTÍAS, G., CHOPRA, M., CIAPPONI, A., FLOTTORP, S., MARTÍ, S. G., PANTOJA, T., RADA, G.,

SOUZA, N., TREWEEK, S., WIYSONGE, C. S. & HAINES, A. 2008. Supporting the delivery of cost-effective interventions in primary health-care systems in low-income and middle-income countries: an overview of systematic reviews. *The Lancet,* 372**,** 928-939.

LEWIS, J. D. & WEIGERT, A. 1985. Trust as a social reality. *Social forces,* 63**,** 967-985.

LIAMPUTTONG, P. 2009a. Pregnancy, Childbirth and Traditional Beliefs and Practices in Chiang Mai, Northern Thailand. *In:* SELIN, H. (ed.) *Childbirth Across Cultures - The History of Non-Western Science* Australia: Springer Science

LIAMPUTTONG, P. 2009b. *Qualitative Research Methods,* Australia, Oxford University Press.

LILJESTRAND, J. 1999. Reducing perinatal and maternal mortality in the world: the major challenges. *BJOG: An International Journal of Obstetrics and Gynaecology,* 106**,** 877-880.

LINDGREN, H. & ERLANDSSON, K. 2010. Women's Experiences of Empowerment in a Planned Home Birth: A Swedish Population based Study. *Birth,* 37**,** 309-317.

LINDGREN, H. E., RADESTAD, I. J., CHRISTENSSON, K., WALLY-BYSTROM, K. & HILDINGSSON, I. M. 2010. Perceptions of risk and risk management among 735 women who opted for a home birth. *Midwifery,* 26**,** 163-172.

LISONKOVA, S., SHEPS, S. B., JANSSEN, P. A., LEE, S. K., DAHLGREN, L. & MACNAB, Y. C. 2011. Birth Outcomes Among Older Mothers in Rural Versus Urban Areas: A Residence Based Approach. *The Journal of Rural Health, 27, 211-219.*

LOCHER, B. & PRÜGL, E. 2001. Feminism and constructivism: worlds apart or sharing the middle ground? *International Studies Quarterly,* 45**,** 111-129.

LOCK, A. & STRONG, T. 2010. *Social constructionism: Sources and stirrings in theory and practice*, Cambridge University Press.

LORI, J. R. & BOYLE, J. S. 2011. Cultural Childbirth Practices, Beliefs, and Traditions in Postconflict Liberia. *Health Care for Women International,* 32, 454-473.

LOZOFF, B., JORDAN, B. & MALONE, S. 1988. Childbirth in cross-cultural perspective. *Marriage and family review,* 12, 35-60.

LUHMANN, N. 1979. *Trust and Power: two works*, John Wiley & Sons Inc.

LUITEL, S. 2008. The social world of Nepalese women. *Occasional Papers in Sociology and Anthropology,* 7**,** 101-114.

LUMBIGANON, P., LAOPAIBOON, M., GÜLMEZOGLU, A. M., SOUZA, J. P., TANEEPANICHSKUL, S., RUYAN, P., ATTYGALLE, D. E., SHRESTHA, N., MORI, R. & HINH, N. D. 2010. Method of delivery and pregnancy outcomes in Asia: the WHO global survey on maternal and perinatal health 2007-08. *The Lancet,* 375**,** 490-499.

LUO, Z. C., SENECAL, S., SIMONET, F., GUIMOND, E., PENNEY, C. & WILKINS, R. 2010a. Birth outcomes in the Inuit-inhabited areas of Canada. *Canadian Medical Association Journal,* 182**,** 235-242.

LUO, Z. C., WILKINS, R., HEAMAN, M., MARTENS, P., SMYLIE, J., HART, L., WASSIMI, S., SIMONET, F., WU, Y. & FRASER, W. D. 2010b. Neighborhood socioeconomic characteristics, birth outcomes and infant mortality among First Nations and non-First Nations in Manitoba, Canada. *Open Women's Health Journal,* 4**,** 55-61.

LUPTON, D. & TULLOCH, J. 2002. Risk is part of your life': Risk epistemologies among a group of Australians. *Sociology,* 36**,** 317-334.

LUPTON, D. 1999. *Risk and sociocultural theory: New directions and perspectives,* Cambridge University Press.

LUPTON, D. 2003. *Medicine as culture: Illness, disease and the body in western societies,* Sage Publications Ltd.

LUPTON, D. 2006. Sociology and risk. *In:* MYTHEN, G. & WALKLATE, S. (eds.) *Beyond the risk society: critical reflections on risk and human security.* London: Open University Press.

LUTTRELL, C. 2007. Operationalising Empowerment: A framework for an understanding of empowerment within SDC. Available: http://www.powercube.net/wp-content/uploads/2009/11/operationalising_empowerment.pdf [Accessed 10th February, 2012].

MACINTYRE, M. 2011. Modernity, Gender and Mining: Experiences from Papua New Guinea. *In:* KUNTALA, L. D. (ed.) *Gendering the field: towards sustainable.* Canberra: ANU E Press.

MACKENZIE BRYERS, H. & VAN TEIJLINGEN, E. 2010. Risk, theory, social and medical models: A critical analysis of the concept of risk in maternity care. *Midwifery*. Available: http://www.sciencedirect.com/science/article/pii/S0266613810001178 [Accessed 11th November, 2011]

MAITRA, P. 2011. Effect of socioeconomic characteristics on age at marriage and total fertility in Nepal. *JHPN,* 22**,** 84-96.

MALLA, D., GIRI, K., KARKI, C. & CHAUDHARY, P. 2011. Achieving Millennium Development Goals 4 and 5 in Nepal. *BJOG: An International Journal of Obstetrics and Gynaecology,* 118**,** 60-68.

MANANDHAR, D. S. 2004. Audit for reducing perinatal deaths in Nepal. *Kathmandu University Medical Journal (KUMJ),* 2**,** 176-81.

MANANDHAR, M. 2000. Ethnographic Perspective on Obstetric Health Issues in Nepal. Kathmandu: Nepal Safer Motherhood Project

MANN, J. M. 1999. *Health and human rights: a reader,* Psychology Press.

MANN, J. R., MANNAN, J., QUIÑONES, L. A., PALMER, A. A. & TORRES, M. 2010. Religion, spirituality, social support, and perceived stress in pregnant and postpartum Hispanic women. *Journal of Obstetric, Gynecology and Neonatal Nursing,* 39, 645-657.

MANSFIELD, B. 2008. The social nature of natural childbirth. *Social Science and Medicine,* 66**,** 1084-1094.

MARAK, Q. 2010. Supernatural beliefs connected with childbirth among the garos of Assam. *Journal of JNU,* 85, 283-289.

MARKENS, S., BROWNER, C. H. & MABEL PRELORAN, H. 2010. Interrogating the dynamics between power, knowledge and pregnant bodies in amniocentesis decision making. *Sociology of Health and Illness,* 32**,** 37-56.

MARMOT, M. & BELL, R. 2010. Health Equity and Development: the Commission on Social Determinants of Health. *European Review,* 18**,** 1-7.

MARMOT, M. & WILKINSON, R. G. 2005. Social determinants of health. *The Lancet,* 365**,** 1099-1104.

MARMOT, M. 2010. Social inequity in maternal health. *Revista Colombiana de obstetRiCia y GineColoGía,* 61**,** 196.

MARMOT, M., FRIEL, S., BELL, R., HOUWELING, T. A. & TAYLOR, S. 2008a. Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet,* 372**,** 1661-9.

MARMOT, M., FRIEL, S., BELL, R., HOUWELING, T. A. J. & TAYLOR, S. 2008b. Closing the gap in a generation: health equity through action on the social determinants of health. *The Lancet,* 372**,** 1661-1669.

MARTELL, L. K. 1990. The mother-daughter relationship during daughter's first pregnancy: The transition experience. *Holistic Nursing Practice,* 4**,** 47-55.

MARTIN, E. 1990. The woman in the body: A cultural analysis of reproduction. *Birth,* 17, 169-171.

MASS, H. & WHYTE, N. 1997. Primary health care in action. *Nursing BC,* 29**,** 13-6.

MATSUYAMA, A. & MOJI, K. 2008. Perception of bleeding as a danger sign during pregnancy, delivery, and the postpartum period in rural Nepal. *Qualitative Health Research,* 18**,** 196-208.

MAYOR, S. 2011. News: More women at low risk of problems should have midwife led care, says King's Fund. *British Medical Journal***,** 342.

MCCLURE, E. M., SALEEM, S., PASHA, O. & GOLDENBERG, R. L. 2009. Stillbirth in developing countries: a review of causes, risk factors and prevention strategies. *Journal of Maternal-Fetal and Neonatal Medicine,* 22**,** 183-190.

MCCOURT, C. 2010a. Childbirth, midwifery and concepts of time. *Slavic Studies,* 11**,** 1-8.

MCCOURT, C. 2010b. Cosmologies, Concepts and Theories: Time and Childbirth in Cross-Cultural perspective. *In:* MCCOURT, C. (ed.) *Childbirth, Midwifery and Concepts of Time.* Breghahn Books.

MCNAMEE, S. & GERGEN, K. J. 1992. *Therapy as social construction*, Sage Publications Ltd.

MEAD, G. H. 1972. *The Philosophy of the Act,* Chicago, The University of Chicago Press.

MEAD, M. & NEWTON, N. 1967. Pregnancy, Childbirth and Outcome: A Review of Patterns of Culture and Future Research Needs. *Childbearing: Its social and psychological aspects.* Baltimore, MD: Williams & Wilkins.

MESKO, N., OSRIN, D., TAMANG, S., SHRESTHA, B. P., MANANDHAR, D. S., MANANDHAR, M., STANDING, H. & COSTELLO, A. M. 2003. Care for perinatal illness in rural Nepal: a descriptive study with cross-sectional and qualitative components. *BMC International Health and Human Rights,* 3**,** 3-15.

MESSER, L. C. & KAUFMAN, J. S. 2010. Invited commentary: The socioeconomic causes of adverse birth outcomes. *American journal of epidemiology,* 172**,** 135.

MILLER, M. A. 1995. Culture, spirituality, and women's health. *Journal of Obstetric, Gynecology and Neonatal Nursing,* 24**,** 257-264.

MINICHIELLO, V., ARONI, R., TIMEWELL, E. & ALEXANDER, L. 1995. *In-depth Interviewing: principles, techniques and analysis,* Australia, Longman Pty Ltd.

MINISTRY OF HEALTH AND POPULATION , NEW ERA & MACRO INTERNATIONAL INC 2007. Nepal Demographic and Health Survey 2006. Kathmandu, Nepal: Ministry of Health and Population, New ERA, Macro International Inc

MITTELMARK, M. B. 2001. Promoting social responsibility for health: health impact assessment and healthy public policy at the community level. *Health promotion international,* 16**,** 269-274.

MOHAMMAD ALI BEIGI, N., BROUMANDFAR, K., BAHADORAN, P. & ABEDI, H. A. 2010. Women's experience of pain during childbirth. *Iranian Journal of Nursing and Midwifery Research,* 15**,** 72-77.

MOLM, L. D. 1997. *Coercive power in social exchange*, Cambridge University Press.

MOLONEY, S. 2006. The spirituality of childbirth. *Birth Issues,* 15**,** 41-46.

MOOK-KANAMORI, D. O., STEEGERS, E. A. P., EILERS, P. H., RAAT, H., HOFMAN, A. & JADDOE, V. W. V. 2010. Risk factors and outcomes associated with first-trimester fetal growth restriction. *JAMA: The Journal of the American Medical Association,* 303**,** 527-534.

MOORE, B., ALEX-HART, B. & GEORGE, I. 2011. Utilization of Health Care Services by Pregnant Mothers during Delivery: A community based study in Nigeria. *Age (year),* 15**,** 864-867.

MORLEY, C. & MACFARLANE, S. 2011. The Nexus between Feminism and Postmodernism: Still a Central Concern for Critical Social Work. *British Journal of Social Work.* Available: http://bjsw.oxfordjournals.org/content/early/2011/07/23/bjsw.bcr107.short [Accessed 11th December, 2011]

MORRISON, J., THAPA, R., SEN, A., NEUPANE, R., BORGHI, J., TUMBAHANGPHE, K. M., OSRIN, D., MANANDHAR, D. & COSTELLO, A. 2010. Utilization and management of maternal and child health funds in rural Nepal. *Community Development Journal,* 45**,** 75-89.

MORRISON, J., TUMBAHANGPHE, K., BUDHATHOKI, B., NEUPANE, R., SEN, A., DAHAL, K., THAPA, R., MANANDHAR, R., MANANDHAR, D. & COSTELLO, A. 2011. Community mobilisation and health management committee strengthening to increase birth attendance by trained health workers in rural Makwanpur, Nepal: study protocol for a cluster randomised controlled trial. *Trials,* 12**,** 128-139.

