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Sabitra Kaphle
Central Queensland University, Australia, s.kaphle@cqu.edu.au

Lareen Newman
Flinders University, Australia, newmlar99@gmail.com

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Critical social determinants of childbirth outcomes in remote mountains: Voices of women from Nepal

[1*]Sabitra Kaphle, [2]Lareen Newman

1. Sabitra Kaphle, Lecturer – Public Health, RN, RM, PhD
   School of Health, Medical and Applied Sciences
   Central Queensland University, Melbourne Australia
   Email: s.kaphle@cqu.edu.au
   Phone: +61 3 9616 0586
2. Lareen Newman, Senior Research Fellow, PhD
   Southgate Institute for Health Society and Equity
   Flinders University, Adelaide, Australia
   Email: newmlar99@gmail.com

Corresponding Author: Sabitra Kaphle

Abstract

Objectives: Despite efforts made by the Government of Nepal to reduce maternal and newborn mortality nationally, the rate is still significantly higher in remote mountain areas. This research aimed to fill a gap by asking women about socio-cultural factors influencing childbirth outcomes in remote mountain areas of Nepal.

Methods: This study used a qualitative approach guided by the principles of social constructionist and feminist critical theories to derive factors influencing women's experiences of giving birth and childbirth outcomes. In-depth interviews were conducted with 25 pregnant and postnatal women. A thematic approach was used for data analysis.

Results: Childbirth outcomes in remote areas are influenced by the broader social determinants; specifically, physical access to hospital services; remoteness, poverty, and food insecurity; and disconnect between policy, practice, and reality.

Conclusions: Women's voices highlight the influence of critical determinants in determining childbirth outcomes, a situation which requires an immediate policy shift to a social determinants approach to improve maternal and newborn survival rates.

Keywords: *childbirth, women, culture, social determinants, remote, Nepal*

Introduction

Globally, inequalities in maternal, newborn and child health across the socioeconomic gradient have been a critical concern, with the gap in low- and middle-income countries widening due to the unequal distribution of resources and services.[1] Given that every five minutes three women die from pregnancy and childbirth related causes, another 60 suffer from associated problems, and 70 children die - nearly half of them newborn babies[2], the imperative for finding solutions has been complex and challenging. Significantly, almost all (99%) of these maternal, newborn and child deaths occur in developing countries.[3]

The influence of broader social factors on maternal, newborn, and perinatal survival is a critical issue in remote communities in Nepal.[4] People in remote areas have particularly poor social, economic, and health conditions while experiencing chronic food insecurity[5] and higher fertility, morbidity and mortality rates.[6] Whilst there are concerns about access to services[6-9] - what remains unanswered is the interplay between social factors influencing birth outcomes, and whether effectively addressing these factors could reduce the death rate.

Perinatal mortality remains significantly higher (over 40/1000 live births) in the remote mountains in Nepal[10], where local traditions, social values, and culture play significant roles in childbirth safety.[11] Regardless, women in the mountains usually experience a series of pregnancies where nearly half the babies die in the perinatal period.[4] Geographic barriers to accessing services and related economic disparities contribute to the experience of poor birth outcomes.

The significance of policies and actions on the social determinants to promote equal health outcomes has been consistently reinforced for over four decades as being imperative to reduce existing inequalities in pregnancy and birth outcomes, as addressing these determinants potentially improves women's access to services and resources.[12] The issue of access is more complex in remote areas with inequitable service distribution and additional costs associated with travel and time off work. [13.14] Effective actions are therefore required to address these underlying determinants of maternal, perinatal, and newborn health outcomes.[15]

