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Health Seeking Behaviour of Pregnant Women in Banke District, Nepal

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ABSTRACT

The study focuses on pregnant women health seeking behavior and access opportunities to maternal health care service in Banke district, Nepal. Social structure, health delivery system, and barriers influence such behavior and opportunities. The objectives of this study are: to study the health seeking behavior of pregnant women; including their socio-demographic characteristics, their social structures, and influence to modern health care delivery system structure and to examine the barriers to maternal health care services and their consequences for the choice of the health care services and the role of government to overcome these barriers

To understand the complex nature of pregnant women in a social structure, structuralist and structurationist approach and furthermore, other models are used in this thesis.

Due to the nature of this study, 15 pregnant women as primary informants and12 key informants such as nurses, doctors, governmental officers, and Non-governmental organizations workers were interviewed. These informants were purposively sampled. Semi-structure interviewed was conducted and supplemented by observational study at their home environment and hospital or clinic.

The use and choice of the health care service for pregnant women are highly influenced by significant other or head of the household and the capacity of health services. Furthermore, there are other barriers that discourage pregnant women to use maternal health services such as knowledge, social norms and values, and other barriers as cultural, health care, geographical and political. However, free delivery and incentives schemes in Nepal have enabled pregnant women to use maternal health services. Nevertheless, the country face challenges to achieve target 5 improve maternal health; 5.A: reduce by three quarters, between 1990 and 2015, the maternal mortality ratio and 5.B: access to reproductive health, set up by United Nations Millennium Development Goals and beyond 2015.

ABBREBRIATION

ANC	Antenatal care
FPAN	Family Planning Association of Nepal
GII	Gender Inequality Index
GNI	Growth National Income
HDI	Human Development Index
INGO	International Non-Governmental Organization
MMR	Maternal Mortality Rate
NGO	Non-Governmental Organization
PPP	Purchasing Power Parity
SBA	Skilled Birth Attendants
TBA	Traditional Birth Attendants
UN	United Nation
WHO	World Health Organization

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1. CHAPTER ONE: STUDY BACKGROUND

1.1. Introduction

Maternal death is a tragic irony, death of women while engaged on creating another life. Maternal mortality is an essential key indicator of population health and of social and economic development. According to World Health Organization (WHO), every day, approximately 800 women die due to the complication related to pregnancy and childbirth. This key indicator shows the differential between developing and developed countries because 99 % of all death related to pregnancy and childbirth occurs in developing countries. Within developing countries setting the maternal mortality is higher especially, in women residing in rural areas in low resource setting. Furthermore, in 2013, the maternal mortality ratio in developing countries was 230 per 100,000 live births while in developing the ratio of maternal mortality was 16 per 100,00 live births. As we can see there is large disparities between developing and developed countries (WHO, 2014). According to World Health Statistics (2014) by the World Health Organization (WHO), maternal mortality ratio is South East Asian Region is 190 per 100,000 live births (Organization, 2014).

The worldwide problem of maternal mortality was first highlighted in 1987 under Safe Motherhood Conference in Nairobi. This international meeting highly emphasized for action at local, national and international levels to reduce maternal mortality by 50 % by the year 2000 especially in developing countries and to improve women's health in general. To accomplish this action to reduce maternal mortality the meeting forwarded some strategies. These strategies were; making family planning universally available, providing prenatal care, providing trained assistance at delivery and ensure access to emergency obstetric care. Soon after, international conferences in 1990s, the World Summit for Children in 1990, the Fourth World Conference on Population and Development in 1994, and the Fourth World Conference on Women in 1995 also initiated for the reducing in maternal mortality (Zureick-Brown et al., 2013). Furthermore, in 2000, Millennium Development Goals (MDGs) were articulated under United Nations. The fifth Millennium Development Goals is to improve maternal mortality. There are two particular targets associated with this goal.

1 Reduce maternal mortality ratio by three quarters between 1990 and 2015.

2 Achieve universal access to reproductive health by 2015.

Many studies have shown that development of modern medicine and expansions of modern health facilities have played a pivotal role to reduce morbidity and mortality in developing countries. However, some argues it is the equalities in access opportunity to maternal health services that could reduce the morbidity and mortality. However, the access opportunity is highly influenced by the health seeking behavior of women. The rational decision of pregnant women to seek health care services is influence by the social structure present. The social structure that influences the pregnant women to seek health care facilities are people close to pregnant women such as relatives, 'significant other' and husbands. Furthermore, the entire maternal health care system, various types barriers to health services and delay of decision making to seek maternal health care also influences the health seeking behavior (Niraula, 1994; Phillips, 1990; WHO, 2014).

This thesis focuses on the maternal health seeking behavior in Banke district in Mid-Western part of Nepal with different opportunities to maternal health services. The access opportunities are highly influenced by social structure, maternal health care system, and barriers to health care services.

1.2. Statement of problem

Access opportunity to education, economy, and politics including health services have been concentrated in urban centers and these access opportunities have been dominating by the upper class in Nepal for centuries. The consequences of such domination have direct negative effects on the poor people in rural areas especially pregnant women. The introduction of modern health services in Nepal is not that long ago. However, the access to modern health facilities is limited to the urban areas even though large proportion of the population resides in rural areas. This describe that the rural areas basically lacks health facilities in terms of infrastructure, modern medical equipment and resources.

The recent years, increase in access to health care facilities especially in rural areas and the government incentives schemes is highly expected to improve the quality of health. However, due to socioeconomic structures, barriers, access opportunities, cultural values and norms, decision delay to seek health care, relationship between patients and staffs, choice of health care services, attitude of patients to the health care system for some women alters the health seeking behavior. This altered health seeking behavior opens for the wide spectrum for pluralist health care delivery that means pregnant women will highly seeking assistance from untrained traditional birth attendant. This pluralist health care delivery leads to increase home birth under the assistance of untrained traditional attendant that is dangerous to mother and child especially if there is complication. Therefore, this study seeks to understand the health seeking behavior.

1.3. Research objectives

The main objective of the study follows

1. To study the health seeking behavior of pregnant women; including their socio-demographic characteristics, social structures, and the influence of modern health care delivery structure in Banke district, Mid-Western part of Nepal.
2. To examine the barriers to maternal health care services and their consequences for the choice of the health care services and the role of government to overcome these barriers.

1.4. Research question

Furthermore, the study aims to present important policies that are implemented by the government in order to encourage pregnant women to visit health services for antenatal check-ups and give birth under assistance of trained health worker.

The study has some research questions to be investigated

1. What are the major influencing factors and barriers for use of health care services in Nepal?
2. Who decides for these pregnant women to use health care services?

3. What are the important interventions implemented by government in order meet the target set by MDGs?

1.5. Personal justifications

Personally, I as was fascinated with this topic because when I was teenager I had an opportunity to travel with my father due to nature of his job. His job took us to rural and urban places of Nepal. During my stay I encountered people talking about taking their wife to the health post because she was about give birth but the crucial problem was how reach to the health post nearby.

Generally, every aspect of a women's life is controlled or dictated by their mother-laws or father-in-laws and husbands in Nepal. This describes that women do not have any autonomy to decide. In addition, the Nepalese society is highly divided in caste system were low caste is discriminated from every access opportunities such as access to politics, economy, education and health especially girls/women. Within this caste, I have seen people residing pregnant women to separate place inside the house or out the house were people usually put their animals and people did not touched pregnant women except few, these are the traditional and cultural belief. I even heard that a women die while giving birth in her house due to birth related complication. I was not able conceptualize such social structure and understand traditional and cultural practices at that time.

Few years' back, I came across to glance the news that Nepal's maternal mortality rate has decreased almost by 50%from 1996 to 2006. In 1996, it was the highest among South-Asian countries. For this significant progress and commitment towards improving maternal mortality rate, Nepal was honored at the 2010 Millennium Development Goals Review Summit (Shrestha, 2012). I was very glad to read this news despite the country's geographical terrain and accessibility challenges, its economy, its traditional and cultural norms and values and the ten years of civil war.

However, in 2012, I read the news from one of the leading newspaper that among the 15 districts in Western region part of Nepal, Banke district had witnessed the highest maternal mortality rate of 23 and children mortality rate 227. This newspaper claims this statistics and report from Regional Health Directorate report

(thehimalayantimes, 2012). Fortunately, I came to know a jolly female gynecologist, who had worked in Government Zonal Hospital in Banke for last 30 years, through my social network. After talking to her I decided to travel to Banke to conduct my research.

Nevertheless, I want look this event through perspective of access opportunities for maternal health services, related social structure and maternal health delivery system that influences on the health seeking behavior of pregnant women. Furthermore, glance at the policy interventions by the government to alter the social structure.

1.6. Organization of the thesis

This thesis is organized into seven broad chapters, as the aim is understand the health seeking behavior of pregnant women.

Chapter 1: opens with introductory and background to the study with justification. Chapter 2: concepts and theoretical approaches, defines relevant concepts that are used in this thesis, before exploring the theoretical approaches that looks complicated problems and social issues through different lenses. Furthermore, different relevant models are used to illustrate health-seeking behavior. Chapter 3: shows the methodology for this thesis as different methods and techniques are used to gather data for this study with ethical consideration and limitations and policy interventions. Chapter 4: the study area, where the study is conducted showing the map of the district. Chapter 5: data analysis and interpretation, deals with demographic and socioeconomic characteristics of informants in study area. Chapter 6: closely looks at the interaction between social structure and pregnant women and the health seeking behaviors. Chapter 7: finally, the last chapter is the conclusion of the study with recommendation from the study.

2. CHAPTER TWO: CONPECT AND THEROTICAL APPROACH

2.1 Introduction

To link the study to theory is always essential for any research. According to Slivermann argument, "*Without theory, there is nothing to research*" (Kitchin & Tate, 2013, p. 33). Theories provide comprehensive understanding of complex things in qualitative research such as why people act or react in certain ways, how societies do function and so on. Furthermore, theories provide researchers "different *lenses through which to look at complicated problems and social issues, focusing their attentions on different aspects of the data and providing a framework within which to conduct their analysis*" (Reeves, Albert, Kuper, & Hodges, 2008, p. 1).

In this chapter, I will discuss relevant concepts that provide brief understanding. Theoretical approaches follows to understand the decision to seek maternal health services. Furthermore, other relevant model including "three delay" model are viewed that illustrate health-seeking behavior. In addition, look at the policies that are formulated by the government to support pregnant women.

2.2 Defining concepts

2.2.1 Access opportunity

The concept of accessibility has been used widely in various fields. According to Gould accessibility *"is a slippery notion… one of those common terms that uses until faced with the problem of defining and measuring it"*(Song, 1996, p. 474). Similarly, Ingram also states that it is difficult to provide true satisfactory definition rather it complicates its measurements. Generally, accessibility defined as the possibility of various opportunities for interaction (Song, 1996). This part of the thesis tries to explore how the concept 'accessibility' has been variously understood and how they have been approached in health related literature.

As we know, globally rural communities comprises of poor health status and problem to access health services compared with their metropolitan counterparts. This due to the distance barriers and availability of health care because of the high cost of providing health services in densely populated areas (McGrail & Humphreys, 2009). Again, according to Humphreys & McGrail emphasize on geographical accessibility as a major concept of access and further illustrates that geographical accessibility comprises of two components such as availability and proximity. Considering high availability of health services does not mean that there is a high guarantee of accessibility because it depends on the proximity or distance of the population to those health services. Similarly, close proximity or distance does not mean that there is a high accessibility to health services because it depends upon the size of the population competing for the services available and potential limitations in terms of fees, opening hours and waiting list.

There are three measures approaches that need to be taken into consideration while taking about accessibility, namely distance/time to the nearest service, gravity model and population-to-provider ratio. The Distance/time to the nearest service is the simplest and most common measure of geographical accessibility; however, this does not capture availability because the focus is on population and proximity. The gravity model measures both proximity and availability that assumes, the closer people are to the health service, more likely they will use the health service available. In contrast to distance/time and the gravity model, population-to-provider ratio focuses on the categorization of population and health services that are located within a common boundary, the basic assumption is that population will only use health services within their catchment areas that is easy to measure (McGrail & Humphreys, 2009).

According to Joseph & Philips, 1984 asserts that accessibility can be of two types physical and socio-economic. Physical involves infrastructure for instance hospitals, clinics or health post, where services and means of reaching it available, which is also known as location access opportunity. While, socio-economic accessibility involves people's ability to pay for the services. For instance, when services and facilities are opened to people and availability to the people in socio-economic terms, which is also known as effective accessibility (Joseph & Phillips, 1984).

Other form of geographical accessibility in geographical studies of health care services generally focuses on the assessment of revealed accessibility and potential accessibility. Revealed accessibility signifies the actual utilizations of the core resources and the level of satisfaction acquired by the population residing in that area, thus, socio-economic and health care system and the facilities plays a determinant factor. As for the potential accessibility, focuses on the need to supply health services such as setting up enough community health institutions, where population can access health services in a walking distance. This accessibility is used by planners and policy makers to evaluate the existing health services and further identifies the room for the improvement for the need to supply health services(Joseph & Phillips, 1984).

In the context of pregnant women, access to health services generally or naturally falls on the proximity and availability as mention above. However, the nearest or closest services capture proximity between population and the service provider, but the population does not consider the availability in terms of qualities or affordability. As we have experienced in our daily life that proximity, do not really matter, if there are number of health service provider nearby and population tends to bypass the nearest services. However, other factors influences health service use such as cost of health services, cost of transport, cost of medicine and others, especially in rural areas and for different socio-economic groups.

2.2.2 Maternal and Child health

According to WHO health is defined as

"*Maternal health refers to health of women during pregnancy, childbirth and the postpartum period*"(WHO, 2014, p. 4).

Similarly, according to WHO child health is defined as

"*Child health is a state of physical, mental, intellectual, social and emotional well-being and not merely the absence of disease or infirmity. Healthy children live in families, environments, and communities that provide them with the opportunity to reach their fullest developmental potential"*(McAvoy, Purdy, Mac Evilly, & Sneddon, 2013, p. 1).

Furthermore, mortality among child are measured by five rates:

Neonatal mortality*: the probability of dying with the first month of life.*

Post-neonatal mortality*: the difference between infant and neonatal mortality*

Infant mortality*: the probability of dying before the first birthday.*

Child mortality*: the probability of dying between the first and fifth birthday.*

Under-five mortality*: the probability of dying before the fifth birthday.*

All rates are expressed per 1,000 live births, except child mortality that is expressed per 1,000 children surviving to 12 months of age (Ndawala, Office, & Macro, 2000).

From early eighteenth century, until today's globalized world, maternal and child health has been the concerned and important topic for the national and international communities, especially for scholars and practitioners of public health. As a concerned and important topic, World Health Organization came into existence in 1948 to help all people achieve highest possible health and further to promote maternal and child health and welfare. In addition, United Declaration of Human Rights included that motherhood and childhood are entitled to special care and assistance. The efforts international community is putting through various organizations to provide adequate health services are remarkable. However, each year there is at least 3.2 million stillborn babies, more than 4 million neonatal deaths and more than half a million maternal death in developing countries especially in sub-Saharan Africa and South Asia. There are number of disease that contributes tremendously on the death role such as malaria, diarrheal, malnutrition, unsafe abortion, tuberculosis, HIV/ADIS and other injuries. The vast majorities of death due to these various diseases are preventable. Nevertheless, due to disparities in physical geographical, exploitable resources, education, civil war, unstable and honest governance, inequality in income, poverty and accessibility it is difficult to acquire the target set up by the MDG till 2015 (Ehiri, 2009)

The gender differences and discrimination has always been an issue of concern in providing and utilization of health care services in developing countries especially in Africa and South Asia. In terms of other expenditure, the health expenditure has always been expensive such as doctor fee, medicines, surgery if needed and transportation cost.

Comparatively females are less priotrized on the quality of the health care services they receive compared to their male counterparts even though males expenditures are significantly higher than females. It seems that females are the ones more likely to be trapped by medical poverty, which has its negative effects on their children(Kumar & Chaturvedi, 2012).

2.2.3 Antenatal care

Good care during pregnancy is important for health of mother and the newborn. Antenatal care (ANC) is a care that pregnant women receive from health professional. It is basically, a medical examination during pregnancy but before birth of a newborn. Antenatal care also provides important information to pregnant women and her families and advice for healthy pregnancy, safe childbirth and postnatal recovery. Furthermore, antenatal care improves the survival and health of babies by reducing stillbirth and neonatal death (Lincetto, Mothebesoane-Anoh, Gomez, & Munjanja, 2006).

2.2.4 Traditional birth attendant

Traditional birth attendant is defined as **“***a person (usually a woman) who assists the mother at childbirth and who initially acquired her skills delivering babies by herself or by working with other TBAs”* (Leedam, 1985, p. 250). Usually they are old women found mostly in rural area of developing countries. Except assisting childbirth, they also provide support and advice during pregnancy and childbirth however; typically they are illiterate and have no medical training. They acquired such assisting through experience and tacit knowledge from a member her family or kin group (Leedam, 1985).

