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Government Efforts and Personal Opinion Explain the Medicalization of Pregnancy and Childbirth Through Time in Lower Mustang, Nepal

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Government Efforts and Personal Opinion Explain the Medicalization of Pregnancy
and Childbirth Through Time in Lower Mustang, Nepal

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Kagbeni, Mustang, Nepal

ABSTRACT

The way that women approach pregnancy and childbirth in rural Nepal has seen an amazing change in the past twenty to thirty years. The medicalization of this entire process, from pre- to post-natal care, comes with government efforts for the increased education of women about family planning, nutrition, hygiene, and the proposed benefits of institutional versus in-home delivery. In 9 villages of Lower Mustang, interviews conducted with Government Health Post workers, Female Health Volunteers, and women of different ages sought to discern personal experience and opinion about pregnancy and childbirth from the perspective of both local women and those with medical training. Today in Mustang, almost all deliveries take place with the help of trained professionals in some type of medical institution, while the elder generation sees weakness in the inability of younger women to deal with the pain in the same way they did for multiple in-home deliveries. Additionally, interviews included questions to gain basic knowledge about the general work of Mustangi Health Posts, in order to better understand their equipment and capability for dealing with patients. This study looks at accessibility of health care, opinions on delivery location, government involvement and incentive in the pregnancy process, and mothers' personal anecdotes regarding their own experiences and the changes they have witnessed in maternal and infant health through time in Mustang.

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INTRODUCTION

The district of Mustang, located in the Western Development Region of Nepal, is nestled into the beautiful landscape of the Himalayas. The district capital, Jomsom, is accessible via airplane and bus or jeep from the closest major city, Pokhara. The Annapurna Conservation Area, which overlays much of the district, makes Mustang a very popular trekking area. Upon arrival in Jomsom, one is greeted by a plethora of hotels and restaurants with English signs that line the main road outside the airport. Often at first glance it is likely that one will see more “westerners” than locals (at least in the high season). While much of Lower Mustang (the southern part of the district) is in fact dominated by “western” people during the trekking season, there are many villages slightly off the beaten path where one can find a more authentic atmosphere, rather than one dominated by a tourist economy. Still, in the 10 villages I visited in my 18 days in Mustang, I was never turned away for an interview (other than for lack of time), and more often than not offered bottomless cups of Tibetan tea and endless stories. This population speaks Tibetan dialects, practices forms of Tibetan Buddhism and often identify politically and historically with the people of Tibet.¹ The people of Mustang, Tibetan-oid in their culture and language, are incredibly hard working, humble, generous, and welcoming of complete strangers. Through their kindness, I was lucky enough to speak with 26 individuals about their experience with and opinion of pregnancy and childbirth. Through these conversations, my aim was to better understand how maternal and infant health has evolved in this section of rural Nepal, how most women choose to go about this process today, and what facilities and support systems are available to them.

November in Mustang sees both the warming sun and the biting cold, the latter causing much of the population to go south for the winter, most often retreating to Pokhara or Kathmandu. Those who can't afford to make the trip to warmer ground or stay back to look after animals, elders, households, etcetera, own stacks of fleece blankets enough to cover an entire wall floor to ceiling. The area is also known as a temporary home to migrant laborers who come from other parts of the country to work as farm hands or construction workers. This community, often less economically independent than most Mustangi locals, make up a significant amount of the population and are seen by health post workers in some places as the most common patients. Although each Village Development Committee (VDC) in Mustang has its own health post, some VDCs are so spread out that even travelling to one's local post can be a trek. Each VDC has nine wards. In some cases a single village is large enough to consist of 3 or 4 wards in itself, but in many cases, multiple smaller villages make up a VDC, each one consisting of 1 or 2 wards. In a government effort to make health education more widespread, each ward is home to a Female Health Volunteer (FHV) who has basic training from local health workers and is a resource to the people of her ward. The health post is located in the largest or most central ward of the VDC in order to maximize accessibility and use.

¹ Sienna Craig, “Migration, Social Change, Health, and the Realm of the Possible: Women's Stories between Nepal and New York,” *Anthropology and Humanism* 36.2 (2011): 196.

The easiest place to find a health practitioner during normal working hours is at the local post. FHV's and women are commonly found working in their homes, running local businesses (commonly guest houses or storefronts), or farming in fields nearby.

HEALTH FACILITIES

The district of Mustang has one hospital, located in the district capitol, Jomsom. Each VDC is also home to a health post (along with the village of Thini, although it is included in the Jomsom VDC). Each post I visited is staffed with 2-4 medically trained workers. All of the health post workers that I spoke to had 2-3 years of training, with qualifications they equated to the title "nurse" or "paramedic". None of the Mustang health posts staff Medical Doctors, although the district hospital has 4 MDs that work on and off. The buildings, equipment, and staff varied from one post to another. Only one health post I visited was equipped for delivery, and while other posts have a delivery room or bed, they do not have either adequate equipment to deal with a delivery or the staff trained to handle these cases.

DISTRICT HOSPITAL

One of the most common professional titles that I ran into during my research was that of ANM or Auxiliary Nurse Midwife. I was lucky enough to talk to Laxmi, an ANM at the district hospital who has been in the business for 37 years, and whose name and reputation is known around Mustang. The hospital has 10 staff, 6 nurses and 4 doctors. Only one of the doctors is permanent while the other 3 are serving the Nepal government's requirement of working in a remote area for 1-2 years after they received government sponsorship for their medical training. There is no gynecologist or anesthesiologist at the hospital, forcing the nurses to handle all deliveries that come through. This also means that the hospital is not equipped for surgery of any kind, forcing mothers in need of caesarean sections to travel to larger (government or private) hospitals in Pokhara or Kathmandu.

The hospital has two wards that house admitted patients, one for males and one for females. Each room has 8 beds, with no curtains or semblance of privacy for those being treated. According to the hospital staff, most people seen are not admitted but require only outpatient care. The number of patients seen each day varies a significant amount according to the season. In the summer when all locals are at home and the area is full of trekkers, Laxmi said that they can see between 90-95 patients in a day, in the fall, it is common to see 30-40. The most common problems they treat are asthma and alcoholism. Trekkers often come in with altitude sickness, frostbite or various orthopedic problems due to physical exertion and their time outside.

The hospital has a small delivery room which features a large poster advertising the loading dose of Magnesium Sulfate for treating Eclampsia or Pre-Eclampsia (a life-threatening pregnancy complication leading to convulsions or seizures). The room has both a regular and delivery bed, keeping up the appearance of being unkempt with piles of blankets and different medication bottles lining the walls. The nurses have seen 2-3 deliveries in a day, often there are none, but women

are taken care of as they arrive. The district hospital has the only ultrasound equipment in the area, but unlike all other medical services, ultrasound requires payment from the patient. The typical pregnancy check-up includes determining the position of the baby by feel, and patients are only sent to ultrasound when there is uncertainty. The hospital provides a urine pregnancy test, although most women seem to determine or realize pregnancy on their own, especially those who are further removed from medical care. Because most Mustangi health posts are not equipped for delivery, some women travel great distances for the services at this hospital. Many come from upper Mustang for birth in Jomsom. Women are encouraged to have check-ups at 4,6,8 and 9 months during pregnancy, and some women are dedicated to making these appointments even if it means days of travel. The hospital provides them with tetanus vaccinations, as well as iron and calcium tablets to take throughout pregnancy.



