



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

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ABSTRACT

Objective: to uncover local beliefs regarding pregnancy and birth in remote mountainous villages of Nepal in order to understand the factors which impact on women's experiences of pregnancy and childbirth and the related interplay of tradition, spiritual beliefs, risk and safety which impact on those experiences.

Design: this study used a qualitative methodological approach with in-depth interviews framework within social constructionist and feminist critical theories.

Setting: the setting comprised two remote Nepalese mountain villages where women have high rates of illiteracy, poverty, disadvantage, maternal and newborn mortality, and low life expectancy. Interviews were conducted between February and June, 2010.

Participants: twenty five pregnant/postnatal women, five husbands, five mothers-in-law, one father-in-law, five service providers and five community stakeholders from the local communities were involved.

Findings: Nepalese women, their families and most of their community strongly value their childbirth traditions and associated spiritual beliefs and they profoundly shape women's views of safety and risk during pregnancy and childbirth, influencing how birth and new motherhood fit into daily life. These intense culturally-based views of childbirth safety and risk conflict starkly with the medical view of childbirth safety and risk.

Key conclusions and implications for practice: if maternity services are to improve maternal and neonatal survival rates in Nepal, maternity care providers must genuinely partner with local women inclusive of their cultural beliefs, and provide locally based primary maternity care. Women will then be more likely to attend maternity care services, and benefit from feeling culturally safe and culturally respected within their spiritual traditions of birth supported by the reduction of risk provided by informed and reverent medicalised care.

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Background

Childbirth is a powerful personal event in women's lives as well as a significant social experience and it differs according to their culture and society (Callister, 1995, 1997, 2004; Callister et al., 1999; Semenik et al., 2004; Liamputtong et al., 2005; Carpenter, 2009; Liamputtong,

2009; Callister and Khalaf, 2010; Schneider, 2010; Farnes et al., 2011; Lemay, 2011; Sawyer et al., 2011; Etowa, 2012). Therefore, any understanding of women's pregnancy and childbirth experiences requires understanding their culture, tradition and social values because the degree of control and type of choice that women can make during pregnancy and childbirth depends on societal values and what societies offer to reproductive women (Janssen et al., 2009; Dahlen et al., 2010a, 2010b; Lindgren and Erlandsson, 2010; Namey and Lyster, 2010; Douglas, 2011; Snowden et al., 2011). Women have the right to control and decide freely and responsibly about their reproductive health and women also have the right to make decisions about their pregnancy and childbirth (United Nations, 1995).

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

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

Safety and risk

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

The socio-cultural context in Nepal is considered to have negative impacts on maternal and newborn outcomes and to deter women from accessing medical services (Thapa et al., 2001; Bennett et al., 2008). However, many women and their families sincerely believe that adhering to socio-cultural tradition is the best way to prevent childbirth related deaths. Schubert et al. (1997) and Dahal (2008) identified the traditional Nepalese practice of giving birth in the cowshed (known as the goth) as a risky undertaking and another cause of adverse birth outcomes, yet at the same time found that women felt this practice was necessary to prevent 'birth pollution'. This concept of 'birth pollution' is constructed spiritually where women and family members see their health as threatened if they do not isolate birthing and postnatal women from contact with household deities (Bennett et al., 2008). Medically, this seclusion of women in the cowshed during and after birth is considered as creating risks of infection leading to higher mortality (Thapa et al., 2001). Contrastingly, researchers have argued that women should not be separated from their cultural settings during pregnancy and

childbirth (Brubaker and Dillaway, 2009; Cindoglu and Sayan-Cengiz, 2010; Kontos, 2011; Hall et al., 2012; Lee et al., 2012) and tradition should be embedded within medical care (Rice et al., 1994; Eckermann, 2006). Women in rural Nepal prefer to birth in their community setting to maintain their cultural safety (Thapa et al., 2001; Sreeramareddy et al., 2006; Bennett et al., 2008) and women in diverse societies act differently to enhance childbirth safety (Miller and Shriver, 2012). Little is known about childbirth experiences of women in remote areas of Nepal.