2.2.5 Midwife

A midwife is a person especially; women who are trained and licensed health worker that provide assistances and advises to other women during childbirth also known as skilled birth attendant as creditable health professional such as doctors or nurses. They

possess skills regarding hygiene, risk factor of mother and child and if there are complications they refer pregnant women to hospital. Furthermore, midwife also take care of newborn & infants similarly, provides counseling and education to family and community regarding antenatal care and postnatal care(Thomas, 2002).

2.2.6 Barriers

According to Joseph & Philip, barriers to use health care are simply a constraints or limited access to utilize particular health care services (Joseph & Phillips, 1984).

Cost of health is one of the common factors that discourage people to use health care services especially for poor people in rural communities. Economic incapiblities in terms of cost of health is considered one of the important barriers for economically poor people in rural communities. In recent years, economical barriers have been removed by introducing 'free' health care services in most of the developing countries. However, this does not include all type of health care and services (Phillips, 1990).

Similarly, geographical barrier is another obstacle to use health care service due to the difficult geographical terrains. This difficulty is not only the case for the health seeker but also for the health care provider. Some places in the developing counties, the lack of transportation due to the difficult terrain health seeker have to trek for at least 2-3 days to reach nearby health post especially in mountain areas; this is especially difficult for pregnant women and the children seeking for health services (Riportella-Muller et al., 1996).

Lack of responsibilities or manageability is another issue that needs to be considered while considering about barriers; this applies for both health seeker and health service provider. From parents perspective is difficult to take time off from their daily work to take pregnant women and children distance away for regular checkups and even they take their children to the nearby health post the health providers such as doctors or nurses are not available. Not only about unavailability of health provider but also about the inconvenient timing of opening and closing of the health post that hampers a lot. Furthermore, health workers such as doctors, nurses and other technical workers do want to reside and provide their services to people in rural areas because of inadequate

income (Riportella-Muller et al., 1996). Therefore, government in developing countries should take a responsibility to create certain rules that health service provider such as doctors, nurses and so on should at least contribute certain years in rural areas and the health post should be opened 24 hours and manage them in a systematic way. Furthermore, educate parents about advantages of regular check-ups.

Probably, education plays an important role in overall health status of any family. Most of all it is suggested that educating women can alter traditional balance of power within the family, changes the decision-making and allocation of resources. Furthermore, education may change knowledge and perception of "significant others" such grandmothers, mother-in-law and so on about the use of the modern medicine rather than use of traditional birth attendance that can benefit their children and her. Several studies have showed that educating mothers were more likely to take advantage of health services than uneducated. Moreover, education prohibits the use of untrained health worker and traditional healers (J. Caldwell & Caldwell, 1993; J. C. Caldwell, 1990).

In addition, according to Jacobs et al., 2012. Table 1 is the combination of Peters and Ensor & Cooper synthesized by (Jacobs, Ir, Bigdeli, Annear, & Van Damme, 2012) framework of barriers to access health care services especially in Low-income Asian countries with specification of supply and demand. Here access has four dimensions: geographically accessibility, availability, affordability and acceptability through supply and demand. The demand-side determinant factors that influences the ability to use health services at individual, household or community, while supply-side determinants factors that hinders service uptake by individuals, households or the community (Jacobs et al., 2012).

Table 1: Dimensions of barriers to access health services

Peters et. al, 2008	Ensor & Cooper, 2004
Geographic accessibility • Service location (S) • Household location (D)	• Transportation cost (D)
Availability • Health workers, drugs, equipment's (S) • Demand for services (D)	• Waiting time (S) • Wage and quality of staff (S) • Price and quality of drugs (S) • Information on health care (D) • Education (D)
Affordability • Cost and prices of service (S) • Household resources and willingness to pay (D)	• Direct price of services (S) • Opportunity costs (D)
Acceptability • Characteristics of the health services (S) • User's attitude and expectations (D)	• Management (S) • Technology (S) • Household expectations (D) • Community and cultural preferences, attitudes and norms (D)

D = Demand; S = supply

Furthermore, in additions to Ensor & Cooper's synthesized by (Jacobs et al., 2012)cultural preferences, attitudes and norms, as mentioned, there are gender difference and discriminations in terms of girls getting married at very young age. If a women/girl gives birth to a girl or finds out that women/girl is going to give birth to a girl they are treated very badly and sometimes forced to abort, which has a negative effect on women/girl and even for a child. Further, son preference attitudes because of future security of parents' leads women/girl to give more birth until and unless they provide a son, which can lead to women/girl and child death (Morgan & Niraula, 1995).

2.3 Theoretical approach

It provides complex and conceptual understanding of problems and issues. Furthermore, it gives researchers an opportunity to look at problems and issues through different lenses and intent to explain them.

2.3.1 Structuralist approach

Structuratlist emphasize that powerful groups or high-class groups in a society are able to impose their preferences such as low payment, privilege access to resources and services on less powerful groups. The powerful groups impose their preferences through the exercise of economic, social and political power (Greig, Hulme, Turner, & Turner, 2007). In addition, according to Gatrell & Elliott (2009), this approach derives much of their impetus from Marxist theories of oppression, domination and class conflict, where inequality is inevitable in society. These theories propose that economic relations and structures underpin all areas of human activities including health and access to health care services (Gatrell & Elliott, 2009; Greig et al., 2007).

The lack of access opportunity has its great significance on children for instance, children born in poor income households with low social status and inadequate political power inevitable fall into an abyss of capability deprivation. Children born in such abyss are underweight and apparently have weak immune systems as their mothers because mothers are also underweight and undernourished and furthermore they lack

access to adequate prenatal, postnatal and infant care. The greater exposure to deprivation has its negative effects on children's physical and cognitive development (Gatrell & Elliott, 2009; Greig et al., 2007).

Similarly, on the health services, according to (Ferguson & Kaniki, 1980) emphasizes medical skills as a commodity that has much on curative medicine than preventive health, which has an exchange value where people can afford. Furthermore, his emphasis is that poverty is the real cause of ill health and poverty is result or generated from capitalism. People working on the health care based on the capitalist ideology have little incentive to attack the root cause, absolute poverty. Nevertheless the focus is more on making money through providing medical cures rather than reducing poverty and preventing diseases and ill health (Gatrell & Elliott, 2009).

However, from power relations between social or ethical group, between man and women, between people with different sexual orientation, between owners and labour classes or between societies, these structures are deeply embedded in the society especially in developing countries. The power structure relation between male and female, where male power has always dictated women including women's use of health care services. Moreover, to improve and the solution to the health problem requires social changes rather than the medical interventions (Gatrell & Elliott, 2009).

2.3.2 Structurationist approach

As, structuralist states that structures constraints every activities or behavior of agents, while structurationist argues that there are two sides of a coin, as it acknowledges that structures constraints every activities or behavior of agents however, it focuses especially the other side; behavior of agents can create and recreate structure.

Furthermore, to understand the fundamental problem in a society, first we need to understand the underlying structures in a society and the action of the agents have on it. The theory of structuration is developed by Anthony Giddens, puts forward the concepts of "structure" and "agent" and how it recreate and reshape each other. The main idea of Giddens' structuration theory is the duality between "structure" and "agency", as it acknowledges that structures shape social practices and action, however,

in return such practices and action can create and recreate social structure but "structure" and "agency" are not prominent to each other (Gatrell & Elliott, 2009).

Agency is a human action and referred as human capabilities. According to Giddens, human agency is "*the capacity to make a difference"*(Giddens, 1984, p. 14). Agency has a power to transform a society and its structure because human are knowledgeable and competent whose action can create and recreate structures.

Structures, according to Giddens, are set of rules and resources that individual actors drawn upon in the practices that reproduce social system(Giddens, 1979). Structures can be formal and informal. Formal set of rules one such as laws, bureaucratic regulation and prohibitions. Informal set of rules or unwritten social rules can be social norms, codes of conduct that guides people's interaction in their daily life. People frequently follow the informal or unwritten set of rules because they are deeply embedded a society. Furthermore, Giddens, points out that set of rules and resources are guided through institutions, which are important parts of a society.

Resources "*are structured properties of social system, drawn on and reproduced by knowledgeable agents in the course of interaction" (Giddens, 1984:15).* He divides resources in to two classes, allocative resources and authoritative resources. Allocation refers to man's capabilities of controlling not just objects but the object world such as finance and land. While authoritative resource relate to the man's capabilities of controlling the humanly created world of society itself such as social status, education and so on (Haugaard, 1997).

Basically, human agency and social structure are related to each other. For an example, pregnant women acts or behavior are influenced by the social structure such as: traditions, social norms & values, institutions, moral codes. Furthermore, social structures within a family induce the level of usage of facilities due to the power-relation and decision making capabilities. However, agency in this case woman responds to the structures in different ways. Knowledge plays a pivotal role to influence or change structure. Agency may decide which health care facilities they want to use private or public, however economy comes into play. Furthermore, they can decide on the number of children they want: however pressure of son preference poses a structural condition.

2.4 Theories and models of health care seeking

2.4.1 Models of health care seeking behavior

Any countries population's health depends upon how the available health services are utilized, which is the main concern for the policy makers and researchers. There have been number of attempts to describe, determine and predict health services utilizations applying different model in social science and in public health area. The majority of models are concern with specific variables for the study of access to health services but some complex in nature. Many developed models assimilated variables from (Gross, 1972) model like predisposing and enabling factors and others added more variables as suitable for the developing countries (Philips, 1990).

The classical study of (Aday & Andersen, 1974), in their framework for the study of access to health services considers characteristics of the patient, service provider and the entire health care delivery system. This also known as behavioral model: three major components determine the use and non-use of health care. First, predisposing factors consists of age, sex, family size, education and employment. Second, enabling factors consists of income, insurance and residence. Finally, need factors consists of health status, symptoms of illness and disability days (Phillips, 1990; Pokhrel & Sauerborn, 2004). Furthermore, according to Philips, they group these factors into input and output factors that influence access to health care facilities (Phillips, 1990).

The framework figure 1, shows the structure and agency relationship for particular case, health behavior for parents especially women who are seeking for their child health care and their own. Furthermore, (Stock, 1983) includes the social, economic and cultural values determines the use of health care services in many developing countries. The attitude of health care system provider are shaped by structural policies but these policies can be altered or recreated through the parents especially mother's behavior that could have a good outcome on the uses of health care facilities. Furthermore, interaction between agency and structure can alter the social values, cultural values and health beliefs.

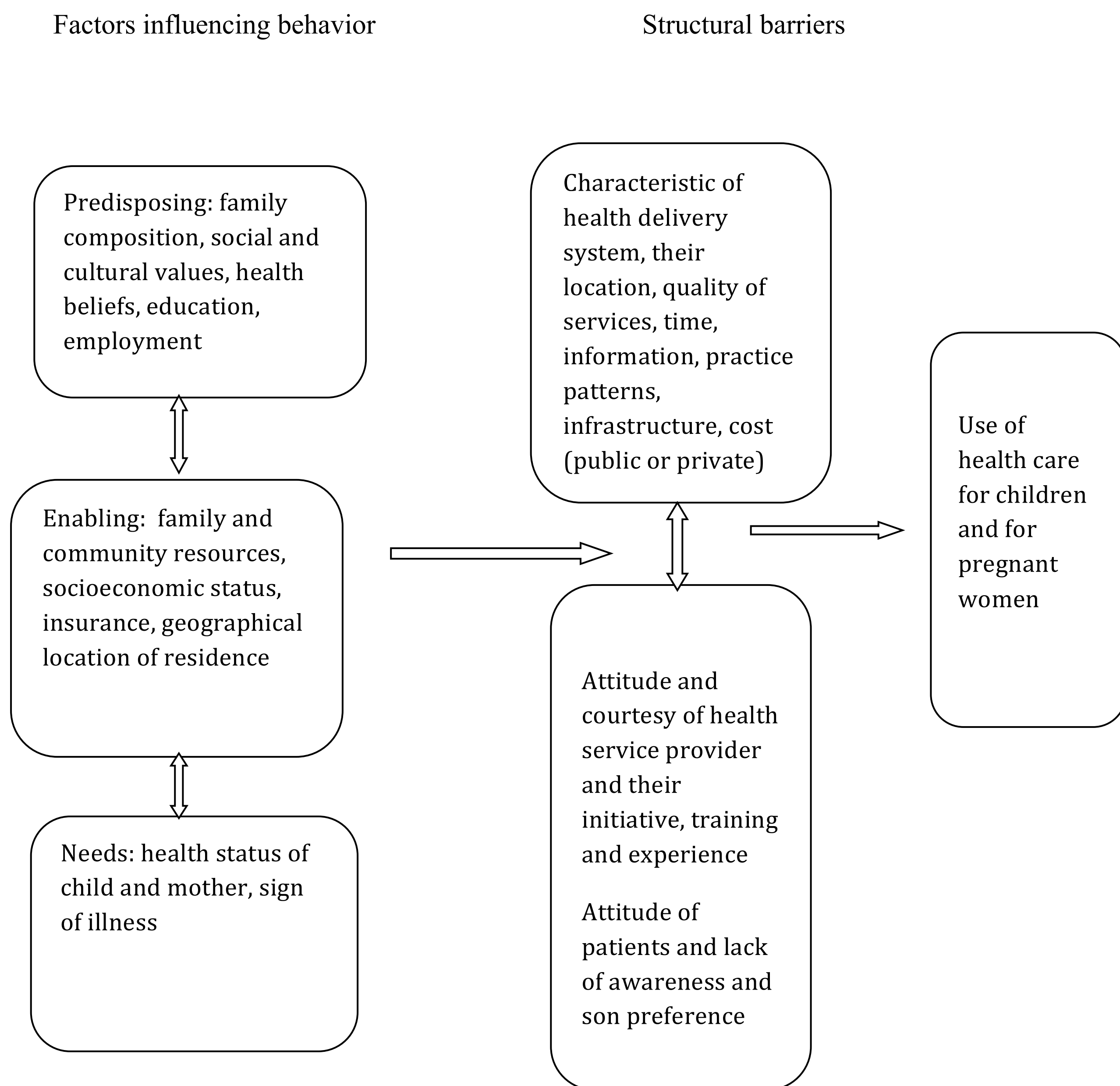


Figure 1: Framework of factors affecting health-seeking behavior

Source: based on (Aday & Andersen, 1974; Dutton, 1986)

On the structuralist aspect, where health provider attitude is driven by the money, which are expensive for poor income families and individuals and the market has created the gap between haves' and have not's could affect the outcome on the use of health care facilities and that might push them to depend upon pluralistic kind of health services.

Some of the other accepts of health care utilizations are health belief model and economic model. In the health belief model, also known as psychosocial model, assumes that a person will take a health related action if that person feels that a negative health condition can be avoided, has a positive expectation and believe that by undertaking a recommended action that a person can avoid health related problems. Finally, economic model, assumes that each individual as both a producer and a consumer of health, where health is treated as a stock for future (Pokhrel & Sauerborn, 2004).

2.4.2 Three-delay model

Poor and rural pregnant women have always been subject that faced with many barriers. These barriers are: social, cultural, economic, geographical and so on. These barriers limits poor and rural pregnant women to access efficient health care delivery.

Figure 2 shows the three phases of delay. The first phase on decision to seek care part, individual and family's socioeconomic/cultural factors shapes the decision. Within this socioeconomic/cultural factors involves education of family member especially mother's, financial status, social norms such as head of a household decision is a final decision. In the second phase, decision to reach health facility are affected by accessibility of facilities such as in adequate transportation facilities & cost to travel, distance to near health post from home, difficult terrains. Finally, in the three phases, waiting for services such as to reach health care facility and waiting at the health care facility for treatment are affected by the quality of services including inadequate supplies of equipment, trained & competence of health personals, attitude of health personals. The three delays model by Maine & Thaddeus, explains the major factors such as community roles, norms, values and health care system affects the utilization of health care especially for pregnant women in developing countries (Thaddeus & Maine, 1994).

