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Gender Inequalities and Childbearing: A Qualitative study of Two Maternity Units in Nepal

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Abstract

The role and status of women in South Asian countries like Nepal are widely recognised to be lower than that of men. This gender inequality can be found throughout all levels of society. Our study is about the influence of gender on pregnancy and childbirth, which are very much in the female domain in South Asia, both at home and in health facilities.

A mixed-method, qualitative research study was undertaken in two birthing facilities in Kathmandu Valley to examine barriers to women accessing these services from the perspective of hospital staff. Thematic analysis identified seven subthemes related to gender, namely: (1) support from family, autonomy & decision making; (2) women's workload; (3) finances; (4) women wanting female doctor; (5) consent; (6) delivery room; and (7) preference for male offspring. Overall, gender-based roles negatively impacted many stages

of the mother's childbirth journey. Some staff recognised gender roles as a barrier to women accessing services but did not recognize themselves or their practices as a potential barrier.

Gender issues identified at both birthing facilities generally reflect those of Nepali society as a whole. Raising awareness among maternity-care workers about gender issues and what they can do about it in personal interaction and how they reflect can on it would be the first step to improving the experiences of women of childbearing age.

Keywords: *Skilled birth attendant, Health personnel, Barriers, Access, Gender, Childbirth, Maternity, South Asia*

Introduction

The experience of pregnancy and childbirth is always set within a particular cultural context. Females are disadvantaged in many cultures from the time of their birth. In South Asia, women's childbearing journeys depend upon many socio-cultural factors including wealth, access to education, women's status in society and within her family, beliefs, customs, traditions and taboos.[1-4] These factors can have an influence on Nepali women's abilities to access maternity care locally. The same factors also impact the mostly female maternity care workforce.

It is not just about the role and place of women in Nepalese society, it is also about attitudes towards and expectations of women. Many authors writing about maternity services in Nepal refer to its patriarchal and traditional value systems and practices that discriminate against women.[4-5] Sociologists use the concept of patriarchy to explain the unequal power relations between the genders whereby women are systematically disadvantaged and discriminated against in (all levels of) society. This unequal relationship exists in both high-income countries, such as the UK (United Kingdom) or the Netherlands, as well as in low-income countries such as Nepal or Pakistan.[6] One of the differences between high- and low-income countries is that the gender inequality in more traditional societies is perhaps more obvious.

In Nepal a woman generally leaves her family home on marrying and lives within the extended family of her husband. In that household there is typically a division of labour based on gender and social position in the family. Her mother-in-law has power over the younger

women in the household and has control over the movements and decisions regarding daughters-in-law.[7-8] This will include a wide range of decisions such as what she eats, how heavy her workload is in and around the house, whether or not her children attend school and whether or not she is permitted to access antenatal care. So a newly married women leaves the home where gender has been the biggest determining factor in her life to a new home in which another layer of power – that of the mother-in-law is added to her life. This affects a woman's chance of having a safe birth. For example, a woman in Nepal is significantly less likely to access a facility for birth if her husband has other wives (OR: 0.17; 95% CI: 0.05–0.63).[4] Having previously explored staff perceptions of barriers to facility birth in Nepal,[9] in this paper we specifically explore how gender is perceived by staff as limiting access to birthing facilities and skilled intrapartum care.

Methods

This mixed-methods study[10] comprised semi-structured interviews and non-participant observations. The primary aim of this qualitative research was to explore staff perspectives about barriers to women accessing a facility birth in Nepal, and in this paper we focus largely on gender roles and inequality.

Semi-structured interviews[11,p.116] were conducted with staff working in two small non-governmental hospitals both offering facility based birth to local poor women within their respective catchment areas. Non-participant observation was conducted by the first author in both of these hospitals.[9] A total of twenty participants (P), both male and female, were interviewed, ten at each hospital site. SBAs (skilled birth attendants) included: three auxiliary nurse midwives, two doctors, five staff nurses and four health assistants as well as four support staff such as laboratory technicians and receptionists. Data collection took place over a period of one month at the two hospital sites. Both hospital sites are located in Kathmandu Valley; one is an urban hospital (UH) and the other a semi-urban hospital (SUH), these abbreviations are used as identifiers in the quotes below.

