A Qualitative Study of Women's Experience and Perceptions of Using Skilled Birth Attendants in Rural Nepal

Yuba Raj Baral[1] Jo Skinner[1], Edwin van Teijlingen[2],

[1]Faculty of Social Sciences and Humanities, London Metropolitan University, 166-220 Holloway Road, London N7 8DB, UK.

[2]Centre for Midwifery, Maternal & Perinatal Health, Bournemouth University, UK.

ABSTRACT

Background: Access of health services such as transportation, cost of the services, women's autonomy, community influences, socio-cultural and gender roles in decision-making are discussed repeatedly. However, women's own perceptions and experiences are poorly explored during service use and health services development. This study aimed to explore women's experiences and perceptions in the use of SBA during the pregnancy and childbirth in rural Nepal.

Methods: Semi-structured interviews were conducted. The data were analysed using the thematic analysis.The fieldwork was conducted in a village of western Nepal.Interviews were conducted with 24 married women aged 18-49 who had given birth within the three years at the time of study.

Results: Health service providers' attitude and behaviour towards women during service use appeared one of the important factors in skilled birth attendants' use. Positive behaviour from health service providers encouraged women to service use while negative behaviour discouraged. Lack of privacy and confidentiality discouraged women to use skilled delivery care. Women expected friendly and respective care but findings show that women were not happy of the services they received during skilled care used.

Conclusion: This study contributes to understanding why women do or do not use Skilled Birth Attendants. Women who had attended hospital in order to receive care by skilled birth attendants generally described this as a negative experience, due to poor quality of services and rude behaviour of female service providers. Many of the participants said that they would prefer to have their babies at home, if they had access to skilled care in their local area.

Keywords: Skilled birth attendants; women's experience; developing countries; Nepal.

BACKGROUND

Nearly three hundred thousand maternal deaths worldwide every year: more than 99% of these occur in the developing world and most could be prevented if available of skilled care during pregnancy, labour, delivery and after childbirth were available1. Increasing the proportion of birth attended by a skilled person is one of the important indicators to reduce the maternal mortality as declared by Millennium Development Goal 5 (MDG). The maternal mortality ratio (MMR) in Nepal is 170 per 100,000 live births is a significant reduction although it is still one of the higher among the developing countries.[3-4] Nepal is a poor country where more than 25% of people live in poverty.[5] Unequal access to various groups of the population to basic human rights, such as education, employment, health facilities, shelter and communication is the key issues in the social sectors. There is an unequal services distribution, low quality of services that are supplied indicate that the government's failure to ensure equal access to basic human rights.[6] In general, women in Nepal from the high mountains and remote hills and economically disadvantaged groups face greater accessibility problems.[7] Experienced from developed countries suggest that skilled care in pregnancy and childbirth can have a significant impact on reducing maternal deaths. In late 19th century in many countries of Europe and the United States (US) maternal mortality was as high as or higher than in today's developing world. Several factors have contributed

Correspondence author: **Yuba Raj Baral, Ph.D Scholar, MSc, baral_yubaraj@hotmail.co.uk**

to reduced maternal mortality in those countries, such as improvements in knowledge, better access and quality of services, equal distribution of services and infrastructure developments.[8]

In the last decade, the reduction of maternal mortality in Nepal has been attributed a number of factors including: a decline in the total fertility rate, increased age on marriage, use of family planning methods, legalisation of the abortion, and expansion of the immunisation and awareness.[9] This study explores the issues why women do or do not want to uptake SBA during childbirth.

METHODS

To explore the women's experiences and perceptions this qualitative study comprised semi-structured interviews, with; **(a) women who had recently had given a birth and used a SBA and; (b) some recent mother who had not used a SBAs at the time of childbirth. A female researcher with midwifery background interviewed the women.**

Study site

Data were collected in a rural area west of the capital Kathmandu. A Village Development Committee (VDC) in a western hills district of Nepal comprised the study area. The VDC is the smallest unit of local government for administrative purposes. The VDC is further divided into smaller units called wards consisting of nine wards.The study village was not that far from the district headquarters but poor road and transportation services made problems access to skilled care at the time of childbirth.