Fig. 2. The delivery room in the district hospital (Jomsom), with the delivery bed on the left.

Contraceptives are widely available in the area and accessible at the district hospital as well as all local health posts. According to Laxmi, women use contraceptives of all kinds, “especially after two children”. Condoms, pills, the shot (Depro-Provera), the implant, and the IUD (intrauterine device) are all used by the local population. In the Jomsom area, Laxmi believes that the IUD is the most popular form of birth control. Women have access to all of these options for free, they simply have to show up at the hospital or a local health post and inquire. Condoms and pills have been widely used for the past 20 years while other more permanent forms of contraception have become more popular in the last 10-12. Abortion was not legalized in Nepal until the year 2002, and before this time women often went to prison for seeking out abortion because the law did not allow it under

any circumstance.² The Jomsom hospital provides abortion services but because the community is so small, many women are embarrassed or nervous about requesting this procedure, causing many to lie about their names or where they are from in hopes that friends and family will not find out. Laxmi as well as many other health practitioners I spoke with were not inclined to speak on the topic of abortion, suggesting that it is not a widely accepted idea in Mustang.

Laxmi showed me many pictures she had taken with her camera phone of difficult deliveries she has dealt with; babies coming out feet first, premature infants surviving early deliver, and one baby with a head so big that his delivery became a danger to his mother. “We do the best we can,” she emphasized to me in English, making it very clear that they do not have the staff or equipment they really need to run a high-functioning delivery ward. The first thing that she would change about the current system would be to have a gynecologist on staff at the hospital so that they could better handle difficult or complicated deliveries, as well as other women’s health issues. Laxmi sees many benefits of hospitalized birth including hygiene and education about post-natal care. When women give birth at a government institution they are told about breast-feeding, proper hygiene, and nutrition for their infant. Women are also asked to return after 24 hours, 7 days, and then every month for a year to check on the baby’s progression and for vaccinations. New mothers are also educated about family planning and the different types of contraceptives available to them. There is much expected of the district hospital nursing staff when it comes to women’s health, but through much experience they have been very successful in providing women with safe deliveries and a comfortable environment to talk about personal health issues.

LOCAL HEALTH POSTS

The variance in the 5 health posts that I visited during my time in Mustang was interesting. The post in Kagbeni is a recently built two story attraction, easily noted as one of the fanciest buildings in the area, but it is not equipped for delivery, while a much more modest 4-room structure constitutes the Marpha health-post where delivery often takes place. Each VDC post is given the same compilation of 35 medications from the government, including mild painkillers, cold and flu medicine, antibiotics, anti-diarrheals, and a few vaccinations. With only the capacity to treat basic ailments, more serious cases have to be referred to Jomsom or to hospitals in Pokhara or Kathmandu. Most of the paramedics I was able to talk to are not originally from their village of employment but are spending time there either by government request or through personal preference.

THINI

The health post in Thini village is only a 30-minute walk from the district hospital in Jomsom, but still widely used by the people of Thini and Dhumba, another nearby village a little further south of Jomsom. This post was built 15 years

² Anand Tamang and Jyotsna Tamang, “Availability and Acceptability of Medical Abortion in Nepal: Health Care Providers’ Perspectives” *Reproductive Health Matters*, 13.26, (2005): 110, accessed November 22, 2014, doi: 10.2307/3776482.

ago and is called home by four staff members. There is 1 ANM, 1 CHA (Community Health Assistant), 1 CMA (Community Medical Assistant), and a “helper” who has only basic training in hygiene and sanitation in order to assist with patient care and keep the post clean. The ANM works solely with women (especially those who are pregnant) while the other staff work with more general cases. The ANM has done 3 emergency deliveries in the area, but women in Thini commonly plan ahead to go to Pokhara or Kathmandu to give birth. Her job consists mostly in pregnancy check-ups; blood pressure, weight measurement, checking the baby’s position, distributing iron and tetanus, and referring women to the local hospital for delivery. Like the district hospital, the population has access to contraceptives here, although more permanent methods like the implant and the IUD are available only at the district hospital. The CHA in Thini had 3 years of training and previously worked at the district hospital, but believes his training is more applicable to working in remote areas; he works in Thini by choice. He most commonly sees chest problems and gastritis in older patients, a result he thinks of their smoking and alcohol use (along with the cold environment). Construction work in the area he believes also influences their respiratory problems. The post sees 12-13 patients per day on average, although the number fluctuates greatly.



Fig. 3. The Thini Health Post.

MARPHA

The Marpha health post was the only post I visited that is equipped and staffed to handle normal delivery. This post has 4 staff members, 1 CHA, 1 ANM, 1 VHW (Village Health Worker), and 1 Senior Auxiliary Health Worker. Those who choose to give birth in the Marpha post are often of a lower income level, which doesn’t allow them the option of travelling to a different location for their delivery. As a result, this post sees 7 or 8 deliveries in a year. Many local women still utilize the health post for their 4 progression check-ups through pregnancy, and are referred to Jomsom if believed their delivery will be complicated or difficult for any

reason. It was very apparent during my time in the Marpha health post that the staff are a high-functioning, well-oiled machine. They worked together fluidly on treating patients, reporting their activity and managing the flow of traffic. The Mustangi health system does differ from many in its lack of privacy or confidentiality in patient care, as many men and women were asked about their issues and treated while I (and other bystanders or patients) sat 6 inches away on the same bench. This seems to be the nature of much of the health care in the area, which can be attributed to both the close and trusting nature of the community as well as a lack of facilities with which to make patient care more private. Women here are also asked to return for check-ups after their child is born, similar to the district hospital, and educated about hygiene, nutrition and vaccination routines for their new infant. In more general terms, this health post commonly treats respiratory issues and gastritis as well as performing minor first-aid. They also emphasized their goal to educate the population about family planning and contraceptives in order to further decrease the incidence of unwanted pregnancy.



Fig. 4. The delivery room at the Marpha Health Post.