Written consent was obtained from each participant and each participant was interviewed separately by the first author in English or through a Nepali interpreter. All interviews were audio taped and transcribed verbatim. Nepali recordings were translated prior to transcribing and four were chosen at random to be translated twice by two independent translators to test the reliability of translation. Twenty five hours of non-participant

observation was undertaken by the first author at each site. The interview and observation data were analysed using thematic analysis.[11-12]

The Nepal Health Research Council and Bournemouth University's ethics committees granted ethical approval.

Results

The theme of gender inequality has been divided into subthemes which are exemplified using extracts from interviews and pertinent observations. These seven subthemes are: (1) support from family, autonomy & decision making; (2) women's workload (women's completing roles, reproduction verses productive); (3) finance; (4) women wanting female doctor; (5) consent; (6) delivery room; and (7) preference for male offspring.

1. Support from family, autonomy and decision making

Participants said that a woman's decision to stay at home to birth her baby or to attend the birthing unit for delivery was predominantly influenced by either the woman's mother-in-law or the woman's husband. Participants made comments indicating it was not the pregnant woman herself who made such decisions:

> "Most of the women do the home delivery as their mother-in-law prefer home delivery practice." (SUH P3).

A hospital secretary noted that:

> "There are many FCHVs (Female Community Health Volunteers) working in [name removed] community and mothers-in-law of pregnant women [are] influenced [by]…them. Then, mothers-in-law…also encouraged pregnant women [daughter-in-law] to go to hospital for delivery. Some women also get help from their husband." (SUH P8).

To a lesser degree, participants from both hospitals also suggested that sometimes either the woman herself or other senior family members, such as the woman's own mother or father or the woman's sisters or neighbours, influenced this decision. A medical officer from the rural unit stated:

"Sometimes they [the women themselves] also decide and sometimes their seniors and their neighbours suggested women to come to hospital." (UH P3).

Whilst a rural staff nurse had observed that:

"Many women in this area think positive as well as other incentives and prefer to come in this hospital." (SUH P3).

One health assistant from the rural facility relayed a story where one woman appeared to have exercised her autonomy regardless of her mother-in-law's wishes

"…many [women] are coming [to hospital] by themselves. Once a patient was sent [from home] for delivery without anything… when we asked her, her mother-in-law said her, she doesn't have to go to hospital for delivery, due time is not near yet and locked the door." (SUH P5).

2. Women's workload (women's competing roles, reproduction verses production)

The fact that women have to work hard in a traditional society like Nepal was highlighted as a barrier to seeking maternity care. This quote illustrates the workload of a typical woman:

"They look after all the house … they cook the …morning meal , they have to farm the cattles they have and also they have to reach the kids going to school and then they at home give medication for them and have to cook the meal again, that's the main barrier." (UH P10).

One doctor added that it is not just the work of looking after children and parents in the household but also the attitudes and expectations regarding the woman by her in-laws, for example:

"Then, they are less likely to come in the hospital for delivery. On top of that, there are many women living with grandmother (in law) who had a traditional home delivery and they are likely to give birth at home." (UH P10).

3. Finances

One nurse-midwife spoke about the strategy she used to influence women's attendance for hospital birth and in doing so exemplified the gender inequality in access to resources:

> "I encouraged them [women] to come in the hospital to deliver baby. I also encouraged women to provide her husband mobile number. Then, when her EDD (expected date of delivery) is approaching…I contact to women and ask her health, e.g. when are you coming to deliver baby. Then, women come to check up. If she is not in labour…then I do counselling about post-date complications. When women cross over a week of EDD, then, I advise her to come to see a gynaecologist (doctor). Then, doctor counsel her about caesarean section or induction of labour." (UH P6).

Similarly, some women depend upon their husbands to finance hospital visits. One staff nurse said:

> "…for many may be harassment from husband (does not provide money for transportation)…others may not have money for food…during their stay at hospital." (UH P6).

Furthermore, even when women undertake paid work they cannot make autonomous decisions about how to use their income and are expected to justify expenses. One obstetrician expressed this as:

> "…if she is earning herself then she will lose a day's salary for coming here (to the facility) and…she has to explain her money for travelling here…" (UH P10).