The Government of Nepal has taken several steps to improve access to health services, but so far has not addressed the social determinants. One of the earlier attempts was a significant shift in childbirth services in 2009 by introducing free services - the Aama Program - with the

aim of addressing financial barriers to accessing institutional and medical care.[16] This is a continuation of Nepal's Maternity Incentive Scheme launched in 2005 which provides cash payment to women giving birth in health facilities or assisted by health workers, and incentive payments to the health workers to attend home births.[17] These policy initiatives enabled Nepal to reduce maternal mortality from 539 maternal deaths per 100,000 live births to 239 between 1996 and 2016, but still only one in three births are attended by skilled birth attendants[10,18] and questions remain regarding the equitability of progress in terms of meeting the needs of women in remote areas, where more than 80% of births occur at home without health workers present.[18]

Despite the efforts made, substantial regional inequalities continue in childbirth outcomes in Nepal.[4] Studies so far mostly focus on service use in urban and semi-urban areas[8,19,20], thus the understanding about the social determinants impacting high rates of maternal, perinatal and newborn health in the remote mountain communities is lacking. The issue of inequities is acknowledged and the attention is given to increase service utilisation[20,21], yet there is insufficient improvement. This research therefore aimed to explore the influences of socio-cultural factors on pregnancy and childbirth experiences of remote mountain women in Nepal.

Methods

In this research, social constructionist and critical feminist theories[22,23] provide a framework for explicating the voices of women from remote and disadvantaged villages in mountainous Nepal; the views of these women are otherwise rarely or never sought or heard by researchers, health service planners or policymakers. Using a qualitative approach, participants shared their experiences of pregnancy and childbirth through an in-depth interview process[24], including relating their personal experiences.[25]

Setting

The lead researcher is a qualified and experienced midwife from Nepal with inherent and formal knowledge and understanding of maternal and newborn health policies, programs, and experiences, including prior experience providing care in remote mountain settings. The fieldwork was conducted in villages in Mugu district, which ranked the lowest in Nepal on the Human Development Index (HDI) at the time of the research in 2010. The researcher had not been involved in any capacity in these villages previously.

The study villages were selected purposively because of their remoteness, being two days walking distance from the district hospital. The higher-level referral hospital with comprehensive services was accessible only by air and with flights mostly inaccessible to village women because of cost, inhospitable weather conditions for half of the year, and the several days walk required to reach the airstrips.

Participants

Study participants were 25 pregnant or postnatal women living in remote mountains in Nepal. Women who had been living in the village for at least the last five years were invited to participate if they were pregnant or had given birth within 4 weeks of the interview date. For recruitment, the researcher used a female community health volunteer (FCHV) who was a trusted and known person by all pregnant and postnatal women. The age range of the women involved was from 17 to 43 years, only one woman was a first-time mother, and 20 women were illiterate. Only five had experienced childbirth in the hospital, and the number of pregnancies each woman had experienced ranged from one to 11, while age at marriage ranged from 13 to 25 years.

Interviews

In-depth interviews were the primary data collection method. All interviews were conducted by the lead researcher in the Nepali language at a location chosen by the women at their preferred time (mainly in the kitchen area of their home, or the farm field if they were working there). Interviews lasted from 40 minutes to two hours in single and multiple sittings as needed to ensure women felt they had said all they wanted to say on the topic. Interviews were guided by broad research questions with prompts as required and were audio-recorded with participants' consent. To enable participants to feel trusted and achieve authentic data, all interviews were conducted in a respectful conversational manner, with the researcher listening attentively and clarifying any concepts as needed. The lead researcher used bracketing during the research to be lateral to the participants with an appropriate professional and ethical distance.[26]

Analysis

Interviews were transcribed verbatim and simultaneously translated into English by the lead researcher. A cross-check of the translation was done with a Nepalese social science researcher

to ensure data integrity and correctness before analysis. Data were analysed using a thematic analysis process.[27] The preliminary themes and the relationships between the themes were checked for credibility and integrity with the other team members and refined as required.

Ethical considerations

This study followed the standards and guidelines for research set by the Australian National Health and Medical Research Council (NHMRC). The Social and Behavioural Research Ethics Committee (SBREC) of Flinders University in South Australia granted ethics approval along with the Department of Health of the Government of Nepal. A verbal consent procedure was used with all participants due to a widespread lack of reading literacy. Permission for women to participate was also sought from their family, as this was culturally appropriate to maintain trust and social expectations. To protect women's identities, pseudonyms are used for interview quotes.