MORSE, J. M. 1989. Strategies for Sampling. *In:* MORSE, J. M. (ed.) *Qualitative Nursing Research: a contemporary dialogue.* Maryland: Rockville.

MORSE, J. M. 2009. "Going Beyond Your Data," and Other Dilemmas of Interpretation. *Qualitative Health Research,* 19**,** 579- 589.

MUELLER, K. J., ORTEGA, S. T., PARKER, K., PATIL, K. & ASKENAZI, A. 2010. Health status and access to care among rural minorities. *Journal of Health Care for the Poor and Underserved,* 10**,** 230-249.

MULINARI, D. & SANDELL, K. 2009. A Feminist Re-reading of Theories of Late Modernity: Beck, Giddenss and the Location of Gender. *Critical Sociology,* 35**,** 493-507.

MULLANY, L. C., DARMSTADT, G. L., KATZ, J., KHATRY, S. K., LECLERQ, S. C., ADHIKARI, R. K. & TIELSCH, J. M. 2007. Risk factors for umbilical cord infection among newborns of southern Nepal. *American journal of epidemiology,* 165**,** 203-211.

MULLANY, L. C., DARMSTADT, G. L., KHATRY, S. K. & TIELSCH, J. M. 2005. Traditional massage of newborns in Nepal: implications for trials of improved practice. *Journal of tropical pediatrics,* 51**,** 82-86.

MULLANY, L. C., DARMSTADT, G. L., KHATRY, S. K., KATZ, J., LECLERQ, S. C., SHRESTHA, S., ADHIKARI, R. & TIELSCH, J. M. 2006. Topical applications of chlorhexidine to the umbilical cord for prevention of omphalitis and neonatal mortality in southern Nepal: a community-based, cluster-randomised trial. *The Lancet,* 367**,** 910-918.

MUMTAZ, Z. & SALWAY, S. 2009. Understanding gendered influences on women's reproductive health in Pakistan: moving beyond the autonomy paradigm. *Social Science and Medicine,* 68**,** 1349-1356.

MURSHED, S. M. & GATES, S. 2005. Spatial–horizontal inequality and the Maoist insurgency in Nepal. *Review of Development Economics,* 9**,** 121-134.

MYERS, H. F. 2009. Ethnicity-and socio-economic status-related stresses in context: an integrative review and conceptual model. *Journal of behavioral medicine,* 32**,** 9-19.

NAMEY, E. E. & LYERLY, A. D. 2010. The meaning of" control" for childbearing women in the US. *Social Science & Medicine,* 71**,** 769-776.

NAST, H. J. 1994. Women in the Field: Critical Feminist Methodologies and Theoretical Perspectives. *The Professional Geographer,* 46**,** 54-66.

NEUPANE, D. & GULIS, G. 2010. Comment on: Attracting and retaining doctors in rural Nepal. *Rural and Remote Health,* 10, 1638.

NIEDHAMMER, I., MURRIN, C., O'MAHONY, D., DALY, S., MORRISON, J. J. & KELLEHER, C. C. 2011. Explanations for social inequalities in preterm delivery in the prospective Lifeways cohort in the Republic of Ireland. *The European Journal of Public Health*. Available: http://eurpub.oxfordjournals.org/content/early/2011/07/09/eurpub.ckr089.short [Accessed 12th December, 2011]

NILSEN, A. & BRANNEN, J. 2002. Theorizing the individual–structure dynamic. *In:* BRANNEN, J. (ed.) *Young Europeans, work and family: futures in transition.* London and New York: ROUTLEDGE.

NODDINGS, N. 2009. Critical Thinking in Religious Education. *In:* SHAPIRO, H. S. (ed.) *Education and hope in troubled times: visions of change for our children's world.* New York: ROUTLEDGE.

OAKLEY, A. 1980. *Women confined: Towards a sociology of childbirth,* Schocken Books.

OAKLEY, A. 1981. Interviewing women. *In:* ROBERTS, H. (ed.) *Doing feminist research.* New York: ROUTLEDGE.

OAKLEY, A. 1983. Social consequences of obstetric technology: the importance of measuring "soft" outcomes. *Birth,* 10**,** 99-108.

OAKLEY, A. 1984. *The captured womb: A history of the medical care of pregnant women,* B. Blackwell, Oxford [Oxfordshire]; New York, NY.

OAKLEY, A. 1993. *Essays on women, medicine and health,* Edinburgh, Edinburgh University Press.

OAKLEY, A. 1996. Childbirth practice should take women's wishes into account. *British Medical Journal,* 313**,** 1557.

OBERMEYER, C. M. 2000. Pluralism and pragmatism: Knowledge and practice of birth in Morocco. *Medical Anthropology Quarterly,* 14**,** 180-201.

OLSEN, O. 2011. Promoting home birth in accordance with the best scientific evidence. *In:* DONNA, S. (ed.) *Promoting Normal Birth-Research, Reflections and Guidelines.* United Kingdom: Fresh Heart Publishing.

OSRIN, D., AZAD, K., FERNANDEZ, A. & MANANDHAR, D. S. 2009. Ethical challenges in cluster randomised controlled trials: experiences from public health interventions in Africa and Asia. *Bulletin of the World Health Organization,* 82**,** 772-779.

OSRIN, D., TUMBAHANGPHE, K. M., SHRESTHA, D., MESKO, N., SHRESTHA, B. P., MANANDHAR, M. K., STANDING, H., MANANDHAR, D. S. & COSTELLO, A. M. 2002. Cross sectional, community based study of care of newborn infants in Nepal. *British Medical Journal,* 325**,** 1063-1073.

OSWALD, I. 1983. Are traditional healers the solution to the failures of primary health care in rural Nepal? *Social Science and Medicine,* 17**,** 255-257.

PAGE, S. J. 2011. Negotiating sacred roles: a sociological exploration of priests who are mothers. *Feminist Review,* 97**,** 92-109.

PANDEY, S., LAMA, G. & LEE, H. 2011. Effect of women's empowerment on their utilization of health services: A case of Nepal. *International Social Work.* Available: http://isw.sagepub.com/content/early/2011/07/15/0020872811408575.abstract [Accessed 12th January, 2012]

PANTER-BRICK, C. 1989. Motherhood and subsistence work: The Tamang of rural Nepal. *Human Ecology,* 17**,** 205-228.

PATTENDEN, S., CASSON, K., COOK, S. & DOLK, H. 2010. Geographical variation in infant mortality, stillbirth and low birth weight in Northern Ireland, 1992–2002. *Journal of epidemiology and community health,* 65, 1159-1165.

PATTINSON, R., KERBER, K., WAISWA, P., DAY, L. T., MUSSELL, F., ASIRUDDIN, S., BLENCOWE, H. & LAWN, J. E. 2009. Perinatal mortality audit: counting, accountability, and overcoming challenges in scaling up in low-and middle-income countries. *International Journal of Gynecology and Obstetrics,* 107**,** S113-S122.

PATTON, M. Q. 1990. *Qualitative Evaluation and Research Methods,* Newbury Park, SAGE.

PEOPLE'S HEALTH MOVEMENT 2000. People's Charter for Health. Dhaka: People's Health Movement.

PETCHESKY, R. P. 2003. *Global prescriptions: gendering health and human rights,* Zed books.

PHILLIPS, G. S., WISE, L. A., RICH-EDWARDS, J. W., STAMPFER, M. J. & ROSENBERG, L. 2009. Income incongruity, relative household income, and preterm birth in the Black Women's Health Study. *Social Science and Medicine,* 68**,** 2122-2128.

PITCHFORTH, E., WATSON, V., TUCKER, J., RYAN, M., VAN TEIJLINGEN, E., FARMER, J., IRELAND, J., THOMSON, E., KIGER, A. & BRYERS, H. 2008. Models of intrapartum care and women's trade-offs in remote and rural Scotland: a mixed-methods study. *BJOG,* 115**,** 560-9.

POKHAREL, S. 2010. Gender Discriminatory Practices in Tamang and Brahmin Communities. *Tribhuvan University Journal,* 26**,** 85-98.

POPAY, J. & WILLIAMS, G. 1996. Public health research and lay knowledge. *Social Science and Medicine,* 42**,** 759-68.

POPAY, J. & WILLIAMS, G. 2006. Lay knowledge and the privilege of experience. *Challenging medicine* [Online]. Available: http://eprints.lancs.ac.uk/id/eprint/8355 [Accessed 9th September, 2009].

POPAY, J., THOMAS, C., WILLIAMS, G., BENNETT, S., GATRELL, A. & BOSTOCK, L. 2003. A proper place to live: health inequalities, agency and the normative dimensions of space. *Social Science and Medicine,* 57**,** 55-69.

POWELL-JACKSON, T. & HANSON, K. 2011. Financial incentives for maternal health: impact of a national programme in Nepal. *Journal of Health Economics,* Available: http://www.sciencedirect.com/science/article/pii/S0167629611001615 [Accessed 10th January, 2012].

POWELL-JACKSON, T., MORRISON, J., TIWARI, S., NEUPANE, B. & COSTELLO, A. 2009. The experiences of districts in implementing a national incentive programme to promote safe delivery in Nepal. *BMC health services research,* 9**,** 97-105.

QUEK, K. M. T., KNUDSON-MARTIN, C., ORPEN, S. & VICTOR, J. 2011. Gender equality during the transition to parenthood: A longitudinal study of dual-career couples in Singapore. *Journal of Social and Personal Relationships,* 28, 943-962.

RAGHUPATHY, S. 1996. Education and the use of maternal health care in Thailand. *Social Science and Medicine,* 43**,** 459-471.

RAI, N. 2010. Constitutional Development of Gender Equality Issue in Nepal. Available: http://dx.doi.org/10.2139/ssrn.1618765 [Accessed 12th January, 2012].

RASANATHAN, K., MONTESINOS, E. V., MATHESON, D., ETIENNE, C. & EVANS, T. 2011. Primary health care and the social determinants of health: essential and complementary approaches for reducing inequities in health. *Journal of epidemiology and community health,* 65**,** 656-660.

RATNER, C. 1996. Solidifying Qualitative Methodology. *Journal of Social Distress and Homeless,* 5**,** 319-326.

RAYMOND, C. M., FAZEY, I., REED, M. S., STRINGER, L. C., ROBINSON, G. M. & EVELY, A. C. 2010. Integrating local and scientific knowledge for environmental management. *Journal of environmental management,* 91**,** 1766-1777.

RECORDS, K. & WILSON, B. L. 2011. Reflections on Meeting Women's Childbirth Expectations. *Journal of Obstetric, Gynecologic, & Neonatal Nursing,* 40**,** 394-398.

REED - DANAHAY, D. E. 1997. *Auto Ethnography: Rewriting the self and the social,* Berg, Oxford University Press.

REGMI, K. & MADISON, J. 2009. Childbirth practices in Nepal: A review of models for reducing adverse outcomes. *International Journal of Gynecology & Obstetrics,* 107**,** S321-S321.

REGMI, K., NAIDOO, J., PILKINGTON, P. A. & GREER, A. 2010a. Decentralization and district health services in Nepal: understanding the views of service users and service providers. *Journal of Public Health,* 32**,** 406-417.

REGMI, K., SMART, R. & KOTTLER, J. 2010b. Understanding Gender and Power Dynamics Within the Family: A Qualitative Study of Nepali Women's Experience. *Australian and New Zealand Journal of Family Therapy (ANZJFT),* 31**,** 191-201.

REIGER, K. 2001. *Our Bodies Our Babies: The Forgotten Women's Movement,* Melbourne, Melbourne University Publishing

REYNOLDS, J. L. 1997. Post-traumatic stress disorder after childbirth: the phenomenon of traumatic birth. *Canadian Medical Association Journal,* 156**,** 831-835.

RHEE, V., MULLANY, L. C., KHATRY, S. K., KATZ, J., LECLERQ, S. C., DARMSTADT, G. L. & TIELSCH, J. M. 2008. Maternal and birth attendant hand washing and neonatal mortality in southern Nepal. *Archives of Pediatrics and Adolescent Medicine,* 162**,** 603-608.

RICE, P. L. & EZZY, D. 1999. *Qualitative Research Methods: A Health Focus,* Melbourne, Australia, Oxford University Press.

RICE, P. L., LY, B. & LUMLEY, J. 1994. Childbirth and soul loss: the case of a Hmong woman. *The Medical Journal of Australia,* 160**,** 577-578.

RIESSMAN, C. K. 1992. *Women and medicalization: A new perspective,* Polity Press/The Open University, Cambridge.

RIFKIN, S. B. & WALT, G. 1986. Why health improves: Defining the issues concerning comprehensive primary health care and selective primary health care. *Social Science & Medicine,* 23**,** 559-566.

RIJNDERS, M. 2011. *Interventions in midwife led care in the Netherlands to achieve optimal birth outcomes: effects and women's experiences.* PhD, University of Amsterdam.