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

Method

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

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

Setting

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

pregnancies resulting in high maternal and newborn mortality and are considered 'oppressed' and 'disadvantaged' because of their lower socio-economic status (Panter-Brick, 1989; Dahal, 1996; Cameron, 1998; Gwatkin et al., 2005; Acharya et al., 2007). In rural Nepal, over 90% of births occur outside a medical setting, mainly with the support of family members, traditional birth attendants and other female relatives (Acharya et al., 2007; Bennett et al., 2008; Regmi et al., 2010; Simkhada et al., 2010).

The fieldwork for this research was conducted in two remote Nepalese mountain villages in the Mugu district between February and June 2010. This district was chosen purposively as one of the poorest and most remote districts of Nepal with the lowest rank of the Human Development Index in 2009; women have a low life expectancy of 42 years, compared with 44 years for men (District Development Committee, 2009). The two villages in this study lacked access to local antenatal care or childbirth services and were approximately one to two days walking distance from the nearest available maternity services. The referral hospital was in the nearest city, accessible only by air, and with flights mostly inaccessible to village women because of cost, weather conditions and distance.

Participants

Participants in this study comprised 25 pregnant or postnatal women (having given birth within four weeks prior to interview), five husbands, five mother-in-laws, one father-in-law, five service providers and five stakeholders from the local communities. The service providers comprised a medical doctor and a midwife working in the district hospital, two local health workers and a female community health volunteer. The stakeholders comprised a school teacher, a male and a female politician, a traditional faith healer, and a local indigenous leader.

Inclusion criteria for the study were women living in one of these villages for the last five years who were married, and either pregnant (more than 24 weeks of current pregnancy) or had given birth within the last four weeks; husbands, mothers-in-law and fathers-in-law of the women participants; service providers working under the district health system of the Nepalese Government and community stakeholders living in one of these villages. The study commenced with the pregnant/postnatal women who were recruited via the female community health volunteer who was approached first by the researcher, informed about the study and who then invited women to be involved. Their ages ranged from 17 to 43 years, with numbers of pregnancies from 1 to 11, and age at marriage ranging from 13 to 25 years. On completion of the interviews with the pregnant/postnatal women, other family members were approached to be involved in the study and, following this, the service providers and stakeholders were identified and invited.

Interviews

In-depth interviews comprised the primary method of data collection with all participants (Liamputtong Rice and Ezzy, 2007). All interviews were conducted by the first author in the Nepalese language at a location chosen by participants, usually their kitchen or working area and at their preferred time. Interviews usually lasted 40 minutes to two hours in single and multiple sittings as needed. Interviews were guided by broad research questions, with prompt questions when required. Interviews were tape recorded with participants' consent and subsequently simultaneously translated and transcribed by the primary author.

Researcher/participant relationship as an essential component of gaining trust to attain authentic data in research. To enable participants to feel trusted and achieve authentic data in

this research, all interviews were conducted in a respectful conversational manner, with the researcher listening attentively and carefully to engage participants and clarify any queries as they arose.

The researcher

The primary author Sabitra conducted the fieldwork interviews in Nepal and bracketed her own values, perceptions and experiences during the research to be lateral to the involvement of the participants. Simultaneously Sabitra was trusted as a Nepalese health professional not local to the district but recognised as a researcher and maintained appropriate professional and ethical distance at all times.

Analysis

Interviews were translated into English and transcribed verbatim by the first author. A random check was made of the translation of five transcripts by another Nepalese-English speaker for accuracy of translation under ethical constraints. The texts were then analysed using thematic analysis (Braun and Clarke, 2006).

Once transcriptions and translations of all interviews were completed, the first author led the analysis, with the co-authors providing collaborative analysis support. The data was read repeatedly to achieve a deep informed understanding. Coding was followed by systematically giving attention to each data item through the entire data set, highlighting important segments. Analysis then progressed to looking at relationships between codes and identifying repeated patterns of data as potential themes. The list of potential themes was then constructed diagrammatically to examine the relationships and interactions between them. Once consensus was gained regarding the way each leading theme represented the data set, sub themes were identified to represent the smaller segments of data that contributed to the leading themes. The rigour of data was maintained throughout the analysis process (Braun and Clarke, 2006).

