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Confronting maternal mortality, controlling birth in Nepal: The gendered politics of receiving biomedical care at birth☆

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ABSTRACT

One way of reducing maternal mortality in developing countries is to ensure that women have a referral system at the local level that includes access to emergency obstetric care. Using a 13-month ethnographic study from 2003 to 2005 of women's social positions and maternal health in a semi-urban community of Hindu-caste women in the Kathmandu Valley, this paper identifies impediments to receiving obstetric care in a context where the infrastructure and services are in place. As birth in Nepal predominantly takes place at home, this paper identifies the following areas for potential improvement in order to avoid the loss of women's lives during childbirth: the frequency of giving birth unaided, minimal planning for birth or obstetric complications, and delayed responses at the household level to obstetric emergencies. Focusing particularly on the last item, this study concludes that women do not have the power to demand biomedical services or emergency care, and men still viewed birth as the domain of women and remained mostly uninvolved in the process. As the cultural construction of birth shifts from a "natural" phenomenon that did not require human regulation toward one that is located within the domain of biomedical expertise and control, local acceptance of a biomedical model does not necessarily lead to the utilization of services if neither women nor men are in a culturally-defined position to act.

Introduction

In an effort to confront the high levels of maternal mortality in developing countries, the Safe Motherhood Initiative (now consolidated under the Partnership for Maternal, Newborn and Child Health) has promoted antenatal, delivery, and post-partum care while also acknowledging contextual challenges to implementing safe motherhood goals at the governmental or policy level, the community or cultural level, and at the household or individual level (Partnership for Maternal, Newborn and Child Health, 2009; cf. Freedman et al., 2007). For particularly poor or rural populations, for example, a standard practice of delivering at hospitals may be untenable for a number of reasons. At the governmental and policy level, the costs of providing adequate facilities and staff throughout a country can be onerous for governmental budgets (AbouZahr, 2003). Universal hospital delivery also may be inappropriate given the desires and/or economic limitations of community members (Berry, 2006). One way the limitations on health services in developing countries has been addressed is through the implementation of referral systems in which low-risk births are handled at the local level and difficult cases referred to a district or regional health center or hospital (Murray & Pearson, 2006). The success of this system, which utilizes a combination of home and hospital deliveries and a variety of skilled practitioners, is undermined if access to emergency obstetric care is not available to women giving birth at home (Koblinsky & Campbell, 2003; Rath et al., 2007). Affordable emergency obstetric care must be available at a health center, and means of transportation to reach the center must also exist. Experts have argued that the provision of emergency obstetric care is a crucial part of achieving maternal health in developing countries (Fortney, 2001; Maine & Rosenfield, 1999).

In Nepal, obstetric health care services are available through a governmental referral system (with the notable exception of remote areas), but they are not being fully utilized. Most women in Nepal give birth without the assistance of a trained professional. There is a tendency for families to delay seeking emergency care and, in the process, to bypass lower level facilities. Such behaviors

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would be understandable in locations where services were of poor quality (Barker, Bird, Pradhan, & Shakya, 2007), of substantial expense, or culturally inappropriate (Justice, 1986). The study described here, however, focuses on a location where hospital and local referral services were available in order to explore why families do not use biomedical options at birth despite governmental and non-governmental agencies' efforts to increase the prevalence of professional assistance at birth in order to confront persistently excessive maternal mortality rates (cf. Jeffery & Jeffery, 2010, in this issue).

Using an ethnographic study of women's social positions and maternal health in a semi-urban community of Hindu-caste women in the Kathmandu Valley, Nepal, this paper identifies impediments to receiving obstetric care in a context where the infrastructure and services were in place. This paper considers the household-level dynamics of giving birth at home in the Nepal context and what characteristics of the situation need to change in order to decrease the loss of women's lives in childbearing. The research is based on interviews and participant observation conducted with women; thus their birth complications obviously ended in receiving assistance and surviving. I present these particular narratives as "near misses" that offer us insight into what goes wrong during home birth that may lead to a woman's loss of life.