RIMAL, N., SHARMA, H. B. & VAIDYA, S. 1997. *Nepal District Profile: A Districtwise Socio-techno-economic Profile Along with a Comprehensive National Profile of Nepal,* Kathmandu, National Research Associates.

RODGERS, B. 2000. Coordination of care: the lived experience of the visiting nurse. *Home Healthcare Nurse,* 18**,** 301-307.

RODIN, J. & JANIS, I. L. 1979. The social power of health care practitioners as agents of change. *Journal of Social Issues,* 35**,** 60-81.

ROGERS, W. S. 1991. *Explaining health and illness: An exploration of diversity,* New York, Harvester Wheatsheaf

ROLLS, C. & CHAMBERLAIN, M. 2004. From east to west: Nepalese women's experiences. *International Nursing Review,* 51**,** 176-84.

ROSENTHAL, L. & LOBEL, M. 2011. Explaining racial disparities in adverse birth outcomes: Unique sources of stress for Black American women. *Social Science and Medicine,* 72**,** 977-983.

ROTHMAN, B. K. & TYSON, H. 2010. Risky business. *Hastings Centre Repository,* 40**,** 6.

ROTHMAN, B. K. 1996. Women, providers, and control. *Journal of Obstetri, Gynecology and Neonatal Nursing,* 25**,** 253-6.

ROTHMAN, B. K. 2000. *Recreating motherhood,* Rutgers University Press.

RUMBOLD, A., BAILIE, R., SI, D., DOWDEN, M., KENNEDY, C., COX, R., O'DONOGHUE, L., LIDDLE, H., KWEDZA, R. & THOMPSON, S. 2011. Delivery of maternal health care in Indigenous primary care services: baseline data for an ongoing quality improvement initiative. *BMC Pregnancy and Childbirth,* 11**,** 16-26.

SANDALL, J., MORTON, C. & BICK, D. 2010. Safety in childbirth and the three 'C's: Community, context and culture. *Midwifery,* 26**,** 481-482.

SANDELOWSKI, M. 1998. The Call to Experts in Qualitative Research. *Research in Nursing and Health,* 21**,** 467-471.

SAPKOTA, S., KOBAYASHI, T. & TAKASE, M. 2010. Husbands' experiences of supporting their wives during childbirth in Nepal. *Midwifery,* Available: http://www.sciencedirect.com/science/article/pii/S0266613810001713 [Accessed 9th September, 2011].

SARANTAKOS, S. 1998. *Social Research,* South Yara, MacMillan Education Australia Pty Ltd.

SARGENT, C. & GULBAS, L. 2011. Situating Birth in the Anthropology of Reproduction. *In:* SINGER, M. & ERICKSON, P. I. (eds.) *A Companion to Medical Anthropology.* Oxford: Wiley Blackwell

SAWYER, A., AYERS, S., SMITH, H., SIDIBEH, L., NYAN, O. & DALE, J. 2010. Women's experiences of pregnancy, childbirth, and the postnatal period in The Gambia: A qualitative study. *British journal of health psychology,* 16, 528-541.

SCHIFFMAN, J., DARMSTADT, G. L., AGARWAL, S. & BAQUI, A. H. 2010. Community-Based Intervention Packages for Improving Perinatal Health in Developing Countries: A Review of the Evidence. *Seminars in Perinatology,* 34**,** 462-476.

SCHNEIDER, D. A. 2011. *Beyond the baby: Women's narratives of childbirth, change and power.* PhD, Smith College for Social Work.

SCHUBERT, J., PILLAI, G. & THORNDAHL, R. 1997. Breaking the mold: expanding options for reproductive health awareness: the CARE experience. *Advances in Contraception,* 13**,** 355-361.

SCHUKLENK, U. & ASHCROFT, R. 2000. International research ethics. *Bioethics,* 14**,** 158-72.

SCHUKLENK, U. 2000. Protecting the vulnerable: testing times for clinical research ethics. *Social Science and Medicine,* 51**,** 969-77.

SCHWANDT, T. A. & BURGON, H. 2006. Evaluation and the study of lived experience. *In:* SHAW, I., GREENE, J. C. & MARK, M. (eds.) *The sage handbook of evaluation.* London: Sage Publications Ltd.

SCOTT, J. W. 1986. Gender: A useful category of historical analysis. *The American Historical Review,* 91**,** 1053-1075.

SHARMA, S. K., SAWANGDEE, Y. & SIRIRASSAMEE, B. 2007. Access to health: women's status and utilization of maternal health services in Nepal. *Journal of Biosocial Science,* 39**,** 671-92.

SHOR, I. & FREIRE, P. 1987. *A pedagogy for liberation: Dialogues on transforming education*, Bergin & Garvey.

SHRESTHA, B., BHANDARI, B., MANANDHAR, D., OSRIN, D., COSTELLO, A. & SAVILLE, N. 2011. Community interventions to reduce child mortality in Dhanusha, Nepal: study protocol for a cluster randomized controlled trial. *Trials,* 12**,** 136-146.

SHRESTHA, S. & SHRESTHA, M. 2010. Women's Role in Nepal in General'and Population Control in Particular--An Assessment. *Tribhuvan University Journal,* 14, 27-41.

SHRESTHA, S. 1994. *Gender Sensitive Planning: What, Why, How in Nepal*, Women Awareness Centre Nepal.

SHROFF, M. R., GRIFFITHS, P. L., SUCHINDRAN, C., NAGALLA, B., VAZIR, S. & BENTLEY, M. 2011. Does maternal autonomy influence feeding practices and infant growth in rural India? *Social Science and Medicine,* 73, 447-455.

SILVERMAN, D. 2005. *Doing Qualitative Research,* London, Sage Publications.

SIMKHADA, B., PORTER, M. & VAN TEIJLINGEN, E. 2010. The role of mothers-in-law in antenatal care decision-making in Nepal: a qualitative study. *BMC Pregnancy and Childbirth,* 10**,** 34-44.

SINGH, A. & RAM, F. 2009. Men's Involvement during Pregnancy and Childbirth: Evidence from Rural Ahmadnagar, India. *Population Review,* 48, 58-65.

SMART, R. & REGMI, K. 2008. Gender and Power in Nepali Families: Women's Experience in the Context of Childbirth Practices. *Australian and New Zeland Journal of Family Therapy*, 31, 191-201.

SMITH, P. B., HUANG, H. J., HARB, C. & TORRES, C. 2011. How Distinctive Are Indigenous Ways of Achieving Influence? A Comparative Study of Guanxi, Wasta, Jeitinho, and" Pulling Strings". *Journal of Cross-Cultural Psychology*, Available: http://jcc.sagepub.com/content/early/2011/01/10/0022022110381430.abstract [Accessed 10th January, 2012].

SMITH, S. L. & NEUPANE, S. 2010. Factors in health initiative success: Learning from Nepal's newborn survival initiative. *Social Science and Medicine,* 72**,** 568-575.

SMITH, T. L. 1999. *Decolonizing Methodologies, Research and Indegenious People,* London & New York, Zed Books Limited.

SMYTHE, E. 2010. Safety is an interpretive act: A hermeneutic analysis of care in childbirth. *International Journal of Nursing Studies,* 47**,** 1474-1482.

SNOWDEN, A., MARTIN, C., JOMEEN, J. & MARTIN, C. H. 2011. Concurrent analysis of choice and control in childbirth. *BMC Pregnancy and Childbirth,* 11**,** 40-47.

SOLAR, O. & IRWIN, A. 2010. *A Conceptual Framework for Action on the Social Determinants of Health. Social Determinants of Health Discussion Paper 2 (Policy and Practice)*. Geneva: World Health Organisation.

SOUZA, J. P., CECATTI, J. G., PARPINELLI, M. A., KRUPA, F. & OSIS, M. J. 2009. An emerging "maternal near-miss syndrome": narratives of women who almost died during pregnancy and childbirth. *Birth,* 36**,** 149-58.

SPENCER, J. 2001. Ethnography after postmodernism. *In:* ATKINSON, P., COFFEY, A., DELAMONT, J. L. & LOFTLAND, L. (eds.) *Handbook of Ethnography.* London: SAGE.

SQUIRE, C. & BEVERLEY, K. H. 2009. Women, poverty and childbirth. *In:* SQUIRE, C. (ed.) *The Social Context of Birth.* United Kingdom: Radcliffe Publishing Ltd.

SREERAMAREDDY, C., JOSHI, H., SREEKUMARAN, B., GIRI, S. & CHUNI, N. 2006. Home delivery and newborn care practices among urban women in western Nepal: a questionnaire survey. *BMC Pregnancy and Childbirth,* 6**,** 27-35.

STACEY, M. 1994. The power of lay knowledge. *In:* POPAY, J. & WILLIAMS, G. (eds.) *Researching the People's Health.* London: Routledge

STAMBACH, A. 2010. Education, religion, and anthropology in Africa. *Annual Review of Anthropology,* 39, 361-379.

STANLEY, D. 1982. Status of Women in Nepal. *FEM,* VII.

STEINBERG, S. 1996. Childbearing research: a transcultural review. *Social Science and Medicine,* 43**,** 1765-1784.

STERN, S. J. 1997. *The secret history of gender: Women, men, and power in late colonial Mexico,* The University of North Carolina Press.

STEVENS, T. 2011. Power and professionalism in midwifery practice: impediment or precursor to normal birth? *In:* DONNA, S. (ed.) *Promoting Normal Birth-*

Research, Reflections and Guidelines. United Kingdom: Fresh Heart Publishing

STEWART, A. J. 1994. Toward a feminist strategy for studying women's lives. *Women creating lives: Identities, resilience, and resistance.* San Francisco: West view Press.

STOLL, B. J. 1997. The global impact of neonatal infection. *Clinics in perinatology,* 24**,** 1-21.

STONE, L. 1986. Primary health care for whom? Village perspectives from Nepal. *Social Science & Medicine,* 22**,** 293-302.

STOPPARD, J. M. 2000. *Understanding depression: Feminist social constructionism approaches,* Psychology Press.

SUBEDI, M. 2011. Caste System: Theories and Practices in Nepal. *Himalayan Journal of Sociology and Anthropology,* 4**,** 134-159.

SUBEDI, R. R., PETERSON, C. B. & KYRIAZAKOS, S. Year. Telemedicine for Rural and Underserved Communities of Nepal. *In*, 2011. Springer, 117-120.

SUPPORT TO SAFE MOTHERHOOD PROGRAMME 2006 Bi-annual Report : Jan - June Kathmandu: SSMP Nepal

SUPPORT TO SAFE MOTHERHOOD PROGRAMME 2006. Bi-annual Report: July - December Kathmandu: SSMP Nepal.

TARKKA, M. T. & PAUNONEN, M. 1996. Social support and its impact on mothers' experiences of childbirth. *Journal of Advanced Nursing,* 23**,** 70-75.

TAYLOR, S. & BOGDAN, R. 1984. *Introduction to Qualitative Research Methods: The Search for Meanings* New York, Wiley.

TEMAN, E. 2011. Childbirth, midwifery and concepts of time–Edited by Christine McCourt; foreword: Ronnie Frankenberg. *Journal of the Royal Anthropological Institute,* 17**,** 196-197.

THADDEUS, S., NANGALIA, R. & VIVIO, D. 2004. Perceptions matter: barriers to treatment of postpartum hemorrhage. *The Journal of Midwifery and Women's Health,* 49**,** 293-297.

THAPA, N., CHONGSUVIVATWONG, V., GEATER, A. F. & ULSTEIN, M. 2001. High-risk childbirth practices in remote Nepal and their determinants. *Women and Health,* 31**,** 83-97.

THAPA, N., CHONGSUVIVATWONG, V., GEATER, A. F., ULSTEIN, M. & BECHTEL, G. A. 2000. Infant death rates and animal-shed delivery in remote rural areas of Nepal. *Social Science and Medicine,* 51**,** 1447-1456.

THAPA, S. 1996. Challenges to improving maternal health in rural Nepal. *The Lancet,* 347**,** 1244-1246.

THATTE, N., MULLANY, L., KHATRY, S., KATZ, J., TIELSCH, J. & DARMSTADT, G. 2009. Traditional birth attendants in rural Nepal: Knowledge, attitudes and practices about maternal and newborn health. *Global public health,* 4**,** 600-617.

THOMPSON, C. 1983. *Women, fertility and the worship of gods in a Hindu village: Women's Religious Experience*. Taylor and Francis.

TITALEY, C., HUNTER, C., DIBLEY, M. & HEYWOOD, P. 2010a. Why do some women still prefer traditional birth attendants and home delivery?: a qualitative study on delivery care services in West Java Province, Indonesia. *BMC Pregnancy and Childbirth,* 10**,** 43-57.

TITALEY, C., HUNTER, C., HEYWOOD, P. & DIBLEY, M. 2010b. Why don't some women attend antenatal and postnatal care services?: a qualitative study of community members' perspectives in Garut, Sukabumi and Ciamis districts of West Java Province, Indonesia. *BMC Pregnancy and Childbirth,* 10**,** 61-73.