4. Women's preference for a female doctor.

In the urban facility the male obstetrician did not think that being a man posed a barrier to women accessing his services and said that if women felt uncomfortable they were able to have a female nurse chaperone. However this was not the view of a number of participants at the semi-urban facility:

> "Number of women for ANC check-up automatically increases if we have woman doctor gynaecologist/in the hospital…We prefer women but sometimes male doctor

also comes here. Local women do not want to examine with the male doctor…we are focusing on female gynaecologist…but they are not regular as they show different reasons. Doctors are getting more money in Kathmandu" (SUH P8).

In the same hospital it was noted that when to female doctor left fewer women came there for their maternity care:

"Many women came to see the female doctor but [she]…discontinued coming here and the flow of women…decreased…we are not able to appoint female doctor to provide the services" (SUH P9).

5. Consent

Consent was often seen as a family affair, not the individualised Western notion of informed consent. One participant, a trained SBA, described the procedure she took when talking to women about safe delivery and risk factors associated with birth saying:

"Before delivery, when they [woman] come with…labour pain, at that time I do the VE [vaginal examination]. Then, I explain about the findings and risk factors before delivery. Then I take consent from the visitors or patient's party…to agree to deliver the baby in this hospital…if they don't have any other family members…[and] the pregnant woman is well educated, then we…take consent from her" (UH P6).

Two things are interesting from a Western notion of informed consent. First, the staff member does a VE before obtaining consent to delivering in hospital; secondly, the discussion around consent is with the woman's relatives, and only if the woman is in hospital without relatives and is educated is her own consent accepted.

A more general problem is related to status and authority, namely that poor women often do not speak up about their problems and issues, making the work of health care providers very difficult, for example one staff nurse noted:

"They [childbearing women] don't speak whether they have the problem or not. How can we know their problems if they don't speak?" (SUH P3).

6. Delivery room

Participants at the urban hospital offered contradictory responses when asked "Who is allowed to accompany women in the delivery room?" One health assistant listed selected female relatives:

> "…sometimes, mother, sister, mother-in-law, senior sister (not younger sister)" [can go into the birthing room] (UH P4).

There were some interesting situations of men being excluded, i.e. gender discrimination against men as one staff nurse highlighted:

> "…we don't allow male visitors…we don't have any fixed policy… if there is someone female who can stand by her side then we allow her. No one has even asked here yet" (UH P2).

Another participant, a doctor, said husbands could go into the birthing room but qualified this by saying:

> " … if he is brave enough, most of the time they do not prefer to go delivery unit…most of the women they don't like their husband to be in labour room" (UH P10).

At the semi-urban hospital one of the participants shared the following story:

> "I was assisting…a young lady…to deliver baby. She was co-operative but her mother–in-law was not…Her mother-in-law wanted to go in delivery room which was not allowed in our country. I think it is allowed in the foreign country, yes? I told her…you are not allowed to go inside. We are trying our best and if any complication we will inform you. At that time, she [mother-in-law] was little bit difficult. Only health care staffs are allowed in to the delivery room" (SU P3).

Expanding upon this discussion to determine whether this prohibitive practice could possibly deter women from facility birth the same nurse said:

> "No. They [public] don't have that type of concept. They know they are not allowed to go into the delivery room. They know the rules of the hospital" (SUH P3).

However, this was not the view of a health assistant working in the same facility who said:

> "Here we don't allow family members during…delivery, but the family members and visitors of patients wanted to stay with the patient during delivery. So we usually have this complaint from visitors" (SUH P9).

Some participants offered explanations as to why relatives were not permitted to enter the delivery room:

> "To maintain privacy. Patients feel odd/discomfort as they don't want to see mother, mother-in-law at that time. Even they [labouring women] feel discomfort with the staff. Also, to maintain sterilization as visitors are wearing outside clothes…Most of the patient[s] don't want…them coming in the room" (SUH P9).

However one participant claimed that husbands were allowed in for delivery saying:

> "It was not before, now they can come in delivery room" (SUH P6).

Despite 25 hours of observations at both facilities by the first author, only one woman was admitted in early labour and she was left to mobilise on her own in the antenatal ward.