Ethical considerations

This study followed the Australian National Health and Medical Research Council Guidelines (National Health and Medical Research Council, 2007). The Social and Behavioural Research Ethics Committee at Flinders University in South Australia granted ethics approval along with the Department of Health Services of the Government of Nepal. Access to the region was negotiated by the fieldwork researcher with Nepalese authorities and approval to conduct the fieldwork was obtained in writing from the Department of Health of the Government of Nepal and district health office. A verbal consent procedure was utilised with all participants due to a lack of reading literacy, with consent also gained for recording of the interviews. For pregnant and postnatal women, permission was also gained from their family as was culturally appropriate.

The researcher endeavoured to maintain privacy, confidentiality, anonymity, and informed consent throughout the study. However, it was not always possible to maintain privacy and confidentiality where participants lived in close physical proximity to others. In the Nepalese culture, talking with someone privately is not commonly appropriate, so the researcher conducting the interviews had to accept the presence of other people during some interviews as well as the close living conditions. This presence of others during the interviews was acceptable to the research participants according to their custom. The important challenge for the researcher was to conduct interviews in a manner that did

not compromise participants or their integrity nor the ethics of the research. All participants were given fictitious names from the beginning of the interviews to assure anonymity.

Findings

Local culture, tradition and spiritual beliefs emerged as the key themes in conceptualising women's beliefs regarding pregnancy and childbirth safety and risk in this research. They influenced choice of birth place, preference of support person, sense of control and hence perceptions of risk and safety. Many complexities, controversies and contradictions were identified in relation to safety during pregnancy and childbirth as the women saw it. Critically, the cultural construction of safety in the village and the medical construction of risk are revealed as contradictory and this influences survival opportunities for mothers and infants.

Giving birth in the Goth: empowering self and maintaining safety

Women spoke of feeling 'empowered' during childbirth by giving birth in a Goth, sustaining their preferred way of gaining safety. While the English-translation is somewhat problematic, Goth is either a small out-building near the main house, or an area within the lower section of the main house for animals. The practice of giving birth traditionally in the Goth was the major factor in women's perceptions of safety in giving birth. Some women emphasised that they always birth there because of their cultural beliefs about birth pollution and untouchability which relate to their need for safety:

We have Deuta [a God] inside the house. We should not be polluting the house. If we do so, our baby might die or something wrong might happen to the family or to the animals. So, we prefer Goth to give birth. You know this is not good if God gets angry. Thuli (age 28, 8th pregnancy, mother of five)

The strong connection between tradition and spiritual beliefs as an essential component of ensuring safety was important for Thuli to minimise the chances of death or injury for both mother and/or infant; her spiritual beliefs are significant in her view of what ensures the health and survival of newborn babies.

The cultural importance of giving birth in the community according to tradition was perceived by Manu (postnatal mother) as the best option compared with giving birth in a hospital setting:

During the turn of my sixth daughter, I had problems before giving birth. They [district hospital staff] sent me to the Nepalgunj [referral hospital in the city]. I did not have any problems when I gave birth to my other five daughters... I was not really happy about going to the city but I went ... I did not feel like living in the hospital anymore. It was not the place where I wanted to give birth. Then, I went to my sister's house and gave birth at her Goth. Nothing wrong happened. I thought that I should not have come down to the city leaving [my] children back home. Manu (age 36, 11th pregnancy, mother of seven)

While women emphasised that their cultural and spiritual beliefs contributed to their safety, for Juna giving birth in the Goth gave her the ability to manage and control the birth process:

We always give birth at Goth. We clean the Goth and we put straw on the floor. Then, we give birth in this straw and we stay there putting more straw for the next 20–22 days after the childbirth. We can touch water at 30 days and are permitted to go inside the house. I felt so happy coming out from Goth without any problems and sickness. I think I never did the

wrong thing, so God is happy to help me all the time. Juna (age 42, 7th pregnancy, mother of six)

Giving birth in the Goth has been a generational, traditional, cultural and spiritual practice. Mother-in-law participants had also given birth in the Goth, and transferred this expectation their daughter-in-laws. This transferred practice was significant in maintaining cultural safety. For example, one mother-in-law said:

I am so happy that my oldest daughter-in-law living in the village is still giving birth in the Goth. Lali (age 44, mother-in-law)

Another mother-in-law said:

We cannot let our daughter-in-law give birth inside the house. We must take them to the Goth. We should follow the system, as it is for a good outcome. Seti (age 42, mother-in-law)

Their positive experiences of birth in the Goth oppose the medical view that this is unsafe, as revealed by a doctor from the district hospital:

Giving birth in the Goth is the reality in the district. This is the tradition here. However, the trend of giving birth in health institutions is improving. So, we are launching various programs and we are raising awareness of people about the danger of having births in Goths and about the risks of infections, neonatal tetanus and all these things. (Young male doctor, district hospital)

The medical exclusion of cultural concepts of childbirth can hinder safety from the women's perspectives. Women will not leave the Goth, believing that is it dangerous to, whereas the doctor believes it is dangerous to stay and wants them to birth in the hospital. So, there is a contradiction between the medical focus on lowering risk and the cultural focus on promoting safety. Accordingly, giving birth in the Goth is constructed as a culturally and spiritually safe practice by the villagers but a risky practice by the medical profession, and accordingly a conundrum exists.

Birth outside the Goth: women's ability to negotiate culture and tradition

Some women's ability to negotiate indicates that culture and tradition are not absolute and static where individuals have no agency. While still following their cultural and spiritual beliefs, some participants saw giving birth in the Goth as unfavourable and chose other places outside the house instead. Nevertheless, this negotiation occurred simultaneously with a determination to hold to beliefs about childbirth pollution:

We have God inside the house. We should not be polluting God's place. We now don't follow the tradition of giving birth in Goth, as we knew that it is not good. But we are not allowed to go upstairs to give birth. I also don't like doing wrong thing and polluting the God's place. So, I [had] all my births outside [she pointed to the corner of the veranda]. Toma (age 26, 4th pregnancy, mother of two)

Keeping God happy and ensuring that no harm comes to tradition were important for birth. Other women similarly aligned to tradition in terms of pollution beliefs but without birthing in the Goth:

In our house, we don't have the system of giving birth in the Goth. I rather had the first two births in the same room outside the house [a room made of mud and stone without windows adjoining the house, usually used for storing wood]. We don't go inside the house during Chau [polluted time]. Even my mother-in-law stays there during the Chau [menstruation] for

four days. Sumi (age 26, mother of three with one week old baby)

Sumi's mother-in-law added:

I had all of my births in the Goth. But time has changed and I had to change practice as well. So, my daughters-in-law are out of the Goth now. But we maintain Chau [*the pollution practice*]. Chameli (age 48, mother-in-law)

In this negotiation between birthplace choice and continuing tradition, there was conciliation by some women between traditional and medical knowledge. A midwife identified her own situation:

I gave birth in the hospital but I did not break the pollution practice. So, I did not go to the kitchen and prayer room for two weeks after the birth. Though I was aware of the medical rationale that this tradition has no connection to birth outcomes, I could not go against the practice. What if something wrong happened to my daughter? Suntali (age 24, mother of 3 week old baby)

Suntali reflects on the cultural and medical paradigms she considered important while still concerned regarding potential outcomes if she 'polluted' the house. Suntali negotiated between midwifery knowledge and cultural knowledge to achieve safety in both realms, showing these two paradigms could work together to improve safety and survival of mothers and infants.

Women's experiences indicate the interplay between themselves as agents and tradition as structure. Women can be powerful actors in determining which traditions need to be sustained and which need to be transformed. Women wanted the benefits of preventing childbirth pollution practices and negotiating birth place while being active agents in maintaining cultural and spiritual safety.

Childbirth as a part of everyday life: women's roles and social expectations

Most women participants viewed childbirth as a normal ongoing event of everyday life where work, pregnancy and childbirth are routine for village women. Most women experienced birth without external medical and technological interventions. Despite newborn deaths, they continued to accept the spiritual control of birth and death and held to childbirth traditions.