KAGBENI

The health post in Kagbeni is removed from the main part of town, allowing patients to enjoy a pleasant 15-minute stroll for health care access. Unfortunately, if an individual was in need of more emergent care the off-set location of this post would presumably cause set-backs. This two-story health facility was built only 3 years ago and looks like a castle in comparison to some other health posts in the area. Unfortunately, the majority of the building sits empty and collecting dust, waiting for government funding to fill it with beds, tables, chairs and medical equipment, a process which is intended to happen slowly over the next few years. This post houses only 2 government staff, a PHI (Public Health Inspector), and an AHW (Assistant Health Worker). Neither of the staff have significant training in facilitating childbirth, and admit that most women from the Kagbeni VDC travel to

Jomsom, even for their check-ups through pregnancy. The majority of their work comes in consultation, recording and reporting (like every post), mainly for the treatment of less wealthy patients. They see on average 10 patients per day, complaining of diarrhea, respiratory issues, common colds and in need of minor first aid. Although they have a beautiful structure, the staff here would rather see a greater amount of equipment to fill a smaller building than to watch this one collect dust, believing that a lack of patients and treatment options make it difficult to create a positive change in health care in the area.



Fig. 5. The Kagbeni Health Post.

JHARKOT

The main room of the Jharkot health post is littered with posters from government organizations about maternal and child health. This post has a delivery room and a qualified ANM who is ready and willing to perform the task of facilitator, unfortunately, the post does not have the proper equipment or medication to actually handle childbirth so women in the area are referred to the local hospital. The women of Jharkot and surrounding areas commonly travel to Jomsom (a few hours by jeep) or bigger cities for their delivery. The post still sees mothers for their pregnancy check-ups and reinforces the importance of hygiene and nutrition for both mother and child, as well as needed vaccinations after birth, which they provide. This post has 2 staff, an ANM and a CMA (Community Medical Assistant). The CMA handles general health while the ANM looks after women and children. An issue this post has run into is into lies in their lack of staff. If one of the staff members is out of town or busy and an emergency case comes through, it can be very difficult to handle alone. Fortunately, this post sees mostly respiratory problems or common colds, but the workers here still hope to fill out the staff in order to feel more qualified and productive.



Fig. 6. The Jharkot health post.

JHONG

The Jhong post is also home to only 2 staff, both women are CMA's but only one is a permanent government employee (meaning that she will receive benefits even after retirement). This facility is not equipped for delivery nor are the staff trained in proper facilitation. Women from Jhong and surrounding villages tend to travel to Jomsom even for their pregnancy check-ups. This post sees 15-20 patients per day with headaches and common colds. The government only requires working hours of 10:00AM – 4:00 PM for government health staff, which the women at this post see as a major benefit in relation to working at a private hospital where the hours are often long and unappealing. While they do not perform deliveries or check-ups here, the staff still educate women on how often they need to go to the hospital and how to best care for themselves through pregnancy. They also provide women with education about post-natal care when they return home from the location of their delivery. While they mostly general health issues, the staff here are very happy with their work and think that the post functions well.

The health post system in Lower Mustang provides local people with easy access to basic western medicine and health education. While posts may differ in their size and level of facilities, they all seek to provide the same accessible and positive health care experience for all of their patients. Every post is incredibly honest in serving their patients to the best of their ability with the resources at hand. The most impressive similarity between all of the health posts was their dedication to education about family planning, their efforts to make contraceptives easily accessible and to teach their patients about the importance of personal hygiene. This improvement in health education for families in rural areas has much to do with the two government programs by the names of "Safe Motherhood" and "Suaahara" which have been implemented in the last 20 years in order to decrease infant mortality and improve the status of maternal and child health in rural Nepal.

GOVERNMENT PROGRAMS

SAFE MOTHERHOOD

The Nepal Safe Motherhood Project (NSMP) is a program that was implemented by the Nepali government in 1997. Based in the government's health division, this program hopes to bring about "a sustained increase in the use of quality midwifery and essential obstetric care (OEC)".³ In 1997, the maternal mortality ratio was 539 deaths for every 100,000 live births, the highest rate in South Asia at the time.⁴ Women's status in the home, low education and literacy rates, and the difficulty of communication in Nepal all contribute to women's inability to access health care and to the high maternal morbidity rate. One of NSMP's goals was to break some of the barriers that denied women access to obstetric care, including increasing education and providing financial support for both transportation and the cost of care especially in emergency situations.⁵ In the year 2006, the home delivery rate was at 81% in Nepal, this number has decreased drastically in the last few years, as seen by the amazing consensus that all Mustangi women today choose institutional birth over home birth, unless there is an emergency or they have no other option.⁶ NSMP operated from 1997 to 2004 and worked to increase quality of care by providing training for medical staff, improving infrastructure and equipment, and raising clinical standards.⁷ "Subsequent to the project, the Nepal Government instituted a policy to reduce financial barriers to institutional delivery through cash payments to subsidize transport costs and free institutional delivery in the poorest districts".⁸ With Nepal's Safe Delivery Incentive Program, which was implemented in 2005, women received a government stipend for choosing institutional delivery. A new system, labeled the "Nepal Safer Motherhood Program" (built off the experience of the Safe Motherhood Project), took over the role of the Safe Delivery Incentive Program in 2007.⁹ Today, women

³ Nepal Safer Motherhood Project. "About Us - Nepal Safer Motherhood Project (NSMP)," last modified 2004, HMGN. Web. 23 November 2014, <http://www.nsmpp.org>.

⁴ Alison Dembo Rath, "Improving Emergency Obstetric Care in a Context of Very High Maternal Mortality: The Nepal Safer Motherhood Project 1997-2004." *Reproductive Health Matters* 15.30 (2007): 72-80, accessed November 23, 2014, doi: 10.2307/25475336.

⁵ "Increasing Access Barriers- Nepal Safer Motherhood Project (NSMP)."

⁶ Rath, Alison Dembo, "Improving Emergency Obstetric Care in a Context of Very High Maternal Mortality: The Nepal Safer Motherhood Project 1997-2004," 73.

⁷ "Service Provision Quality- Nepal Safer Motherhood Project (NSMP)."

⁸ Rath, Alison Dembo, "Improving Emergency Obstetric Care in a Context of Very High Maternal Mortality: The Nepal Safer Motherhood Project 1997-2004," 76.

⁹ Carol E Barker, Cherry E. Bird, Ajit PRadhan and Ganga Shakya, "Support to the Safer Motherhood Programme in Nepal: an integrated approach" *Reproductive Health Matters* 15.30 (2007): 81, accessed November 24, 2014 doi: 10.2307/25475337.

from Mustang receive 1500 Nepali rupees if they give birth in a government hospital or health post, and an additional 400 if they also attend each of 4 required pregnancy check-ups. The Safe Motherhood Program focuses on increasing the incidence of skilled attendants being present at birth, “In Nepal it has been agreed that a doctor, nurse or auxiliary nurse-midwife who has received standard training in the internationally defined set of core midwifery skills qualifies as a skilled birth attendant”.¹⁰In Mustang, the district hospital and almost every health post houses an ANM, and is so in compliance with this set of standards for proper delivery care. This program is also supporting the government efforts to attach community birthing centers to rural health posts, which are intended to be staffed by at least 2 trained nurses and be open for service 24 hours a day.¹¹This process has not yet begun in Lower Mustang but seems like it could provide beneficial services to the women of the area and solve the issue of lack of staffing in some of the district health posts. While it is hard to say how much of an affect the monetary incentive for institutional birth has affected delivery choices of Mustangi people, it was clear from personal interviews that the younger generation is very dedicated to institutional delivery. Those who can afford private hospitals much prefer this option to the government alternative, showing that the stipend is not enough to persuade those of higher economic status to give birth in a government institution. Still, if they are choosing an alternative institutional delivery, a positive change is still happening in the eyes of the Nepali government because women are no longer dedicated to home delivery in the way that they were 20-30 years ago. The Safe Motherhood Program is not the only government project dedicated to improving maternal and child health in the area, Suaahara, with help from USAID, has an overwhelming presence in Mustang.