7. Preference for male offspring

Several participants from both facilities talked about preference for male offspring and the pressures placed upon staff as a consequence:

> "…I think when somebody gets daughter, after that it's still, we need son… family members [say] why did you not get son?" (UH P5).

Interviewees hinted at sex selection whereby women go over the border to India, one doctor noted:

> "Occasionally, some women prefer male child. They want to make sure either this is a male child or not (although it is illegal)…they go to neighbouring country India to find out the sex of the child and if it is female, they do abortion" (UH P10).

The same doctor highlighted how far women would go to come home with a baby boy. They may accuse health workers of swapping the baby in the hospital and giving them a girl as this quote illustrates:

> "Recently ... two women had delivered at same time and the women had come to claim the baby was mine as she felt baby was swapped. Then we did blood test, DNA check to show the proof for evidence" (UH P10).

Interestingly one interviewee specifically referred to gender discrimination:

> "…women do not get family support...for example, one woman came alone for delivery. The woman has already two daughters, her husband preferred son and he encouraged (her to) …abortion but she came alone … Family pressure is another barrier. There is gender discrimination in the society and it is other barrier" (SUH P9).

Discussion

The themes of gender roles and gender discrimination affecting women's use of maternity services were referred to by participants without this having been the main area of questioning at the time of interview. The seven sub-themes identified in this paper are inter-related and all point to the overall finding that most women have very little decision-making power over their own pregnancy and childbirth experiences. However, we should not forget wider gender issues such as the gap in access to education between boys and girls as well as social inequalities deriving from social stratification other than gender, particularly caste and social status. Although gender remains a major societal issue, on a local level, an increase in staff awareness around the existence of gender issues and the effects these have on women accessing facility birth is paramount. We concur with Sharma and colleagues[13] who concluded that "Maternity care providers need to be aware of local values, beliefs and traditions to anticipate and meet the needs of women, gain their trust and work with them". These seven subthemes (1) support from family, autonomy & decision making; (2) women's workload; (3) finance; (4) women wanting female doctor; (5) consent; (6) delivery room; and (7) preference for baby boys, will be discussed in turn below.

The first subtheme 'support from family, autonomy & decision making', relates to the point that when women of childbearing age access services their mothers-in-law and husbands predominantly exercise power over decisions made with regard to where to give

birth.[8] Thus, the female mother-in-law and the male husband have a powerful influence on decisions around women's reproductive health.[14] They can advocate for the woman, but there is fine line between advocating on behalf of someone who is unable to voice their own needs and making decisions on their behalf and not allowing them to express their own needs and wants. Lama et al. have a great quote[15] illustrating Nepali women's general perception that men make the decisions in life: "Women don't speak up in the assembly . . . they think that men will discuss and make decisions, so they just go and leave before the assembly ends." At the point at which a woman comes into contact with facility staff many decisions around her pregnancy and childbirth appear to become the automatic remit of staff. These members of staff are often a combination of male and female health care providers. Overall childbearing women seem to have little opportunity to make autonomous childbirth decisions themselves, such lack of dignity and respect has been noted by Bowser and Hill.[16]

Secondly, our interviewees talked about the high workload of women, something widely reported especially reports on rural Nepal.[17] Many women of childbearing age lack support from family regarding their unpaid workload in the home and caring for family members. Although there have been a social changes in Nepal, the social inclusion of women has been uneven.[18]

Thirdly, 'financial control' which links strongly to the first theme of autonomy and decision-making in a patriarchal society. It is worth remembering that many rural women work very hard in the home or on family land yet they may not have access to money, hence they are financially and materially dependent on men.[18] Without access to cash any decision that has a cost attached, such as paying for transport to get to clinic, or paying for medical supplies requires permission of the person in the family who controls the purse strings. Acharya and colleagues highlighted that Nepali women who earn money are more likely to participate in health care decision making than those not employed and not working for cash.[19]

Fourthly, it is relatively common for female patients to prefer female health workers, especially around issues of sexual and reproductive health.[20-22] For example, several participants in a study in Nepal by Wasti and colleagues were too shy to discuss sex and family planning methods with or even approach a health worker about services, especially if they were of the opposite sex.[23]

Fifthly, our findings suggest that staff seek support from relatives to explain aspects of care to women; this observation is supported by Erlandsson *et al*.[24] Shrestha[25] noted that the law in Nepal states that "consent has to be obtained for treatment or operation by certified physician and in case there is no one to give consent and if the certified physician feels that it is for the benefit of the patient, he or she can proceed without consent…..It is so vague and incomplete." It seems from our study that staff members assume that the husband and family elders (usually mother-in-law) are the right people to make decisions on behalf of the woman rather than thinking: "Is the woman in my care herself able to understand what is being requested?"