Participants

In total, 24 married mothers were interviewed, 16 were SBA users and eight were non-SBA users aged 18-49 years who had given birth within the three years prior to the time of interviews. Due to the cultural and traditional practices it is very rare to encounter an unmarried woman with children in Nepal. In rural Nepal, early marriage is the common and more than 75% of women give birth before age of 25. The reason for choosing a three-year period was to capture women's recollections of obstetric events andsubjective elements related to their labour and delivery while their reminiscences were still fresh and relevant to the local situation in maternity care.[10]

Data collection procedures

Data were collected over a four month period in 2011. In-depth interviews were conducted using semi-structured interview guideline in Nepali by first author and female interviewer (both native Nepali speakers). All interviews were electronic recorded. Each interview lasted on an average of 30 to 45 minutes.[11] Three days training was provided to a female interviewer by the first author. In a traditional rural society, it was very difficult to interview women by strange man on a topic like reproductive health as it is associated with sexual activities. Considering the culture sensitivity the female interviewer was recruited to interview women. Before the actual interviews took place, pilot interviews were conducted.[12]

Ethical Approval

Ethical approval was obtained from Nepal Health Research Council (Ref no: 853/2011). Since some of the women could not read and write verbal consent was also taken. Women were told that the information they provided would be kept secure and interviews were conducted in a place as women preferred.

Data Analysis

First author listen to the recorded interviews several times in order to familiarise himself with expressions and words used by the participants. They were first transcribed verbatim in the Nepali language and then translated into English.[13] Transcribed words were translated to English as closely as possible for real meaning. Three transcripts were 'back translated' into Nepali by a person who had knowledge of both English and Nepali language for quality purposes.[14] Thematic analysis was carried out to analyse the data.[15] A series of discussion was also held with co-authors to verify categories and themes.

FINDINGS

To explore women experience and perceptions, altogether 24 married women who had delivered baby within last three years at the time of interview were included. To understand women's experience and perceptions following themes are identified: women's individual characteristics; choices and access to services; women position in the households and living arrangements; direct and indirect cost of services; privacy and confidentiality; gender role in decision-making; culture and traditional beliefs; gender and attitude of service providers; women expectations before SBA use and delivery preferences for childbirth were developed and discussed.

Women's Experiences and Perceptions of Using Skilled Birth Attendants

- Women's individual characteristics, for example: age, education, employment and living arrangements are discussed repeatedly but how they impact decision making on SBA uptake is poorly addressed during service use and policy development.
- Quality of services and hospital environment play a part on SBA uptake.
- Lack of Privacy and confidentiality in the hospital are important barriers for SBA uptake.
- Cultural practices and gender roles are vital to decision-making in SBA uptake.
- Positive behaviour from SBAs encourages women on SBA uptake while negative behaviour discouraged.

Women's characteristics

Women expressed varieties of experiences and preferences for utilisation of skilled birth care. One first time and young woman stated:

"I was too young to give birth at the age of 18. Due to my age, there was chance of high risk during childbirth" (SBA user woman 1).

A woman who had some independent income stated that:

"I had a paid job during pregnancy. I didn't depend on anyone for money to go to the hospital for pregnancy checkups" (SBA user woman 4).

Choice of services

Women stated that they had no choices of health services at the local level. One woman expressed;

'There were no alternative maternal health services for childbirth in the village. If women had any problem they have to go to the city" (SBA user woman 1).Rural women living in remote villages were faced numerous problems in accessing appropriate maternity care. A woman shared her experience as:"The road and transportation services were the main problems in going to the hospital. Travelled in poor road made it more difficult and painful to reach to hospital" (SBA user woman 11).

Living arrangements and women's position in the family:

Some women reported that a woman's position in the household was influenced in decision-making for SBA use. A woman who considers herself as a household head reported:

"I was living with my daughters. I am the person in the family making decisions because I was already living separately" (SBA user woman 10).

Cost of services: Both direct and indirect costs of services have significant constraints on SBA uptake. Women commonly reflected these views during the interviews. One woman said:

"The cost of hospital birth was high. At least 2-3 people need to go to hospital to care for the newborn and mother."(Non-SBA user woman 6).

Another woman mentioned her experiences that cost as a barrier of skilled care use as:

"It is expensive and difficult to manage SBA service use for poor people like us. My husband did not work for a week due to the birth in the hospital" (SBA user woman 3).

Privacy and confidentiality issues at hospital: It was shameful to show body parts to others and embarrassing if male SBAs were there to help. There were no curtains in hospital rooms and no way of maintaining privacy after the baby was born. A woman described:

"I felt embarrassment and did not ask any questions about my pregnancy situation. There were no curtains and no private room so this made it difficult to change my clothes and breastfeed the baby after baby was born" (SBA user woman 6).