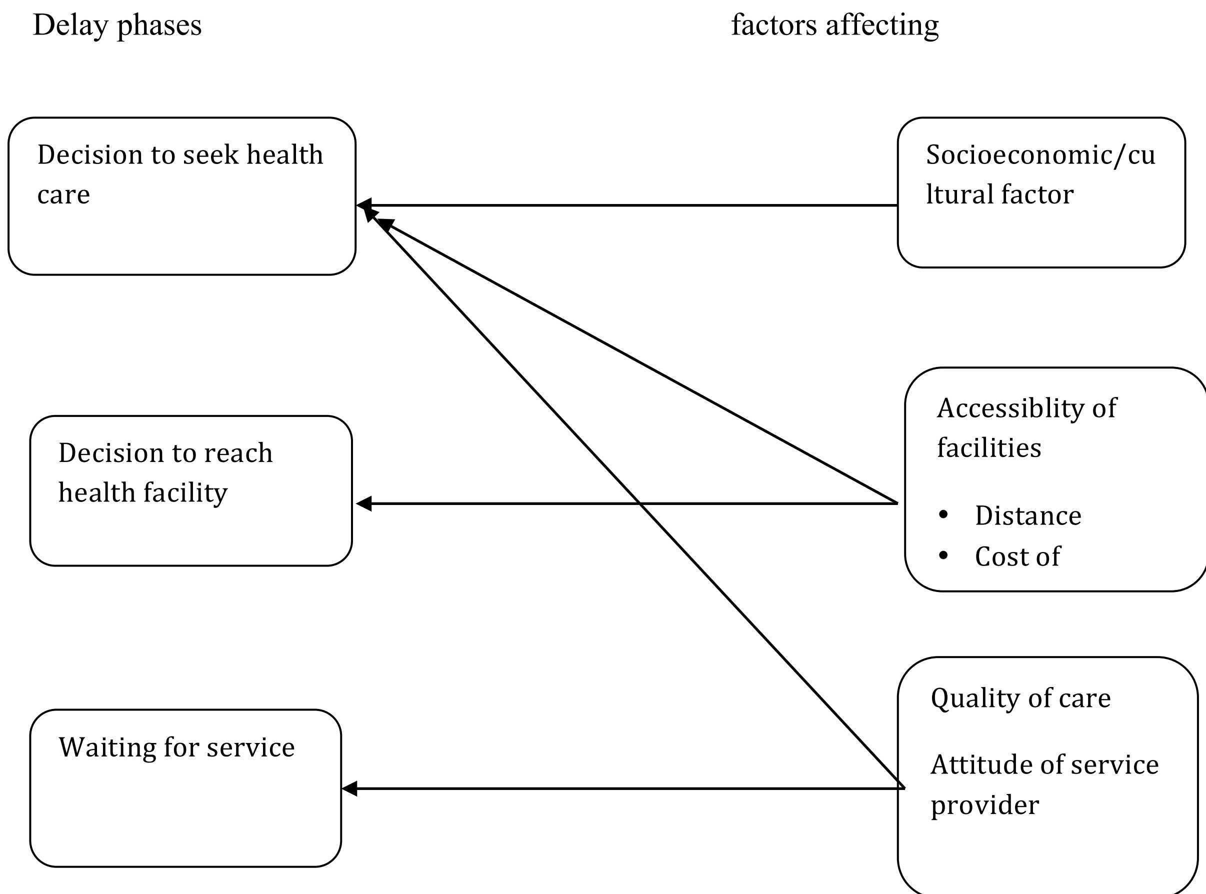


Figure 2: Three-delay models to health care

(Thaddeus & Maine, 1994)

Furthermore, Save the Children and other researchers have adapted the three delays model framework to understand the major contributing factors to children death context in developing countries because it has the similar features (Sitrin et al., 2015).

2.5 The political factor, Nepal Government initiations

Policies and politics are the most important determinant factors that enable any country to achieve development such as social and economic. Basically, health policy refers to plans, decision and action that are taken to achieve specific health goals within a society. Furthermore, policies provide access to health care services for every people, increase equality to access and use health care services, it reduces barriers, produces quality of care and so on. According to Aday and Andersen 1975 in Philips, 1990 states

that policies are the positive inputs to health services and seen as the influencing factor for utilizing health care services. Here are some of the health policies formulated by the government of Nepal.

First shift toward comprehensive public health system started in 1962. The initial effort was to train people and place them in every village. For instance, at least one health worker per village and one community health volunteer per ward. During the period from 1960-1990, hospitals were established at every level such as district, zonal, regional and central. Furthermore, there were health center and health post established at local level. Such kind of establishment increased the access to health care service and promoted the health seeking behavior of the people. However, at this time, the health system was limited to urban areas, poorly managed and over-centralized.

In 1990, the only recorded stats; one in every seven children died before their fifth birthday and life expectancy was only 54 years. The first WHO, in 1990 estimated MMR was over 870 deaths per 100,000 births and less than 2% of trained health workers assisted the delivery.

The political transition and restoration of multi-party democratic system in 1990, most likely provided the space for substantial reforms to enhance health status of the people including maternal and child health.

2.5.1 National health policy 1991

The prime aim of this health policy was to up-grade the health standards especially focused for rural population of rural area. Furthermore, provide the modern medicine and modern facilities because such kind of initiation was unable to be addressed before due to poor political commitment, poor strategies and weakness to implement health programmes. This policy was unable to implement as anticipated in every district of the country because of ecological nature and economy. However, it provided pregnant women an opportunity to utilize modern medicine and facilities that reduce maternal mortality.

2.5.2 Second long term health plan, 1997 – 2007

Second long-term plan has been formulated to improve the health of the population especially those whose health needs are not met, basically; increase equality in access to health care. Furthermore, the target was to reduce maternal mortality up to 250 per 100,000 live births, increased contraceptive prevalence rate, improved number of trained worker to assist deliveries, improvise women to attend antenatal visits. This policy is one of the relevant for pregnant women help improve their and their child health standard and further provided access opportunity to maternal health care facilities.

2.5.3 Safe motherhood policy, 1998

Safe motherhood programme addressed reproductive health issues and developed maternal care guideline, midwifery practice, safe motherhood clinical protocols and management guidelines, national information education and communication and training strategies, quality control strategy for maternal health care, national strategy for control of anemia among women and children under UN. Furthermore, fifteen year safe motherhood plan of action was also developed to provide basic emergency obstetric care in all 75 districts and skilled attendance at birth including increased access to emergency fund and transportation. It provided pregnant women with information about the advantages of using maternal health facilities compared to traditional birth attendant. Furthermore, it helped reduce dependency in terms of economy because of the incentive schemes.

2.5.4 National safe abortion policy, 2003

Finally, after long discussion on abortion issue, in 2002, parliament passed safe abortion law. However, it states that this law should be practiced as an alternative method for family planning. The expectation behind this law was to reduce illegal abortion because unsafe abortion accounts for 13% of maternal death. Furthermore expectation was to also reduce malpractices associated with abortion. This legal policy

tremendously reduced the maternal death as son preference attitude led pregnant women to go under unsafe abortion.

2.5.5 Nepal health sector programme- implementation plan, 2004

Implementation of this plan was to achieve millennium development goals with improved health outcome for rural and poor people. The strategy was to improve health status by delivering well-managed health services, reduce maternal mortality from 539 to 300 per 100, 000 live births, increase skilled health workers and birth attendance and further increase the budget in health sector. This could improve the pregnant women health status and reduces the dependency on traditional birth attendance.

2.5.6 Maternal incentive scheme, 2005

The aim of this scheme was to increase utilization of professional care at childbirth and institutional deliveries. Furthermore, this scheme provides cash incentive to women who give birth in health facilities and for health worker for each delivery attended. The incentives depended upon the ecological zone: for mountain districts women receives 1500 Nepali rupees, 1000 rupees for hill districts and similarly, 500 rupees for Terai districts. The incentive scheme reduced transportation barriers and delay in maternal care seeking. Furthermore, encouraged health workers to provide their health services in rural areas.

2.5.7 Safe motherhood and neonatal health long-term plan, 2006-2017

The main aim of safe motherhood and neonatal health long-term plan 2006-2017 was to improve maternal and neonatal health especially poor and socially excluded. The goal is to reduce maternal mortality ration to 134 per 100,000 live births and 15 per 1,000 live births by 2017. Furthermore, under Safe Motherhood Programme, the incentive was upgraded, 400 rupees to women who receive at least four ANC visits and at least

one postnatal care visit. These schemes diminished the cost dependency for pregnant women and furthermore, increase the use of health care facilities.

2.5.8 National policy on skilled birth attendants, 2006

The aim to formulate national policy on skilled birth attendant was to increase the percentage of birth assisted by skilled birth attendants and furthermore, increases the training sites that the country required. The main objective was to reduce maternal and neonatal morbidity and mortality by ensuring availability access and utilization of skilled care at every birth. This policy reduced the dependency on traditional birth attendant and home delivery.

2.5.9 National free delivery policy, 2009

National free delivery policy with Rastriya Aama Surakchhya Karayakram was lunched to provide free childbirth and upgrade on travel coast to women and reduction of first and second delays to avoid the maternal death. Furthermore, this policy provided cash incentives to health worker. Under this policy began to provide free institutional delivery care such as normal, complication and caesarean section for every woman at all facilities that are capable to provide the services. This policy provided access opportunity to pregnant women especially poor and improves health-seeking behavior. Further, diminish the cost barriers and dependency upon head for the household.

2.5.10 Nepal health sector programme implementation plan II, 2010-2015

Implementation plan II programme was to promote the "health status of the people by facilitating access and utilization of essential health care and other health services, emphasizing services to women, child and other deprived as well as excluded people. First priority was reproductive health including family planning, antenatal care, delivery and neo-natal care, institutional delivery, safe abortion and prevention of uterine prolapse". The main focus was to achieve target set by the Millennium

Development Goal 5, reducing maternal mortality up to 134 per 100,000 live births. It provided access opportunity especially to social exclude poor pregnant women and provided information to use maternal health care facilities.

Source: (Baral, Lyons, Skinner, & Van Teijlingen, 2012; Bhadari & Dangal, 2014).

These initiations from Nepalese government through the support from multi-lateral organizations and bilateral organizations have been able achieved a lot in recent years. The maternal mortality has dramatically decreased (figure 6). Similarly, childhood mortality also decreased (figure 5) even though the geographical terrain limits for the delivery of essential health care services. Furthermore, Human Development Index has improved in recent years (figure 4). However, the country's internal issues is obstructing what these policies intend to achieve such as issues of education, women rights, centralized financial administrations, slow decentralization process, weak supervision, infrastructure, inadequate supply of drugs and equipment and the major source of implementation failure is the political instability both in central and local level. The continuous change of government changes priority and strategy for policy implementation. Furthermore, the political interference in management is another issue of implementation failure.

3 CHAPTER THREE: METHODOLOGY

3.1 Introduction

This chapter depicts what kind of methodology and methods that can be employed to conduct in order to acquire data for a research. Before diving into the procedure of data acquiring, it is important to understand the difference between methodology and method in a research. Methodology is a systematic way for solving various research problems. This explains how the research should be conducted in a broad sense. Furthermore, "*the procedures by which researchers go about their work of describing, explaining and predicting phenomena*" (Rajasekar, Philominathan, & Chinnathambi, 2006).

According to (Bryman, 1984), traditionally there are two systematic ways to collect data for solving various problem, quantitative and qualitative ways in social science. However, the choice of the research methodology depends on the type of the research problem and the theoretical approach.

3.2 Quantitative research

To conduct a social research, quantitative approach is an approach that applies natural science to depict the social phenomena. Quantitative researcher uses any research method that produces hard number that can be turned into statistics. Such research method attempts to answer the question like "when", "Where", "How many" as well as "How often" through questionnaires, survey and polls. However, various scholars have criticized such kind of research method because according to them, people are treated as objects without any consideration of the values and meaning (Marston, Jones, & Woodward, 2005).

3.3 Qualitative research

While Qualitative methodology, explores the feelings, understandings and knowledge's of others. Such feelings, understandings and knowledge's are acquired through interviews, participation observation and discussion that help to understand the

complexity of people's everyday life in order to get deeper knowledge within different context (Limb & Dwyer, 2001). Furthermore, it attempts to answer the question like "Why" and "How" and provides the deeper meaning and intentions. Some of the technique includes participation observation, interviews, reviews and focus groups furthermore; this research method allows people to express on their life in their own word (Bryman, 1984). However, some of the scholars have questioned such method data's validity and reliability furthermore, argued that it is not scientific, not reliable, biased and too subjective (Berg, Lune, & Lune, 2004). However, both quantitative and qualitative have own unique style to analysis social problems.

In this study, I used qualitative approach particular to understand health-seeking behavior of pregnant women and why for such health seeking behavior to various maternal health services available to them. As, qualitative approach allows me to understand subjective knowledge that might be difficult to understand quantitatively. The study was conducted in Nepal and more focus in Banke District in Bheri Zone, located in the Mid-Western Region of Nepal. To further supplement, I used help of the statics report from Nepal Health Demography and census report to see rise and fall in maternal and child mortality over past 15 years. Both quantitative and qualitative research used because it provides more comprehensive validity of the results (Morse, 1991).

3.4 Study design

The function of a research design is to ensure that the evidence obtained enables us to answer the initial question as possible (De Vaus & de Vaus, 2001).

In other words, a research design, in general, is a series of decision and planning such as most logical and appropriate method, technique and instrument used that helps collect data and answer the question (Limb & Dwyer, 2001). Basically, research design is a decision-making process.

3.5 Research assistants

I was worried before entering the field because I was concerned about how and where to find interpreter even though I am from Nepal and my study area is in Nepal. There are different spoken languages in different places and I could not speak or understand the local language. I shared my concern with one of the female Gynecologist from my study area as I came to know her from my social network. She consoled me saying that she will manage it when I arrive there. When I reached to my study area, she welcomed me and told me that she and one senior nurse from Bheri zonal hospital will be volunteering to assist me for my research. I was very glad and honored.

Both of my co-interviewers as I would like to call them are working with pregnant women and children in that particular area for years and most of the people in that area knew them. They are both married women and belonged to higher caste, with higher education. The gynecologist was 69 years old and the senior nurse was 45 years old.

3.6 Interviews

Researchers in social science have used interviews in various ways and it is considered as source of learning any individual experiences. Such learning about any individual experiences is complex (Campbell et al., 2006). Furthermore, according Cloke, it is described as conversation with a purpose (Cloke et al., 2004). As mentioned above in qualitative research part, among all other techniques in a qualitative research, interview is one of the important method or techniques of collecting data that specifically involves asking series of questions, which provides deeper meaning of a particular context. In the quest of acquiring deeper meaning, there are various approaches to interview such as structured interviews, unstructured interviews, semi-structured interviews, informal interviews and focus groups (Seidman, 2012).

3.6.1 Semi-structured interviews

Sometimes, in our daily lives, we talk with different people from diverse educational, political social and economic background. In the process of conversation, we tend not be that careful and systematic such as talking very fast, listening, interrupt in a different

way and become very judgmental. According to (Clifford, French, & Valentine, 2010), states that a conversation should be in such way that are self-conscious, orderly pattern and very structured. They further implies it not only about talking but it also about

"…about listening. It is about paying attention. It is about being open to hear what people have to say. It is about being nonjudgmental. It is about creating a comfortable environment for people to share. It is about being careful and systematic with the things people tell you" (Clifford et al., 2010, p. 103).

A semi-structured interview is a verbal conversation where one person such as an interviewer tries to acquire answers from another person such as informants by asking questions. It is one of the most commonly used method or technique to collect data by the researchers for their research. In qualitative interviews, the researchers prepare set of questions in a structured manner with predetermined topics. However, semi-structured interviews are actually, directed by the informants rather than a set of questions. Open-end questions provide flexibility to informants to express them with their own content and understand. The semi-structured interview is conducted upon certain guideline with particular focus on the issue (Clifford et al., 2010).

In this study, sets of semi-structured interviews were used to conduct interviews with the subjects to collect primary data. This allowed free flow of conversation with the subjects and the interviews was framed around the research objective and research questions.

My first, official visit was at Health Department in Kathmandu, Nepal. In context to Nepal, it is difficult to find out the phone number and the e-mail address of any person so, I took my chance and went to the Health Department. Before the interview, I had to present my letter of consent from the University (NTNU) and explained furthermore about my objectives. Surprisingly, after a while, I was escorted inside and I conducted my interview. I had my interview guide prepared that helped me stay in the topic. During interview, I tried to explore upon the main issues, such as awareness programmes for pregnant women, technical advice in formulating health related policies, initiate to develop and expand health instruction, providing necessary drug, equipment's, instruments and other logistics at regional, district and below, short term and long term plans, coordination with NGOs and INGOs, maintain data, financial and

information management. In way, he kindly directed me towards to explore the Nepal Demographic and health survey and Census report.

Little bit of different set of question was conducted for instance for my second official visit at District Health Public Department in Banke District, Nepal. The officials were very generous and enthusiastic to answer my questions. Furthermore, officials also provided me secondary data in terms of maternal mortality, infant mortality and child mortality report.

Similarly, different set of questions was established to acquire deeper knowledge from semi-structured interview about social and health structure with NGOs workers, doctors, nurses, counselor, volunteer worker, pregnant women and women that have given birth.

3.6.2 Types of informants

Informants are the very important people that shed light on the researchers' objectives and research questions in a qualitative research because informants possess knowledge about culture, tradition, politics and economical ability and geographical terrain of that particular area and these people will to share this knowledge are called informants. According to Bernard, there are generally, two types of informants used in qualitative interviews: key informants and primary informants (Bernard, 2011).