Results

Three key determinants derived from the data are: (1) physical access to hospital services; (2) remoteness, poverty and food insecurity, and (3) disconnect between policy, practice and reality. These determinants added to the complexities of social context within the women's daily lives. These factors are explained herein using the women's voices.

Physical access to hospital services

Since the Government of Nepal announced free services for pregnant and birthing women in 2000, there has been an expectation that women would increase their service use.

Between 1996 and 2016, there was an average 71% increase in institutional deliveries in urban areas, but only around a 36% increase in remote areas.[21] Some insight into this is provided by women who raised a question about the feasibility of them walking two days from their village to a hospital.

Juna questioned why the current health system even wants women to go to hospital:

> *To be honest, we don't think about going to hospital for check-ups or to give birth. Going to hospital is not our tradition and we give birth where we are – sometimes at Goth (cow shed beneath the house),*

sometimes at Lek (farmland) and sometimes at home. Why do they want us to go to hospital which is miles away? We are happy to stay home and give birth instead of walking several hours. If they make hospital in the village, then we will think about it. Otherwise, this doesn't work for us. Juna (age 42, 7th time pregnant, mother of six)

Women like Juna feel comfortable to stay home and give birth in their village. They do not see any need to go to hospital and see no benefit of walking a long way to reach a hospital to give birth. Women also saw the local geography as a major barrier to accessing formal care; for example, to get to hospital requires a long walk over steep mountainous terrain with makeshift bridges crossing fast-running rivers far below. In addition, the concomitant interruption to their everyday household chores makes seeking to hospital services inappropriate for women.

Jitu talks about this complexity:

Even if we want to give birth in the hospital; we can't do it. We have chores, family, and children – we can't just leave them and walk off. People [referring to health workers] don't understand our problems. I don't have time to walk to hospital and walk back – it takes a week. I can't lose a week of work. Everything needs to go with the season here – otherwise we will go hungry. Jitu (age 42, 8th times pregnant, mother of six)

Jitu's last baby died in pregnancy but she did not make any comment as to whether hospital services could have saved its life. For most women, the requirement to leave their domestic responsibilities to travel to hospital reflects the lack of understanding of women's social circumstances in service design.

Toma expressed similar concerns and raised several questions:

They [health workers] want us to have regular check-ups and give birth in the hospital. This is not going happen for us. Who will do our work? Who will take care of our children? Who will cook for our family? This might make no sense to them, but we can't avoid our work to go for check-ups. Toma (age 26, 4th time pregnant,

mother of two)

Toma gave birth to all her babies at home, one of them died within a month. She was told to have regular checks during pregnancy, but she could not afford to leave household responsibilities and make a trip to the hospital for a check-up. In that sense, it was unreasonable and impractical advice that health workers were giving to these remote women to follow to manage their pregnancy, childbirth, and postnatal experiences.

Toli gave birth to twins and both died within five days. She thinks that services could have helped prevent their deaths but felt she had no choice:

> *If there were better services; my babies could have survived. I heard in the city hospital not many babies die. We can't go the city and there are no services available in the village. Regardless our circumstances, we need to keep going [carry on with our life] and accept any outcomes. Toli (age 20, 3rd time pregnant, mother of one)*

These narratives highlight the need to take women's social context into account in health policy, service delivery and program design. As women made clear, asking them to walk to the hospital for prenatal checks or to give birth in health institutions is not practical, particularly when they are heavily pregnant. The reasons for women not accessing services are not easily overcome without addressing the geographic, social, structural, and economic barriers they face.

Remoteness, poverty and food insecurity

Women involved in this study consistently referred to themselves as poor, uneducated, disadvantaged and "remote mountain women". Our analysis confirmed the significant interrelationship of geographic remoteness, poverty and ongoing food insecurity with their pregnancy and childbirth experiences.