SUAAHARA

Suaahara, “the Integrated Nutrition Project” was designed by USAID and the Government of Nepal in improve “the health and nutritional status of pregnant and lactating women and children under 2 years of age, thereby directly addressing the vulnerable points of development which result in chronic undernutrition or stunting”.¹² As a 5-year project functioning in 20 districts of Nepal, Suaahara works to improve sanitation, hygiene, nutrition, family planning services, and even home-based gardening. ¹³Female Health Volunteers are essential to the dissemination of Suaahara’s teaching, receiving training from local Suaahara representatives and relaying information to friends and neighbors. Suaahara also works closely with local health posts in Mustang, providing them with extensive literature to distribute to patients as well as giving posts informative posters that are often plastered over

¹⁰ Carol E Barker, Cherry E. Bird, Ajit PRadhan and Ganga Shakya, “Support to the Safer Motherhood Programme in Nepal: an integrated approach,”84.

¹¹ Ibid, 86.

¹² USAID. “Suaahara Project – Good Nutrition,” last modified December 4, 2013, Web. 24 November 2014. <http://www.usaid.gov/nepal/fact-sheets/suaahara-project-good-nutrition>.

¹³ Ibid.

every flat surface. Each VDC in Mustang has its own Suaahara representative who is responsible for occasional trainings with local Female Health Volunteers and keeping the health post updated and informed on the current projects and goals of the program. With their efforts to educate the hill and mountain population about proper hygiene, Mustang has seen a great increase in toilets and hand washing. Mothers also noted major differences in post-natal care since Suaahara's presence. Older mothers admitted no special nutrition for newborns, and no sense of the importance of hygiene. Today, mothers are educated on the proper position for breast-feeding, when to start their children on a solid food diet (and what to feed them), and to bathe their children and dress them in clean or new clothes. The Suaahara project has been incredibly successful in advertising and educating the public about healthier and safer ways to prepare food and raise healthy infants both during and after pregnancy.



Fig. 7. A Suaahara poster in the Kagbeni Health Post shows information about proper nutrition at different ages for young children as well as proper hygiene.

HEALTH PRACTITIONERS

The role of government workers in Mustangi Health Posts is not to go unappreciated. Given a cabinet of 35 medications with which they are expected to treat any patient that walks through their door (or turn them away for lack of resources), they have to be resourceful, intelligent, and compassionate. Health post staff work with local people of different religious and economic backgrounds, and different understandings of western medicine. Most staff moved to Mustang from other areas in order to work with rural populations, submerging themselves in a completely new environment and community to perform basic care to rural populations.

PATIENTS OF DIFFERENT BACKGROUNDS

Mustang is home to both Hindu and Buddhist people, but most medical practitioners don't see major differences in treating those of different religious backgrounds. "They celebrate certain festivals differently but other things are the same for them" said a Health Assistant from Thini. While they may have different beliefs, they are living in the same locality and there is no difference between the diseases they have or how they want to be treated. A Public Health Inspector from Kagbeni believes that religious background used to be more relevant than it is today, and working at a government health post he sees rarely sees differences because of its accessibility to all parties.

Many communities in Mustang are home to an "amchi," or traditional Tibetan doctor. Before the existence of health posts in Mustang, most Buddhist people would go to their local amchi with all types of ailments. This type of medicine, all herbal, combines both the mind and the body and uses the pulse to identify illness and determine treatment. Amchis still exist in Mustang, spread out in different VDCs, they are still visited frequently, especially by older Buddhists. Choices in seeking out medical care differ between families and generations, "yet people make pragmatic choices about when and how to access biomedicine, Tibetan medicine, and ritual healing, based on their economic constraints and their own understanding of the nature of their illness."¹⁴ The younger generation, having grown up in the presence of health posts, often no longer go to the amchi for help, believing that western medicine is both more powerful and effective in treating persistent symptoms. The older generation, adapting with the changing times, often use a combination of both traditional and western medicine, choosing to go the amchi for certain ailments and the health post for others, or trying herbal medicine first and then visiting the health post if the original treatment was unsuccessful. Because the older generation is taking advantage of health post services, if only on occasion, it is clear that a major cultural shift is in process. The modernization of the medical system in Nepal through the presence of health posts in rural areas may be contributing to a loss of certain traditional values or customs that were in place for many years before the existence of modern medicine.

The most notable difference in the realm of patients of different economic status seems to be that those with more money are much less commonly seen by the health post. "People of high caste with enough money will charter a helicopter and go to Pokhara if they have health issues, they don't even come to this health post" said the same Thini Health Assistant. He noted that some of the lower castes in Nepal are marginalized, "we are treating those people who are economically poor," he said. In Marpha, the Health Officer argued that people with a lot of money still use the local post for check-ups or minor health issues, but will go south if an issue becomes more serious. This disparity in wealth can also be seen in women's choice to give birth in a private versus government hospital, or even in a local health post versus a hospital in Pokhara or Kathmandu. Travel expenses alone can be enough to deter families from making the journey to lower ground to give birth, and those who

¹⁴ Craig, "Migration, Social Change, Health, and the Realm of the Possible: Women's Stories between Nepal and New York," 196.

choose to give birth in local health posts or the district hospital in this era are not often those of high economic status.



Fig. 8. Thini Health Assistant pictured outside the Thini health post.

HOPES FOR THE FUTURE

While the existence of health posts is already a change from the Mustang of 30 years ago, many health practitioners are itching for improvements. Lack of government funding makes change difficult at the local level, still, many health post staff are doing their best to make changes as they are able. Many of their hopes live on a larger scale, requiring much more funding and often more staff, dreams that may not feasibly come true for many years.

The district hospital ANM's biggest wish is to have a trained gynecologist on staff. Not only would this provide a certain level of comfort for the nursing staff who often take on cases beyond their level of training, but someone with this training could also prove an amazing resource for the entire Mustang community. Not only in assisting with deliveries but also with other female reproductive health issues that seem to be common in the area. Sexually Transmitted Diseases are apparently common, as a level of infidelity from Mustangi husbands is almost expected by many women. A lack of proper hygiene and other uncontrollable factors also lead to women's health issues that require them to travel to larger hospitals for gynecologic care or even surgery, issues which could be prevented or treated closer to home with the help of a women's doctor in the district. In a similar light, some health posts are hoping for a doctor of any sort, someone of higher medical training could make these posts much more qualified and reliable in terms of patient care. Even things like basic lab facilities or the ability to provide patients with oxygen would greatly increase the level of care that local posts are able to provide.