For these women safety lay in God's wishes, which could not be interfered with by any outside influence:

I lost my previous son after 9 months. You know I have three children, they are all girls. We cannot live only with these three girls. I have never been to the hospital and I've never had any problems in giving birth either. Who knows what happens tomorrow? It is not in our control. They [*babies*] will come and go. We cannot stop them going. We have to accept whatever comes. Prema (age 29, 5th pregnancy, mother of three)

Losing a child is a customary part of continuous pregnancy and childbirth in these villages. Believing that survival during pregnancy and childbirth is not always possible, the women accept conditions as they come and outcomes as they experience them. Previous deaths of infants did not lead these women to change childbirth practice:

It is not a big deal to get pregnant and give birth. Some will grow and some will die. There is nothing unusual about that. As women, what do we do if we don't get pregnant and we don't do all the house work, farming and labor work? Dolma (age 35, 10th pregnancy, mother of five)

This social expectation of women as bearers of children and carers of the family confounds their choice for pregnancy and birth leaving them to accept it silently. But women were not necessarily happy about losing infants and children:

During the cropping and harvesting season, women even give birth in the farmland [*fields*]. Indeed, this is not in our hands to save the mother or the baby. But we cannot happily accept the loss of babies either. Toli (age 20, 3rd pregnancy, mother of one)

Toli was concerned about the survival of mother and infant in these circumstances and was reluctant to accept this as normal; culture is not seen as all good, but also entails sadness. This sadness opens a space for the medical model to identify how to improve safety. Most of the husband participants actually saw medical care preventing newborn deaths and spoke against women staying in their community setting to give birth:

I have seen many babies dying in my village. I think that we could prevent these deaths if we could bring women to the hospital to give births. Ramesh (age 27, husband)

There is a critical need for culture and medicine to harmoniously come together to maximise newborn survival while women sustain their childbirth traditions and beliefs to balance both sets of perceptions regarding risk and safety.

Certainty and uncertainty of outcomes: increasing safety and survival

Although childbirth was seen as routine in village life, there were both certainties and uncertainties about outcomes. Although women believed that birth, survival and death are spiritual aspects they have no control over, women were still anxious about their outcomes – of survival or death. Some women and family members expressed worries about these uncertainties because of past experiences:

We lost our previous child on the ninth day after birth. You know, it was a son. This time we don't know what will happen but we hope that the birth will go in a good way unless the things turn out another way. We are hoping to have a son, but what can we do if God wants things to happen another way? Pema (age 33, 6th pregnancy, mother of three)

For this mother, the worry about her infant's survival was mediated by her spiritual belief and trust in God. The knowledge of possible threat and uncertainty about survival during birth did not change tradition but prepared Pema to accept the situation whatever the outcome. In the medical view there is no God to ensure the survival of mother and infant, yet women's belief in their God's control gives them some sense of security.

In some women's experiences, social obligations created a fear of uncertainty about safety during pregnancy and childbirth. For example, there was an expectation that once married, a woman should get pregnant and give birth, and as far as possible (the marriage age for women in these areas is between 12 and 15 years). This compelled young women to continue with a pregnancy despite not feeling safe:

I am feeling lonely and helpless. I did not want to get pregnant that early but I could not avoid it as well. He [*My husband*] told me I have to continue the pregnancy. I am so anxious about it. I am feeling sick. I have fear. I am worried. Sunita (age 17, 1st pregnancy)

Sunita expressed how women can feel powerless and unable to make decisions about their own pregnancies. Although some village women demonstrated abilities to make decisions and control their birth place and birthing process, they still lacked

such agency in fertility decisions. Similar uncertainties emerged where women had knowledge of possible problems during pregnancy and childbirth, as with a local primary school teacher:

I am worried about the birth. I know there is a possibility of having many problems during pregnancy and childbirth. I am just worried about so many things. I am thinking all the time how will the birth take place. Oh God, I hope everything will go well. You see, I just can't stop thinking and it is really stressful these days. Rita (age 25, 2nd pregnancy, mother of one)

Knowledge of possible physical problems during pregnancy and childbirth and fear of uncertain outcomes increased the expectation that God could help. Whether it came from women's experiences or being told about medical risks, fear was generated and women sought medical and similarly spiritual help to minimise threats to their safety.

