Pregnancy and Childbirth in Nepal: Women's Role and Decision-Making Power

Pratima P. Acharya and Dilu Rimal

Nepal is a land-locked country situated between India and China. The landmass of Nepal is 147,181 sq. km and the population is 23.1 million (Central Bureau of Statistics 2001). Nepal is famous for outdoor adventures, as eight out of ten of the world's highest peaks are there.

This country's lifestyles, dress and foods are similar to China and India as it advances through the trans-Himalayan and North-Indian trade route. Although only approximately 11% of Nepalese believe in Buddhism, Buddha's spiritual thoughts spread throughout the world from within the borders of present day Nepal. However, about 81% of its population believes in Hinduism, and Nepal was the only Hindu kingdom in the world until 2006, when a secular constitution was adopted. Nepal has a history of originating two major religions in the world.

Nepal is one of the poorest countries in the world, with a gross domestic product (GDP) of US$1,500 (CIA 2007). The country's difficult topography, lack of natural resources and lack of sea access isolated it for centuries and slowed down economic growth. Many Nepalese are still living in isolated villages without transportation, electricity and means of communication and travel by foot for food, clothes and healthcare to town centers.

As shown in Fig. 1, Nepal is divided into three main regions based on topography: mountainous (snowy mountains), hilly (middle) and terai (narrow strip of flat terrain). The density of population is rising in the terai region, because the topography is suitable for agriculture. The climate varies significantly between regions from extreme cold to moderate and hot in the mountain, hill and terai respectively.

Nepalese communities have a multi-ethnic and caste system. Each ethnic group and its castes has its own culture, lifestyle and beliefs. Although there are 102 ethnic groups/castes (Central Bureau of Statistics 2001), they can be divided into two

P.P. Acharya (✉)
Auckland City Hospital Auckland, New Zealand
e-mail: ppoudel@yahoo.com

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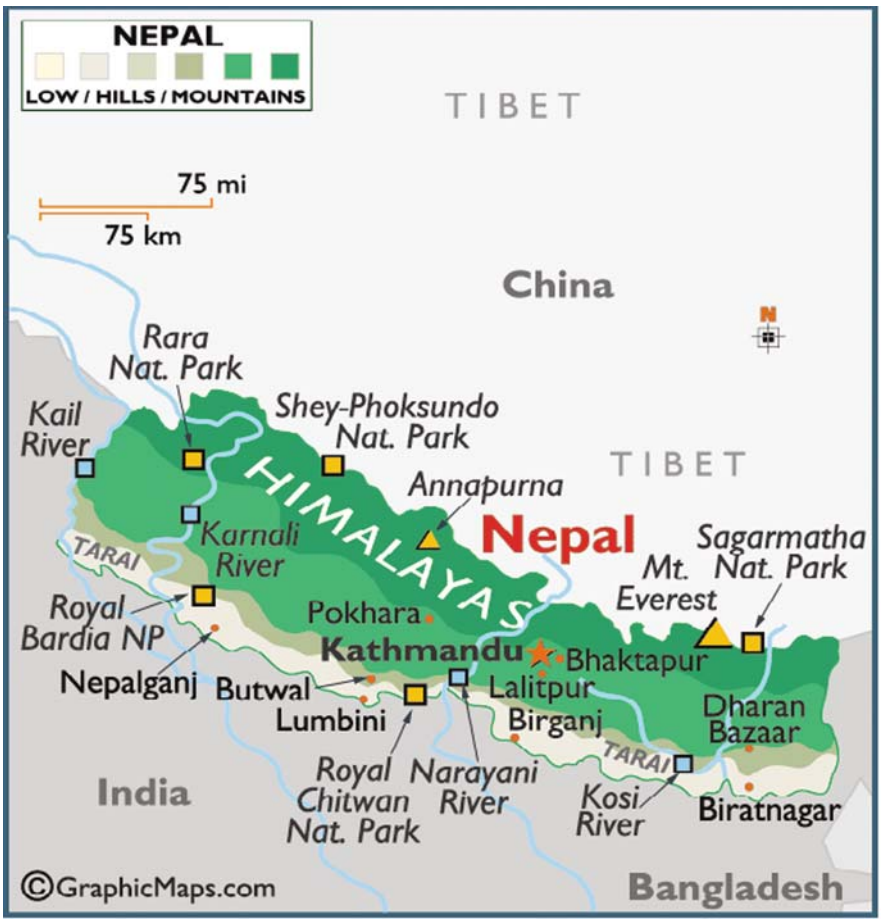

Fig. 1 Map of Nepal retrieved from worldAtlas.com. Used with the kind permission of the publisher

main ethnic groups: Indo-Aryan from India – Nepal's largest ethnic group – and Tibeto-Burmese.