The sections below will further illustrate on the informants and the procedure for selecting informants. Nevertheless, this study includes informant's background such as, age, sex, education level, occupation, ethnicity and residence.

3.6.3 Key informants and sample procedure

The key informant technique is an ethnographic research method that is used by anthropologist, sociologists, and geographers. However, a technique that is widely used by social science scientists to investigate the society because key informants are the expert source of information. Key informants are the people who possess enough knowledge about certain aspect of the community. Key informants hold important

position in any society and may further supplement with relevant information that other informants would not reveal or have access to. They could be community leaders, professionals and others with a community responsibility (Marshall, 1996). During my fieldwork, I had an opportunity to interview such people who had a special position in that particular District such as a Gynecologist, she worked in Bheri zonal hospital for 30 years and presently runs her own clinic, two senior nurses at Bheri zonal hospital particularly specialist in women and child health issues, one senior doctor, one senior nurse and one senior counselor from FPAN a NGO Similarly, one field officer and one statistician from district health department. Furthermore, two public health experts from Save the Children, one doctor from Nepalgunj medical college a private hospital and one volunteer health work. They are all of these key informants agreed to participate for my research. The position these people hold in the district made them qualified choice for the interview.

3.6.4 Sampling procedure

Sampling is one of the most important steps after researcher has chosen what to investigate and how to in a study. This important step is to select a pool of participants to be in a study that can unravel a test or an objective. For a researcher, it is impossible to study every people of interest because of time constrain and resources. Therefore, a researcher selects a subset of the population of interest as sample.

According to (Rubin, 2009, p. 148)"*Selecting a sample based on your own judgment about which units are most representative or useful*". Among different sampling technique, in this study, virtually I was thinking about progressive sampling technique to select the participant from study area as mentioned because according to my own judgment those participant could be the most useful with in a limited time frame.

As, Banke District is not my home town, it would be very difficult for me to conduct my research and select the participants however, one individual, who was a Gynecologist at the Bheri zonal hospital for 30 years and now practicing privately directed me to those participants. This direction towards other participants is called snowballing technique. Snowball sampling is a technique for gathering research subject through the initial subject that provided other subjects and such technique is widely

used in qualitative research because this technique helps to identify people of same trait as initial subject basically, initial subject tends to introduce people they know, which can lead researchers not to know the real distribution of the population, process is simple, saves time if a research has a time limit (Rubin, 2009). Fortunately, I came across identifying the initial subject through my social network and contacts. So, in this study, snowballing technique was adopted to select other subjects. Some argues that such technique hinder researchers control over other subjects and representatives of the sample is not guaranteed. While, others argue that such technique enables researchers to reach real population that are difficult to reach through other technique. Furthermore, this technique is simple and cost-efficient (Browne, 2005).

3.6.4.1 Key informants by age, gender, occupation, practice, Banke district

Table 2 represents the distribution of key informants by occupation. The occupation ranges from doctors to volunteers. As shown, in the table informants practice their work at important places and organizations such as Zonal hospital, Medical College, Save the Children, FPAN, District Health Department and maximum numbers of informants are female. These key informants are the export source of information that possess knowledge about culture, tradition, politics and economy of the Banke district.

Table 2: Key informants by age, gender, occupation and practice, Banke district

Age	Sex	Occupation	Practice
69	**Female**	**Gynecologist**	**30 years at Bheri Zonal hospital, now private**
56	**Male**	**Public health expert**	**Save the children**
53	**Female**	**Volunteer**	**Through Bheri zonal hospital**
50	**Male**	**Senior doctor**	**FPAN**
45	**Female**	**Senior nurse**	**Bheri zonal hospital**
45	**Female**	**Senior counselor**	**FPAN**
43	**Female**	**Senior nurse**	**Bheri zonal hospital**
38	**Female**	**Public health expert**	**Save the children**
38	**Male**	**Field officer**	**District health department**
38	**Male**	**Statistician**	**District health department**
35	**Female**	**Senior nurse**	**FPAN**
25	**Female**	**Doctor**	**Nepalgunj medical college**

Source: Field Survey, 2014

FPAN: Family Planning Association of Nepal

3.6.5 Primary informants and sampling procedure

As, we already know that sampling is an important step is to select a pool of participant to be in a study that can unravel a test or an objective. Primary informants are those individuals who represent characteristics that researcher are interested to investigate in targeted population. These primary informants have the first-hand experience that supplements to answer the researcher's objectives. The representatives of the targeted population are called sample size and sample sizes are crucial for generalability.

3.6.6 Sampling procedure

Purposive sampling was chosen for this part of sampling process. There were eight women selected for the interview. The study was interested in women who were the age between 15-49 categories because this is a standard age to start ovulating and stop ovulating. Actually, my original target was to interview at least 20 women in their different stages of motherhood and in a process of becoming. However, due to the sensitivity of the topic that could infiltrate in these women private sphere and discomfort and shyness, five of the selected primary informants rejected to be interviewed. These women were selected form zonal hospital, Nepalgunj medical college and Family Planning Association of Nepal (FPAN) center. My first visit to these places was to educate myself with the environment and know which time would be suitable for me to interview patients and the nurses themselves. One of the interesting case during this interview, I came across a women whose first child was born in home with the use of traditional birth attendance. The sampling procedure chosen to collect data for this study could criticize for being subjective in relation to other techniques; however, it becomes relevant when a researcher argues that such informants are selected according to the aim of the research (Coyne, 1997).

3.7 Interview and tape recording

The venue of the interview is an important part of any research not only for the researcher but also to the informants especially, primary informants. It plays a significant role for possibility to collect sensitive information. For this purpose, the researcher has to select a quiet environment, which is comfortable enough for the informants to reveal. For this study, I asked my informants both primary and key for their permission to conduct an interview in a quite environment. Furthermore, I asked their permission to records them as well. All my informants had no problem using a mobile phone for recording our conversation.

During my interview, I used the help of the technology, an iPhone to capture the conversations I had with both key and primary informants. Recording the conversation is very important because records are more accurate and in detail than writing out notes. Furthermore, it allows the researcher to listen the recording repeatedly, if there were something important point missing. One of my primary informants, a young mother asked me, if I can play our conversation because she just wants to hear voice.

3.8 Observation

Observations involve looking at activities carefully. Normally, we tend to watch people in our daily life but we do not watch them in order to discover particular information. Researchers conduct observation to learning the meaning behind people‘s action. There are two types of observations in qualitative research, participatory and non-participatory observation. In participatory observation, observer participates in informant’s daily life of certain amount of time. While non-participatory observation, observers distance themselves from the participants but watches and records through recorder or cameras. Non-participant observation may be overt or covert (Feng Liu) In this study, I have conducted a non-participant covert observation but could be ethically thoughtful. Mostly, I observed level of living conditions of primary informants such as their housing standard, neighborhood, hygiene, sanitation and waste disposal as I was given consents by some of my informants.

Similarly, I observed the institutions standard in Government hospital, Nepalgunj medical college and FPAN center such as infrastructure, what kind of quality services they provide, what kind of equipment they possess to assist patients and ambulances available for dispatch. In addition, I made an assessment on the extent of equipment and capacity of existing staff. All these observation was conducted at the same time as I conducted my interviews.

3.9 Secondary data sources: - quantitative and qualitative data

Secondary data are vital resources because it provides guidance for any researchers in their study. This data is the collection of other researcher's previous work that is publicly available for access that could be relevant for primary data (Smith, 2008).

According to(Clifford et al., 2010)questions the quality of data because they argues that data could be manipulated for different political and economic purposes. Furthermore, the quality of data could be compromised because of under reporting as the hospital are not computerized as, this was the case of the hospital I visited, not all the pregnant mothers are registered by health workers, there could be no registration of death occurrence of pregnant women and children because it is an emotional topic especially in rural areas, which is still present in Nepal. Therefore, this makes the use of secondary data problematic sometimes.

3.10 Ethical issues

Ethical issues are present in any kind of research. Ethics, broadly defined as being about " the conduct of researchers and their responsibilities and obligation to those involved in the research, including sponsors, the general public and most importantly, the subject of the research" in (Dowling, 2000, p. 25). Furthermore, Dowling, points out that a researcher should consider what they should do and should not.

While conducting my research it was important to consider the ethical aspect. And with this aspect maintaining privacy and confidentiality of informants was very important because in qualitative method invasion of someone' privacy is inevitable.

As my topic is sensitive in Nepali context, I presented informants with the outline of what my research is about because it is my duty or responsibility and other necessary information before giving me consent to use them as a part of my data collection but first I asked for permission from my informants to involve them in my quest. Considering informed consents, I explained that if they do not want to answer particular question or do not want to participate in the interview process due to various reasons, they have their rights not to. Furthermore, I was very careful that I did not expose my informants and myself to any social and physical harm because it might raise issue that might upset people or informants as; the topic is sensitive (Dowling, 2000).

Therefore, I was very careful while asking personal question and try not to invade in informant's personal space while observing my informants and furthermore, not release my informant's detail in public. And I was extra careful to store my field notes, tapes and transcripts in a secure place so others cannot access them. During my research, informants might reveal some sensitive statements but do not want informant's name to be revealed on my research paper therefore, I ensured the anonymity of my informants by pseudonyms or other identifying characteristics and in addition, I was also careful that my research does not enable others to identify my informants (Dowling, 2000).

As I had selected my primary informants through purposive sampling, as mentioned above, I explained the research objective to them and further explained and assured that the information they provide will be treated with confidence and their name will remain anonymous because this study is only for academic purpose. Somehow, they felt ease and participated to my research questions but their request was that no other people could listen to our conversation so; as their request, I conducted my interview in quiet place according to their convenience. I also asked their permission to record our conversation, which was granted. In addition, I had two co-interviewer or assistance, female Gynecologist and a senior nurse; at least one was available when I conducted my interview. Number of people rejected my request to be my informant, as they told me that they are not comfortable with explaining themselves to a stranger especially to a man so, respecting them I backed out. Similarly, I explained myself to key informants about my research and they provided information without any hesitation.

During my observation, I asked both my primary and key informants permission to take photos of them in different situations and photos of the infrastructures. I was

allowed to do that except one of my primary informants did not want her face to be visible.

3.11 Reflexivity and positioning

The reflexivity is not a new phenomenon while conducting qualitative research in social science. It is the way of “turning back upon itself”, meaning looking back and self-reflecting upon researchers own work such as questionnaires; how could the questionnaires be more better executed with much more effectiveness, interview; how can interviews be more in depth and while conducting a research a researchers will come across some important facts or statement that need to be noted and analyzed later (Macbeth, 2001). According to (Ortlipp, 2008), suggests that keeping notebooks or journals would be a good strategy on reflexivity because it allows researchers to more critical about own work.

For my researches, to be very productive, I followed the idea of keeping a journal where I noted my ideas and thoughts, furthermore, analyzed upon my own work, and was critical about it so that I could avoid absolute conclusion about what I find in the field and make assured that it did not affect the validity of the research.

The concept of positionality refers to the researcher’s position in society by sexual identity, age, gender, ethnicity, education, social and economic status that might inhibit or enable fieldwork methods and interpretation. This can be advantageous or disadvantageous for a researcher (Morse, 1991).

For my master thesis fieldwork, I conducted my research in one of the districts in Nepal, my home country but not my home district. Nevertheless, I drew some advantages of my social and contacts to know the environment of this district.

I have the knowledge about culture and way the people live. This is an advantage for me and allowed me to be in better position as an insider to interact with informants. Furthermore, since, I am doing a master study in foreign country; this might give an impression of an intellectual that might provide me with enough information. However, due to my gender, ethnicity, social and economic status, the community might have seen me as outsider. This had little affected the easiness while communicating and interacting with my informants. I was also aware that informants might perceive me as

economical well off because I am study in a foreign and of my social background, hence can demand for economic benefits and favors but fortunately, it did not happened.

3.12 Credibility and dependability

Credibility and dependability are the two most essential components of a scientific research that a researcher needs to consider. Credibility in qualitative approach was use for validity in quantitative approach. Similarly, dependability in qualitative approach was use for reliability in quantitative approach. According to Lincoln and Guba 1985, cited in Gartell and Elliot 2009, credibility is a way to check the trustworthiness of the result. In this study, as a researcher, I selected those informants whose everyday experiences can answer my research problem from their perspective. As I was able to gain their thrust, they reveal their experiences and the focus was on the quality of information they provide due to their position (Gatrell & Elliott, 2009).

The transferability in qualitative approach refers to the degree at which study can be generalized or transferred to other setting. This may not be achieved because of researcher's position, interests and time gap (Crang & Cook, 2007).The conformability refers to degree were results of a study could be confirmed by others. However, I think I have brought my unique perspective in this study. Dependability simply defined as the minimization of idiosyncrasies in interpretation. Therefore, I was neutral to the information I acquired from my informants and further to assure I asked the informants permission to quote those (Gatrell & Elliott, 2009).

3.13 Limitation of the study and some self-reflection

I would have wished carrying out this research from start to finish without any challenges. However, the truth is that, I had some challenges and dilemmas. I had to take some tough decisions especially in the field. This last section of the methodology chapter throws some light on these limitations in the field. In this section, the limitation would be mentioned and reflected upon.

First it was practical challenge; I was supposed to travel around June 2014 to collect data for my research. However, due to my visa problem of Norway, my traveling was postponed. Therefore, I conducted my fieldwork during August 2014. That was the month of the monsoon season in Nepal. I had chosen to travel to the mid-western region of Nepal; a District called Banke further explained in study area chapter, I choose to take a bus, which economical even though it was 15-hour bus ride. As this was the monsoon season, natural disasters was inevitable, the landslide had blocked the main highway so, I had to return to the capital and booked a flight, which was expensive and scheduled to fly after four days. The situation in Banke was terrible because it was almost 48-50 degree Celsius and 15-hour power cut. As I am not from this part of Nepal, it was tremendous challenge for me physically and mentally.

During my first day in Banke, I was going around knowing the environment and tried to acquire an interview with one of the officer at the District Public Health Department without using any reference. Unfortunately, the official at the District Public Health Department did not have time for me. I had to face the same situation at hospitals.

My initial plan was to interview 20 primary informants but due to the shyness and the uncomfortable or sensitive topic some of them reject my request and I had 15 participants for the interview. This could have limited my study because those people could have shed light on their health seeking behavior and the choice of the health care facilities and further could have shared different interest and experience.

Furthermore, traditionally in Nepal, women especially, pregnant are escorted to health care facilities by ‘significant others’. Inevitably same situation was in Banke district, every primary informant who participated in the interview were escorted by ‘significant others’ or by their husbands. Participant was quiet uncomfortable to express themselves because of my position, as male researcher asking questions about maternal issues, their

behavior, their decision of choice and use or non-use of facilities could have evoked cultural norms or values that may have affected the response. For example: one of my primary informants, I interviewed was escorted by her mother-in-law and she answered most of my questions because as she is the head of the household and decides everything on her behave, which is typical in Nepali context. This was a disadvantage for me to look at things from the pregnant women's perspective. However, my clear introduction and my academic purpose made my informants comfortable.

Researchers' access to information may depend upon the position as insider or outside. The insider says that they have an advantage to more privileged information because of their ties with area or group they study. While the outsider argues that they are likely to acquire more privilege information since they may be considered neutral (Mullings, 1999). For me as a researcher, although I am from Nepal and know the culture and tradition, I may still be considered as an outsider because I do not belong to Banke district. However, to overcome as an outsider I build trust with my informants to gather information.

As for the language, there was a little barrier, most of them speak the official Nepali language but they prefer to communicate in their own local language. However, my qualified co-interviewer assisted me during this process. But I thought it was a barrier because I felt some the vital comments or statements were lost in translation, which may have provided me with their health seeking behavior, choice of health care facilities and social structure.

Another challenge of acquiring data from hospital regarding the pregnant women coming for checkup or the maternal death and childhood death because hospital are not equipped with computer to keep records that limited the exact number of registered.

Finally, time and cost have been crucial factors limiting the study. These factors also limited my stay in Banke district.

Although the collection of data, is from different informants and secondary data but the result of this research is solely based on my own interpretation of those data collected. I do agree that during my fieldwork, I encountered different situations such as informant's behavior especially primary informants and their emotional stories had

affected my emotions, which could influence on the way I analyze data. However, I controlled and managed my emotions that could have influence my research.

I am from the capital, Kathmandu and considered as a higher caste in Nepalese society. In addition, there been a conflict between Hindus and Muslims some time ago. Therefore, I was afraid that I would be treated badly, which could hinder my research. However, most of the people I encountered were very friendly and welcoming.

4 CHAPTER FOUR: STUDY AREA

4.1 Introduction

This chapter presents reader a general picture of Nepal from various dimensions especially focused on maternal mortality and childhood mortality. A description of a study area follows that has been conducted in the Mid-Western part of Nepal.