Hira spoke about everyday challenge:

> *We live in remote area. We are poor. We don't have food to eat. We don't have money to buy food. We can't grow anything. We need to*

> *go to headquarters to collect rice that the government provides, which does not last long for our family. We are stressed. What to eat is our everyday struggle. Hira (age 17, 2nd time pregnant, mother of one)*

It is difficult for women to stay healthy and strong to give birth to strong babies when there is a consistent food shortage. The villagers are not able to produce enough food for the whole year due to the high-altitude topography and extreme cold weather. Food supplies brought from the urban area via helicopter have been attempted but this is not a reliable or sustainable option. Generally, women walk to the district's administrative headquarters for several hours to fetch rice supplied by the government, which is an inefficient and unreliable system. In a culture where women also eat last in the family, they tend to not get a decent amount food at any point, even when required for pregnancy health.

The issue of not having enough food to eat, which, in turn, required women to work harder with no rest during pregnancy, is further highlighted by Dolma:

> *We are very poor. We have a daily struggle to find food in the village. We don't have money to buy food. We don't have business or jobs. I worry that my children may die of hunger. It is a hard work to find food. Check-ups, nutritious food or taking rest during pregnancy doesn't work for us. Dolma (age 35, 7th time pregnant, mother of five)*

For most women who have consistent pressure and responsibilities for household chores and feeding their family, it is not feasible to attend services which are miles away. Even if services are made free in hospital, taking women away from their daily routines on long trips to and from the hospital adds further risk to their physical and emotional wellbeing. Against this scenario, it is not at all surprising that there is no increase in the uptake of medical/hospital care during pregnancy and childbirth.

Disconnect between policy, practice and reality

A tension existed for women when they were informed about the need for hospital care and good nutrition in a situation where no services and resources were made locally available to

them. Women were concerned that health workers would tell them what to do without knowing their circumstances.

Tolma shared her concerns:

> *They [health care providers] often come and tell us to eat better food, to take rest and to go for regular check-ups. They do not understand our struggles in the village. The nurse should come and stay here, so we can do check-ups. They never come but they want us to do all those things which are impossible for us. Tolma (age 23, 6th times pregnant, mother of three)*

Telling women what needs to be done without enabling the environment for that to happen cuts off dialogue and raises a social justice issue. Some women hoped that services could be provided at the village level.

Rima mentioned:

> *The health workers don't care what we need. They keep asking us to come to hospital. The way these health workers are treating us is not helping to improve our situation. Rima (age 35, 10th time pregnant, mother of six)*

In this complex social environment, women strongly believe that if the health workers want them to do regular check-ups, then the services should be made available in the village.

Toli commented about the lack of local health services and support:

> *We have a health centre building with no people here. The health workers don't come, and the building is mostly closed. We don't get any care or medicines in the village. Our men usually buy some medicines when they go to the city. We use that when we have fever, pain or headache. This is how we manage. We do not have a doctor or nurses here to do pregnancy check-ups or to treat our sick babies. Toli (age 20, 3rd time pregnant, mother of one)*

The geographic disadvantage and difficulties of accessing basic care in the village highlights the criticality of addressing structural and system barriers if mortality rates are

to be further reduced. Overcoming geographic inequity in the utilisation of services has been a critical barrier in promoting maternal and newborn health in many developing countries (28, 29). However, our research raises the issue of how women are supposed to access medical services when they are provided in inaccessible locations, given the social, structural, and practical contexts of their daily life.

Discussion

The geographical context of women in this study not only restricted them from access to services but also limited their access to a reliable food supply, which is important for the overall health of mother and baby. Given the continued focus of the government on strengthening and maximizing the impacts of primary health care, women are urged to attend institutional birth, yet the women raised significant concerns about the way the health system does not work for them due to an institutional-centric focus which does not acknowledge their daily realities.