Women and Power

Traditionally, Hindu values and patriarchic ideology are the governing forces of the Nepalese social system, and these establish the status of women and their power. Although some exception exists in Tibeto-Burmese groups, the increasing trend is towards adaptation of these values by upwardly mobile groups (UNICEF 1996). In Hindu mythology, the goddess Laxmi symbolizes women's birth. In addition, women divinities such as Durga [mother of the universe] and Kali [a form of the

mother goddess] hold equal power as men. However, in reality, women have a lower status than men. Thus, socially constructed gender ideology, i.e. patriarchic rule, plays a key role in defining women's power and status.

Because of this, the birth of a baby girl is not often welcomed. Women did not have birthrights over patriarchal property until 1990 and they are excluded from the death rite of their parents (Malla 2000). By contrast, our tradition and cultural system recognize the status of sons, knowing that they will carry the family name and provide a gateway to heaven by performing the death rites of their parents (UNICEF 1996). It is therefore, mandatory for a Nepalese family to have at least one son to gain the above rights and control over parental property. In most of the developing world, even where women are economically independent, women's pride and prestige is determined primarily through their roles as sons' mothers (Van de Walle and Ouaidou 1985). Further, women consider bearing more children, as they wish to have more sons and improve their social and spiritual status. This puts women in a paradoxical situation by creating a high fertility rate, which often involves related complications and even death (Thaddeus and Maine 1994). The maternal death rate is 281/1000 with a high fertility rate of 4.01 children born/women. The average annual birth rate is 30.46 /1000 women (CIA 2007; USAID 2006). Approximately 868,540 women get pregnant in Nepal in each year and 10% of these pregnancies end up with surgical abortion due to complications during pregnancy or self-birth termination with herbal remedies.

Education and socialization play a pivotal role in developing courage, self-confidence, self-esteem and decision-making ability. Education and socialization between boys and girls in Nepal differ (UNICEF 1996). For instance, many Nepalese parents invest in the education of their sons, because sons support their parents when they are old (UNICEF 1996; Subedi 1993). To some extent, underdeveloped retirement schemes increase fear and insecurity during old age, further emphasizing the importance of investment in boys' education (personal experiences, 2006). Instead of being educated and socialized, girls are protected against wrongdoings relating to their character and virginity, which may exaggerate unnecessary harassment and burdensome marriage. Girls in Nepal must marry. They are brought up with many social restrictions and interact only with their mothers inside the home, where they learn family values and household chores (Tuladhar 1995). In addition, decision-making, opinion-formation, strength of expression, and assertion of needs are discouraged during the growth and development processes. Such processes ultimately suppress emotional growth and personal power and freedom, but they develop "feminine" qualities such as self-denial, self-effacement, unassertiveness, gentleness, sacrifice, obedience and submissiveness (Subedi 1993). In this way, a daughter grows up without her own rights and the power to control her own life, but she certainly knows family duties.

Women learn to remain under the control of men throughout their lives, as they must depend on their father before marriage, then on a husband and finally on a son in their older years. Nepalese girls face early marriages before the age of twenty. This also lowers the female literacy rate, which is currently 35% (CIA 2007; personal experiences 2004).

Reproductive Health

The reproductive health of women to a large extent is determined by general health. This means that the health of the mother begins with her own birth, and includes how she had been looked after in her childhood. During pregnancy and around the time of childbirth, the health of the woman depends on her pre-pregnancy health status, nutrition and access to health care. In many developing countries including Nepal, the girl child is discriminated against in accessing quality health services and food, both in her early childhood and later in life when resources are scarce. A study conducted by Hossain and Glass (1988) in Bangladesh indicates that doctors were consulted three times as often for sons than for daughters. Further, purchases of drugs prescribed by physicians were approximately three times as frequent when the prescription was for a boy. A study conducted in Asia (Glik et al. 1986) said that parents' expenditures often reveal a preferred investment in their sons' health. Further, they found that even where health care and transportation costs were free of charge, parents used services more frequently for ill boys than girls. Thus, the low value placed on girls adversely affects their utilisation of health services.