The spiritual meaning of childbirth was strongly embedded in women's experiences because they thought no other intervention could ensure safety and maternal/newborn survival. Although women held a strong sense of spiritual control in relation to survival and death, a doctor simultaneously blamed culture and tradition for creating risks and blamed one family for a maternal postnatal death:

There was one case of maternal death which was brought to the hospital. It was festival time and people were feasting in the village. She gave birth at home and had retained the placenta. She bled and bled and bled. Her family members did not bother to bring her to the hospital promptly. She was brought at the last minute [pause] and she died [pause]. I felt so sad that time. (Young male doctor, district hospital)

Prompt medical support may or may not have prevented this woman's death. Medicine might play a significant role in reducing obstetric risks and increasing survival rates of mothers and infants in these villages, but only when negotiation occurs between the cultural and medical paradigms without compromising local cultural values and spiritual beliefs. Village people have strong faith and trust in their traditional healers, but not yet in medical care and service providers:

Still, there is strong cultural belief and traditional practices in the village where people trust more in traditional faith healers, for example Dhami or Jhankri [*Shaman*] during the sickness. There are high numbers of deaths of newborn babies in the village. Yesterday only, two newborns died in the village. (Young male local politician)

While newborns die in the villages, women can be blamed for not seeking medical help and for depending on traditional healing systems. Yet there is a schism between medical and cultural understanding; tradition is blamed for perinatal mortality, rather than blaming medicine for not understanding and accommodating culture and tradition.

Discussion

This study contributes significantly to the limited literature uncovering and authenticating the voices of women living in remote Nepalese mountain districts with great disadvantage, illiteracy and poverty. Women in this study see pregnancy and birth as fundamental life events which occur naturally and relatively easily and do not require special medical or technological support and/or intervention. On the contrary, they feel that what happens during pregnancy and birth is in the hands of their God, and they should continue their traditional practices to

keep the God happy and avoid negative outcomes for themselves and their newborns. Many of their family members and key people in their communities also hold these views. Consequently, the dominant cultural practice of giving birth in the Goth ('cowshed') persists and is highly valued. In particular, women feel it confers a sense of cultural safety, allows them to be in control of their own birth, and they understand this way of reducing risk.

Women in these remote study villages have good reasons for continuing to give birth according to tradition in the Goth. This is despite the practice being seen as medically risky with infection and neonatal deaths (e.g. [Thapa et al., 2001](#); [Regmi and Madison, 2009](#); [Ahmed et al., 2010](#)). Women in this study affirmed traditions and beliefs as positive contributors to their safety and survival and likewise their babies during pregnancy and birth. Indeed, the significance of culture, tradition and spirituality in pregnancy and childbirth is well recognised (e.g. [Oakley, 1980](#); [Rice et al., 1994](#); [Callister et al., 1999](#)) and women in this study depended on cultural and spiritual meanings around birth; their decisions about birthplace were directed by their belief and trust in God. For women in these villages, the broad schemata they internalise are based on trust in a supernatural power, which directly counters the dominant medical view of risk factors; they would not abandon tradition to seek medical care during pregnancy and birth. Women's decisions to continue tradition reveal them as strong social actors within their local setting ([Giddens, 1984](#)) and owners of their birth experiences ([Jordan and Davis-Floyd, 1993](#); [Davis-Floyd, 2004](#)). They perpetuate cultural values, traditional practice and spiritual beliefs in choosing their birthplace and continue collective ownership of birth. Interestingly, the few voices which suggested that village women should go to hospital to give birth were male, two professional young men and a young husband.

Women considered the loss of a baby during pregnancy or birth as a natural event, posing a challenge to promoting maternal and newborn survival. Although [Brunson's \(2010\)](#) study among semi-urban Nepalese women found a shift in the cultural construction of birth towards seeking biomedical care, for the remote mountain women in this study it was dominant tradition and spiritual values which socially and culturally constructed the meaning of safety. Women were concerned about maintaining cultural safety, without which they saw themselves at threat of death or illness. Given the value of tradition and spiritual powers, safe childbirth depended on God, not medicine.