4.2 Country profile

Nepal is a landlocked country and lies between two economically and geographically huge countries, India in the east, west and south and the China from north in South Asia. The total land of the country is 147,181 square kilometer and population of 26.6 million resides with in this square kilometer. Topographically, Nepal is divided into ecological zones: Mountains, Hills and Terai (plains).

Table 3: People residing in each ecological zone in Nepal and the area covered

Ecological zone	Area (sq. kilometer)	Percentage
Mountain	51,817	35
Hills	61,345	42
Terai	34,019	23
Total	147,181	100

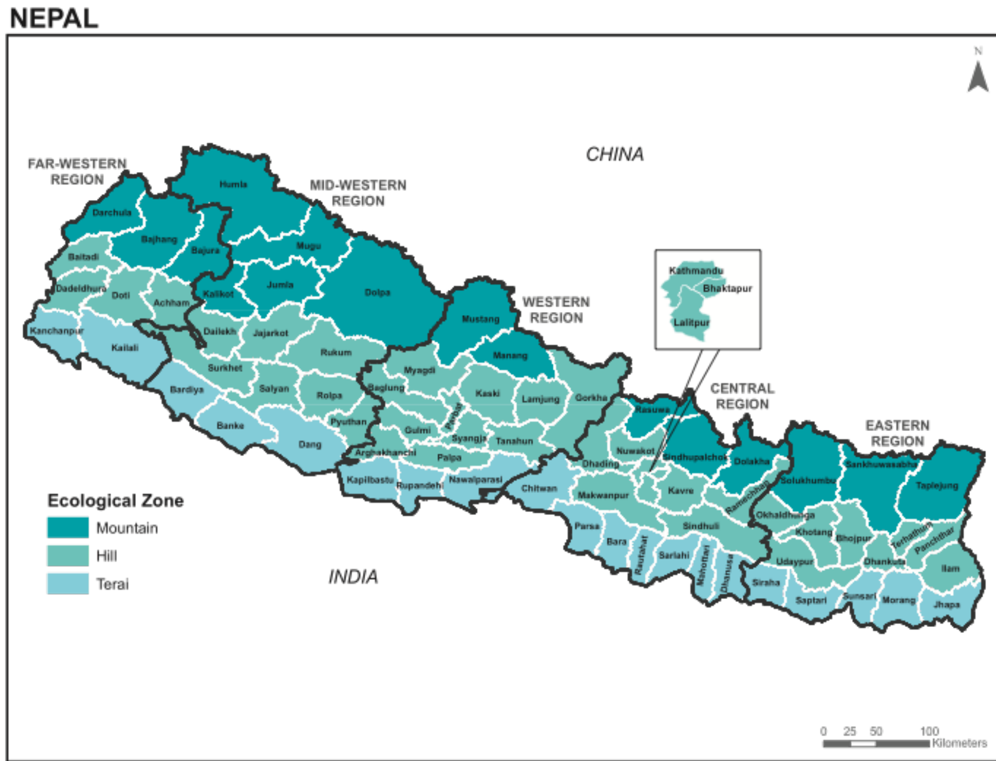


Figure 3: Map of Nepal with ecological zones and five regions with districts.

Source: (Nepal, 2012)

Further, the country is divided into five development regions: Far-Western, Mid-Western, Western, Central and Eastern regions as can be seen on the figure 3. These regions are divided for the administrative purpose and consist of 14 zones and 75 districts; furthermore, these 75 districts are sub-divides into Municipalities (urban areas) and Village Development Communities (VDCs or rural areas).

Essentially, Nepalese communities are known by castes among themselves. There are 126 caste/ethnic groups, speaking 123 different languages as their mother tongue. Basically, the caste system is divided into four folds such as Braham (priests and scholars), Kshatriya (warriors), Vaisya (merchants and traders) and Sudra (laborers also known as untouchables or Dalits).

Despite, its natural beauty and various divisions among population in terms of castes, the country is considered one of the poorest in the world, where more than 70% of its population lives on less than USD 2 per day(Statistics, 2014). Furthermore, according to (Bank, 2014), Nepal's GNI per capita in PPP is 2,260 from 2010-2014.

Nepal's HDI value for 2013 is 0.540, which considered as the lowest human development and below the average in South Asia. This HDI value ranked the country at 145 places out of 187 countries (Nepal, 2012; Statistics, 2014).

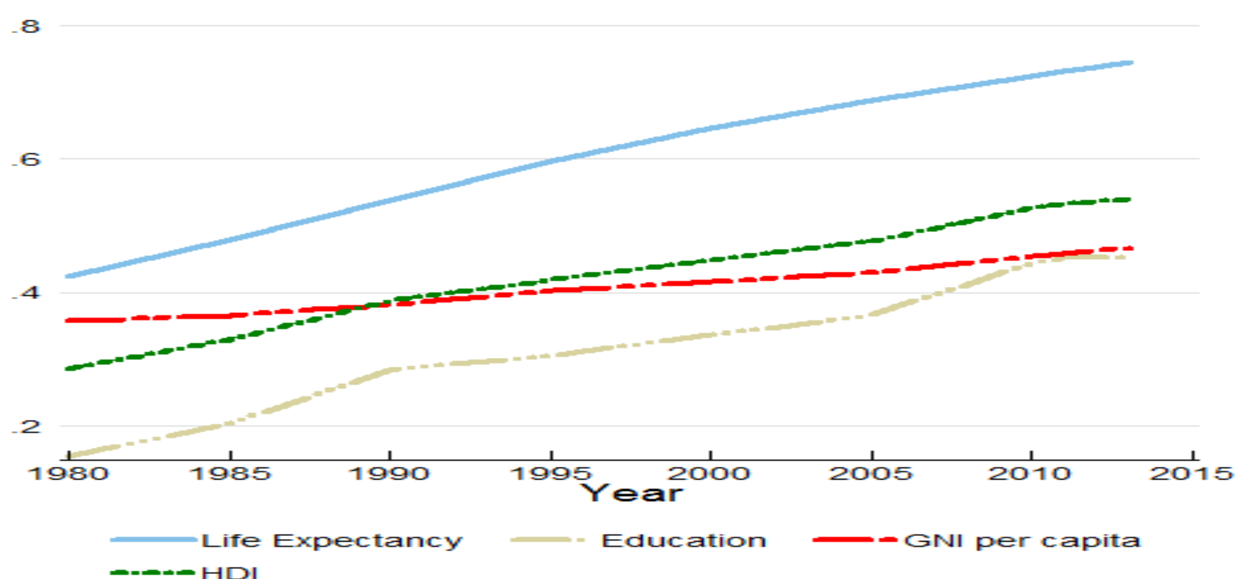


Figure 4: Trends for some selected vital development indicators for Nepal 1980-2013

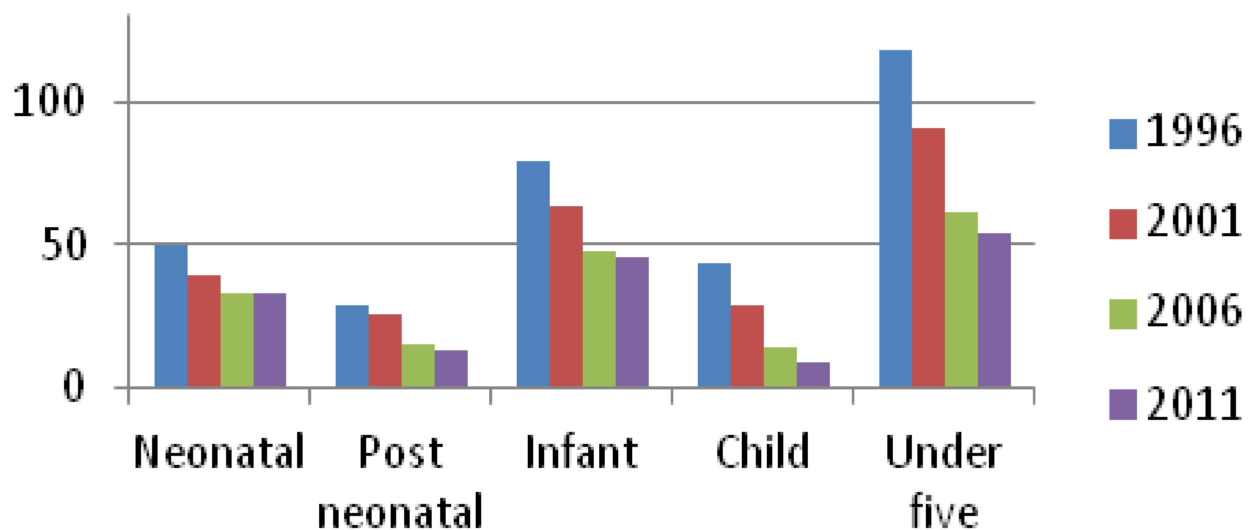
Source: (Report, 2014).

In terms of gender and equality, which remains the major barrier to human development in most of the development countries. According to Human Development Report, Nepal's value on the Gender Inequality Index (GII) is 0.479, which ranked the country on 98th among participating countries and in low human development category. Actually, Gender Inequality Index (GII) measures gender inequalities between male and female. Inequalities are measured in terms of reproductive health that is measured by maternal mortality ratio and adolescent birth rate, empowerment; in terms of female representative in parliament and education achievement & labour force participation. Thus, it can be figured out that the higher the GII value, the more disparities between

male and female. The country also falls below the South Asia average of 0.558 (Malik, 2013).

However, despite, a decade of civil war, political instability, poor economy, lack of constitution, division in social hierarchy, over the last 15 years, Nepal has abled to acquire the positive result in terms of meeting Millennium Development Goal 4 (child mortality) and Goal 5 (improving maternal health).

Figure 5, depicts that over the last 15 years, neonatal mortality rates have declined from 50 to 33 per 1,000 live births, post-neonatal rates from 29 to 13 per 1,000 live births, infant mortality rates from 79 to 46 per 1,000 live births, child mortality from 43 to 9 per 1,000 live births and Under-five mortality from 118 to 54 per 1,000 live births in 2011 (Statistics,



2014).

Figure 5: Trends in childhood mortality in Nepal 1996-2011

However, accuracy of mortality depends upon the data sampling. In this context, there might be a reporting error such as parents might not keen about talking their death children because of the sorrow and some culture prohibits to discuss on such topics.

Similarly, figure 6, shows that maternal mortality ratio of women aged 13-49 as this the

standard reproductive age, had declined dramatically in last 2 decade from 850 per 100,000 deaths to 229 per 100,000 deaths (Bhadari & Dangal, 2014).

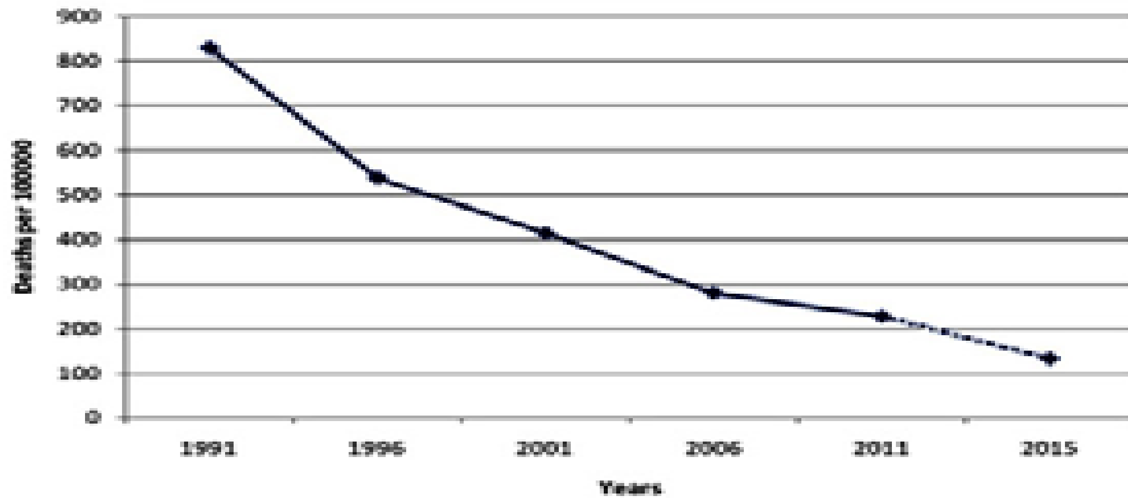


Figure 6: Trends and forecast in maternal mortality in Nepal 1992-2015

Figure 5 and 6, shows the continuous decline in mortality over 15 years. Such a decline is the result of improved health care services and accessibility. Furthermore, significant awareness campaigns conducted under various programmes by various government organization, local-government bodies, development partners and international & national non-governmental organizations.

4.3 Banke District – Bheri Zone – Mid-Western Development region

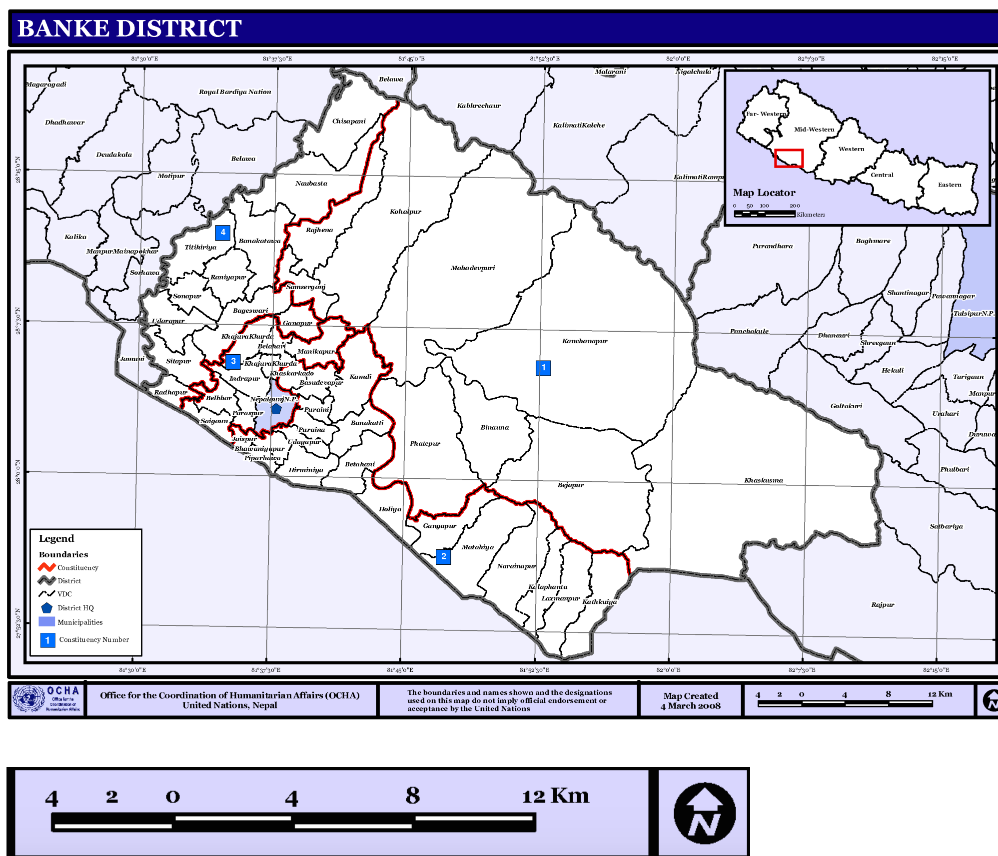


Figure 7: The location of Banke district among all districts in Nepal

Source: (OCHA, 2008)

Banke district is a Terai (plain) region in Bheri zone situated in the commercial center of Mid-Western Region of Nepal with Nepalgunj as its administrative headquarters. This area is a fertile area and agriculture is main backbone for the people residing. The area is known as commercial center because it shares its border with India and most of daily used goods are imported through. Furthermore, as commercial center people often migrate from various district nearby especially from hilly areas for job opportunity. The migration can be permanent, temporary or seasonal. According to Department of Roads, 2015, distance calculator, Nepalgunj is around 512 kilometer away from the capital Kathmandu and it almost takes 10-12 hours bus ride or 1 hour flight. Within Bheri zone, there are four other districts such as Bardiya, Surkhet, Dailekh and Jajarkot

districts. The Banke district covers an area of 4337 sq. kilometers with a total population of 491,313, male 244,225 and female 247,058 and the children population (aged 0-14 years) is 65,900. There are four major groups that dominate this area like Musalman 19%, Tharu 15.6%, Chhetri 14.8% and Brahman- Hill 6.6%. Furthermore, these major groups are divided into sub- caste groups, which is complex and they prefer to call themselves “Madhesi”. In this area of Teari it is difficult to identify the socio-economic status among there population (Statistics, 2014).

As my study area, I came to experience form my observation and engagement that they are not clear about their socio economic status and are relatively poor. Similarly, suppressive attitudes towards women and son preference are still embed in their mind set and their cultural norms or values dictate them not to send their women for maternal check-ups even if the doctor is a women especially, in Musalman community and furthermore, not all but some still practices home birth.