Another major change that some health post staff are looking for is widespread knowledge about “reporting early”. According to the Thini Health Assistant, most patients show up after their condition has already had time to progress, in some cases to a point where it is no longer possible to treat them with the resources they have available at the local post. He would like to “make more people more aware so that they come to the health post when the disease starts”. This requires a greater amount of education and community outreach so that people know the services that are available at their local health post, as well as warning signs of the onset of common diseases so that they know what to look out for. Instead of treating chronic diseases, the posts could be responsible for preventative vaccination. Some local practitioners are desperate enough for change that they have taken matters into their own hands. The Kagbeni health post, a large and mostly empty shell, didn’t have electricity or running water before one of their staff arrived. After his work towards providing the bare essentials to this post he believes that he will also be able to make other more significant changes, with the goal of providing services to all sectors of health care so they can help every patient that walks through the door. He believes this will take greater manpower and facilities, recognizing that it may take much time and effort.



Fig.9. Kagbeni Health Post worker in front of his post.

CHANGES OVER TIME

In order to better understand the recent and popular change to institutional births, and the general trend towards the use of western medicine, I was also curious about health worker’s perspectives on how things have changed through

their time working in the health sector. Even when asked about general changes in they have seen in health care, most practitioners' responses included the medicalization of birth in some form. Programs like Suaahara have had a positive influence on most demographics in their effort to promote healthy diets and support local farming efforts, but are also primarily dedicated to the health of both mothers and young children. This progressive effort from the government seems to be urging mountain and hill populations towards more modern trends.

Many health post workers noted no significant change during their time as medical professionals. This could be because they have not been in the field for many years, or because are simply following protocol and have yet to notice any drastic change in patient care. The most common list of obvious changes seen includes nutrition, hygiene, and vaccinations. Some practitioners raved about the use of toilets, facilities that did not even exist in the area 25 years ago. Some also are surprised by the number of local people who now seek out vaccinations for themselves and their children, "before people didn't care," said a practitioner from Marpha, now mothers especially are very concerned about vaccinating their children and using other efforts to keep them healthy. Others note government programs; namely Safe Motherhood, which have created "rapid changes in delivery and check-ups for pregnant women". Many follow the Safe Motherhood change by Suaahara, which promotes an increase in the kitchen garden relationship and a focus on nutrition that was never before present in rural populations.

One health post worker noted the country's ability to make change through citing the recent maternal mortality rate of 539 deaths in every 100,000 births and emphasizing how much it has improved in recent years, believing the current rate is something like 182. This Kagbeni paramedic believes that the health sector has many indicators that need to either increase or decrease, and the fact that maternal mortality has gone down is a major success story. He has also seen an increase in the acceptance of western medicine as a positive health care choice, relating to the decrease in use of traditional medicine.

In reference to maternal and child health, many also noted the common change in personal choice from home to institutional delivery. In the past, women would not only give birth at home but also attended no preliminary health check-ups through pregnancy. This allowed infants out of position to cause difficult deliveries that often led to the death of mother, child, or both. "Now, these problems are very rare", and a Jharkot ANM attributes much of the change to the 1500rs incentive for institutional birth. Those working in the medical field have seen change in different areas of human health, but most changes are related to modernization throughout the country and specifically government (and international) efforts to increase medicalization of birth throughout Nepal.



Fig. 10. Jharkot ANM poses in front of the Jharkot Health post.

FEMALE HEALTH VOLUNTEERS

Every VDC in Lower Mustang has 9 wards, and as an effort to make knowledge about health care more accessible to the public, each ward has a Female Health Volunteer (FHV) whose job is community outreach. FHVs are first trained for 7 - 10 days at the district hospital in Jomsom, learning about family planning, the schedules for necessary check-ups, vaccinations and medications needed by pregnant women and young children, general hygiene and infant care, breast-feeding position, and basic health and first-aid. “To increase access to family-planning services and their acceptability by rural people, the Government of Nepal initiated the Female Community Health Volunteer (FCHV) programme in the 1980s. The FCHVs are local women trained to provide maternal and child health and family-planning services to rural communities”.¹⁵FHVs are also given periodic trainings throughout the year by their local health post, mobile camps travelling from the district hospital, or from local Suaahara representatives, although the frequency and length of these trainings is difficult to determine and seems to depend upon both the individual and their location. Volunteers are also given a small array of medications which they are to distribute to the local population upon request, including both contraceptives (pills and condoms), mild pain medication for common ailments like headaches or back pain, and anti-diarrheals for both children and adults. Each FHV is publicly marked with a blue sign above their door that denotes them as the volunteer for their ward. Through conversations with 8

¹⁵ Sarala Shrestha, “Increasing Contraceptive Acceptance through Empowerment of Female Community Health Volunteers in Rural Nepal,” *Journal of Health, Population and Nutrition* 20.2 (2002): 157-58, accessed November 25, 2014, doi: 23498937.

volunteers, I was able to inquire about their daily volunteer work (or lack thereof), and other details of their position.

Volunteers are often chosen by the community or local post for their involvement and presence in village life, with qualities like good leadership, higher levels education, and more free time making them stand out as good candidates for the position. Some, as in the case of Tenzin, a volunteer from Jomsom, inherit the position from their mother who was the previous volunteer for the ward, after becoming too old to perform her duties. The government likes volunteers to continue their work until the age of 60, although they are not required to volunteer for a certain amount of time and can theoretically drop the responsibility if they ever become unfit. A few FHV's though, had expressed interest to their local post in passing on the responsibility to someone else because of lack of free time, and were requested multiple times by the staff to hold their position because they already had the training and experience, something that takes years to build for a new volunteer. In some cases, FHV's never went to school, and still do not know how to write their own names (a problem in the eyes of some local health practitioners who believe a certain level of education is required for them to perform their duties fully). Others are chosen because they have completed a certain level of schooling.

A government goal in creating the FHV program was to spread knowledge about family planning and contraceptives, in hopes that having them more widely available (in the possession of FHV's) might make them more known and utilized. While contraceptives do seem to be widely used in Mustang today, many women find more permanent methods of birth control easier and more effective, types of contraceptives that are available only at the district hospital or health post which volunteers are not qualified to "implant" or distribute. Depro Provera (the birth control shot), which needs to be administered once every three months, seems to be the most widely popular form of birth control in the area and is available at all of the local health posts as well as the district hospital. Some FHV's reported having distributed the pill on occasion to women who live nearby, but condoms especially are almost never requested. Most volunteers attribute this to embarrassment in asking for contraceptives, especially as a male asking a female, and because communities are so close-knit that these interactions are never anonymous. FHV's agreed that most men would rather retrieve condoms from the box outside the health post than ever ask one of their neighbors or family friends.