TORRES, J. M. & DE VRIES, R. G. 2009. Birthing ethics: What mothers, families, childbirth educators, nurses, and physicians should know about the ethics of childbirth. *The Journal of Perinatal Education,* 18**,** 12-24.

TORSVIK, M. & HEDLUND, M. 2008. Cultural encounters in reflective dialogue about nursing care: a qualitative study. *Journal of Advance Nursing,* 63**,** 389-96.

TREAS, J. & DROBNI , S. 2010. *Dividing the domestic: men, women, and household work in cross-national perspective*, Stanford University Press.

TRIANDIS, H. C., BONTEMPO, R., VILLAREAL, M. J., ASAI, M. & LUCCA, N. 1988. Individualism and collectivism: Cross-cultural perspectives on self-ingroup relationships. *Journal of personality and Social Psychology,* 54**,** 323-338.

TRITTEN, J. 1992. Giving voice to wisdom. *Midwifery Today Childbirth Education***,** 3, 33-37.

TULADHAR, H. 2010. Determinants of home delivery in a semi urban setting of Nepal. *Nepal Journal of Obstetrics and Gynaecology,* 4**,** 30-37.

UNGER, R. K. & CRAWFORD, M. 1992. *Women and gender: A feminist psychology*, McGraw-Hill New York.

UNITED MISSION TO NEPAL 2010. The Annual Report Kathmandu: United Mission to Nepal.

UNITED NATIONS 2000. Millennium Development Goals. New York, United Nations.

UPRETY, M. & ADHIKARY, S. 2010. Perceptions and Practices of Society Towards Single Women in the Context of Nepal. *Occasional Papers in Sociology and Anthropology,* 11**,** 244-254.

URQUIA, M. L., FRANK, J. W. & GLAZIER, R. H. 2010. From places to flows. International secondary migration and birth outcomes. *Social Science and Medicine,* 71, 1620-1626.

VAN DIJK, J. A. W., ANDERKO, L. & STETZER, F. 2010. The impact of Prenatal Care Coordination on birth outcomes in Wisconsin. *Journal of Obstetrics, Gynecology and Neonatal Nursing. doi: DOI,* 10.

VAN OLMEN, J., CRIEL, B., DEVADASAN, N., PARIYO, G., DE VOS, P., VAN DAMME, W., VAN DORMAEL, M., MARCHAL, B. & KEGELS, G. 2010. Primary Health Care in the 21st century: primary care providers and people's empowerment. *Tropical Medicine and International Health,* 15**,** 386-390.

VAN TEIJLINGEN, E., SIMKHADA, P. & STEPHENS, J. 2010. We are all to blame! *Republica,* 22.

VANN MAANEN, J. 1988. *Tales of the field: On writing ethnography,* Chicago, University of Chicago Press.

VEALE, D., FURMAN, K. & OLIVER, D. 1992. South African traditional herbal medicines used during pregnancy and childbirth. *Journal of ethnopharmacology,* 36**,** 185-191.

WAGLE, R. R., SABROE, S. & NIELSEN, B. B. 2004. Socioeconomic and physical distance to the maternity hospital as predictors for place of delivery: an observation study from Nepal. *BMC Pregnancy and Childbirth,* 4**,** 8-18.

WALBY, S. 1997. *Gender transformations,* Psychology Press.

WALKER, D.-M. 2009. Book Review: Fielding, N., Lee, R. M., & Blank, G. (Eds.). (2008). The SAGE Handbook of Online Research Methods. London: Sage. *Qualitative Health Research,* 19**,** 1025-1026.

WALLERSTEIN, N. 2002. Empowerment to reduce health disparities. *Scandinavian journal of public health,* 30**,** 72-77.

WALSH, D. & DOWNE, S. 2005. Meta-synthesis method for qualitative research: a literature review. *Journal of Advance Nursing,* 50**,** 204-11.

WALSH, D. J. 2010. Childbirth embodiment: problematic aspects of current understandings. *Sociology of Health and Illness,* 32**,** 486-501.

WATKINS, J. 1996. *Spirited women: gender, religion, and cultural identity in the Nepal Himalaya,* Columbia University Press.

WEIHOLTZ, D. & KACER, C. 1995. Salvaging Quantitative Research with Qualitative Data. *Qualitative Health Research,* 5**,** 388-397.

WEINGARTEN, K. 1991. The discourses of intimacy: Adding a social constructionismand feminist view. *Family process,* 30**,** 285-305.

WIKLER, D. 2002. Personal and social responsibility for health. *Ethics and International Affairs,* 16**,** 47-55.

WILKINSON, R. G. & MARMOT, M. 2003. Social determinants of health: the solid facts. Zeneva World Health Organization.

WILKINSON, R. G. 2000. The need for an interdisciplinary perspective on the social determinants of health. *Health Economics,* 9**,** 581-583.

WILLIAMS, L. & LABONTE, R. 2003. Changing health determinants through community action: power, participation and policy. *Promotion and Education,* 10**,** 65-71.

WINCH, J. & HAYWARD, K. 1999. Doing it our way: Can Cultural Traditions Survives in Universities? *New Doctor,* Summer**,** 22-29.

WITTER, S., KHADKA, S., NATH, H. & TIWARI, S. 2011. The national free delivery policy in Nepal: early evidence of its effects on health facilities. *Health Policy and Planning,* 26**,** ii84-ii91.

WODAK, R. 1989. *Language, power and ideology: Studies in political discourse,* John Benjamins Publishing Company.

WORLD HEALTH ORGANIZATION 1978. Declaration of Alma Ata: International Conference on Primary Health Care. Geneva: World Health Organisation.

WORLD HEALTH ORGANIZATION 1986. Ottawa Charter for Health Promotion. Geneva: World Health Organisation.

WORLD HEALTH ORGANIZATION 1994. Mother-Baby Package: Implementing safe motherhood in countries. Geneva WHO/FHE/MSM/94.11, Geneva, Switzerland.

WORLD HEALTH ORGANIZATION 2004. Making pregnancy safer: the critical role of the skilled attendant:. Geneva: World Health Prganization.

WORLD HEALTH ORGANIZATION 2005. The Bangkok Charter for Health Promotion in a Globalised World. Geneva World Health Organization

WORLD HEALTH ORGANIZATION 2008. Primary Health Care Now More Than Ever Geneva World Health Organization

WORLD HEALTH ORGANIZATION AND UNICEF 2010. Countdown to 2015 Decade Reort (2000-2010): taking stock of maternal, newborn and child survival. Geneva: WHO and UNICEF.

YANG, Q. & WALKER, M. C. 2010. Neighbourhood Family Income and Adverse Birth Outcomes Among Singleton Deliveries. *Journal of Obstetric and Gynaecology Canada,* 32**,** 1042-1048.

YOUNG, I. M. & DANIELLE, S. 2011. *Justice and the Politics of Difference,* Princeton University Press.

YOUNG, I. M. 1990. *Justice and the Politics of Difference,* Princeton University Press.

YOUNG, I. M. 1992. Five Faces of Oppression. *In* Waterberg, T. (ed.) *Rethinking Power.* Albany: SUNNY Press.

ZADOROZNYJ, M. 1999. Social class, social selves and social control in childbirth. *Sociology of Health and Illness,* 21**,** 267-289.

ZERE, E., TUMUSIIME, P., WALKER, O., KIRIGIA, J., MWIKISA, C. & MBEELI, T. 2010. Inequities in utilization of maternal health interventions in Namibia: implications for progress towards MDG 5 targets. *International Journal for Equity in Health,* 9**,** 16-27.

ZIMMERMAN, M. A. & RAPPAPORT, J. 1988. Citizen participation, perceived control, and psychological empowerment. *American Journal of Community Psychology,* 16**,** 725-750.

ZUO, J. & TANG, S. 2000. Breadwinner status and gender ideologies of men and women regarding family roles. *Sociological Perspectives,* 29-43.

Appendices

Appendix 1: Letter of Introduction (English and Nepali)

To Whom It May Concern

This letter is to introduce Sabitra Kaphle who is a PhD student in the Discipline of Public Health, School of Medicine, Flinders University, Adelaide, South Australia.

She is undertaking research concerning the factors influencing health of mothers and babies during pregnancy and childbirth among remote mountain women in Nepal.

She would be most grateful if you would volunteer to assist in this project by sharing your knowledge, ideas, thoughts and experiences in relation to pregnancy and child birth of yourself, in your family and community which provide great insight for this study. It will take about 60 to 90 minutes to complete interview on one occasion.

Be assured that any information provided during the interview will be treated in the strictest confidence. You are, of course, entirely free not to participate in this study, and if you decide to participate, you are entirely free to discontinue your participation at any time or to decline to answer particular questions.

The interview will be conducted by Sabitra herself. She is an experienced person who is sympathetic to the issues which this project covers and has previously conducted other work in this topic in remote areas of Nepal.

Since she intends to make observation, take photographs and make a tape recording of conversation, she will seek your consent to note observation, take photographs and record the interview and to use these photographs and recording or a transcription in preparing the thesis report or other publications**.**

Any enquiries you may have concerning this project should be directed to me Frank Tesoriero, at the address given above or by telephone on 00 61 8 72218417, fax 00 61 8 8204 5693 or e-mail frank.tesoriero@flinders.edu.au.

Thank you for your attention.

Yours faithfully,

Associate Professor Frank Tesoriero

जो जससंग सम्बन्धित छ

यो पत्र एस विश्वविद्यालयमा जनस्वास्थ्य विषयमा विद्यावारिधि अध्यनरत सावित्रा काफ्लेको परिचयको लागि तयार पारिएको हो। सावित्रा काफ्ले नेपालको दुर्गम हिमाली भेगमा बसोबास गरिरहेका महिलाहरूबीचमा गर्भवती तथा सुत्केरीआमाहरूको स्वास्थसम्बन्धी अनुसन्धान गरिरहनुभएको छ ।

तपाईंले दिनुभएको समय र सहयोगले उहाँलाई यो अनुसन्धान सम्पन्न गर्नको लागि निकै ठूलो भूमिका खेल्नेछ । आशा छ, तपाइले आफ्नो, आफ्नो परिवार र समुदायको आमा तथा नवजात शिशुको स्वास्थसम्बन्धी ज्ञान, विचार, अनुभव तथा घटनाहरू बाँडेर यो अध्यनमा थप उर्जा प्रदान गर्नुहुनेछ। यो अन्तर्वार्ताको लागि एक घन्टादेखि दुई घन्टाको समय लाग्नेछ ।

तपाईंले अन्तर्वार्ताको लागि दिनुभएका सबै सूचनाहरूलाई अत्यन्त गोप्यरूपमा प्रयोग गरिने कुरा निश्चिन्त पार्न चाहन्छु । र यो पानि अवगत गराउन चाहनछु, तपाईं यो अध्ययनमा सहभागी हुने अथवा नहुने निर्णय गर्न सक्नुहुन्छ र हुने निर्णय गर्नुभयो भने पनि अध्ययनको क्रममा जति बेला पनि छाड्न सक्नुहुन्छ वा कुनै प्रश्नको जवाफ नदिन सक्नुहुन्छ ।

यो अन्तर्वार्ता अनुसन्धानकर्ता आफैंले लिनुहुनेछ । जो यस क्षेत्रमा लामो समयको अनुभव र विज्ञता हासिल गर्नुभएको छ । सावित्रा समझदार र परिपक्व महिला अनुसन्धानकर्ता हुनुहुन्छ, उहाँले केही समय दुर्गम पहाडी तथा हिमाली क्षेत्रमा महिलाहरुको बीचमा काम गर्नुभएको थियो।

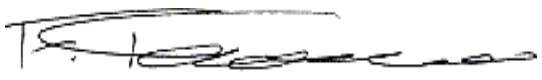
यो अध्ययनमा तपाईंसँग भएको कुराकानीलाई तपाईंको अनुमतिमा रेकर्ड गरिनेछ र त्यो रेकर्ड रुपान्तर गरी अध्ययनको प्रतिवेदन तथा प्रकाशनको लागि प्रयोग गरिनेछ ।

यस अध्ययनसँग सम्बन्धित केही प्रश्न तथा जिज्ञासा भएमा तपाईंले सीधै मलाई सम्पर्क गर्न सक्नुहुन्छ । मेरो सम्पर्क ठेगाना यस प्रकार छ :- फ्रान्क टेसोरिएरो, सम्पर्क टेलिफोन: ०० ६१ ८ ७२२१८४१७,फ्याक्स ००६१ ८ ८२०४ ५६९३, इ सम्पर्क: Frank.tesoriero@flinders.edu.au

तपाईंको सहयोगको लागि धन्यवाद !

भवदीय,

फ्रान्क टेसोरिएरो



Appendix 2: Research Information Sheet (English and Nepali)

2.1 Research Study Information (Pregnant, Birthing and Postnatal Women)

A PhD candidate from the Department of Public Health at Flinders University is undertaking research into the social determinants of perinatal health among women in remote mountain areas of Nepal.