According to district Public Health Office, Banke conforms that maternal mortality in this particular area is 22 deaths in 2013. Similarly, according the latest report that is not officially published yet, as I have acquired from my source reveals the data for child mortality, infant mortality and under 5-mortality. The child mortality is 18.4, which is second highest compared to 4 other districts. Infant mortality is 48.2, which is third highest among others and finally, under 5-mortality is 66.03, which is third highest. According to district Public Health Office, Banke acknowledges that maternal mortality has fluctuating in last 3-4 years.

Table 4 shows the number maternal death within 3 years. In 2011, there were 22 maternal deaths per 100,000 live births. Similarly, in 2012 there were 11 maternal mortality deaths per 100,000 live births and in 2013 there were 22 maternal deaths per 100,000 live births in Banke district. This data was acquired from the District Public Health Department, Banke. This show that compared to 2012 the number of maternal mortality has increased, which was same as 2011.

Table 4: Maternal mortality, Banke district, 2011-2013

Year	Maternal death	Total
2011	**22**	**22**
2012	**11**	**11**
2013	**22**	**22**

Source: District Health Department, Banke, 2014

Two biggest hospitals are situated in Banke district, Bheri zonal hospital and Nepalgunj Medical College or hospital. Nepalgunj Medical College is a teaching college therefore; the checkup charge is minimum and has 220 beds with modern medical facilities. Bheri Zonal Hospital is a government hospital with 180 beds and the bed occupancy rate is 81 in 2011 (Field Survey, 2014).

Especially, in Zonal Hospital the women are admitted until and unless there is a complication and the average length of stay is 3-4 days, and under the circumstances most of them sleep on a floor. However, there are alternative treatments such as private clinics including the Nepalgunj Medical College but the stay charge are unaffordable for most the people.

Table 5 shows, the literate population aged 5 years and above by education attainment of Banke district. As we can see that 52,002 female has achieved primary school however after primary education the number of attainment decreases dramatically. This dramatically decrement is due to poor economic disadvantage and some of the parents have the conception that education is not that important for female.

Table 5: Literate populations by education attainment, Banke district, 2012

Total female	126,159
Beginners	5,521
Primary (1-5)	52,002
Lower Secondary (6-8)	26,102
Secondary (9-10)	13,118
S.L.C **School Leaving Certificate**	12,124
Intermediate &Equivalent	7,219
Graduate & Equivalent	2,691
Post Graduate Equivalent & above	621
Others	426
Non-formal	5,766
Level not stated	569

Source: (Govermant of Nepal, 2012)

5 CHAPTER FIVE: DATA ANALYSIS AND INTERPRETATION

5.1 Introduction

This chapter deals with demographic and socioeconomic characteristics of population includes age & sex composition, education, marital status, occupation, caste/ethnicity, religion, mother tongue, maternal status, belonging and economic activities of my primary informants.

5.2 Key informants by age group and sex

These key informants are important people among others because they possess broad and often deep knowledge about culture, tradition, economy, preferences and behavior of the pregnant women. As shown in the table 6, the number of male and female informants, in which the total number of female informants is relatively high. These female informants have first-hand connection with pregnant women and pregnant women are relatively more comfortable with them in the context to Nepal’s traditional and cultural sphere, i.e. gender issue and sensibility.

Table 6: Key informants by sex and age group, Banke district

Age	Female	Male	Total
25-35	2	0	2
36-46	4	2	6
57-57	1	2	3
57+	1	0	1
Total	8	4	12

Source: Field Survey, 2014

5.3 Primary informants by marital status

Table 7 shows, current marital status by age of primary informants. The maximum numbers of primary informants were 12 from age 19-25 and 3 informants were above 25. It was not surprising for me as researcher that women in such young age get married because it is a traditional practice that is still present. Furthermore, none of them were divorced, separated or widowed. Generally, women in Nepal do not practice such divorce and separation especially, in such part of Nepal like Banke because the tradition and culture prohibits such practices or it's a "taboo". Furthermore, Women tend not to abandon their husband legally or illegally no matter how abusive they might be under the influence such as alcohol or gambling.

Table 7: Primary informants by age and marital status, Banke district

Age	**Number of women**	**Married**	**Divorced**	**Separated**	**Widowed**	**Total**
19-25	12	12	0	0	0	12
26+	3	3	0	0	0	3
Total	15	15	0	0	0	15

Source: Field Survey, 2014

5.4 Literacy and education

This part shows, the distribution of primary informants by literacy and education level. Out of 15 primary informants, five of them have achieved primary education. Similarly, four of them have achieved low secondary. The number of educational level diminishes after low secondary school like two have achieved secondary education and two achieved S.L.C (School Leaving Certificate) and other two did not want to state their educational level however, they mentioned that they could read and write. As a researcher, I ask these women about why they did not pursue further to acquire education. All of them replied that due to the economic disadvantage they were not able

to do so. It was more convenient to help their parents on the field, to run small business or assist them in household work to sustain the entire family.

Out of 15 female, four of them added that their parents give priority to males for acquiring education. Furthermore, in this part of the world, people have perception according to the misconception that female will move out when they get married therefore, investment on female education is seen as waste of money.

5.5 Economic activities

Female economic participation plays a pivotal role to their family because husband's income is not adequate to cover the basic needs. It is difficult to categories the economic activities however, table 8 shows, the distribution of informants by economical participation and maximum number of women, five of them participate in economic activities through household work; meaning working in other houses such as cleaning house, washing dishes, and washing clothes including their own. Similarly, three of them participate in economic activities through business; meaning has a small teashop in the neighborhood. As data also shows, two of them participates in agricultural activities; meaning supporting their husband working in the others land. Likewise, two of them participates in a labour market; meaning carry bricks and stones in construction area. Finally, three of them did not participated in any economic activities, which is very normal in Nepal's context.

Table 8: Primary informants by economic participation, Banke district

Economic activities	Number of female
Agriculture	2
Business	3
Household work	5
Services	0
Labour	2
Non	3
Total	15

Source: Field Survey, 2014

5.6 Castes and religions

As already mention in study area chapter, mostly four major groups represent Banke district and it were obvious that my informants belong from these castes. Table 9, shows the distribution of informants by castes and religion. The highest numbers of informants were Tharu. Respectively, four female informants were Chhetri. It is followed by the proportion of two Musalman and similarly, two were Brahman-hill. Basically, the idea of distributing my primary informants in castes is to know who are receiving antenatal care from skilled care birth attendance because in this area traditional birth attendance is well practiced, especially among Muslim community.

Furthermore, we can agree that religion is affected by castes and geographical area of the population residing. Furthermore the table illustrates the majority of 12 informants followed Hindu as a religion. Similarly, two of the informants followed Islam as a religion even though Muslman population dominates this area. And one of the informant followed Christianity as a religion that belongs from Chhetri caste.

Table 9: Primary informants by castes and religions, Banke district

Caste	Religion	Number of female
Musalman	**Muslim**	2
Tharu	**Hindu**	6
Chhetri	**Hindu /Christian**	3/1
Brahman-hill	**Hindu**	2
Total		15

Source: Field Survey, 2014

5.7 Mother tongue

The census of 2011, identified 123 languages are spoken as a mother tongue in Nepal (Population Monograph of Nepal, 2014). This part shows, the distribution of informants by mother tongue in Banke district in which six of them spoke Tharu as their mother tongue. Similarly, other six of them in the study area spoke Nepali as their mother tongue. And three informants spoke other language as mother tongue, others refer: unidentified and other inter-community mother tongue.

However, in these arrays of spoken languages, Nepali is the official language. As Nepali is an official language not everybody can speak Nepali therefore, it can create problem for pregnant women to understand and conceptualize what nurses and doctor are saying and vice versa.

5.8 Maternal status

Table 10 shows, the distribution of informants according to their maternal status. There were eight pregnant women, in the process of giving birth for the very first time. Similarly, five pregnant women had already experienced the first birth and now in the process of giving second birth and two pregnant women respectively were in the process of giving birth to their third child.

Table 10: Primary informants by maternal status, Banke district

Maternal status	Number of female
First baby	8
Second baby	5
Third baby	2
Total	15

Source: Field Survey, 2014

5.9 Delivery

Table 11 shows that one individual pregnant woman who is pregnant for 2nd time had given birth to her 1st child at home and six other pregnant women delivered their 1st child at hospital and respectively two pregnant women delivered their 2nd child at hospital who are pregnant for 3rd time. All these, 15 pregnant women are planning to delivery their child at hospital.

Table 11: Place of delivery

Place of delivery	First baby	Second baby	Third baby
Home	1	0	0
Hospital	6	2	0
Total	7	2	0

Source: Field Survey, 2014

5.10 Belonging

As mentioned, in the study area that Banke district is located in Bheri zone of Mid-Western region and there are four other districts that come with in Bheri zone perimeter. Table 12 shows, the number of informants originally belonging from. Here nine of the informants were originally from Banke district, while others are from different districts. In total of six informants had migrated to Banke district for various commercial reasons. These six women are using different health care facilities for antenatal check-ups and for delivery.

Table 12: Primary informants by birth place

Place	Number of female
Banke	9
Bardiya	3
Jajorkot	2
Surkhet	1
Total	15

Source: Field Survey, 2014

5.11 Place of interview

Table 13 show, the places where the interview was conducted and the place they gave birth except two female interviewed at FPAN. The Bheri Zonal hospital is the governmental hospital, were maximum number informants were interviewed, ten. Similarly, three informants were interviewed at Nepalgunj medical college. Finally, two informants were interviewed at FPAN. FPAN is the leading national Non-governmental organization devoted to SRHR (Sexual and Reproductive Health and Rights of Women) and it is referral center to Bheri Zonal hospital or Nepalgunj medical college. The place of interview might supply with information about pregnant women

preference or choice of maternal health care services to use antenatal care visit and for delivery.

Table 13: The places where the interview was conducted

Place of interview	**Number of female**
Bheri Zonal Hospital (Public)	10
Nepalgunj Medical College (Private)	3
FPAN clinical center (NGO)	2
Total	15

Source: Field Survey, 2014

FPAN: Family Planning Association of Nepal

6 CHAPTER SIX: HEALTH CARE SEEKING

6.1 Introduction

Pregnancy and Childbirth complication is a leading cause of death for girls/women and their child. Also, when it comes to other health issues such as anemia, under nutrition, hypertension and infections in most of the developing countries decisions are conducted or decided by others rather than the women.

In this chapter, the sections attempts to describe how decision are made on the choice of health care facilities and how the social and cultural disposition influences the decision of women. Furthermore, what influences the choice and use of maternity care and the facilities used by women in Banke district? In addition, this chapter also seeks to explore, how the interaction between social structure and women influences their health seeking behavior.

6.2 The decision of women in seeking health care

The decision of the health issue can range from own health to her child health. Furthermore, If the women is pregnant, the choose of a health care facilities is decided by the people closer to the pregnant women (Furuta & Salway, 2006). In the study how women make decision of choice of facility depends upon the people closer to them as mentioned above for birth. Generally, in Nepal, decision to choose a maternal health facility among women is with the assistance of 'significant others' such as mother in law, sister in law or grandmother in law or women own mother and similar norms it practiced in Banke district.

For instance, pregnant women biological mother escorted some of my informants because in Nepal, traditionally it is normal that pregnant women usually stay with their biological mother in the process of giving birth. And one of my informant aged 22, I interviewed at Zonal Hospital said:

"Currently, I am staying with my mother and she recommended me to give birth at hospital and feel very safe with health professionals"

This pregnant woman is giving birth for the very first time and was quite nervous.

However, most of the pregnant women mothers-in-law and sister-in-law have escorted other informants and one 24 years old informant, pregnant for first time explained:

"I am here with my mother-in-law or sister-in-law and recommended me to give birth at the hospital and they have been escorting me for my regular checkup for last several months"

Usually, pregnant women in Nepal stay at their mother's house during the final days prior to the delivery but during the other stages they stay at their husband house. Hence, the escorting of pregnant women to the hospital or a clinic changes according to the stage of pregnancy.

Similarly, a husband escorted two primary informants to the Zonal Hospital. One was a 22 years old woman pregnant for first time and another was a 25 years old woman pregnant with her second child on the way. The 22 years old pregnant women said

"I am here with my husband because we migrated from Jajorkot district and our relatives and friends told us that it's safe to be in professional hand at hospitals"

The 25 years old pregnant women said

"*I am here with my husband because we migrated from Surkhet district and I had my first child in hospital on my husband recommendation*"

This situation actually, does not mean that women do not have any autonomy to choose health facilities for maternal health services. But the experience of people closer to the pregnant women highly decides in the decision of choice of health facilities. For instance, I interviewed one 24-year-old pregnant woman with her second child. The case was really interesting because she had her first baby at home through the assistance of traditional birth attendance. When the question was asked about the decision to give birth the second child at the Zonal Hospital, she replied:

"She felt that it would be safe in the hands of professionals because at home she felt unsafe and there was complications"

Again, as a researcher I asked, who made you decide to visit hospital during her second child. She relied:

"It is my mother-in-law who decided for me because recently she volunteers"

This 24 years old pregnant woman's mother-in-law is volunteering on the behalf of Bheri Zonal hospital about educating pregnant women to visit hospital for antenatal care, keeping clean and maintaining hygiene. The hospital encourages people to volunteer to provide awareness to pregnant women in their communities such as nutrition's, hygiene, and potential risk-deliveries and further encourage pregnant women to visit hospital for antenatal care and for the delivery. The volunteers acquire basic knowledge and training from the hospital before going to the field.

Then, I continued my conversation with the mother-in-law, I asked her, why she did not escorted her daughter-in-law to the hospital during her first childbirth? She replied:

"First of all, I gave birth to my child at home, there was no complication and the boy turn out to be a health person. Therefore, I decided same thing for her but later when I join volunteering service than I understood the positive aspect of regular antenatal check-ups and giving birth at hospital"

It shows that the power relation between female head of a household and pregnant women, As structuralist argues that social structure constraints the activities or behavior of agents in this case behavior of pregnant women and further domination of such practices influence the decision-making on every aspect of life including decision in seeking health services. Women especially, my informants in Banke district, as mentioned in chapter five, their inadequate socioeconomic status like education and income level forces themselves to depend upon 'significant others' especially husbands. As Thaddeus and Maine, 1994, points out in three-delays model that factors such as 'signification others' affects the decision of health care. However, it also shows that providing knowledge to people can alter the concept of giving birth at home through assistance of untrained traditional birth attendant.

Nevertheless, Kabeer, points out that dependency upon 'significant others' can be reduces if socioeconomic status of women can be increased. This makes women more independent to make decision for herself and for her child (Kabeer, 1999). Perhaps, the

free deliver policy i.e. giving birth free of charge at public health services, have provided certain strength to empower women on decision making. This policy provided free childbirth and travel cost to women and reduction of first and second delays to avoid a maternal death and infant mortality. Furthermore, it encourage pregnant women to visit hospitals for antenatal check-up so, women can acquire knowledge and information regarding healthy pregnancy. Before, free delivery policy, women did not have such autonomy to decide because head of the household for example husband or 'significant others' had to pay for the health care facilities and knowledge and information regarding health pregnancy. Furthermore, normally, in the case of the Nepal, the health seeking practice is that they never visit hospital or clinics until and unless there is a complication.

One woman, aged 26+ accompanied by others pregnant women above 26+, who were pregnant with their third child at Zonal Hospital replied that

"Because of the experience and the knowledge acquired during the process and free delivery made quite independent to decide, which health facility is appropriate"

As figure 1 shows that the inadequate knowledge is kind of a predisposing factor but free delivery policy enables pregnant women to decide the use health care services. Similarly, it shows that human as Giddens, refers to agency and human agency is "*capacity to make a difference*"(Giddens, 1984, p. 14). In this case women has the power to transform a society and its structure because of the knowledge and competence they have acquired whose action can create and recreate structure. However they need social support to break these traditional social norms.

6.3 Free maternal care

Considering the free maternal health care service, the study of pregnant women behavior and the use of the health care services in Banke district. These pregnant women are not only the passive recipients of the initiation of the health care system but they are active decision maker as we can see in above statement by pregnant women with her third child age 26+.

In this study a women with the knowledge of complicated birth during her first childbirth decided to use the hospital and other women who have birth experience decided to use hospital to ensure uncomplicated safe delivery and of course of the free maternal delivery and incentive schemes.