FHV's are expected to attend all trainings offered by their local post, Suaahara, or mobile camps that pass through their village, but this can often be difficult for many volunteers. The most common occupations in Mustang are farming and operating guesthouses, both which in the right season require a large amount of work and attention. One FHV even reported having left her initial training at the district hospital a few days early because she had work to attend to at home. Things like this often happen with offered trainings, leading to less than 100% turnout.



Fig. 11. Condoms available outside the health post in Jhong. A box similar to this can be found on every local health post in Lower Mustang.

FHVs are also expected to be present as assistants whenever a mobile camp comes through the area. Volunteers do not receive a salary but are given a government stipend for a “work uniform,” (matching sari or chuba) which they wear to make themselves known when assisting at the health post or mobile camps. Nurses travel from the district hospital twice a year to provide care for women especially, educating about contraceptives, providing vaccinations and checking female reproductive systems to the best of their abilities. FHVs are to be present at every mobile camp in their VDC assisting the traveling staff and making the process more efficient (these are often very popular occasions). It is also their duty to inform the public about an up-coming mobile camp and what services will be available so that the local population knows when and where to receive additional care. Many also reported door-knocking to educate families about other health care opportunities, and informing women about family planning options and care available to them through pregnancy. Radika, a volunteer from Jharkot, explained that she often attempts to speak to migrant laborers in the area, who are often less educated and with less economic means. These people usually have too many children to educate and are unaware of family planning options, Radika tries to tell them their options for having less (or no more) children and being able to provide a better education for the children already present. She is apparently received with mixed reviews, some grateful for the new knowledge and some offended that she would try to interfere with their personal lives. She continues to do this type of community outreach whenever she sees fit because she believes it is part of her responsibility to the community as FHV. Other community outreach efforts such as this are expected of all FHVs as well, but times and content to be shared are not specified by the local post or any authority figure.

The number of times that FHVs are taken advantage of by community members varies from village to village, but most women I spoke with expressed a

low level of use in their ward. Many volunteers live so close to the local health post, that they believe most potential patients would rather consult the health post staff for minor health issues than their local volunteer. Most volunteers reported being used on occasion for headaches requiring mild painkillers or for birth control in the form of the pill. Otherwise, their work is minimal when health post staff or mobile camps do not need their assistance. Many admitted that most days require no work from the volunteer position. There also seems to be a major disparity in the level of training received by each volunteer. "It has been observed that the FCHVs were not working fully; their training was inadequate; and almost 90% of rural women did not receive any family planning services from them. The duration of existing training of FCHVs is less than two weeks, and a top-down approach is mostly used for training, without involving trainees and the community while identifying their needs".¹⁶ While the program has good intentions and some mothers did report having learned about contraceptives from the local volunteers, it seems that there could be improvements or at the least more uniformity in their training, and more systematic tasks assigned to spread specific types of knowledge. Still, volunteers are utilized on occasion (especially in villages farther away from the VDCs health post), by those in need of contraceptives or minor health care, and are important in community outreach and spreading knowledge about resources available at the local health post and beneficial health decisions to be taken by pregnant women.

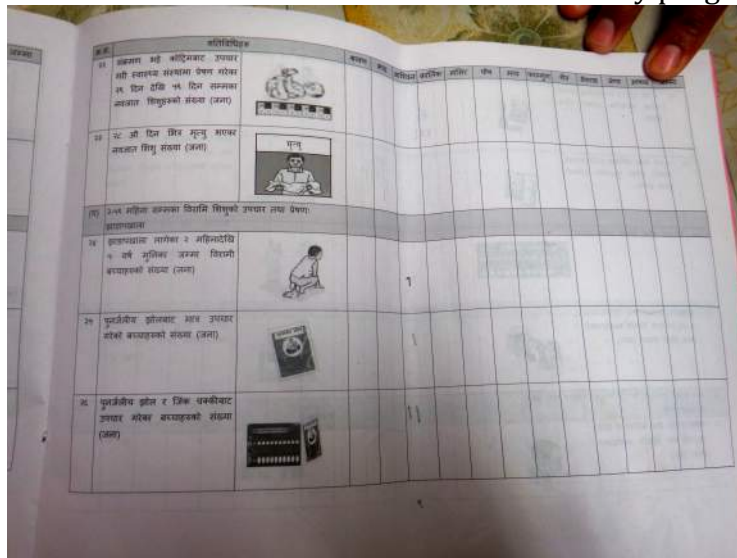


Fig. 12. A Female Health Volunteer monthly reporting booklet, Volunteers denote the type and amount of medications they distributed in a given month.

MOTHERS

I was lucky enough to speak with 18 mothers about their experience with childbirth in Mustang. These women were 27 to 72 years in age, and included a wide range of experience and opinion regarding their personal deliveries and the way most women go about the process of childbirth today. Women in Mustang typically marry early, and often start having children in their early twenties. Tradition can

¹⁶ Ibid, 158.

sometimes include marriage to multiple wives, and many couples live with the mother of the groom, whose opinion is made known and well respected by the bride. It was not uncommon 50 years ago for one woman to bare 10 children, but it was expected with the time that many children would be lost at a young age to illness or lack of nutrition. Today, with the availability of contraceptives and their wide use throughout the district, many families are choosing to limit family size, slowing the growth of population in the area, but allowing them to provide more opportunities for the few children they have. Through conversation I was better able to understand the changes in the pregnancy and childbirth process that have occurred through generations, and to gain personal perspective on positive and negative aspects of both home and institutional delivery.

BIRTH CONTROL AND FAMILY PLANNING

The incidence of contraceptive use in Mustang today is amazingly high. Most women of child-rearing age use some form of contraceptive, and many older women have had permanent surgery that prevents them from having more kids. Not only has fertility decreased from 6 births per woman in Nepal in the 1970s to 3.1 in 2006, but in the year 2006, 44% of women were some method of contraception compared to 22% in 1996.¹⁷ Women start using contraceptives at different stages of life depending on their age. Mothers I spoke to over the age of 60 often knew about contraceptives by the time their youngest children were born, but chose not to use them due to fear of negative effects on their health. Many women in their 40s and 50s have used different combinations of contraceptives including the pill, Depro Provera (the shot), condoms, and permanent surgery. The most common family planning regimen I ran into included use of some form of contraceptive between births. In these cases, women would start using the shot or the pill after the birth of one child for a few years until they were ready for another pregnancy. Often women of this persuasion would choose sterilization after the birth of their last child to ensure no unwanted pregnancies.