Gender role in decision making: Women reported that male family members had more influence in decision-making. An SBA non-user woman reported on the role of gender in decision-making in maternity service use: *"Men are the main breadwinners in most households in our society. Men's voices are always up than women's" (SBA user women 1).*

Culture and tradition: Some women reported that social norms and beliefs such as childbirth is a normal process not requiring any help from skilled persons

discouraged women from seeking care at appropriate time. A woman reported as: *" My mother-in-law made me vomit by putting hair in my mouth and asked for Panifukarakhane (drink of healing water and mantra by traditional healer) for placenta out but it did not work" (Non-SBA user woman 8).*

Attitude of service providers: Women mentioned that the positive behaviours of the SBAs during labour and delivery encouraged but in reverse of that the negative behaviour discourages women in SBA uptake. One of the SBA user women shared her experience:

> *" I saw a woman in hospital crying due to labour pain, a nurse came and shouted at her saying stop crying; you are not the only woman in this labour room but there are other women too" (SBA user woman 6).*

Women expectations: Women felt uncomfortable and embarrassed about childbirth with the help of a male doctor and declined to partly because male doctors were helping the childbirth. One of the women explained:

> *"I was in a panic during the antenatal checkups. It was difficult to discuss problems with a man in a closed room. I feel embarrassed when a male doctor asked me to pull up my blouse " (Non-SBA user woman 2).*

Women had a positive expectation about quality of SBA services before use. However, they found things different in reality. One of the SBA user women reported:

> *"I had thought that the health personnel would behave nicely and politely but I found the reverse of what I hoped" (SBA user woman 9).*

Delivery preferences: Some women reported that the idea of using the SBA was not very important unless there were complications in pregnancy. However, women preferred to deliver at home with help of SBAs if available. A woman stated:

> *"It would prefer deliver at home with the help of trained health people if available. It would be better to have a skilled person but it was not possible in this village" (Non-SBA user woman 7).*

DISCUSSION

This study is explored women's experiences and perceptions why they do or do not want to uptake SBA during childbirth in the context of rural Nepal. The data indicates that gender and other divisions are still strong in Nepali society despite some societal change over the past few years. Women usually held lower status not only than men but also than older women. In the family hierarchy young women are near the bottom in terms of decision-making due to their age, gender and lack of economic autonomy.[16] Educated women are more likely to make decisions for themselves on SBA uptake.This is related to the role of education in giving women confidence and knowledge in their approaches to problems, as well as making it more likely that such women have some economic autonomy.However, in some case even better educated women may not feel able to challenge the age and gender norms in decision-making associated with the wider societal culture.[17] This reflects women's overall status in society as well as cultural beliefs about childbirth. Pregnancy is widely considered as a taboo subject based on gender norms that pregnancy is a 'women's matter.[18] In many South Asian countries, including Nepal, there is lack of open discussion related to pregnancy due to its association with sexual activities and sometimes the view continues that women should not be seen to be pregnant.

Some women were shy and reluctant to express their needs during pregnancy. The shyness relating pregnancy reflects the culture of silence surrounding sexual matters. Some rural women did not want to discuss their pregnancy, assuming that it is a private matter, which in turn leads to problems accessing pregnancy care in an appropriate time.

Social inequalities based on gender, caste, economic status and place of residence, affecting women's lives in many ways, including health service utilisation. Continuing gender discrimination can be seen in the difference in the literacy rates between males (71%) and females (46%) aged over 15 years with significant implications for women's life chances and choices.[19] It is likely that these differences are higher in low caste ethnic, rural living and deprived groups.

Culture and tradition has strong link to service use. For example, after marriage it is customary for a woman to move in with her husband's family and traditionally, most rural families in Nepal still live in extended family arrangement.[20] As a daughter-in-law a young married woman has to perform her duties under the supervision of senior member of the family specially, mother-in-law. In such situations the senior member of the family is the final decision-maker.

Women participated in this study expressed a preference for SBA use, the main reason given for going to hospital was 'for safety reasons'. However, some suggested that they would not make this choice again if they had a 'normal pregnancy' and/or if SBA care were available locally. Similarly, other women 'chose' to use traditional birth attendants as it was

cheaper and comfortable with known people. The lack of SBA services compelled some rural women to deliver their babies at home without the help of skilled birth attendants.[21] However, some women from both SBA users and non users in this study identified some actual or potential benefits of a home birth. These included a more relaxed and known environment with support during labour from their mother-in-law or other female family members, as well as privacy at the time of childbirth.

