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Childbirth traditions and cultural perceptions of safety in Nepal: Critical spaces to ensure the survival of mothers and newborns in remote mountain villages

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ABSTRACT

Objective: to uncover local beliefs regarding pregnancy and birth in remote mountainous villages of Nepal in order to understand the factors which impact on women's experiences of pregnancy and childbirth and the related interplay of tradition, spiritual beliefs, risk and safety which impact on those experiences.
Design: this study used a qualitative methodological approach with in-depth interviews framework within social constructionist and feminist critical theories.
Setting: the setting comprised two remote Nepalese mountain villages where women have high rates of illiteracy, poverty, disadvantage, maternal and newborn mortality, and low life expectancy. Interviews were conducted between February and June, 2010.
Participants: twenty five pregnant/postnatal women, five husbands, five mothers-in-law, one father-in-law, five service providers and five community stakeholders from the local communities were involved.
Findings: Nepalese women, their families and most of their community strongly value their childbirth traditions and associated spiritual beliefs and they profoundly shape women's views of safety and risk during pregnancy and childbirth, influencing how birth and new motherhood fit into daily life. These intense culturally-based views of childbirth safety and risk conflict starkly with the medical view of childbirth safety and risk.
Key conclusions and implications for practice: if maternity services are to improve maternal and neonatal survival rates in Nepal, maternity care providers must genuinely partner with local women inclusive of their cultural beliefs, and provide locally based primary maternity care. Women will then be more likely to attend maternity care services, and benefit from feeling culturally safe and culturally respected within their spiritual traditions of birth supported by the reduction of risk provided by informed and reverent medicalised care.

Background

Childbirth is a powerful personal event in women's lives as well as a significant social experience and it differs according to their culture and society (Callister, 1995, 1997, 2004; Callister et al., 1999; Semenic et al., 2004; Liamputtong et al., 2005; Carpenter, 2009; Liamputtong, 2009; Callister and Khalaf, 2010; Schneider, 2010; Farnes et al., 2011; Lemay, 2011; Sawyer et al., 2011; Etowa, 2012). Therefore, any understanding of women's pregnancy and childbirth experiences requires understanding their culture, tradition and social values because the degree of control and type of choice that women can make during pregnancy and childbirth depends on societal values and what societies offer to reproductive women (Janssen et al., 2009; Dahlen et al., 2010a, 2010b; Lindgren and Erlandsson, 2010; Namey and Lyerly, 2010; Douglas, 2011; Snowden et al., 2011). Women have the right to control and decide freely and responsibly about their reproductive health and women also have the right to make decisions about their pregnancy and childbirth (United Nations, 1995).

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Lupton (1999) notes that although cultures and traditions are different, human experiences such as pregnancy and childbirth may be considered universal. However, women in both Western and non-Western cultures situate their childbirth experiences within the differing socio-cultural circumstances of their lives (Oakley, 1980, 1996; Rice et al., 1994; Rice, 1997; Belousova, 2010; Marak, 2010; Douglas, 2011; Graham, 2011; Haines et al., 2011b; Lewallen, 2011). Nepalese rural and semi-urban women's pregnancy and childbirth experiences reside heavily in their socio-cultural values, norms and traditions (Regmi and Madison, 2009; Regmi et al., 2010; Basnyat, 2011; Sapkota et al., 2011; Basnyat and Dutta, 2012).

The socio-cultural understanding of pregnancy and childbirth is restrained in contemporary medical literature and many scholars argue that the medical view of pregnancy and birth often fails to acknowledge socio-cultural dimensions important to women (Kitzinger, 1997; Johnson, 2008; McCourt, 2009; Titaley et al., 2009, 2010a, 2010b; Benoit et al., 2010; Haines et al., 2010, 2011a; Lori and Boyle, 2011; Sawyer et al., 2011; Teman, 2011). Additionally, the medical interpretation of childbirth does not acknowledge existent traditional birthing practices which subsequently influence use of medical services; accordingly women and family members are often blamed for their poor utilisation of medical services during pregnancy and childbirth (Douglas, 1994; Cindoglu and Sayan-Cengiz, 2010; Harris et al., 2010; Varley, 2010; Brown et al., 2011; Castells, 2011; Koolenga and Stewart, 2011; Moore et al., 2011; Coxon et al., 2012). This is particularly so in Nepal (Thapa et al., 2001; Regmi and Madison, 2009; Ahmed et al., 2010; Brunson, 2010; Basnyat, 2011).