A 67-year-old mother from Khinga reported hearing about contraceptives from younger women after already having had a child. Unfortunately, open communication about this topic was at the time uncommon. She did not know how contraceptives were meant to be used, and did not want to take them for fear that it might affect her health if used incorrectly. Younger mothers learn about contraceptives via many different avenues. Many of the mothers I spoke with were also Female Health Volunteers, so they learned about contraceptives through their own training. Others learn from local FHV's, mobile camps that travel through the area, or from the local health post. Depro Provera was the most common form of birth control among the women I interviewed. Condoms and the pill were rare to hear about, the IUD and the implant in use but much less commonly than the shot. It seems to be too early for current mothers to have learned about contraceptives

¹⁷ Bina Gubhaju, "The Influence of Wives' and Husbands' Education Levels on Contraceptive Method Choice in Nepal, 1996-2006," *International Perspectives on Sexual and Reproductive Health* 35.4 (2009): 176, accessed November 26, 2014, doi: 10.2307/25614614.

from their own kin, but some women I spoke with agreed that they wanted their children to be informed about family planning before they started having sex. These women however, had not yet told their children because “they are not married, too young,” or they already know about it from the media so it was no longer their responsibility. It seems that even those who hope to spread knowledge to their children about the importance of family planning will not do so until their children are married, the idea of sexual interaction before marriage does not seem to be widely accepted.

Permanent surgery is available in different forums both in Mustang and south of the mountains. On occasion, mobile camps will travel through the district setting up operation rooms in local schools or the health post if it allows, and offering women the option of permanent sterilization. Women learn about these opportunities from FHVVs or their local health post, often with little planning or time to prepare. A woman from Pagling reported hiking more than an hour to the Kagbeni health post with 5 close friends when they heard about a mobile camp offering hysterectomy surgery for women. Some women also choose to have the operation in Pokhara or Kathmandu, most commonly immediately after the birth of a child. When giving birth in a hospital outside of Mustang women can decide ahead of time that they want the doctor to perform the surgery after birth if they know that they are not interested in more children. It has been shown that women more commonly choose the option of sterilization than men, although male education levels seem to carry more weight in the choice of contraceptive use.¹⁸ Women declared different reasons for wanting to use contraceptives; the expense of having a child was common, especially in relation to the necessity and expense of education in current-day Nepal. Many women expressed the ability to afford education as a major benefit of having fewer children. It seems that in most cases the use of contraceptives is up to the discretion of the woman in the relationship, and I came across no situations where women were not using contraceptives at the request of their husband, although this type of information may have been uncomfortable to share.

DELIVERY

The most notable change in the childbirth process has come in women’s choice for the location of their delivery. No women I spoke with over the age of 45 had given birth at home, although there was an obvious trend of proximity to higher medical care and incidence of home birth. Those from Jomsom or Marpha, locations where institutional delivery is available close to home, started choosing hospital or health post births at an earlier age than those further removed from health care. Women from Khingra or Jhong, both north of Jomsom, gave birth at home later in life, possibly because of cost of transportation or lack of knowledge required to seek out institutional birth.

This disparity according to generation also comes with opinions from both ends on the “best” option for delivery location. Women in their 50s and 60s report having kept up their daily commitments through pregnancy, working in the home

¹⁸ Ibid, 176.

and the field with no opportunity for extra time to rest. While this was often a challenge, many attribute their continuation of physical exertion through pregnancy to quicker and easier deliveries. Their opinion of younger women's choice for institutional birth varies some, but most agree that women giving birth today are weak and their extra pampering through pregnancy makes them less able to handle the pain of delivery. They also believe this is part of the incentive that is increasing the number of caesarean sections occurring (by choice) today. Caesarean sections have become an increasingly popular option, not only for their convenience in planning ahead (this makes things easier when women are traveling hours or days to the hospital for birth), but also because they are viewed by the younger generation as the safest delivery option. A woman from Kagbeni who recently helped with her sister-in-law's delivery said she planned the c-section herself, we "weren't going to take any chances" she said.

Maya, a 65-year-old mother from Kagbeni currently lives with her daughters and her grandson, farming and selling apples for a living. Maya has been pregnant 9 times, and is currently mother to 6 children. She had one stillbirth, one child who died shortly after birth, and one who passed away from measles at the age of three. She was incredibly willing and casual in speaking about her deceased children, although they must have been very challenging losses. Unfortunately, many women her age reported having lost children to measles, diarrhea, or challenging deliveries; these were common occurrences of birth in Mustang in the 1970s and 80s, before vaccinations and knowledge about the importance of hydration with diarrhea. She became very familiar with the pregnancy process, knowing that she was carrying another child at the onset of nausea and appetite loss.



Fig. 13. Maya, 65-year-old Kagbeni mother pictured with her grandson in her home.

Maya gave birth to all 9 of her children at home with the help of her mother, close relatives and neighbors. Like other women of her generation, she did not use any western pain medication to make delivery easier, but did take advantage of some common natural tactics for decreasing delivery pain. Family members or

pilgrims traveling to Tibet when the border was open would often bring back a specific kind of fish from Mt. Kailash. These fish would be given as gifts to family members and friends back in Nepal, with the knowledge that they were a hot commodity come labor time. Maya's parents saved some Mt. Kailash fish for her deliveries with the knowledge that eating them at the start of delivery pain makes delivery much less painful. Unfortunately with Tibet's closed border the Mt. Kailash fish in Mustang have run out and are no longer used during delivery. Maya also used another pain remedy; butter carved into the shape of a child blessed by a high lama. Eating the small butter sculpture on the onset of labor pain apparently made delivery almost immediate, and by some miracle, the butter would always appear again, coming out with the baby. Regular butter does not work for this purpose, it must be blessed, therefore Maya was not able to use it for every birth. She is not the only woman having reported using blessed butter, but other women did not remember the butter appearing again with the newborn. Her mother showed Maya how to take care of her first child, after which she became master of the routine. Now she helps her daughter take care of her youngest grandson who was born via caesarean section in a Kathmandu hospital. "Now people cry and don't push, which makes it more difficult," said Maya in regard to women's delivery practices today.

Pema, a 43-year-old mother from Tiri has two sons and lives with multiple family members including her husband and children. Pema has used both the IUD and the implant, which she learned about from a mobile camp run by the district hospital that came to the Kagbeni VDC many years ago. After getting married she attends frequent gynecologic check-ups in Kathmandu. She used to travel to the valley yearly for her sweater business, and gave birth to her first son in a hospital in Kathmandu during this time. Seeking out health care during period of migration to larger cities has become common practice to many Mustangi women in the last 30 years, and labor migration patterns often affect where women choose to give birth.¹⁹



Fig. 14. Pema, 43-year-old mother from Tiri pictured in her home.

¹⁹ Craig, "Migration, Social Change, Health, and the Realm of the Possible: Women's Stories between Nepal and New York," 199.

Pema was 40 years old for the birth of her second son who she wanted to deliver in the Jomsom hospital, but because of her age they referred her to Pokhara as a precaution for potential complications. For both of her deliveries she was tended to by nurses and an occasional doctor, medical personnel being the only friendly faces in the delivery room. She didn't notice any differences in her delivery experience in Pokhara or Kathmandu even though they were 15 years apart, both took place in government hospitals. She chose to have her pregnancy check-ups in a private Pokhara hospital because she believed they were more qualified or had more facilities, but for birth she thought that government doctors had more experience so the government hospital seemed the safer option. She was taught about breastfeeding and how to hold her new baby in the hospital after birth, and received a stipend for institutional delivery. Pema was given some sort of painkiller for births but thinks she was in too much pain to remember what it was or how it was administered.