There may also be financial and economic constraints on the family regarding decisions about SBA use, which for rural women in this study meant going to hospital for childbirth. Pregnancy and childbirth are regarded as a women's issue but men have a lot of power over women's lives in Nepali culture.Socially and culturally there is a big gender gap between men and women from childhood on. Based on gender norms men not only have more life chances and opportunities than women (in terms of health, education and employment as well as other social activities), but they also generally control the use of financial resources within the family have significant impacts on service use.[22]

Women in this study have reported that poverty is a major factor limiting SBA uptake. In addition, living in a rural community compounds other inequalities such as, education, awareness level and service distribution affecting SBA uptake. Nepal is one of the poorest and least developed countries in the world: 81% of its population is rural and more than 25% of its population survive on less than one dollar per day. Agriculture is the main livelihood of the population and 38% of Nepal's GDP comes from the agricultural sector. However, 46% of its population are unemployed or working only in subsistence agriculture which has direct impact on SBA uptake.[19]

It is clear that rural women face inequalities in health service provision due to difficulties in accessing urban based health facilities. This is partly related to the mountainous terrain and high costs of developing the roads and transport infrastructure. The Government of Nepal had previously established a policy to increase the number of maternity care centres in rural areas.[23] But there is no evidence from this study that this has yet addressed the challenges which rural women face in accessing maternity related health care.

Women had concerns about the quality of maternity services provided in the public hospital, partly related to the SBAs themselves. Positive interpersonal aspects of maternity care are crucial to ensure that women take up SBA services.[24] For pregnant women the relationship with the care providers and the maternity care system influences service use.[25] The 'concept of safe motherhood' concerns not only the physical safety of women but is also related to deep cultural and personal feelings. 'Motherhood' is specific to women and related to a gendered notion: thus safe motherhood must be expanded beyond the prevention of morbidity or mortality to encompass respect for women's basic human rights, as well as respect for women's autonomy, dignity, feelings, choices, and preferences including for companionship during pregnancy and childbirth.[26] However,evidences from this study suggested that these issues are poorly addressed while developing maternal health policies in Nepal.

There is also a gender dimension in the characteristics of the female SBAs since, few doctors are female. Women in this study reported that disrespectful care in the hospital, such as physical abuse, clinical care without the woman's consent, lack of confidential care, and undignified care were common.[26] Some women experienced rude behaviour from SBAs especially from nurses. Positive attitude by SBAs (providing respectful care and encouragement through polite behaviour) could promote women's use of SBAs in future, while negative attitudes (neglect, shouting and use of rude language) are discouraged.[15] Some women in rural Nepal still believed that childbirth is a natural process, not needing any biomedical intervention unless there are complications. However, studies from many developed countries suggested that use of SBAs significantly reduces maternal morbidity and mortality.[27-29]

The decision to use health services might be seen as an individual choice but cultural norms and values, gender inequality in decision-making, the views of the household head and women's low autonomy in financial matters all play a part. In Nepali traditional society men play an important part in decision-making about SBA uptkae.[30]

Use of SBAs in future is related partly to how well women's expectations had been met in the past and whether their previous experience of service use was satisfactory with a good pregnancy outcome.[31] However, it is indicated that many SBA users had negative experiences in the hospital, including in their treatment by some SBAs including refusal to assist during labour and childbirth. Lack of empathy and moral support from SBAs: such experience tended to discouraged women from going to hospital for subsequent births. Furthermore, if rural women do not have a choice of services locally or cannot afford the costs of going to hospital. So they may compel to deliver their babies at home with the help of traditional birth attendants.

Conclusion

This study has tried to capture the essence of women's experiences and perceptions with regards to maternal health service utilisation in Nepal and thus contribute to an understanding of why women do or do not use SBAs. Factors that predictably influence SBA use include cultural factors affecting women's lack of autonomy in resource control and decision-making process. Issues of access of health services and to the economic circumstances of individual families are also vital in service uptake. The difficult terrain of the country; widespread poverty and illiteracy; limited resources for the improvement of existing services are also important barriers. Traditional, cultural attitudes and gender related factors pose challenges when considering how policies could be changed and services developed to meet the needs of rural women.

However, the qualitative data about women's actual experiences of hospital based maternity care and their preferences with regard to future service use have yielded new knowledge and two findings in particular have implications for improvement of existing services and development of new ones. Participants' who had attended hospital in order to receive care by SBAs generally described this as a negative experience, due to the rude behaviour of female SBAs and the poor physical standards of the facility, with direct implications for the training and management of staff. In addition, women reported that they would prefer to have their babies at home, if they had access to SBA care in their own local area.

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