As mentioned in chapter two, maternity scheme, Aama Program and Safe Motherhood program provides cash incentives that cover transport expenses and antenatal and postnatal care visits. Such schemes provided pregnant women with certain autonomy to decide the use of a health care services and further provided them with the knowledge. However, one senior nurse aged 45 accompanied by other senior nurse mentioned that

"*Pregnant women do not get to utilize the money they receive from the maternity scheme because 'significant others' and husbands usually take control of the cash and allocate only certain money to be used by pregnant women. I think it is more effective for pregnant women and her child health if the cash goes to pregnant women hand because in some cases the drinking habitat of husband uses all the money received, so there should be changes"*

In Nepal such practice of controlling and allocating cash by 'significant others' and husband is normal because of the lack of education of a women in general, dominating characteristics of the 'significant others' and husband and of the social hierarchy.

6.4 The choice of maternal health facilities

In the study of Banke district, two main hospitals, Bheri Zonal hospital a public hospital and Nepalgunj medical college a private hospital, provides the maternal health facilities. However, the choice and the use of the maternal health facilities are defined by various factors such as behavior and structural barriers. This factors influencing behavior and structural barriers are already mentioned in chapter three.

One of my primary informants aged 22, accompanied by other primary informants, interviewed regarding the choice of the facilities explained that

"Among the other determinant of choice of maternal health facilities, distance especially, transportation is one of the main concern for us especially at night because

of the unavailability of transport and the poor nature of road. The Bheri Zonal Hospital cannot provide transportation due to the limited ambulance. While, Nepalgunj Medical College charges for the transportation. And if there is a complication than we have a problem. However, there is facility at the Zonal Hospital but due to the poor infrastructure the stay time is limited and Nepalgunj College charges a lot for the stay time"

In Banke district there is no taxi available. In the name of transport there is "rickshaws" and horse-drawn vehicle so, it is difficult of the pregnant women to reach health care services on time.

As Thaddeus and Maine, 1994, points out in three-delays model that factors such as accessibility of facilities and furthermore (Jacobs et al., 2012) geographical accessibility in dimension of barriers to access health services with specification of supply and demand influence affects the use of health care and this opens for the wide spectrum for pluralist health care delivery system for women to choose as Philips argues (Phillips, 1990). One possibility that this rigidity and restriction may leads to increase in home birth and other forms of assistance to women in labour by untrained traditional birth attendance.

One key informant, age 45 senior nurse told that

"There are cases, where women has given birth at home due to transportation problem especially at night and people usually rely on the traditional birth attendance"

This choice of dependency on traditional birth attendant due to the lack of transportation especially at night and in monsoon season is inevitable.

Furthermore, behavior on seeking health care facilities bypasses the health facilities nearby this is also present case in Banke district. As we already know that people tend to bypass the nearest health facility, if there are number of health service provider are nearby. However, other factors did also influence the choice of health care facilities such as cost of health care and medicine (Phillips, 1990).

I asked to nine of my primary informants, who came for antenatal check-up at Bheri Zonal hospital, they are lots other small private clinics nearby that can accommodate pregnant women, as other private clinics are not considered in this study. Why did you

choose to come her? One of the 24 years old pregnant women, with her second child on the way, accompanied by other pregnant women replied

“The maternal care facility is free. Other places charge money for that proposes”

I asked the same question to three of my primary informants, who came for antenatal check-up at Nepalgunj Medical College. One of the 23-year-old pregnant women, giving birth for the first time replied

“It is free and as this is private hospital we think there more facilities her such as logistics and we feel secure”

I asked them if they knew about free antenatal check-up and free delivery. Two out of three pregnant women age 23 and 24 respectively, pregnant for first time replied that

“*We just knew about it*”

People were unaware of the information that even in Nepalgunj Medical College a private hospital also provides such free delivery and transportation incentive schemes because according to the policy mentioned in chapter two, they are supposed to.

One of the informants, age 25, pregnant with her second child replied

“*I knew it from before because one of my relative told me and I gave birth to my first child her”*

This shows the choice of the health care services is highly influenced by person closer to the pregnant women and the experience acquired in the process as (Phillips, 1990) argues.

In case of surgery of risk delivery such as caesarian section they charge money. So, if patient know, they tend to go to Zonal hospital as they told me.

By logistics the informants meant equipment’s such as x-ray machines, ultra sound machines and other.

Another interview was with a 25-year-old doctor. I asked what happens if there are emergency cases, were they needed to perform a surgery and later the patients do not have money to pay their bills. The doctor replied

"There are charity fund available in such cases"

Actually, one the doctor I interviewed told me that people especially women do not know about this charity because this is not advertise public. Such advertisement is not public because this is how the hospital management has managed. This is only for emergency cases if pregnant women are brought suddenly in complication stage and they do not have money to pay for the treatment. The potential Caesarian section women are not requested for payment prior to their admittance. The Hospital does not refuse to conduct such operation. Furthermore, pregnant women are still unaware about the free antenatal check-ups and free delivery facilities because they perceive that this is a private health care facility that charge money for every check-up so, supplying information is important. The lack of information and knowledge are structural barriers for pregnant women to use health care services that is illustrated in the classical study of (Aday & Andersen, 1974)on factors affecting health-seeking behavior. Furthermore, (Jacobs et al., 2012) also expresses that such barriers in this framework of barriers to access health care.

The women interviewed in Nepalgunj Medical College tend to choose another health care services available, in this case Zonal Hospital for giving birth if these pregnant women know that there will go under Caesarian section as this a rational human behavior. Furthermore, such rational human behavior that influenced to seek alternative health care services is due to the cost of health care services (Phillips, 1990). Furthermore, two pregnant women interviewed at FPAN, aged 19 and 21 respectively escorted by mother-in-law pregnant for first time told that

"I haven't decided the choice of the maternal health care facilities for delivery. I might flow the doctor and nurse recommendation but I have ask my mother-in-law"

6.5 Healthcare delivery system and health seeking behavior

The health facilities; their location, referral, practices, attitude of the staff and attitudes prevailing norms and value among people the influencing health seeking behavior, are the main characteristics of analysis. In this study, various characteristics of maternal health care delivery system were considered to determine women's decision to seek

health care, choice of maternal health services available, which includes location, capacity, quality, availability of the health facility and relation between the health service provider and women seeking for services.

As (Phillips, 1990), points to, the location of the health facilities influences the health seeking behavior and it is natural that people uses health facilities that are closer to them other thing being equal. However, women may decide to use health care facilities distance away due to various advantages such as reliable, experienced and qualified staff and obstetric logistics. This decision is because women can trust and rely on such facilities while delivering.

In addition, policies structure also influences the health seeking behavior on decisions, choices and the use of maternal health services (Phillips, 1990). Among others policies that are mentioned, free maternal health care policies has changed the health seeking behavior among women economically. However, almost all of the women interviewed in Banke district among other factors that hinders them to seek assistant, they are primarily more concern about what to do if the labour occurs suddenly, prior to term, at night?

One women, aged 26 giving birth to her third child and another women aged 25 giving birth to her second child that I interviewed at Zonal Hospital told

"*During the final stages of labour, we have a relative her in the city, we stayed at their place last time during the final stages because hospitals are close by, so this time also we are doing that"*

Others reside nearby but it is difficult to get transportation at night if emergency occurs. Therefore, the choice of the health care facilities varies according to the situation and geographical distance is most important regarding acute deliveries.

6.5.1 Capacity or facility of health services and behavior of women

The capacity of a health facility determines the services pregnant women acquire during the several stages of pregnancy. The order of capacity includes; number of skilled staffs that can provide services, number of delivery wards, obstetric logistics,

and technology and transportation services such as ambulances. Lack of such capacity is barriers for pregnant women to use and choose the health care facilities as illustrated in the three-delay model, in framework of factors affecting health-seeking behavior and similarly, in dimensions of barriers to access health services.

In the study on health seeking behavior of women in Banke district, as a researcher, my special focus was Bheri Zonal Hospital and it is a referral center. One pregnant women aged 26, pregnant women with her third child, accompanied by other pregnant women interviewed in this hospital mentioned that

"*The hospital has three nurses and a doctor every time we come here for the check-up and delivery. There is only one labour ward here..... building is old and small but it's very clean... we don't have any knowledge about the technology or machine but "one" was broken a month ago but now the hospital has repaired it. The maternity ward closes around 15:00 and the lack of sufficient ambulances came it more inconvenient*".

In this quotation "one" means one ultra sound machine. Furthermore, even the maternity ward closes around 15:00, but the emergency ward is opened 24 hours and they perform deliveries.

Similarly, a key informant, a senior nurse aged 45 mentioned that

"*We have only one ultra sound machine that was broken a month ago and it was inconvenient. Personally, we have requested to the management to provide more technology, increase ambulances and extend the closing hours but the decision has not been finalized yet*"

Such kinds of the decisions as pointed to be finalized through board meeting. The lack of manageability and responsibility is one of the barriers for pregnant women to seek health care facilities as (Jacobs et al., 2012), points out in dimension of barriers to access health services.

While, primary informants interviewed in Nepalgunj Medical College mentioned that

"*The Medical College is big, new and clean, lots of machines. Basically, the facilities are good*".

As a researcher, my own observation indicated that especially, in Zonal hospital there is lack of technology, transportation and infrastructure but hygiene wise it was good. In terms of the support from the health care staff, they were very supportive but some nurses were rude to the pregnant women.

This capacity of health services is one of the barriers or factor affecting the health seeking behavior for pregnant women as mentioned in three-delay model, in framework of factors affecting health-seeking behavior and similarly, in dimensions of barriers to access health services.

6.5.2 Staff- patient relation

The level of relationship between staffs (hospital) and patients depends upon the satisfaction of services that patient acquire form staffs because satisfied patients are more likely to utilize health facilities (Bekele et al., 2008). Again, according to Bekele, satisfaction is related to social conversation, courtesy, communication and information and respect among others.

The relationship between staffs and patients especially, pregnant women in the study area influenced health seeking behavior outcome. Most of the pregnant women interviewed at Zonal hospital were satisfied with the relationship among staffs such as nurses and doctors. One of the 26 years old women, pregnant with her third child mentioned that

"*They communicate nicely and supply enough information furthermore, beside professional suggestion they make us comfortable talking about personal stuff*"

These staffs not only supplied and treated pregnant women professionally but also made these women comfortable and welcoming to talk about their person issues.

I again asked if nurses and doctors are humble and may be you do not want me tell the truth?

She replied:

"As you told me that you will not say anything what we say to you to others so why should we lie, honestly they are humble and kind"

Similarly, primary informants aged 25, pregnant with her second child, accompanied by other pregnant women at Nepalgunj Medical College, mentioned that

"*I am satisfied with the relation with staffs because they are really kind besides providing professional suggestion*"

However, there were some primary informants at Zonal hospital, especially 22 years old, pregnant for first time mentioned that

"*Some nurses are treating me as a little girl when I go for Antenatal care check-up and scold me, which it is quite embarrassing*"

The pregnant women did not want to mention what they said because in Nepalese culture, it is a taboo to talk about the embarrassing comments of womanly body or intercourse. And from the ethical aspect, I just did not follow up questions on this issue.

Different women have their different experience and perception about the hospital staffs. Some of the staffs were kind to them whereas, some of them were rude to them. One of the 24 old pregnant women mentioned that

"*I precisely, waited for this particular nurse because she is so kind and courteous*"

As, Aday and Andresen (1974) in (Phillips, 1990), points out that courtesy on the part of the staffs is one factors affecting health seeking behavior. As we know, nurses are the important actors in the health care system and play a major role in maintaining link between individuals, families, communities and health care system. Nevertheless, the behavior of some of the nurses mentioned by primary informants is due to the stress from work overload, schedule problem, inadequate time to complete their work task and support the patients (pregnant women) emotionally (Gray-Toft & Anderson, 1981). I also observed during my research in Zonal hospital, some nurses behaved rudely to patients such as scolding pregnant women if they missed the antenatal check-up and so on. However, such kind of staff's behavior is one of the barriers or factors affecting to bypass the facilities by the health-seekers Aday & Andresen (1974) in (Phillips, 1990; Thaddeus & Maine, 1994). As staff's professional attitude should not let stressful

working condition harm that patients. After my observation, I asked to doctors and senior nurses about the rude behavior of some nurses towards pregnant women?

One of the senior nurse aged 43 replied that

"*Some pregnant women are careless to come for antenatal cheek-ups, do not follow what is best for them and for their child, basically do not understand. These attitudes make nurses and doctors become furious sometime*"

As, Aday and Andresen (1974) in (Phillips, 1990), points out that such attitude is a structural barrier to utilization if effective health services are to be delivered. This attitude could block important communication, advices and messages.

Furthermore, I again ask, if such behavior of health service provider is due to the clothing or the caste they belong to or because of the pregnant women mother tongue. According to Van Hollen, sometime hospital staffs treat lower-class women with disrespect because of their "backward" status (Van Hollen, 2003).

She replied that

"*Our ethic will not allow us to do that and we do not practice such discrimination but it's because of education and sometimes language too"*

On the same statement, 25 years old female doctor from Nepalgunj Medical College replied that

"*We do not practice discrimination. But most of the pregnant women speak their own mother tongue but we have local staff that can speak their languages. However, sometimes it's difficult to make them understand because of lack their lack of education"*

Considering myself, an insider such discrimination practices are embedded in the local culture, no matter what people say there is some discrimination especially among the elderly generation. Furthermore, these Hospitals and clinic had posters and pamphlets that described precaution steps to be taken during pregnancy stage to be flowed that made some pregnant women ease who had language barriers.

6.6 Barriers for seeking maternal health care

As, mentioned according (Joseph & Phillips, 1984), barriers to use health care are simply a constraints or limited access to utilize particular health facilities. In addition, (Jacobs et al., 2012), points out that socio-culture norm & values and knowledge, are the factors that discourage in use of health services. Furthermore, political instability is also another barrier (Simkhada, van Teijlingen, Porter, & Simkhada, 2006; Thaddeus & Maine, 1994).

6.6.1 Knowledge barriers

Many literatures points out that providing or improving education to women is the best strategy to improve maternal & child health and as well as women status in the society. In Nepal, it has shown that mother's education is the very important factor that influences antenatal care visits. As show (methodology chapter), education level of my primary informants of my study area is relatively low. It clearly shows that none of them have acquired higher education, which demonstrates lack of individual decision power in seeking health care services.

One senior nurse aged 45, accompanied another senior nurse aged 43 commented that

"Yes, these women are not educated and we see it every day such lack of inadequate education is disadvantage because these women could not decide on their own. However, these women have some knowledge about general health issue about what to do in pregnant stage and postnatal care. They usually acquire this knowledge through radio, pamphlets, television and volunteers that travel to educated women all around".

These nurses further shares their experience

"*In last decade, I have experienced that even though women are not educated they have acquired some knowledge, which is very impressive and important for themselves and their child. And they ask such important question, sometimes we are just shocked such as nutrition level in food and so on and these women flow exactly what we guide them, sometime they are better than educated women"*

Women with lower education may be sensitive to advices and further they are not able to utilize the information best for them and their child.

Similarly, interviewed key informants from Save the Children, FPAN and Banke District Public Health. One of the 38 years old male field officer from the Banke District Public Health mentioned that

"*We are doing our best to educated people especially pregnant women all over through radio, pamphlets, television and volunteers and we are getting good responds".*

As most the women have relatively low education, which is predisposing factor, the technique for educating pregnant women through radio, pamphlets, television and volunteers is an excellent medium.

Furthermore, my very important key informants, a female Gynecologist aged 69, mentioned that

"*It's not only about educating pregnant women about what to do and what not to do, it is also important to educated them about the policies and facilities that are available to them because as most of them are not educated*"

As most of the time "significant others" decides nearly everything for pregnant women but due to this effort even "significant other" have acquired some knowledge and thought this is better for the pregnant women and the child.

Furthermore, a primary informant told me that (did not wanted to disclose the identity)

"Some doctors tell patients that they should come to their private clinic to perform operation. This is another way doctors earn a lot. Lack of knowledge about of facilities available, patients is tricked. This is the lack of responsibilities of doctors and the lack of responsibilities of government official to tackle such inhuman conduct"

There are many cases were doctors take advantage of uneducated pregnant women and their uneducated family members. This were structuralist argues that medical professional treat their medical skill as a commodity that is generated by capitalism and the victims are the poor pregnant women. Furthermore, this is the lack of knowledge were especially pregnant women are ticked and the responsibility of health service provide and government officials to monitor such inhuman act are huge barriers for

pregnant women to trust health care facilities that make difficult to decide to seek health care as (Phillips, 1990) points out and also the three-delays model points as the attitude of health service provider.

6.6.2 Social norms and value barriers

Social values and norms are always barriers for pregnant women for seeking health care service as mentioned in table1(Jacobs et al., 2012). In my study area, social norms & and values still dictates pregnant women for using health care services.

The 69 years female Gynecologist mentioned that

"*Especially, in Muslim community people still do not allow their wife or daughter-in-law to visit health services, even if the doctor is a female and it is very difficult to penetrate such values & norms".*

Furthermore, the Gynecologist explains that

"*To overcome this situation, which is a very a sensitive issue because couple of years ago there was ethnic conflict. The Gynecologist association with the help of NGOs and government is having regular talks with Mullah to convince people to allow their wives and daughter-in-laws to use health care services because of various reasons"*

In this particular context, Muslim community people may behave and seek care according to their cultural norms and values.