Purpose of the research

The purpose of this research is to explore the pregnancy and childbirth experiences of women in order to identity the factors that influence the health of mother and babies in relation to childbirth in remote mountain areas.

What will you be asked to do?

You will be asked to share your knowledge, experiences and life stories related to pregnancy and childbirth of yourself through natural conversation.

What types of things will we be talking about?

I wish to discuss

- Your ideas and knowledge of pregnancy and childbirth
- Your personal experiences of pregnancy and childbirth
- Events, beliefand practices which are related to pregnancy and childbirth
- Responses to pregnancy and childbirth made by family and other people
- How decisions are made within your family and society
- Your views of making this pregnancy and childbirth safe and successful
- The things that you feel are important to have your safe childbirth
- Your expectations about how pregnancy and childbirth should be

Benefits of the research

This study will give a greater understanding of the many factors that affect the health of mother and babies in relation to childbirth in communities like yours. It will ultimately contribute to help to provide culturally, socially and women friendly to

improve health of mother and babies in relation to childbirth and ensure survival of mother and newborn babies.

Risks

This research will require a maximum of two hours of your time. Given that we are discussing issues regarding the life experiences of pregnancy and childbirth, there is potential that this process may cause you anxiety or distress. If you find that this is becoming an issue during your participation, you are free to decline to answer particular questions and to withdraw from the project at any time.

How will confidentiality be maintained?

Participation in the interviews is voluntary and you are free to not answer a question, to end the interview at any time, or to withdraw your data at any stage of the field work. We will treat any information provided by you as an individual in the strictest confidence and you will not be individually identifiable.

To ensure your confidentiality we will maintain a central database of participants that is only available to me and my PhD supervisors. You may choose a name (pseudonym) for yourself which will be used in any published work related to this study. The information available to my supervisors will use the pseudonyms rather the names of informants. The recording and transcript of your interview will be labelled with this pseudonym to protect your identity.

How can I find out more information?

If you have any concern and queries regarding your involvement in this project, you are encouraged to contact **Sabitra Kaphle** by telephone: +9779741102755 (while in Nepal); +61 403241160 (while in Australia) or by email kaph0001@flinders.edu.au.

Any enquiries you may have concerning this project should be directed to Frank Tesoriero by telephone 00 61 8 72218417, fax 00 61 8 8204 5693 or e-mail frank.tesoriero@flinders.edu.au.

२.१ सहभागीहरुको लागि अनुसन्धान सम्बन्धि महत्वपुर्ण सुचनाहरु (गर्भवती, प्रसब तथा सुत्केरी महिलाको लागि)

यो अध्ययन फ्लिन्डर्स विश्वविद्यलयको जना स्वास्थ्य विभागअन्तर्गत नेपालको दुर्गम हिमाली भेगका महिलाहरुको बीचमा आमा तथा शिशु स्वास्थ्यको सामाजिक कारक तत्वहरू विषयमा विद्यावारिधि विद्यार्थीबाट गरिएको हो।

अनुसन्धानको उद्देश्य

यो अनुसन्धानको उद्देश्य दुर्गम पहाडी भेगमा रहेका महिलाहरुको गर्भवती र प्रसवसम्बन्धी अनुभवहरुको लेखाजोखा गरी आमा तथा बच्चाको स्वास्थ्यमा प्रभाव पर्ने तत्वहरू विष्लेषण गर्नु रहेको छ।

सहभागीहरुसँगको अपेक्षा

सहभागीहरुसँग सहज र स्वाभाविक कुराकानीको माध्यमबाट गर्भवती तथा प्रसवसम्बन्धी ज्ञान, अनुभव तथा जीवनमा घटेका घटना र कथाहरु आदानप्रदान गर्नको लागि भनिनेछ ।

अन्तरबार्तामा छलफलको बिषयहरु

निम्न बिषयहरुमा छलफल हुने अपेक्षा गरिएको छ।

- गर्भवती तथा प्रसव सम्बन्धि ज्ञान र सोचाई
- गर्भवती तथा प्रसव सम्बन्धि व्यक्तिगत अनुभबहरु
- सम्बन्धित घटनाहरु, बिस्वाशहरु र प्रयासहरु
- गर्भवती तथा प्रसव सम्बन्धि व्यक्तिगत तथा परिवारको प्रतिक्रियाहरु
- परिवार तथा समाजमा निर्णय गर्ने प्रक्रिया

- सुरक्षित र सफल गर्भवती तथा प्रसवको लागि तपाइको विचार
- तपाइको सुरक्षित प्रसवको लागि तपाइको बिचारमा महत्वपूर्ण लागेको कुराहरु
- तपाइको अपेक्षाहरु

अनुसन्धानका फाइदाहरू

यो अध्ययनले श्रोतको कमी भएको क्षेत्रमा आमा तथा नवजात शिशुको स्वास्थ्यमा प्रभाव पार्ने गहन सामाजिक तत्वहरुको बृहत बुझाई प्रदान गर्नेछ। यसले स्थानीय, राष्ट्रिय तथा अन्तराष्ट्रिय समुदायलाई सचेत बनाई आमा तथा शिशु को जिबन रक्षाको किटान गर्न आमा र बच्चाको स्वस्थ्य प्रबर्दन गर्ने सामाजिक र सास्कृतिक रुपमा स्वीकार्य कार्यक्रम बनाउनको लागि पनि योगदान दिनेछ।

सम्भावित खतराहरू

यस अध्ययनमा तपाईंको करिब दुई घन्टाको समय आवश्यक पर्नेछ। यस अध्ययनको लागि तपाइको व्यक्तिगत जीवनसँग सम्बन्धित सवालहरूमा छलफल गर्नु आवश्यक भएकोले अनुभव आदानप्रदान गर्ने प्रक्रियामा यसले तनाव तथा चिन्ता सिर्जना गर्न सक्ने सम्भावना रहन्छ। यदि तपाईंलाई सहभागी हुने क्रममा त्यस्तो अनुभूति भयो भने तपाईं आफ्नो सहभागितालाई जुनसुकै समयमा छाड्न सक्नुहुन्छ र कुनै पनि प्रश्नको जवाफ नदिन सक्नुहुन्छ।

अध्ययनमा विश्चसनीयता कायम

यस अध्ययनमा तपाईंको सहभागिता स्वेच्छामा भर पर्नेछ र तपाई कुनै पनि प्रश्नको जवाफ नदिन स्वतन्त्र हुनुहुन्छ अथवा अध्ययनको समयमा कुनै पनि बेला तपाईंले दिनुभएको सूचनालाई समावेश नगर्न सक्नुहुन्छ। तपाईंले दिनुभएको सूचनालाई हामीले अत्यन्त विश्वसनीय र गोप्य रूपले प्रयोग गर्नेछौं जसबाट तपाईंको व्यक्तिगत परिचय कुनै अवस्थामा पनि खुला हुनेछैन।

गोप्यतालाई किटान गर्नको लागि तपाईंसँग सम्बन्धित सूचनाहरूलाई केन्द्रीय सूचनाप्रणालीमा व्यवस्थित गरेर राखिनेछ । जसमा म र मेरा सुपरिवेक्षकहरूको मात्र पहुँच रहनेछ तपाईंले अध्ययनको प्रयोगको लागि नक्कली नाम प्रस्ताव गर्न सक्नुहुन्छ। उपलब्ध गरिने सूचनाहरूमा तपाईंको नक्कली नाम प्रयोग हुनेछ जसबाट तपाईंको परिचयको खुलासा हुनेछैन, तपाईंसँग सम्बन्धित अभिलेख र प्रतिवेदनमा तपाईंको नक्कली नाम मात्र प्रयोग गरिनेछ।

यदि तपाईंलाई यस अनुसन्धानमा सहभागी हुने सम्बन्धमा कुनै जिज्ञाशा भएमा अनुसन्धानकर्ता सावित्रा काफ्लेलाई सम्पर्क गर्न उत्प्रेरित गरिन्छ। सम्पर्कको लागि ००९७७ ९७४१ १०२७५५ नेपालमा रहँदा र ००६१ ४०३२ ४११६० अस्ट्रेलियामा रहँदा टेलिफोन अथवा kaph0001@flinders.edu.au मा इमेलबाट पनि सम्पर्क गर्न सक्नुहुन्छ।

यस अध्ययनसँग सम्बन्धित थप केही प्रश्न तथा जिज्ञासा भएमा तपाईंले सीधै फ्रान्क टेसोरिएरोलाई सम्पर्क गर्न सक्नुहुन्छ। सम्पर्क ठेगाना यस प्रकार छ; फ्रान्क टेसोरिएरो, सम्पर्क टेलिफोन: ०० ६१ ८ ७२२१८४१७, फ्याक्स ००६१ ८ ८२०४ ५६९३, इ सम्पर्क: Frank.tesoriero@flinders.edu.au

2.2 Research Study Information (Famiily Members)

A PhD candidate from the Department of Public Health at Flinders University is undertaking research into the social determinants of pregnancy and childbirth experiences among women in remote mountain areas of Nepal.

Purpose of the research

The purpose of this research is to explore the pregnancy and childbirth experiences of women in order to identity the factors that influence the health of mother and babies in relation to childbirthin remote mountain areas.

What will you be asked to do?

You will be asked to share your knowledge, experiences and life stories related to pregnancy and childbirth of yourself and your family members through natural conversation.

What types of things will we be talking about?

I wish to discuss

- Your ideas and knowledge of pregnancy and childbirth
- Your personal experiences of pregnancy and childbirth
- Your experiences of pregnancy and childbirth of your family members (Wife, Daughter, Daughter in Law, Grand Daughter, Grand Daughter in Law)
- Events, beliefand parctices which are related to pregnancy and childbirth
- Responses to pregnancy and childbirth made by family and other people
- Decision making practice within household and society
- Your views of making pregnancy and childbirthsafe and successful
- The things that you feel are important to have safe pregnancy and childbirth
- Your expectations about how pregnancy and childbirth should be

Benefits of the research

This study will give a greater understanding of the many factors that affect the health of mother and babies in relation to childbirth in communities like yours. It will

ultimately contribute helping to provide culturally, socially and women friendly to improve health of mother and babies in relation to childbirth and ensure survival of mother and newborn babies.

Risks

This research will require a maximum of two hours of your time. Given that we are discussing issues regarding the life experiences of pregnancy and child birth, there is potential that this process may cause you anxiety or distress. If you find that this is becoming an issue during your participation, you are free to decline to answer particular questions and to withdraw from the project at any time.

How will confidentiality be maintained?

Participation in the interviews is voluntary and you are free to not answer a question, to end the interview at any time, or to withdraw your data at any stage of the field work. We will treat any information provided by you as an individual in the strictest confidence and you will not be individually identifiable.

To ensure your confidentiality we will maintain a central database of participants that is only available to me and my PhD supervisors. You may choose a name (pseudonym) for yourself which will be used in any published work related to this study. The information available to my supervisors will use the pseudonyms rather the names of informants. The recording and transcript of your interview will be labeled with this pseudonym to protect your identity.

How can I find out more information?

If you have any concern and queries regarding your involvement in this project, you are encouraged to contact **Sabitra Kaphle** by telephone: +9779741102755 (while in Nepal); +61 403241160 (while in Australia) or by email kaph0001@flinders.edu.au.

Any enquiries you may have concerning this project should be directed to Frank Tesoriero by telephone 00 61 8 72218417, fax 00 61 8 8204 5693 or e-mail frank.tesoriero@flinders.edu.au.