Further, this study could not find the practice in which tradition and spiritual beliefs had been accommodated in medical services for women from these villages. Nevertheless, research in Lao and Australia demonstrates that it is possible for medicine and culture/tradition to co-operate to provide experiences and outcomes for women which are both medically and culturally safer ([Rice et al., 1994](#); [Eckermann, 2006](#)). In Lao, the practice of traditional initiation for the infant and the recovery of mother immediately after birth by spiritual healers are allowed to be performed in hospital and have contributed to managing medical risks and maintaining cultural safety ([Eckermann, 2006](#)). Similarly, one Australian hospital now accommodates migrant women's desires to continue their tradition of the soul calling ceremony in the operating theatre, without which they experience inconsolable postnatal depression ([Rice et al., 1994](#)). There is a potential for the Nepalese Government to initiate culturally appropriate approaches to maternity care, for example allowing midwives support women giving birth within their socio-cultural setting.

'Medicine' often blames 'culture' for causing high rates of maternal and newborn deaths ([Douglas, 1994](#)), as this study found. Clearly, it is inappropriate for these women to reject their traditional place of birth for a medical setting because this actually

threatens their safety, albeit a safety which is culturally constructed. If mother/newborn survival rates in these villages are to improve, it is critical to harmonise medical knowledge of risk with women's traditional practices to ensure that both cultural and medical safety are aligned. Labonte (1992) argues that no single approach of interventions is sufficient to enhance health. There is space for optimism in bringing cultural and medical paradigms together to develop a woman-centered model of care, addressing the risks of maternal and newborn deaths while sensitively maintaining women's feelings of cultural safety. As women in these villages preferred to stay in their community for birth, providing local skilled birth attendants could enable ongoing and emergency assistance when required without compromising cultural security.

Given the United Nations (1995) statement that women have the right to control and decide freely and responsibly about their reproductive health, it seems inadvisable to encourage women of remote Nepalese villages to birth away from their home and community in hospital settings because this negates their social agency and control, a potential further detriment for women who are already disadvantaged. Simple strategies such as local health services providing village women with clean birthing kits and educating them for use in the Goth present a cheap, effective primary health initiative which reduces the likelihood of infection and neonatal tetanus (Simkhada et al., 2010) and enables women to birth according to tradition sustaining culturally determined benefits. Where women in this study found the district health services hard to access, better outcomes with increased provision of primary health care could be provided through increased local community-based midwifery care. Where village women are able to access district health posts and hospitals, a specific focus on developing culturally respectful maternity care that enables women to feel safe and trust their care-givers is essential.

Conclusion

The importance of modern medical technology and management for averting proven risks of injury and death during pregnancy and childbirth is known internationally. This study reveals that women in remote mountain areas of Nepal hold strongly to cultural tradition and spiritual belief systems, created and perpetuated within their social structure which informs perceptions of and decisions for safety and risk.

Given the complexity of women's construction of safety and the medical view of 'risk', careful consideration is necessary of women's preferences and choices within their structural constraints. Critically, the notion of safety interacts with women's everyday life experiences to shape how they perceive, describe, interpret and evaluate childbirth. While women adhere to tradition and their belief system, asking them to come into medical settings to give birth actually threatens their safety and promotes risk. While women and their families value traditional knowledge more than medical knowledge, they will not seek medical care. The findings of this study highlight what is deemed important by women in remote Nepalese villages, which is significantly different to what is identified in studies of women in other areas of Nepal. This demonstrates the importance of researching with women from different backgrounds within the one country, if initiatives to reduce maternal and infant mortality are to be accepted by diverse communities.

This research exposes critical spaces for ensuring maternal/newborn survival in complex socio-cultural settings. Against the policy direction of maximising the numbers of women in Nepal giving birth

in hospitals and increasing medical attendance during pregnancy and birth, this study uncovers the plight of women who will not leave their community setting nor be separated from their traditional practices. Researchers, policy makers and practitioners must take a culturally respectful approach to maternity care provision, promoting maternal/newborn survival without forcefully separating women from their community and undermining their spiritual security. Ways to embed divergent cultural constructions of birth and traditional belief systems within public maternal health to ameliorate the 'risks' and enhance 'safety' during pregnancy and birth are needed for all women everywhere.

Conflict of interest

None.

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