6.6.3 Cultural barriers

Son preferences are another issue that needs to be concentrated on because this practiced all over Nepal. In Hindu culture, it is believed that son is important because they can only perform funeral rite and for taking care of parents when they get old but girls are considered liability because she will need a dowry, will marry and live away. Furthermore, according Clark, in this part of the world, parents prizes their son for economical, religious or social regions(Clark, 2000). Such belief, pressure women to give birth again and again till there is a son (Brunson, 2010). This preference often may

result in gender biases. This bias definitely creates negative affect on girls and women education, welfare, and health. Apparently, girls are discriminated by their own parents (Matthews, 1998).

In my interview with primary informants, especially, two women; one 24 years old woman pregnant with her second child and 26 years old woman pregnant with her third child expressed that

"It is a social pressure that I should have son this time because my first child was girl, next week we are doing ultra sound and I am scared".

There are different approaches of care towards pregnant women if the child is a son/daughter or going give birth to a son/daughter. If family member including husband knows that a women is going to give a birth to a son or if the born child is a son, the family members will take extra care and provide with enough food and do not let women do any household work but if it is not a son than the women is a part of verbal and physical abuses and forced for abortion. Furthermore, women will not provide with enough food that needed in this condition, which very dangerous for the life of women and child. Moreover, family members often threaten saying that if the next child is not a son than the husband will divorce and find another suitable that might provide them with son (Puri, Adams, Ivey, & Nachtigall, 2011). It can be noticed that social structure constraints or dictates and controls agent's activities.

I wanted to ask what if it is girl again but I did not for ethical reasons want to upset my informants. However, I asked this question to the female gynecologist, 45 years old senior nurses and 45 years old senior counselor at FPAN. The 45 years old senior counselor explained that

"*Usually, if the child born is a girl women become pregnant again. We provide counseling to both husband and wife in cases about how much risk is there if women become pregnant again after short period of first birth and we have seen cases of abuses for giving birth to daughter. We do our best to stop abuses by counseling. But it is difficult to make people understand".*

This is the social characteristic present in Nepalese community because of the people lack of education and of the son preferences attitude, which is a structural barrier as

mentioned by Aday & Andersen and Dutton in their model (Aday & Andersen, 1974; Dutton, 1986).

Furthermore, I asked about abortion practice.

She replied *"there is a legal abortion law so they can abort. It is expensive in private hospital or a clinic compared to public but pregnant women usually do not practice abortion"*.

In this study, some family members' like to know the sex of the child forehand from ultra sound but some does not want to know. However, to know the sex of the child depends upon the decision of the head of the household and furthermore, pregnant women feels pressure because of the social pressure of son preference attitude. Furthermore, women do not usually abort child even though it is a girl because of the religious beliefs that it is a sin to take a life.

6.6.4 Involving men in maternal health

Male involvement in maternal health has been promoted as a good strategy in recent years. It is argued that male involvement is absolutely an important need to improve women in general and maternal well-being of women. Nepal is a male dominating society in every aspect and they are the decision making of a household, involving men in maternal health matters could improve the understanding and relationship between men and women (Simkhada et al., 2006). As structurlist argues that such male dominating structure is embedded in this society that creates barrier for women for access opportunity. While, structurationist argues that such change in social structure can recreate and reshape social structure.

In my study area, I asked to 25 years old female doctors, 45 and 43 years old senior nurses and 45 years old female counselors do you recommend pregnant women to be accompanied by their husband. They expressed the same statement that

"*We recommend the pregnant women to come together with their husbands for check-ups and delivery because they both can decide on different issues arise"*

I asked them, do the pregnant women come with their husbands. They replied

"Only sometimes they come because of course, in our tradition it is unusual but we need to change this thinking, change culture and educate"

Usually, especially husbands are not involved in the maternal health because of the tradition and norms and men uneasiness to participate as this is perceive as a womanly thing. Involving husband's in maternal health is enabling factor to utilize and improve well-being of pregnant women.

6.6.5 Health care barriers

The structure of health care delivery system has medical barriers that are difficult for pregnant women in seeking maternal health care. According to (Thaddeus & Maine, 1994), the waiting time for services at the hospital is the delay stage for pregnant women. In this study, the Zonal hospital has one labour ward so the waiting time is extended even though pregnant women reach the hospital on time. This waiting time is extended due to lack of logistics, infrastructure and attitude of health personals.

As I was observing, I noticed pregnant women waiting for an hour before they are called in for their check-up. I managed to ask, one women age 19, pregnant with her first child that how long have you been waiting?

She answered me

"I *have been waiting for an hour and hopefully the nurse will call my name*"

I again asked, are you not tired?

"*Yes, I am tired but I have to here when they call my name otherwise they might sought at me*"

The extended waiting for services and the attitude of the health personals affects the utilization of maternal health care for pregnant women.

6.6.6 Political barriers

10 years of civil war in Nepal had its negative impact, infrastructures were damaged, doctors and nurses were scared to travel and unable provide their services in rural areas. Due to this political turbulence many pregnant women and their children lost their lives because of the closed hospitals, unstaffed hospitals

Till today, political instability has led to many pregnant women died because they could not reach obstetric care due to the general strike nationwide due to the restriction movement of vehicles. In some case, even ambulances were stop by the protestors. Furthermore, even health workers that are responsible for providing health services are organizing strikes by closing hospitals, clinics and health post for several days in order to make their demands get heard.

6.6.7 Geographical barriers

The difficulty that pregnant women have to face to seek health care facilities is the distance especially in development countries. The difficult geographical terrain hinders pregnant women to reach health care facilities on time especially in Nepal as its terrain is illustrated in chapter four. Even though maternal incentive schemes act as a pull factors for pregnant women however the cost of transport, availability of transport, and natural disasters especially in monsoon season blocks roads due to the landslides remains obstacles to reach health care facilities. As three-delay model points that distance between the pregnant women and health care facilities is due to the geographical. Furthermore mentioned in dimensions of barriers to access health services and in framework of factors affecting health-seeking behavior.

My study area, Banke district is a plain area as it is not difficult travel as hill and mountain areas but the distance and cost of the transport and lack of transportation facilities and blocked roads due to landslides still plays a barrier to reach health care facilities.

As mentioned above, two pregnant women from Surkhet and Jajorkot expressed that

"In *their birth area it is really difficult to reach public health post nearby because of the geographical nature and the lack of transportation as there is no roads*"

I asked all my informants about the cost incentive, is it enough? One of the 26 years old women pregnant with her third child replied that

"*It is not enough because everything is getting expensive however something is better than nothing*"

As mentioned in chapter two, the maternal incentive scheme to pregnant women varies according to ecological zone, pregnant women residing in terai region achieves less incentive than other regions and furthermore, in this globalized world everything is getting expensive such as food, clothes, schooling as structurlist argues that this because of capitalist ideology.

Summary

In this study, there is a strong influence of "significant others" and the head of the household on decision-making for women especially pregnant women on every aspect of life including decision in seeking health services because of the experience "significant other" holds.

The behavior of pregnant women to choice health care facilities in this district is the result of facilities or capabilities and the interaction between health care services provider and women. The interaction especially between nurses with pregnant women affects the choices of the health care facility or bypassing it because of the social treatment pregnant women acquires.

The most important barriers for pregnant women as mentioned in this study are the discouragement to use health care service and facilities. However, the involvement of the husband in maternal health might alter women wellbeing and empower them.

7 CHAPTER SEVEN: SUMMARY, CONCLUSION AND RECOMMENDATION

The study of health seeking behavior among pregnant women in Banke district in Nepal examines how access opportunities, social relation and structures influences decision to seek health care services. This chapter draws the conclusion from various important results and further recommends for improving health-seeking behavior.

The objectives of study were

1. To study the health seeking behavior of pregnant women; including their socio-demographic characteristics, social structures, and influence to modern health care delivery system structure in Banke district, Mid-Western part of Nepal.
2. To examine the barriers to maternal health care services and their consequences for the choice of the health care services and the role of government to overcome these barriers.

Qualitative approach was adopted to understand the health seeking behavior of pregnant women in Banke district. For this purpose 15 primary formants and 12 key informants were interviewed due to the nature of information that was required. All the 15 primary informants were purposely sampled and for 12 key informants were selected through snowball technique. Semi-structured interviews were conducted to interview with both primary and key informants. Furthermore, personal observation was conducted to acquire more information about social and economic status of primary informants, capacity and facilities of the hospitals and behavior of health providers to pregnant women.

In this study, the decision for pregnant women to seek modern health care is strongly influenced by 'significant others' and relatives experience, who recently have used health care facilities. However, for the pregnant women giving birth for first time, decision to use and chose health care facilities were highly influenced by 'significant others' in the family or the elderly women with experience such as mother, grandmother of the pregnant women. Furthermore, other factors that strongly influenced the pregnant women to seek health care facilities are the risk of

complication, caesarean section and safeness in terms of hygiene and infection. The influence of ‘signification others' and other people decisions to seek health care facilities for pregnant women may be reduced by increasing socioeconomic status of the mothers. However, the free maternal care policy and incentive schemes have given pregnant women autonomy to decide for themselves and the influence of others are slowly diminishing.

The choice of maternal health services among the pregnant women in Banke district involved substantially long distances to health services. A problem is the lack of transportation during night if the complication occurs. Such problem opens for the pluralist health care delivery system that puts pregnant women in the hand of untrained traditional birth attendant with no professional health education. Furthermore, choice of the maternal health service depended upon the cost-structure of various hospitals, facilities available, information, capacity and quality of the health care facility. Women used private and public health facilities in Banke district. Women who used private facility chose this because private provides more facilities than public as what they heard from relatives. Similarly, choice of the maternal health facilities also depended on the relation between patients and staffs. Pregnant women tend to bypass health care facilities as some women complained because of the treatment they got from staffs. As Aday and Andersen’s 1974 in Phillips 1990, points out in his classical model on health seeking that courtesy from the staffs decides the choice of the health care services.

The most important barriers that pregnant women faced and discouraged them to use health care facilities in Banke district were transportation barriers that delay pregnant women to reach health care facility. Similarly, another delay is the pregnant women waiting to receive services after reaching the hospital in terms of labour wards as Thaddeus and Maine (1994), point out in three delay models, certain health cost remains further another barrier for pregnant women because of the cost of the family visit at the hospital. Similarly, social norms and values is further barrier to pregnant women especially, among Muslim community to access health care facilities, as one of the key informant explained that even female health service provider are not allowed to examine Muslim women in some household because of their belief. Generally, in Nepal, cultural barrier such as son preferences and involving men in maternal health are disadvantages for women on decision-making process for herself and for child. These

cultural traits are strong in plain areas like Banke district. Similarly, political instability fosters another barrier for pregnant women to access health care facilities because of the general nationwide strike due to the political instability were each political party want to stay in power. Furthermore, even health workers those are responsible for providing health services organizing strikes because of their demands to be heard. These political tussles of power and demands created a gap between the service provider and service receiver. However, education plays a pivotal role for pregnant women to overcome hinder on access and decision making for health care's facilities.

However, due to the political turmoil, inadequate management skills and responsibility, corruption have hindered Nepal to fully implement its policies especially health policies. Nevertheless, the country has able to reduce it maternal and child mortality rates. But it has to work a lot to achieve target set up by UN MDGs and beyond 2015(Annie Kearns, 2014).

Relatively low sample size and the position I possess as a male researcher, researching about the reproductive health seeking behavior of pregnant women could have affected the perception and experiences shared by my informants. But my clear explanation of my objective to my informants was helpful. The result acquired will not be any different until and unless researcher brings personal interest and biases.

However, I was not able to interview midwives but I felt that the study needed midwives perspective because they are trained birth attendant in rural areas as government, NGOs and INGOs are training them. Furthermore, I did not get an appointment with "Mullah" of that area because it was really difficult to get an appointment because of my topic, which hindered me to understand the social norms and values of Muslim community. Similarly, I was not able to interview traditional birth attendants because they are the first to respond for women in labour in rural communities. And the time for the study was limited that hindered me from making of the follow-up with my informants for instance after giving birth. Furthermore, the study could have provided more specific insight and understanding of reproductive health seeking behavior of pregnant women, if the focus was precisely on caste/ethnicity or in religion. Therefore, study in near future should focus on this determinant to understand the behavior.

7.1 Recommendation

The study reveals that the influence of 'significant other', close relative, friends, husbands and other social factors affect the health seeking behavior and decision to choice health care facilities of pregnant women. These people may not be unaware of maternal practices. Therefore, providing maternal health care practice and education not only for pregnant women but also to girls of childbearing age, to 'significant others' and husbands.

Traditionally, in Nepal especially, in rural communities TBA plays very important role and they are the first person to assist pregnant women. Therefore it is necessary to increase trained birth attendants such as midwives to save life of women and child. Further, provide mobile clinics for antenatal care and giving uncomplicated birth to every village in Nepal.

One factor that affects the choice of health care facilities is the relationship between medical staffs and the patients so, try to introduce such programs that creates better environment for both staffs and patients. Furthermore, improvement in infrastructure, transportations and essential obstetric care that will provide more room for women to seek for health care facilities and prevent maternal mortality. In addition, create a system so, pregnant women do not have to wait for health services for a long time.

Education plays a pivotal role not only for individual but also for the socio-economic factor of family, community and country. It is well know that providing education to girls can increase decision quality for herself and for her child. Therefore, prioritize education especially for girls, educated parents about the advantages of education and formulate free education policy that obligates girls to acquire at least higher secondary education.

In Nepal, there are various religious and ethnic groups as mentioned. They have their own social norms and values and cultural practice that have some negative impact on pregnant women and their child. Therefore, it is necessary to education people to change and diminish such practices and further explain negative consequence of such practices for pregnant women.

In addition, Political stability and their commitment are really important to achieve MDGs 5: 5.A and 5.B for Nepal.

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Appendix 1: interview guide for primary informants

Background information

Name:

Age:

Marital status:

Religion:

Language:

Education level:

Occupation:

District:

- Are you pregnant for first time? Yes/No
- If no, how many children do you have? Girl/boy
- If girl, do you have any pressure to produce a boy? Yes/no. Explain
- How old were you when you gave birth for first time?
- Did you receive any ANC during your pregnancy?
- If yes, whom did you visit?

  Doctor, nurse, midwife or traditional birth attendant

- Where did you give birth to your child? And why did you select that place?

  Hospital, home or clinic

- Who assisted you during delivery?

  Doctor, nurse/midwife or traditional birth attendant

- Did you have any complication while giving birth? Yes/No. Explain
- If yes, were you rushed to emergency? Yes/No
- If there was not complication have ever visit hospital? Yes/No.

- Where you aware that there will be complication? Yes/No.
- Did you go through caesarean section? Yes/No.
- Why did you select hospital? Explain.
- Did you select yourself for the place of birth? Yes/No. Explain
- How did you know that you should come to hospital?
- How decide where to give birth? Explain why?
- Did you have to travel long to reach her? Yes/No.
- How is behavior of the hospital or referral center staffs?
- Did you have to wait for long time before you get checked-up?
- Does/did it affects the choice of place to delivery? Yes/No. Explain
- Did you face any problem while seeking health care facilities?
- Do you think about infrastructure, equipment and service they provide? And are satisfied?
- What is the difference between private and public hospitals?
- Will you recommend hospitals to other pregnant women?
- Do you know about free delivery policy? Yes/No
- What changes do you want in health care services?

Appendix 2: interview for key informants (officials, NGOs workers)

Background information

Name:

Age:

Occupation/ position:

- What kind of educational programm for pregnant women are you currently conduction?
- In addition, what are you doing to educate families and husbands to pregnant women?
- How many staffs and volunteers involved in such educational program?
- Have u have enough budgets?
- To increase number of midwives what are you doing?
- What are you doing to penetrate cultural norms and values?
- Do you think maternal and childhood mortality has increased in recent years?
- What are you doing to change the health seeking behavior?
- What kind of facilities are you providing in rural areas for pregnant women?
- What kind of changes would expect in near future?
- What kinds of extra financial and technical support are expected from the center?

Appendix 3: interview for key informants (doctors, nurses and counselor)

Background information

Name:

Age:

Occupation/position:

- How many pregnant women does this facility check every day?
- What kind of pregnant women usually visit this facility, in terms of economy, social and cultural backgrounds?
- What kinds of service do your facility provides to pregnant women before, after and during pregnancy?
- Does your facility have enough equipment for maternal health care?
- How is the relationship between you and patients?
- Do they flow what you recommend?
- What do you further do to encourage pregnant women to visit facilities often?
- What do you tell them about TABs?
- Do patients share personal stories with you?
- What kind of contribution are you making to change the perception of people in this community?
- What kind of changes you aspect in this facility?