२.२ सहभागीहरुको लागि अनुसन्धान सम्बन्धि महत्वपुर्ण सुचनाहरु (परिवारको सदस्यहरुको लागि)

यो अध्ययन फ्लिन्डर्स विश्वविद्यलयको जना स्वास्थ्य विभागअन्तर्गत नेपालको दुर्गम हिमाली भेगका महिलाहरुको बीचमा आमा तथा शिशु स्वास्थ्यको सामाजिक कारक तत्वहरू विषयमा विद्यावारिधि विद्यार्थीबाट गरिएको हो।

अनुसन्धानको उद्देश्य

यो अनुसन्धानको उद्देश्य दुर्गम पहाडी भेगमा रहेका महिलाहरुको गर्भवती र प्रसवसम्बन्धी अनुभवहरुको लेखाजोखा गरी आमा तथा बच्चाको स्वास्थ्यमा प्रभाव पर्ने तत्वहरू विष्लेषण गर्नु रहेको छ।

सहभागीहरुसँगको अपेक्षा

सहभागीहरुसँग सहज र स्वाभाविक कुराकानीको माध्यमबाट गर्भवती तथा प्रसवसम्बन्धी ज्ञान, अनुभव तथा जीवनमा घटेका घटना र कथाहरु आदानप्रदान गर्नको लागि भनिनेछ।

अन्तरबार्तामा छलफलको बिषयहरु

निम्न बिषयहरुमा छलफल हुने अपेक्षा गरिएको छ।

- गर्भवती तथा प्रसव सम्बन्धि ज्ञान र सोचाई
- गर्भवती तथा प्रसव सम्बन्धि व्यक्तिगत अनुभबहरु
- परिवारको सदस्यहरुको गर्भवती तथा बच्चा जन्म सम्बन्धि अनुभबहरु
- सम्बन्धित घटनाहरु, बिस्वाशहरु र प्रयासहरु
- गर्भवती तथा प्रसव सम्बन्धि व्यक्तिगत, पारिवारिक तथा सामाजिक प्रतिक्रियाहरु

- परिवार तथा समाजमा निर्णय गर्ने प्रक्रिया
- सुरक्षित र सफल गर्भवती तथा प्रसवको बारेमा तपाइको बिचारमा
- सुरक्षित र सफल गर्भवती तथा प्रसवको लागि तपाइको बिचारमा महत्वपूर्ण लागेको कुराहरु
- तपाइको अपेक्षाहरु

अनुसन्धानका फाइदाहरू

यो अध्ययनले श्रोतको कमी भएको क्षेत्रमा आमा तथा नवजात शिशुको स्वास्थ्यमा प्रभाव पार्ने गहन सामाजिक तत्वहरुको बृहत बुझाई प्रदान गर्नेछ। यसले स्थानीय, राष्ट्रिय तथा अन्तरास्ट्रिय समुदायलाई सचेत बनाई आमा तथा शिशु को जिबन रक्षाको किटान गर्न आमा र बच्चाको स्वस्थ्य प्रबर्दन गर्ने सामाजिक र सास्कृतिक रुपमा स्वीकार्य कार्यक्रम बनाउनको लागि पनि योगदान दिनेछ।

सम्भावित खतराहरू

यस अध्ययनमा तपाईंको करिब दुई घन्टाको समय आवश्यक पर्नेछ। यस अध्ययनको लागि तपाइको व्यक्तिगत जीवनसँग सम्बन्धित सवालहरूमा छलफल गर्नु आवश्यक भएकोले अनुभव आदानप्रदान गर्ने प्रक्रियामा यसले तनाव तथा चिन्ता सिर्जना गर्न सक्ने सम्भावना रहन्छ। यदि तपाईंलाई सहभागी हुने क्रममा त्यस्तो अनुभूति भयो भने तपाईं आफ्नो सहभागितालाई जुनसुकै समयमा छाड्न सक्नुहुन्छ र कुनै पनि प्रश्नको जवाफ नदिन सक्नुहुन्छ।

अध्ययनमा विश्चसनीयता कायम

यस अध्ययनमा तपाईंको सहभागिता स्वेच्छामा भर पर्नेछ र तपाई कुनै पनि प्रश्नको जवाफ नदिन स्वतन्त्र हुनुहुन्छ अथवा अध्ययनको समयमा कुनै पनि बेला तपाईंले दिनुभएको सूचनालाई समावेश नगर्न सक्नुहुन्छ। तपाईंले दिनुभएको सूचनालाई हामीले अत्यन्त विश्वसनीय र गोप्यरूपले प्रयोग गर्नेछौं जसबाट तपाईंको व्यक्तिगत परिचय कुनै अवस्थामा पनि खुला हुनेछैन।

गोप्यतालाई किटान गर्नको लागि तपाईंसँग सम्बन्धित सूचनाहरूलाई केन्द्रीय सूचनाप्रणालीमा व्यवस्थित गरेर राखिनेछ। जसमा म र मेरा सुपरिवेक्षकहरूको मात्र पहुँच रहनेछ तपाईंले अध्ययनको प्रयोगको लागि नक्कली नाम प्रस्ताव गर्न सक्नुहुन्छ । उपलब्ध गरिने सूचनाहरूमा तपाईंको नक्कली नाम प्रयोग हुनेछ जसबाट तपाईंको परिचयको खुलासा हुनेछैन, तपाईंसँग सम्बन्धित अभिलेख र प्रतिवेदनमा तपाईंको नक्कली नाम मात्र प्रयोग गरिनेछ।

यदि तपाईंलाई यस अनुसन्धानमा सहभागी हुने सम्बन्धमा कुनै जिज्ञाशा भएमा अनुसन्धानकर्ता सावित्रा काफ्लेलाई सम्पर्क गर्न उत्प्रेरित गरिन्छ। सम्पर्कको लागि ००९७७ ९७४१ १०२७५५ नेपालमा रहँदा र ००६१ ४०३२ ४११६० अस्ट्रेलियामा रहँदा टेलिफोन अथवा kaph0001@flinders.edu.au मा इमेलबाट पनि सम्पर्क गर्न सक्नुहुन्छ।

यस अध्ययनसँग सम्बन्धित थप केही प्रश्न तथा जिज्ञासा भएमा तपाईंले सीधै फ्रान्क टेसोरिएरोलाई सम्पर्क गर्न सक्नुहुन्छ। सम्पर्क ठेगाना यस प्रकार छ; फ्रान्क टेसोरिएरो, सम्पर्क टेलिफोन: ०० ६१ ८ ७२२१८४१७, फ्याक्स ००६१ ८ ८२०४ ५६९३, इ सम्पर्क: Frank.tesoriero@flinders.edu.au

2.3 Research Study Information (Service providers and Local Stakeholders)

A PhD candidate from the Department of Public Health at Flinders University is undertaking research into the social determinants of pregnancy and childbirth experiences among women in remote mountain areas of Nepal.

Purpose of the research

The purpose of this research is to explore the pregnancy and childbirth experiences of women in order to identity the factors that influence the health of mother and babies in relation to childbirth in remote mountain areas.

What will you be asked to do?

You will be asked to share your knowledge, experiences and life stories related to pregnancy and childbirth through natural conversation.

What types of things will we be talking about?

I wish to discuss

- Your ideas and knowledge of pregnancy and childbirth
- Your experience of dealing with pregnancy and childbirth in your practice
- Events, beliefand parctices which are related to pregnancy and childbirth in the community
- Your role in supporting others during pregnancy and childbirth events
- Your views related to the factors that are crucial in women's life to have safe pregnancy and childbirth
- Your views on gender and power structure and decision making process in household and society
- Your thoughts about safe practice during pregnancy and childbirth
- Your expectations about how pregnancy and childbirth should be

Benefits of the research

This study will give a greater understanding of the many factors that affect the health of mother and babies in relation to childbirth in communities like yours. It will

ultimately contribute to help to provide culturally, socially and women friendly to improve health of mother and babies in relation to childbirth and ensure survival of mother and newborn babies.

Risks

This research will require a maximum of two hours of your time. Given that we are discussing issues regarding the life experiences of pregnancy and childbirth, there is potential that this process may cause you anxiety or distress. If you find that this is becoming an issue during your participation, you are free to decline to answer particular questions and to withdraw from the project at any time.

How will confidentiality be maintained?

Participation in the interviews is voluntary and you are free to not answer a question, to end the interview at any time, or to withdraw your data at any stage of the field work. We will treat any information provided by you as an individual in the strictest confidence and you will not be individually identifiable.

To ensure your confidentiality we will maintain a central database of participants that is only available to me and my PhD supervisors. You may choose a name (pseudonym) for yourself which will be used in any published work related to this study. The information available to my supervisors will use the pseudonyms rather the names of informants. The recording and transcript of your interview will be labeled with this pseudonym to protect your identity.

How can I find out more information?

If you have any concern and queries regarding your involvement in this project, you are encouraged to contact **Sabitra Kaphle** by telephone: +9779741102755 (while in Nepal); +61 403241160 (while in Australia) or by email kaph0001@flinders.edu.au.

Any enquiries you may have concerning this project should be directed to Frank Tesoriero by telephone 00 61 8 72218417, fax 00 61 8 8204 5693 or e-mail frank.tesoriero@flinders.edu.au.

२.३ सहभागीहरुको लागि अनुसन्धान सम्बन्धि महत्वपुर्ण सुचनाहरु (सामाजिक सदस्यहरुको लागि)

यो अध्ययन फ्लिन्डर्स विश्वविद्यलयको जना स्वास्थ्य विभागअन्तर्गत नेपालको दुर्गम हिमाली भेगका महिलाहरुको बीचमा आमा तथा शिशु स्वास्थ्यको सामाजिक कारक तत्वहरू विषयमा विद्यावारिधि विद्यार्थीबाट गरिएको हो।

अनुसन्धानको उद्देश्य

यो अनुसन्धानको उद्देश्य दुर्गम पहाडी भेगमा रहेका महिलाहरुको गर्भवती र प्रसवसम्बन्धी अनुभवहरुको लेखाजोखा गरी आमा तथा बच्चाको स्वास्थ्यमा प्रभाव पर्ने तत्वहरू विष्लेषण गर्नु रहेको छ ।

सहभागीहरुसँगको अपेक्षा

सहभागीहरुसँग सहज र स्वाभाविक कुराकानीको माध्यमबाट गर्भवती तथा प्रसवसम्बन्धी ज्ञान, अनुभव तथा जीवनमा घटेका घटना र कथाहरु आदानप्रदान गर्नको लागि भनिनेछ ।

अन्तरबार्तामा छलफलको बिषयहरु

निम्न बिषयहरुमा छलफल हुने अपेक्षा गरिएको छ।

- गर्भवती तथा प्रसव सम्बन्धि ज्ञान र सोचाई
- व्यक्तिगत, परिवारको सदस्यहरु तथा समुदायको महिलाहरुको गर्भवती तथा बच्चा जन्म समयमा सहयोगको अनुभबहरु
- समुदायमा रहेका सम्बन्धित घटनाहरु, बिस्वाशहरु र प्रयासहरु
- गर्भवती तथा प्रसव समयमा सहयोग पुरयाएको अनुभबहरु
- परिवार तथा समाजको लैगिक तथा सक्ति संरचना र निर्णय गर्ने प्रक्रिया

- सुरक्षित र सफल गर्भवती तथा प्रसवको बारेमा तपाइको बिचार
- सुरक्षित र सफल गर्भवती तथा प्रसवको लागि तपाइको बिचारमा महत्वपूर्ण लागेको कुराहरु
- तपाइको अपेक्षाहरु

अनुसन्धानका फाइदाहरू

यो अध्ययनले श्रोतको कमी भएको क्षेत्रमा आमा तथा नवजात शिशुको स्वास्थ्यमा प्रभाव पार्ने गहन सामाजिक तत्वहरुको बृहत बुझाई प्रदान गर्नेछ। यसले स्थानीय, राष्ट्रिय तथा अन्तराष्ट्रिय समुदायलाई सचेत बनाई आमा तथा शिशु को जिबन रक्षाको किटान गर्न आमा र बच्चाको स्वस्थ्य प्रबर्दन गर्ने सामाजिक र सास्कृतिक रुपमा स्वीकार्य कार्यक्रम बनाउनको लागि पनि योगदान दिनेछ।

सम्भावित खतराहरू

यस अध्ययनमा तपाईंको करिब दुई घन्टाको समय आवश्यक पर्नेछ । यस अध्ययनको लागि तपाइको व्यक्तिगत जीवनसँग सम्बन्धित सवालहरूमा छलफल गर्नु आवश्यक भएकोले अनुभव आदानप्रदान गर्ने प्रक्रियामा यसले तनाव तथा चिन्ता सिर्जना गर्न सक्ने सम्भावना रहन्छ। यदि तपाईंलाई सहभागी हुने क्रममा त्यस्तो अनुभूति भयो भने तपाईं आफ्नो सहभागितालाई जुनसुकै समयमा छाड्न सक्नुहुन्छ र कुनै पनि प्रश्नको जवाफ नदिन सक्नुहुन्छ।

अध्ययनमा विश्चसनीयता कायम

यस अध्ययनमा तपाईंको सहभागिता स्वेच्छामा भर पर्नेछ र तपाई कुनै पनि प्रश्नको जवाफ नदिन स्वतन्त्र हुनुहुन्छ अथवा अध्ययनको समयमा कुनै पनि बेला तपाईंले दिनुभएको सूचनालाई समावेश नगर्न सक्नुहुन्छ। तपाईंले दिनुभएको सूचनालाई हामीले अत्यन्त विश्वसनीय र गोप्य रूपले प्रयोग गर्नेछौं जसबाट तपाईंको व्यक्तिगत परिचय कुनै अवस्थामा पनि खुला हुनेछैन।

गोप्यतालाई किटान गर्नको लागि तपाईंसँग सम्बन्धित सूचनाहरूलाई केन्द्रीय सूचनाप्रणालीमा व्यवस्थित गरेर राखिनेछ । जसमा म र मेरा सुपरिवेक्षकहरूको मात्र पहुँच रहनेछ तपाईंले अध्ययनको प्रयोगको लागि नक्कली नाम प्रस्ताव गर्न सक्नुहुन्छ । उपलब्ध गरिने सूचनाहरूमा तपाईंको नक्कली नाम प्रयोग हुनेछ जसबाट तपाईंको परिचयको खुलासा हुनेछैन, तपाईंसँग सम्बन्धित अभिलेख र प्रतिवेदनमा तपाईंको नक्कली नाम मात्र प्रयोग गरिनेछ ।