Sixthly, our interviewees offered a range of quite different insights into who was allowed into the delivery room and when. It also appeared that once staff had obtained consent from relatives these relatives are no longer required by the staff and were expected to leave the room. There appears to be no formal hospital policy or around whether or not a birthing woman can have her husband or other family members accompany her during birth in either of the birthing facilities. The general consensus appears to be that husbands are not allowed in the delivery room whilst older female relatives are. However, this practice was inconsistent even among staff working in the same establishment. Observations are unable to support or refute staff claims as no women were admitted in established labour to the labour or birthing room during observational visits.

The literature suggests that it is common for men who escort their wives to a birthing facility to have to wait outside the delivery room while their wife gives birth.[26] However, some birthing facilities in Nepal are changing and 'encouraging' husbands to be present at the birth.[24,27] Although Nepalese husbands tend to feel emotionally overwhelmed when they attend the delivery room during their baby's birth and prior preparation in the form of couple counselling had been advocated.[27-29] At the same time studies suggest women want their husbands to be involved during childbirth.[29-30]

Finally, there is a preference of sons over daughters in large parts of South Asia, for example in Pakistan[31] and Nepal.[32] Mahato and colleagues[33] recently commented that among Nepali women self-stigma related to giving birth to a female child is a social problem. Furthermore, Wasti *et al*. highlighted the seriousness of the situation as some men in their study threatened to leave their wives if they do not give birth to a son.[23] Patriarchy is

ingrained in Nepali society as illustrated by Sharma[34,p.53]: "Females are discriminated against since early childhood and it goes on till their adult reproductive years and beyond."

Strengths and weaknesses of the study

This qualitative study looked at barriers to accessing two different maternity hospitals from a staff perspective. An additional strength is that it highlighted a range of issues related to gender inequalities. A weakness is that it is hard to determine whether staff perspectives truly represent communities' points of view or just their own. For example, they say no one was allowed in the labour room because they are trying to reduce cross infection and there is not enough room. But this is perhaps their excuse because they do not agree with the labouring women having female companions or her husband. Is it possibly a form of defensive practice because they are worried about possible consequences if relatives witness a difficult birth or feel ill prepared to deal with possible confrontation or complaints. Furthermore, it is difficult to focus on gender issues without also taking into consideration other social stratification, such as inequalities in education, caste or age. A recent study elsewhere in Asia in Afghanistan[35] contends that there are deeper layers of culture and meaning that affect maternity care staff's ways of thinking and working, which are not limited to gender.

We have to remember that gender inequalities affect both men and women in society. For example, qualitative evidence reports husbands' feelings of belittlement by friends and neighbours when they have tried to participate in their wives antenatal care .[36-37] In other words, men who try to be more supportive of their pregnant partners are also 'offending' against gender norms and stereotypes.

Conclusion

Gender issues are cutting across women's child birthing journeys including those identified at both birthing facilities generally reflect those of Nepali society as a whole and mirror those experienced in high-income countries such as UK years ago. When the woman's journey through the process of childbirth is mapped, the powerbase fluctuates between various people who believe they are supporting her, but is seldom seen to be in the hands of the woman herself.

Gender issues need to be addressed to help tackle barriers to women accessing and receiving appropriate facility birth care. Members of staff need to be mindful of the way they practice as they often, perhaps unintentionally, perpetuate gender discrimination practices that are not always in the best interests of the women and families they care for. Raising awareness among maternity-care workers about issues of inequality (not just gender) and what they can do about it in their personal interactions and how they reflect on it would be the first step to improving the experiences of women of childbearing age. At the same time Nepal has to work at the societal level to increase the role and status of women in society.

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