It is customary for the men to eat first, and to eat the most and the best, leaving the women and children to eat last and the least (UNICEF 1996). Then, mothers feed sons the best of what is left at the expense of their own and their daughter's nutritional wellbeing. This traditional practice is seen as offering consideration and respect to the men who leave home, finding food to feed their families. This is one of the main reasons for the high incidence of malnutrition in girls who grow up to bear growth-retarded infants, thus perpetuating their failure to fulfill their genetic potentials (Krasovec 1991). Coupled with poor education, under-nutrition and minimal healthcare services, girls grow up with nutritional deficiencies, such as insufficient intake of vitamins and minerals including calcium, iron and vitamin D. This may result in contracted pelvises, obstructed labor and chronic iron deficiency and often death due to severe hemorrhage during childbirth. Royston and Armstrong (1989) concluded that the impact of gender discrimination on maternal mortality has been largely ignored, and it has been subsumed within the general issues of poverty and underdevelopment, which is assumed to put everyone at equal disadvantage in health terms. Additionally, women's growth and development before pregnancy is critical to childbearing, and this impacts both the infants' and mothers' health.

When women's needs are neglected during the reproductive years, there are extreme implications for women and future generations. Reproductive health determines the wellbeing of the mother, the fetus, the infant, and the child (either boys or girls) and in turn determines the health and reproductive capacity of the next generation's mothers (World Health Organization (WHO) 1995).

> Reproductive health refers to women capable of having a responsible, satisfying and safe sex life, who have the capability to reproduce and the freedom to decide when and how often to do so. Women have a right to be informed and to have access to safe, effective, affordable, and acceptable methods of family planning or other methods for regulation of fertility according to their choice, which are not against the law. In addition, they have the right of access to health care services that make it possible for women to proceed safely

> throughout pregnancy and delivery and that provides the couple with the best chance of having a healthy baby (UNDP/UNFPA/WHO/World Bank 1997: 3).

The section below highlights women's rights and powers over controlling their own fertility and childbirth.

Power During Pregnancy and Childbirth in Village Areas

The ability to create a human being is a unique source of female generative power and often represents the traditional base for defining and recognizing the status of women in society. This power of women is sacred, inexplicable and from mysterious sources as indicated by recent phenomenology and embodiment approaches (Dornan 2004). Pregnancy and childbirth not only bring a time of great hope and joyful anticipation, but also a time for fear, suffering, and sometimes even death. In developing countries, most women do not have the privilege of access to care and support during pregnancy and each pregnancy represents a journey into the unknown from which many women never return (World Health Organization 1998).

Pregnancy is often associated with risks to health and survival both for the woman and the infant. These risks are present in every society and setting. In developed countries, they have been largely overcome by the provision of proper care during pregnancy and childbirth for all pregnant women (World Health Organization 1998). Indeed, women's decisions about sexuality, fertility, pregnancy, childbirth, and healthcare during that time are largely controlled by the values and gender ideologies prevailing within the society. For instance, the negotiation of sex in heterosexual encounters is shaped by the power that men exercise over women at all levels in male-dominated societies (Poudel and Carryer 2000). Because of bride price, men acquire the exclusive right to their wives' wombs. A wife has no right to the regulation of her reproductive and sexual functioning (Varkevisser 1995). This creates an unequal power relationship between men and women reinforced by culturally based male dominance ideology and female submissiveness. This delays the decision-making concerning medical and obstetric health seeking behaviour. In addition, girls' socialisation, education and economic dependency following marriage also force them to depend on their husbands and his family and seek decisions from others on their own health care. The husband and his family income largely determine goods, services and assets available at their own house. This influences maternal health by determining the quality of food, transportation, and healthcare during childbirth and pregnancy.

Thaddeus and Maine (1994) conducted a study on causes of maternal death considering cultural practices in seeking regular healthcare during pregnancy in Nigeria, India, Ethiopia, Korea, and Tunisia. They showed that women are often not able to decide on their own to seek timely care, awaiting decisions from senior members of the family, such as their spouses or their mothers-in-law. Moreover, women's mobility is often limited because they require permission from their mothers-in-law or spouses to travel away from home. This practice is common in Nepal both in rural and urban areas (Poudel 1995). When women face obstetric complications,

they tend to use the health care facilities available within their own community. Often these facilities are inadequate. For instance, positions for trained health workers, especially doctors, health assistants, and staff nurses remain unfilled in district hospitals due to topographical difficulties, lack of basic resources for functioning, and again the unwillingness on the part of health personnel to stay away from urban centers (The Ministry of Health 1996; UNICEF 1996). Health services in some areas of Nepal are far from ideal. Sometimes drugs run out before the new supply arrives or equipment breaks down and cannot be repaired (The Ministry of Health 1996). The Safe Motherhood Program was adopted to improve such conditions but it is still difficult to enforce because of Nepal's difficult topography, with its lack of infrastructure such as roads and communication systems.