Safety and risk

Concerns about safety and risk during pregnancy and birth are critical for women and service providers to ensure maternal and newborn survival. Mackenzie Bryers and Van Teijlingen (2010) identify risk as a negative concept of seeking to prevent, manage and control situations resulting in adverse and unintended consequences. Although the number of institutional births is increasing in Nepal, many women still give birth in their community with assistance from family and neighbours (Basnyat, 2011). Outsiders often see women who embrace long standing traditions of childbirth in their communities as unaware of 'real risks' (Obermeyer, 2000). Yet many factors encompassing perceptions, culture, tradition, rituals, spirituality, familial social relationships, birth place and birth supports are considered important aspects of childbirth (Callister, 1995; Downe, 2007; Hodnett et al., 2007; Liamputtong, 2009; Hodnett et al., 2010; Walsh, 2009; Douglas, 2011; Lori and Boyle, 2011).

The socio-cultural context in Nepal is considered to have negative impacts on maternal and newborn outcomes and to deter women from accessing medical services (Thapa et al., 2001; Bennett et al., 2008). However, many women and their families sincerely believe that adhering to socio-cultural tradition is the best way to prevent childbirth related deaths. Schubert et al. (1997) and Dahal (2008) identified the traditional Nepalese practice of giving birth in the cowshed (known as the goth) as a risky undertaking and another cause of adverse birth outcomes, yet at the same time found that women felt this practice was necessary to prevent 'birth pollution'. This concept of 'birth pollution' is constructed spiritually where women and family members see their health as threatened if they do not isolate birthing and postnatal women from contact with household deities (Bennett et al., 2008). Medically, this seclusion of women in the cowshed during and after birth is considered as creating risks of infection leading to higher mortality (Thapa et al., 2001). Contrastingly, researchers have argued that women should not be separated from their cultural settings during pregnancy and childbirth (Brubaker and Dillaway, 2009; Cindoglu and Sayan-Cengiz, 2010; Kontos, 2011; Hall et al., 2012; Lee et al., 2012) and tradition should be embedded within medical care (Rice et al., 1994; Eckermann, 2006). Women in rural Nepal prefer to birth in their community setting to maintain their cultural safety (Thapa et al., 2001; Sreeramareddy et al., 2006; Bennett et al., 2008) and women in diverse societies act differently to enhance childbirth safety (Miller and Shriver, 2012). Little is known about childbirth experiences of women in remote areas of Nepal.

Regardless of women's choices and safety, research consistently reveals a complex relationship between culture and medicine and women's childbirth preferences and practices. In Nepal, policy is medically driven by the concept of 'risk' which requires women to give birth in health care centres and hospitals where services are increasingly technological and instrumental (Regmi and Madison, 2009) despite the practical challenges of this. In this policy context, our paper explores how women living in Nepal's remote mountainous areas experience pregnancy and birth and the related interplay between tradition, spiritual beliefs, risk and safety related to pregnancy and childbirth with implications for improving policy and practice.

Method

The research was guided by social constructionist and critical feminist theories (e.g. Goffman, 1974; Crotty, 1998; Walsh, 2009; Horton-Salway and Locke, 2010). We wished to uncover the Nepalese social constructions of pregnancy and birth, and conduct research to give voice to women from two disadvantaged districts whose views are otherwise rarely or never heard by health services/providers and policymakers. A qualitative approach was utilised with in-depth interviews to derive Nepalese women's accounts of their personal pregnancy and birth experiences in remote mountain villages. This is an appropriate research approach for working with marginalised and vulnerable population groups (Liamputtong, 2009).

Freire's (1970) concepts of oppression, conscientisation and dialogue added insight in considering women's status and control in pregnancy and birth. Central to Freire's (1970) pedagogy is the notion of conscientisation, of gaining consciousness of oppression and making a commitment to end that oppression through dialogue between oppressors and the oppressed. Applying this concept enabled the researcher in this study to examine the influences of associated oppressive relationships and interactions in women's pregnancy and birthing experiences in remote Nepal. Young's (2011) concept of the 'politics of difference' provided an informed understanding of social relations regarding trust, respect and denied differences and the need for mediation with those not local to the community to recognise their differences. Heath's (2007) concept of collaborative dialogue enabled local voices to be foremost while recognising the diverse factors impacting on women's safety and risk during pregnancy and childbirth. Participants' experiences were deemed authentic sources of knowledge (Popay and Williams, 1996, 2006), pregnancy and childbirth experiences were viewed as naturally occurring interactions (Lincoln and Guba, 1985; Mead, 1972; Charon and Hall, 2004) and the researcher's reflexivity was sustained throughout (Mannen, 1988; Hammersley and Atkinson, 1989; Reed-Danahay, 1997).

Setting

The primary author is a midwife from Nepal with inherent knowledge and understanding of maternal/newborn health in Nepal. Women living in remote mountain villages in Nepal often experience lower life expectancy and a higher burden of