Women in remote villages prefer to give birth in their familiar community settings.[4] One of the critical factors raised is the lack of village-based basic healthcare. We argue that these women are struggling to exert their basic human rights in maternity care,[30] in that they should be supported to achieve "their right to have control over and freely and responsibly on all matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence" as enshrined in the 1995 United Nations 4th World Conference on Women. Studies conducted in Uganda[31], Brazil[32] and Ethiopia[33] provide similar insights about women's preference for homebirth to continue alongside household responsibilities, so as to meet the expectations of family and society.

While other studies also report the socio-economic disadvantages experienced by women in remote Nepal[4,19], our research explored the complex social and structural determinants impacting pregnancy and birth outcomes. The associated financial costs and physical exhaustion to reach the only services provided are often overlooked, thereby clearly limiting the women's abilities to stay healthy and well in pregnancy and early motherhood. Research in Tanzania[34, 35], Cambodia[29], and Nigeria[36] highlights similar barriers for women to access quality maternity care. For remote mountain women, though there was no direct financial cost for services if they could get to the district hospital, the women's absence from their everyday work in the village, the physical hardship of walking to hospital (not to mention particular difficulty in the seasons with heavy snowfall) and the psychological impact of leaving

the family behind are critical factors which intertwine to prevent them from wanting to use the care on offer.

It was noted that the serious impact of ongoing food insecurity in these regions for a significant number of months each year was overlooked at many levels. This also relates to the social expectation for women to feed the family and was most concerning to the researchers when considering ways to make pregnancy and childbirth a safer experience with mothers needing to receive at least a basic level of food intake (far from the good nutrition encouraged for pregnant women in Western nations). This issue is complex because no or minimal food production relates to the region's climate in the mountains, while external food supplies have not been reliable enough to meet the needs. In this scenario, educating women about the need for eating healthy food seems unethical and further marginalising as they are struggling to gain access to basic food supplies. Many studies report the direct link between food insecurity and maternal mental health[37-39] which women in this study indicated as an everyday worrying matter.

Women's emphasis on bringing services to the village rather than the women having to get to services, which were miles away, is an important approach that may improve basic healthcare provision which, in turn, could help improve survival rates for mothers and newborns. If services are not located where women need them to be, it is more likely that women will continue to give birth in their village in the absence of any opportunity to be supported to change. Unless these questions and the socio-structural aspect of general wellbeing are effectively addressed, these women will not be unlikely to change their practice. In Nepal's remote regions, almost nothing has changed in two decades since the United Nations Population Funds (UNFPA) observed that "women's needs often do not rank high on government's or communities' list of priorities.[40] Women still lack full power to choose the care they want, and available safe motherhood services cannot address demand because of distance, cost, or socio-economic factors.

Although improving maternal, perinatal, and newborn survival has been a political priority in Nepal, these remote women's voices show that it has not been effectively translated into practice to address existing social and structural determinants, thereby perpetuating regional inequities. This study identified the influences of critical determinants to pregnancy and childbirth experiences of women in remote mountains, which are also acting as barriers to ensuring equity in health service use. Consequently, women living in remote mountain areas

have been experiening the ongoing burden of poor pregnancy and childbirth outcomes. Thus, these social determinants must be considered in planning and addressed effectively while developing future strategies and actions in order to reduce the inequities of maternal, perinatal and newborn health outcomes across Nepal.

Conclusion

This paper presented findings from research conducted with women in remote mountain villages of Nepal. It showed that critical social determinants are impacting childbirth outcomes by making women unable or unwilling to seek or use health services. These determinants play a significant role in determining why, where, and how women choose to give birth. Women highlighted two alternatives that work for them: to continue giving birth within their community setting in the same way as they undertake other everyday chores and accept the outcomes – whether positive or negative, or for the government to make services available in the community for women to access when needed. The findings suggest that policy and programs should focus more broadly than on services and address key determinants impacting mountain women's everyday life so that these women are empowered to experience birth as a celebratory event in the same way as many women do in urban Nepal.

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Conflict of interest

The authors declare that they have no conflict of interest.

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