Because of these restrictions, women in villages do not seek medical attention during pregnancy unless complications arise. The mother-in-law would be the first person to know and hold power about pregnancy or childbirth and its related complications. She provides assistance through the Traditional Birth Attendants (TBAs). TBAs are older women who gain respect and recognition from the community for assisting women during childbirth (UNFPA 1996). Only 25% of deliveries are attended by TBAs at home out of 50% of home deliveries.

During delivery, women are placed in a squat position, hanging both hands from the ceiling in a dark room. The TBA provides fundal [the upper part of the uterus] pressure with oil massage. They ask women to push hard without recognizing cervical dilations. If labor is prolonged, traditional healers are called to encourage the labor and minimize the pain. Further, if the placental delivery is not normal, then TBAs or other helpers hang spades for a few days until the placenta emerges. Consequently, women can bleed to death due to post-partum hemorrhage. There are many of these events, but they are difficult to quantify.

Following delivery, women must stay at least eleven days in a dark room having no contact with the sun or with men. Isolation is recommended because the sun represents masculine energy and the symbolic power of the male god and it is sinful to see them. The name giving ceremony is arranged with a ritual of purification for the woman and her baby on the eleventh day where men can participate. During this time, women are given high-energy foods made from ghee [clarified butter], chaku [a sweet of hardened molasses], and a soup of Juwano (caraway) so that they produce more milk. Most of the green vegetables commonly found in villages are prohibited; Nepalese believe that the baby might suffer from green stool and diarrhea. More probably this is caused by contaminated water and poor hand hygiene (Acharya 1999), but that is the tradition. Similarly, commonly homegrown vegetables and herbs such as papaya, honey, taro leaves, and green leafy vegetables are also prohibited during the pregnancy. The myth says that they cause miscarriages.

However, these practices have been decreasing since the safe motherhood program was implemented in Nepal in the 1990s (USAID 2006). The safe motherhood program recognizes the power and prestige of TBAs and traditional healers in the remote communities where healthcare facilities are scarce. Since 1990, TBAs are provided training to prevent mortality and morbidity relating to pregnancy and childbirth, particularly in remote villages.

Power During Pregnancy and Childbirth in Urban Areas

Although we earlier discussed patriarchal ideology and women's subordination within the Nepalese context, there are some exceptions found in women's status and behavior. Women who are educated have different roles from illiterate, uneducated and traditional women. They may have slightly different behaviors and power relations with their husbands and in-laws in health-seeking behavior and control over their own pregnancy and childbirth.

A birth is a rare opportunity for women who are working. Coupled with their education, exposure to the outside world and their self-possessed conduct during pregnancy and childbirth, the birth represents courage and honor to the family. These women can recognize complications and decide to seek care immediately. However, there is an increasing trend with medical practitioners, particularly gynecologists, especially in urban Nepal, who assume the power during pregnancy and childbirth. This often leads to unnecessary medicalization during pregnancy and childbirth, a practice which often takes away the essential importance and satisfaction of childbirth to women.

In Nepalese culture, women are brought up to play a passive, subservient, unassertive, gentle, sacrificial role, so they rarely communicate their own desires or comments on the clinical decisions. A great deal of trust and respect is shown by staying quiet when clinical decisions are made, along with a fear of having poor treatment in case the woman is difficult. Instead of feeling that pregnancy and childbirth are rewarding and joyful occasions, women often become anxious with additional stress when the clinician is unable to consider their emotional needs. However, there are almost no studies which describe Nepali women's power and their relationship with medical practitioners. We need more studies to empower women during their own pregnancies to make more joyful experiences.

Conclusion

We have provided a glimpse of Nepali women, ranging from traditional, illiterate or uneducated to modern, autonomous and educated. Their thinking, behavior, status, power and roles are shaped by the society and culture to which they belong (Bali 1995). An in depth understanding of the social and cultural systems of any community may help to improve women's status and autonomy. Then, we can objectively identify issues relating to women's autonomy and assist in developing awareness programs to improve women's status as a whole.

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