Background

Nepal's official reported maternal mortality ratio (MMR) of 281 (per 100,000 live births) for the period 1999–2005 (Ministry of Health and Population, New ERA, & Macro International Inc., 2007) makes maternal health a concern of the Ministry of Health and Population (MoHP) and non-governmental agencies alike. The World Health Organization (WHO) and UNICEF provide a more dire picture; they report an adjusted MMR of 830 for 2005 (UNICEF, 2009). While the MMR in Nepal and whether it is decreasing remain a topic of debate (cf. Pant et al., 2008), the Demographic and Health Survey (DHS) has documented the at least partially successful efforts of national and international players to combat maternal mortality through modest increases in the following: the percentage of births delivered at health facilities, the percentage of women making four antenatal care visits, the percentage of births assisted by a Skilled Birth Attendant (SBA), and the percentage of women receiving postnatal care (Ministry of Health et al., 2007). Since this paper focuses on emergencies during home births, I shall not address postnatal care visits in the following discussion.

The prevalence of skilled care received by Nepali women during pregnancy and birth has increased noticeably within the last decade. However, the experience of procreative processes for women in Nepal varies significantly along the lines of wealth and place of residence (we know little about the significance of caste or ethnicity since the Nepal Demographic and Health Surveys do not report on these variables). There are dramatic differences in the practices and experiences of procreation for women in rural versus urban areas and in wealthy versus poor families; as in many countries, reproduction is stratified (Rapp, 2001) in Nepal. Women in the most disadvantaged sectors of society receive the lowest levels of biomedical health care. The effects of wealth and the urban/rural divide can be observed in the tables that follow on delivery location, antenatal care, and assistance at birth by a skilled birth attendant.

The large majority of births by Nepali women occur at home (see Table 1). In the five years preceding the 2006 DHS, 81 percent of births took place at home. Only 18 percent of births were delivered in a government health facility, and less than 1 percent of births occurred in a private health facility. The majority of women who had given birth in the five years before the survey reported that they believed it was not necessary to give birth in a health facility (73 percent), 17 percent said that it was not customary, 10 percent said that it cost too much, and 9 percent that a health facility was too far or that there was no transportation available. In addition, 3 percent of women mentioned that they gave birth before they could get to a facility, even though they had planned to go to a health facility for delivery (MoHP et al., 2007). Since home births are so prevalent, other aspects of care become all the more important: antenatal care in order to identify high-risk births along with general preparations for birth, and delivery assistance in order to manage complications and advocate for hospitalization when necessary.

Table 1
Place of delivery. Percent distribution of births in the five years preceding the survey according to place of delivery (2006 Nepal DHS).

	Health facility	Home	Other	Number of births
Birth order				
1	31.7	66.8	1.5	1676
2–3	14.8	84.2	1.0	2342
4–5	6.9	91.9	1.3	946
6+	6.3	91.6	2.1	580
Residence				
Urban	47.8	51.5	0.7	677
Rural	13.5	85.1	1.4	4868
Mother's education				
No education	7.9	90.7	1.4	3343
Primary	18.9	80.2	1.0	1009
Some secondary	34.6	64.1	1.3	848
SLC and above	67.4	31.6	1.0	345
Wealth quintile				
Lowest	4.3	93.3	2.4	1412
Second	9.3	90.0	0.8	1180
Middle	11.9	87.1	1.0	1132
Fourth	21.7	77.0	1.3	983
Highest	55	44.3	0.8	838

In terms of antenatal care, national level statistics from the 2006 Nepal DHS show a markedly higher percentage of women in younger age groups who utilize antenatal care from a trained health professional. This higher percentage is the combined result of a historical change – an increase in availability of services and the development of a trend in going for antenatal check-ups – and the fact that a higher percentage of women seek antenatal care for their first birth but not for subsequent births. This difference in behavior for first birth versus subsequent births holds true for seeking a hospital (or other health facility) delivery for the first child and not for higher parity children (see Table 1). In the decade between 1996 and 2006, the proportion of women who received antenatal care from an SBA increased from 24 percent in 1996 to 28 percent in 2001 and 44 percent in 2006 (MoHP et al., 2007).

The concept of birth preparedness, like antenatal care, is a part of a biomedical model and risk framework; when birth is considered a natural event, it does not require planning. Birth preparedness in the context of Nepal and similar developing countries is of great relevance to a successful delivery (which most often begins outside a health facility). Ideally it ensures appropriate care and reduces delays in obtaining emergency care when necessary. In a rural setting in the Terai (southern plains of Nepal), McPherson, Khadka, Moore, and Sharma (2006) documented the effectiveness of a birth-preparedness program that encouraged preparation for normal birth through promoting the selection of an SBA and place of delivery, preparation of essential items for delivery such as a clean delivery kit, knowledge of danger signs for mother and newborn and when, whom, and where to seek help, and the