यदि तपाईंलाई यस अनुसन्धानमा सहभागी हुने सम्बन्धमा कुनै जिज्ञाशा भएमा अनुसन्धानकर्ता सावित्रा काफ्लेलाई सम्पर्क गर्न उत्प्रेरित गरिन्छ । सम्पर्कको लागि ००९७७ ९७४१ १०२७५५ नेपालमा रहँदा र ००६१ ४०३२ ४११६० अस्ट्रेलियामा रहँदा टेलिफोन अथवा kaph0001@flinders.edu.au मा इमेलबाट पनि सम्पर्क गर्न सक्नुहुन्छ ।

यस अध्ययनसँग सम्बन्धित थप केही प्रश्न तथा जिज्ञासा भएमा तपाईंले सीधै फ्रान्क टेसोरिएरोलाई सम्पर्क गर्न सक्नुहुन्छ । सम्पर्क ठेगाना यस प्रकार छ; फ्रान्क टेसोरिएरो, सम्पर्क टेलिफोन: ०० ६१ ८ ७२२१८४१७, फ्याक्स ००६१ ८ ८२०४ ५६९३, इ सम्पर्क: Frank.tesoriero@flinders.edu.au

Appendix 3: Information Sheet of Pregnant and Postnatal Women Involved in the Study

Name	Age	Marriage Age	Religion	Ethnicity	Education	Preg.	MisC	SB	END	L B	Number of Children	Current Status Preg/PN
Laxmi	26	14 Yrs	Hindu	Chettri	Illeterate	4	0	0	0	3		38 Wks
Rama	20	15 Yrs	Hindu	Chettri	Illeterate	2	0	0	0	1	1	35 Wks
Thuli	28	13 Yrs	Hindu	Chettri	Illeterate	8	0	1	2	7	5	25 Days
Sarita	19	16 Yrs	Hindu	Chettri	Primary L	1	0	0	0	1	1	6 Days
Prema	29	17 Yrs	Buddha	Lama	Illeterate	5	0	0	1	4	3	36 Wks
Toma	26	20 Yrs	Buddha	Lama	Illeterate	4	1	0	0	2	2	32 Wks
Lashi	24	15 Yrs	Buddha	Lama	Illeterate	2	0	0	1	2	1	15 Days
Pema	33	20 Yrs	Buddha	Lama	Illeterate	6	1	0	1	4	3	37 Wks
Tolma	23	13 Yrs	Buddha	Lama	Illeterate	6	2	0	3	6	3	11 Days
Urgen	42	14 Yrs	Buddha	Lama	Illeterate	7	0	0	0	6	6	34 Wks
Dolma	35	14 Yrs	Buddha	Lama	Illeterate	10	1	1	2	6	5	32 Wks
Sonam	43	25 Yrs	Buddha	Lama	Illeterate	7	1	0	3	6	3	42 Wks
Toli	20	15 Yrs	Buddha	Lama	Illeterate	3	0	0	2	3	1	37 Wks
Manu	36	14 Yrs	Hindu	Chettri	Illeterate	11	2	0	1	8	7	39 Wks
Hira	17	14 Yrs	Hindu	Chettri	Illeterate	2	0	1	0	0	0	34 Wks
Kiru	23	14 Yrs	Hindu	Chettri	Illeterate	3	0	0	1	2	1	35 Wks
Sumi	26	18 Yrs	Hindu	Thakuri	Illeterate	3	0	0	0	3	3	40 Wks
Rima	22	14 Yrs	Christian	Dalit	Illeterate	3	1	0	0	1	1	38 Wks
Juna	42	10 Yrs	Hindu	Chettri	Illeterate	7	0	0	0	6	6	36 Wks

Jitu	42	16 Yrs	Buddha	Lama	Illeterate	8	0	0	0	8		5 Days
Suntali	24	22 Yrs	Buddha	Lama	Midwife	1	0	0	0	1	1	13 Days
Sunita	17	15 Yrs	Buddha	Lama	Primary L	1	0	0	0	0	0	34 Wks
Sanju	18	15 Yrs	Buddha	Lama	Primary L	2	0	0	0	2	2	4 Days
Kabita	24	19 Yrs	Hindu	Chettri	Intermed.	2	0	0	0	2	1	35 Wks
Rita	25	19 Yrs	Hindu	Chettri	Intermed.	2	0	0	0	1	1	33 Wks

Appendix 5: Brief Introductions of Pregnant and Postnatal Women Participants of this Study

Prema

About 29 years old, Prema is a mother of three children. She has been married for 17 years and had her first child at the age of 18. She lost her second baby at nine months. She is in the third trimester of her fifth pregnancy. She has had all her births at home with the assistance of her mother-in-law.

Toma

Toma is a mother of two babies. She has had one miscarriage during her childbirth journey. She is currently in the eighth month of her fourth pregnancy. Toma was married at the age of 20 and had her first baby after a year of marriage. About 26 years old, Toma has had all her previous births at Goth with the assistance of her mother-in-law.

Lashi

Lashi was married at the age of 15. She became pregnant in the same year and had her first baby. Unfortunately, she lost her first baby. Now, she has become the mother of her second baby at the age of 24. Her husband works in India. Lashi had her first birth at Goth with the support of her mother-in-law. This time she gave birth in the corner of the house she has been living in with the help of a neighbouring aunty.

Tolma

Tolma is about 23 years' old and is a mother of three children. She was married at the age of 13 and went through two miscarriages. Tolma gave birth to triplets recently and she lost all babies within 10 days of birth. She has had all births at home with the support of her sister and aunty. She is now living with the three remaining children and her husband in the village.

Pema

Pema was first married at the age of 15 and had a daughter. She left her first husband because of his emotional torture and married Jabling when she was 20 years old. She is a mother of other two children from her second husband. She had one miscarriage while she was with her first husband and she lost her second baby with Jabling on the ninth day after birth. She is now 33 years old and looking forward to having another baby next month. Pema has had all births at home.

Urgen

Urgen is about 42 years old and was married at the age of 14. She had her first baby at the age of 18. Her husband is working as a primary school teacher in the village. She has had seven pregnancies during this period and has been lucky to have all babies survive. She is now experiencing her eighth pregnancy, while her daughter-in-law is also pregnant. Urgen has had all births at home with the support of her mother.

Dolma

Dolma is just 35 years old but she has already gone through 10 pregnancies. She was married at the age of 14 and had her first pregnancy at 16 years. During her childbirth journey, Dolma has experienced one miscarriage, one stillbirth and two neonatal deaths. She lost one child at three years of age. She is now a mother of five living children and experiencing her 10^{th} pregnancy. She has had all births at home.

Sonam

Sonam gave birth recently at the district hospital due to complications. She had walked for three days to reach the hospital during her complicated labour. She was married at 25 years and had her first baby at 26 years of age. She is now about 43 years old. She has gone through the experiences of three neonatal losses and one miscarriage. She is now a mother of three living children ranging from the just born little boy to a 17 year old son and a 21 year old daughter. This is the only time Sonam has come to hospital to give birth because she could not give birth at home.

Toli

Toli is about 20 years old. She was married to a boy from the same village when she was only 15 years of age. Toli did not get any opportunity to learn to read or write. She became pregnant the year after her marriage. It was a twin pregnancy. She gave birth to the twins at home with the help of her mother. Unfortunately, the twins died on the ninth and tenth day after the birth. She gave birth to a baby boy at 17 years of age. He is now three years old. Toli is giving birth to another baby in one month.

Jitu

Jitu is about 42 years' old and is a mother of seven children ranging in age from five days to 25 years. She has had all births at home with the assistance of her mother-in-law and other relatives. She was married at the age of 15 and had her first baby at the age of 16. She lost her 13 year old son last year because of a wasp bite. Soon she will give birth to her eighth child.

Suntali

Suntali is trained as a midwife and has recently become a mother of her newborn daughter. Her husband is a school teacher working in another district. Suntali is a 24 year old mother of her first child and was married according to her wishes when she was 22 years old. She is now living alone taking care of her daughter. She had this birth at the district hospital.

Sunita

Sunita is the first time pregnant mother involved in this study. Sunita is now 17 years old and is due to give birth in a few weeks. Sunita ran away with a school mate two years ago and got married. She has completed primary level schooling. Her husband also dropped out of school after his marriage to Sunita. She is living with her in-laws and has infrequent prenatal check-ups.

Sanju

Sanju is a mother of two children including the recently born one. She also ran away with her school mate when she was in seventh grade and got married at the age of

15. They did not continue school afterwards. Sanju became a mother of two babies within three years after marriage. She had both births at the local health post. Now, she is living with her husband taking care of two babies in the adjoining room of her in-law's house.

Laxmi

Laxmi is about 26 years old and was born in a remote village of this district. She did not get any opportunity to learn how to read and write. Instead, she learnt to work in the fields and to perform female duties according to the Hindu culture. She was married to a boy from the adjoining village when she was 14 years old. Her husband is now working as a lecturer in the only college at the district headquarters. She gave birth to her previous three babies at home. Her mother-in-law has assisted all her births. This time she has also given birth to her fourth baby at home with the support of her mother-in-law.

Rama

Rama is experiencing her second pregnancy. She became a mother of her first baby at the age of 17. She married a functionally literate boy in the village when she was just 15 years old. Now, she is about 20 years old. Rama had her previous birth at Goth and spent her 20 days of birth pollution also in Goth. She did not have any prenatal consultations and now is planning to give birth to her forthcoming baby also in Goth.

Thuli

Thuli does not know how to read and write. She lives in the village with her husband and five children ranging from 28 days to seven years of age. She goes out for daily waged work on the farm of other people. Thuli was married at 13 years of age. Her husband was also from a very poor family, and is dumb and deaf. It was Thuli's female duty to give birth as soon as possible according to the Hindu system. She has been pregnant eight times and now she is about 28 years of age. She gave birth to all her babies in Goth. She had one still birth and two neonatal deaths while she was in Goth. Thuli does not know for how long she has to go through pregnancy and childbirth experiences.

Sarita

Sarita married a boy in the Maoist camp during the people's war, when she was 17 years old. It was her choice to have him as a husband. They knew each other very well and understood each other well. Sarita has lived with her husband and father-in-law in a rented flat since the people's war ended. Sarita, a first time mother, gave birth to a preterm baby in the local hospital six days ago. It was a normal birth after a night of labor pains. It was her first childbirth experience. Unlike other women in the community, she was confident in sharing her experiences. Sarita has also been freed to decide whatever she likes to do during her pregnancy and childbirth. Sarita and her husband were functionally literate and able to read and write to manage their daily living.

Manu

About 36 years old, Manu was married when she was about 14 years of age. She had her first baby after two years of marriage. She is now a mother of seven children. During her childbirth journey, Manu has gone through eleven pregnancies, of which two ended as miscarriages and she lost one baby three months after birth. She is now experiencing the last month of her 11^{th} pregnancy. Manu has had all her births at Goth at her home and she is now expecting to give birth in the same place. Manu's family relies on farming and some daily waged work for their survival. Both Manu and her husband cannot read and write.

Hira

Nineteen years old, Hira was married five years ago, when she was about 14 years old. Both Hira and her husband are illiterate and are involved in daily waged work including household farming. She gave birth to her first child after two years of marriage and lost him before his first birthday. The death of her first child made her panic and compelled her to go to the hospital for a prenatal check-up. She expects to give birth at home without any problems. She wishes not to have complications that require her coming to hospital. During this pregnancy, she is feeling lonely because of the death of her mother-in-law last year. Currently she is the only female member in her family where she cannot find anyone to share her problems and discomfort

with. Despite this fact, she is looking forward to having a comfortable birth at home.

Kiru

Kiru reached the hospital after two days' walk last Thursday because she did not know that Wednesday is the only clinic day to have her prenatal check-up. She was told to wait until the next Wednesday. She booked a room in a local hotel and waited for six days just to have her check-up. The cost of living became more expensive than expected. She borrowed some money from her village sister to pay for the hotel. She was wondering about the work at home. This is her third pregnancy. Her first baby died the day after birth. About 23 years old, Kiru was married when she was 14 years old. She had left her three year old daughter at home with her husband and father-in-law to come to the district hospital for a check-up. Noone in her family can read and write but they believe that having a visit to the hospital during pregnancy will ensure the safety of mother and baby during childbirth. She had both previous births at home and this time she is also not planning to come to the hospital.

Sumi

Sumi gave birth to her third baby at the district hospital four days ago. 26 years old, Sumi was married at the age of 18 according to the wishes of her parents. She is now a mother of three children. She had two previous births at home with the support of her mother-in-law. This time she went to hospital because of the prolonged labour at home. Sumi's family is comparatively educated in the village where male members of the family are involved in public services. However, Sumi is not able to read and write. She is fortunate to have the opportunity to sleep inside the room adjoining the house during her impure days of the postnatal period. Sumi expressed her strong preference for and satisfaction with home birth.

Rima

Rima was married when she was 15 years old according to her wishes. She had her first pregnancy at the age of 16 but it ended at three months. She gave birth to her daughter at 17 years of age though Caesarean Section at the city hospital. She is now 22 years old. Rima gave birth to her second daughter also in the city hospital recently. This time also she had to go through a C section to give birth. Rima is an

illiterate mother, while her husband has completed a graduate degree in education. They were both running a hotel in the district headquarters to earn their living. Rima expressed guilt for not being able to experience natural childbirth.

Juna

Although Juna lives a few hours' walking distance from the district hospital, she had all births at Goth and she remained in the shed for 30 days after childbirth. She is not sure how old she is but she looks more than 40 years of age. She has continued her childbirth journey since 16 years of age. This is her seventh pregnancy. She was not even 10 years old at the time of her marriage. She was glad that all of her births did not have any bad fortune. She has six children already and is still not thinking of stopping giving birth. She is looking forward to having her baby this month and she does not want to violate the tradition of giving birth in Goth and observing birth pollution for 30 days. Juna has never had any medical consultations during her earlier pregnancies and childbirth. This time she came to the district hospital to have her first prenatal check-up during the last month of pregnancy because of discomfort and pain a few weeks earlier than the expected time of childbirth.

Kabita

Kabita is working as a primary school teacher in a local private school. She completed a graduate degree in education before marrying four years ago. She is now 24 years old and a mother of a three year old daughter. Kabita is expecting to have her second child in two months' time. She had her previous birth at the district hospital and this time she is also having regular prenatal check-ups in this district hospital and planning to have the baby there as well. Her husband has completed an undergraduate degree. He has not been doing any professional work since he completed his undergraduate course. Kabita has been living with her mother-in-law since she married. Her family profession is agriculture for which she has been involved in work inside and outside the house including her fulltime teaching responsibilities.

Rita

Rita's husband went to Qatar for work last month. She has a five year old daughter

with her. She has been working as a primary school teacher in the district headquarters but came back to the village to live with her in-laws once her husband went overseas for work. She is feeling lonely, helpless and stressed about the upcoming childbirth because of the absence of her husband. Rita also misses her mother who passed away when she was a small child. She has been married for six years and had her daughter when she was 20 years old. Rita completed her undergraduate degree before marriage and could not continue her study afterwards. She gave birth to her daughter in the district hospital and now she has been stopped from making regular prenatal visits since she came to the village. She is confused and uncertain about where she will give birth.

Appendix 5: Ethics Approval and Permission Letter

Flinders University and Southern Adelaide Health Service

SOCIAL AND BEHAVIOURAL RESEARCH ETHICS COMMITTEE

Room B1, Union Building, Flinders University,
GPO Box 2100, ADELAIDE SA 5001
Phone: (08) 8201 3116
Email: human.researchethics@flinders.edu.au

FINAL APPROVAL NOTICE

Principal Researcher:	Ms Sabitra Kaphle
Email:	kaph0001@flinders.edu.au
Address:	Public Health
Project Title:	Social Determinants of Perinatal Health: Pregnancy and Childbirth Experiences of Indigenous Women in Remote Mountain Areas of Nepal

Project No.:	4591	Final Approval Date:	8 September 2009	Approval Expiry Date:	31 December 2011

The above proposed project has been **approved** on the basis of the information contained in the application, its attachments and the information subsequently provided.

For projects where approval has also been sought from another Human Research Ethics Committee, please provide a copy the ethics approval notice to the Committee on receipt.

In accordance with the undertaking you provided in your application for ethics approval for the project, please inform the Social and Behavioural Research Ethics Committee, giving reasons, if the research project is discontinued before the expected date of completion.

You are also required to report anything which might warrant review of ethical approval of the protocol. Such matters include:

- serious or unexpected adverse effects on participants;
- proposed changes in the protocol (modifications); and
- unforeseen events that might affect continued ethical acceptability of the project.

In order to comply with monitoring requirements of the *National Statement on Ethical Conduct in Human Research (March 2007)* an annual progress and/or final report must be submitted. A copy of the pro forma is available from http://www.flinders.edu.au/research/info-for-researchers/ethics/committees/social-behavioural.cfm. Your first report is due on **8 September 2010** or on completion of the project, whichever is the earliest. *Please retain this notice for reference when completing annual progress or final reports.* If an extension of time is required, please email a request for an extension of time, to a date you specify, to human.researchethics@flinders.edu.au before the expiry date.

Andrea Jacobs
Acting Secretary
Social and Behavioural Research Ethics Committee
8 September 2009

c.c A/Prof Frank Tesoriero, frank.tesoriero@flinders.edu.au

Government of Nepal
Ministry of Health & Population
DEPARTMENT OF HEALTH SERVICES
Tel. : 4261436
: 4261712
Fax : 4262238
Pachali, Teku
Kathmandu, Nepal

Ref. No. 665/066-67

Date : .....

21st February, 2010

To Whom It May Concern

This letter has been prepared upon the request of the Flinders University of South Australia for the provision of permission to carryout field of **Sabitra Kaphle** during her PhD candidature.

With the permission of Family Health Division, I would like to request to the District Health Office of Mugu to provide essential support for the completion of the fieldwork of the research entitled, 'Social Determinants of Perinatal Health of Indigenous Women Living in Remote Mountain Areas of Nepal'.

Dr Shilu Aryal
Sr. Cons. Obs.and Gynecologist

CC: District Health Office, Mugu.

Appendix 6: Interview Guide

6.1 Interview Guide for Women Participants

We know that there are various factors that attached with our lives. We, being women have various stories to share in relation to our life and sometimes women are not able to find someone with whom they can share these experiences. I understand that because I have also had the same feelings and experiences in my life. Today, I am interested to listen to you about your life, pregnancy and childbirth experiences, which will help me to understand possible factors that may interact with or influence the health of mother and babies. There are no right and wrong answers. I would like to understand how you feel about these areas and what your experiences are. We will have a conversation across various areas that may be related to your life. I will use language so that you can understand me and the words that are familiar with you. If I ask a question that you do not want to answer, you do not have to answer. You can say, "I don't really want to talk or I don't know about that", when you feel not answering or discussing any particular areas.

Opening the interview will follow the introduction, information sharing and verbal informed consent process. The conversation will start talking about their everyday work and more general discussion in some areas which is not directly related to research before focusing on the specific theme. More general questions for example are; could you please tell me how you normally spent your day? How you feel being a woman? How you feel and see your family life? Would you mind to tell little bit about your life experiences that you remember most and that touch you most?

The main part of interview will focus following areas.

Pregnant and Postnatal Women

1. Their view about being a woman
2. Their meaning of pregnancy and childbirth
3. Their perceptions and knowledge of pregnancy and childbirth
4. Their experiences of pregnancy and childbirth

5. Related events, beliefs, practices and life stories
6. The old-wives tales, legends, superstitions and folklores that women, families and community have
7. Their expectations about what would happen during pregnancy and child birth
8. The types of childbirth experiences that they wish to have
9. The possible reasons for having good or bad experiences
10. Their opinions for making these experiences joyful and comfortable
11. Any other comments that women would like to make
12. Conclusion

Mother-in-law

Along with above areas, their experiences of supporting the pregnancy and childbirth of their daughters in law will be added.

Finally, researcher will acknowledge participants for their time, trust and information provided during the interview. It will be assured that their anonymity, privacy and confidentiality will always be respected.

6.2 Interview Guide for Husband

We know that there are various factors that attached with our lives. The influences of these factors are crucial in pregnancy and childbirth experiences of your wife. Today, I am interested to listen from you about your experiences while your wife had pregnancy and child birth, which will help me to understand possible factors that may interact for the health of mother and baby. We will have a conversation across areas that related to your role, experiences, events and ideas in relation to your wife's pregnancy and child birth. There are no right and wrong answers. We will have a conversation across various areas that are related to pregnancy and child birth of your wife. I would like to understand how you feel about these areas and what your experiences are. I will use language so that you can understand me and the words that are familiar with you. If I ask a question that you do not want to answer, you do not have to answer. You can say, "I don't really want to talk or I don't know about that", when you feel not answering or discussing any particular areas.

Opening the interview will follow the introduction, information sharing and verbal informed consent process. The conversation will start with more general discussion before going to specific theme of research. The questions that are not directly related to the study will be asked to open the conversation. More general questions for example are; how you normally spent your days? How do you feel being a husband? How do you feel about your life and the areas you are living? How many cattle do you have? Do you entertain with children? Would you like to share the most romantic part of your life that you wish to recall?

The conversation related to main theme of research will focus on following areas.

1. Their understanding of pregnancy and child birth
2. Their perceptions and knowledge of pregnancy and child birth
3. The experiences of pregnancy and child birth of their wife
4. Related events, beliefs and practices
5. His role in family and support during pregnancy and child birth

6. Their expectations about what would happen during pregnancy and child birth
7. His thoughts for making pregnancy and child birth safer
8. The possible reasons for having good or bad experiences
9. Their opinions for making these experiences joyful and comfortable
10. Any other comments that informants would like to make
11. Conclusion

Finally, researcher will acknowledge participants for their time, trust and information provided during the interview. It will be assured that their anonymity, privacy and confidentiality will always be respected.

6.3 Interview Guide for Local Stakeholders

We know that there are various factors that may be attached to pregnancy and childbirth experiences of women living this area. The support role of local stakeholders is important for helping to make pregnancy and child birth safer. Today, I am interested to listen to your experiences of understanding pregnancy and child birth as a member of this society, which will help me to explore factors that are related to and interact with the health of mother and baby. We will have a conversation across areas that are related to your role, experiences, events and ideas in relation to health of women during pregnancy and child birth living in your community. There are no right and wrong answers. I would like to understand how you feel about these areas and what your experiences are. I will use language so that you can understand me and the words that are familiar with you. If I ask a question that you do not want to answer, you do not have to answer. You can say, "I don't really want to talk or I don't know about that", when you feel not answering or discussing any particular areas.

Opening the interview will follow the introduction, information sharing and verbal informed consent process. The conversation will start with more general discussions that are not directly related to research theme. The questions for example are; what do you normally do during the day? How you feel being a member of this society? Do you have particular thought about differences in men and women? Would you like to share the most joyful events in your life that you feel proud of recalling today? How many members do you have in your family? What kind of people does you like meeting with and sharing the feelings with? Do you have any dreams in your life that you wish to bring in reality?

The conversation related to research theme will cover following areas.

1. Their understandings of pregnancy and child birth
2. Their perceptions and knowledge of pregnancy and child birth
3. Their role in society
4. Their experience of supports in community during child birth

5. Related events, beliefs and practices
6. Their thoughts in relation to gender role and practice within household and community
7. Their expectations in relation to child birth
8. Their thoughts for making pregnancy and child birth safer
9. Their opinion for saving maternal and newborn life
10. Any other comments that informants would like to make
11. Conclusion

Finally, researcher will acknowledge participants for their time, trust and information provided during the interview. It will be assured that their anonymity, privacy and confidentiality will always be respected.

Appendix 7: Conference Proceedings

1. Childbirth as a Casual Event: Experiences of Women Living in Remote Mountain Areas of Nepal, Association of Qualitative Research Conference, Cairns, August 2011
2. Walking Through River and Stone: Reflections from Fieldwork with Women in Remote Mountain Villages of Nepal, University of Melbourne/Monash University, Melbourne, October 2010
3. Stories of Perinatal Losses: Childbirth Experiences of Women from Remote Mountain Villages of Nepal, 40th Public Health Association of Australia Annual Conference, Adelaide, September 2010
4. Birth After Death Continues: Pregnancy and Childbirth Stories of Women From the Himalayas, AWGSA Annual Conference, Adelaide, June 2010
5. Researching Childbirth Experiences of Women: Insight from the Fieldwork of Remote Areas of Nepal, DelPHE Conference on Education, Gender and Development, Kathmandu, April 2010
6. Social Determinants of Pregnancy and Childbirth: Pregnancy and Childbirth Experiences of Women in Remote Areas of Nepal, Poster Presentation on State Population Health Conference, Adelaide, October 2009
7. Poster Presentation on "Social Determinants of Perinatal Health: Pregnancy and Childbirth Experiences of Women in Remote Areas of Nepal", Second International Meeting on Innovations and Progress in Healthcare for Women, Royal College of Gynaecologists and Obstetricians, London, November 2009
8. Social Determinants of Perinatal Health: Factors Influencing Pregnancy and Childbirth Experiences of Women, Australian College of Midwives Conference, 16th National Conference, September 2009