CHANGES OVER TIME

Through comparing the two above stories, one may discern the many apparent changes in Mustangi childbirth practices that happened in the span of just 20 years. Before the change to institutional childbirth, birth in Mustang had been the same for many years. I asked women about their mothers experience versus their own, and differences in their own experiences and today's practices. Older women especially were adamant that little progress in rural Nepali health care had been made between the time of their own birth and the birth of their children, insisting that their mothers' experience with home birth and the process they personally went through were close to identical. Before the presence of health posts and the district hospital, women had no choice but to give birth at home, used only natural pain remedies, and often had little or no assistance through the birthing process.

Traditional Birth Attendants (TBAs), a term that is commonly used in regard to women who assist in home births, especially in rural areas of developing countries. The term TBA has never been popular in Mustang, especially as home births have become increasingly uncommon. "The World Health Organization (WHO) defines TBA as 'a person who assists the mother during childbirth and initially acquired her skills by delivering babies herself or through apprenticeship to other TBAs'. TBAs are integral members of their communities and provide an important window to local customs, traditions, and perceptions regarding newborn care".²⁰ While the women I spoke with often had assistance during home births, their helpers were most commonly mothers (in-law), or neighbors and friends. While many of these women had assisted with multiple previous births, the term is not used in the area, and was not familiar to interviewees nor acknowledged by medical practitioners in the hospital or local health posts. Laxmi, the district hospital ANM,

²⁰ Tina Y Falle, Luke C. Mullany, Nandita Thatte, Subarna K. Khatri, Steven C. Leclerg, Gary L. Darmstadt, Joanne Katz, and James M. Tielsch, "Potential Role of Traditional Birth Attendants in Neonatal Healthcare in Rural Southern Nepal," *Journal of Health Population and Nutrition* 27.1 (2009): 53, accessed 25 November, 2014, doi: PMC2650835.

believes that TBAs should be “discouraged,” because they “often given the wrong medicine”.

Most older mothers suggested that the biggest differences between their birthing experience and women’s delivery stories today lie in both location and practice. Most mothers over 50 are disappointed in the number of women who choose to have operations for birth. Their main concern is recovery time, noting that women cannot work in the same way they used to after delivery and are required to rest, taking away from the productivity of the home and outside obligations. Older mothers are also worried about the child “limit” that comes with c-sections, explaining that once you have the operation once you have to do it again, and it limits women to only 3 children. When asked, some of these women agreed that home birth is “better” than institutional delivery.

Arguments for home delivery include hospital expenses, side effects of western medicine, and the business-like atmosphere created by hospital staff. A 72-year-old mother argued that c-sections are recommended as an excuse for doctors to make money and an easy way to gain time and practice in the OR. This makes her feel that doctor-patient relationships are less genuine and more like business deals. Some women also argued that hospital delivery, vaccinations, and the general increase in the use of western medicine is causing more illness in children. With kids growing up in a more sterile environment, they are not exposed to the same bacteria as children used to be, and so do not build the same repertoire of antibodies as children once did. Home delivery leads to a healthier life for the baby said a 58-year-old mother.

Younger women often lean more towards the benefits of institutional delivery. Hygiene seems to be the most popular benefit of the controlled atmosphere of institutional birth. With more education about the importance of bathing and hand-washing, women have become more aware of the lack of hygiene in home births, and the fact that there is often not much they can do to make their home much more sanitary. The sterile hospital room as well as clean baby clothes, are now seen as a major benefit of hospital birth. Women also noted the importance of the presence medical personnel, and their ability to correct major problems that at home could lead to the death of both mother and child. In a study about the use of skilled birth attendants in mid and far-western Nepal, it was found that women choose delivery with the help of a skilled birth attendant (such as an ANM) for reasons of safe delivery (70%), and “better management of potential complications” (26%).²¹ Institutional delivery is seen as less risky by the younger generation, the option of surgical removal of the baby a welcome reassurance in case of emergency. Issues like excessive bleeding or problems with the placenta are also common and often frightening in the home, but are easily avoided or remedied with the help of a

²¹ Bishnu Choulagai, Sharad Onta, Narayan Subedi, Suresh Mehata, Gajananda P Bhandari, Amod Poudyal, Binjwala Shrestha, Matthews Mathai, Max Petzold and Alexandra Krettek, “Barriers to using skilled birth attendants’ services in mid- and far-western Nepal: a cross-sectional study,” *BMC International Health and Human Rights* 13.49 (2013): 5.

doctor and western medicine. The presence of a health post, hygiene, an increase in knowledge about proper nutrition, opportunity for check-ups during pregnancy and contraceptive use have led to women having more control over their own bodies and to be more informed about the inevitable changes that come with pregnancy and how to deal with them.

CONCLUSION

By approaching this topic from the perspective of both those experiencing and those assisting, my aim was to provide a complete picture of the pregnancy and childbirth process and how opinions are formed and choices made in regard to this issue. Maternal and child health has taken great strides in rural Nepal since the 1980s. Government efforts towards family planning education not only benefits women's health and gives them more freedom in choosing what they want to do with their bodies, but it also benefits families (and the country's literacy rate) in affording them more opportunities to educate their children. Unfortunately, use of contraceptives and an increase in the number of Mustangi children being educated also leads to a population outflux from the district, leaving older members of the population to fend for themselves in the face of harsh winters, old age and disease. This trend of outward migration is causing "older villagers continue the back-breaking work of harvest long after they would have a generation ago because their children and grandchildren are now running businesses in Kathmandu or cleaning houses Long Island".²² It is hard to tell how far this issue may progress in the next few years.

It is clear that the health workers can find many improvements to be made with the current system and facilities, but what may not be clear to some of them is the positive impact that they have already created on the community. The ability to seek out medical care so close to home is still a fairly new concept to Mustangi villagers, and the older generation especially is still getting used to the convenience of local health posts. Since their presence, the maternal mortality rate has decreased, less children are lost to diseases like measles, and women are aware of the any opportunities available in terms of family planning, pregnancy and delivery. Although institutional delivery is received differently by different generations, its current popularity is an obvious success story in the eyes of the Nepali government. And while improvements to the government system could still be made, such as providing more locations for institutional delivery in Mustang and making this option more accessible within the area, it is obvious that health care there has become much more accessible in the last 30 years.

Education through the avenues of FHV's, health post staff, and programs like Suaahara have had a serious impact on the way that women view their health care options today. Being informed about opportunities for care has led to greater use of local health posts and an increase in institutionalized birth. While this transition is looked on with some skepticism from older women, the younger generation has broken the barriers of mother-in-laws often judgmental opinions, and have created

²² Craig, "Migration, Social Change, Health, and the Realm of the Possible: Women's Stories between Nepal and New York," 210.

their own opinions about the utilization of western medicine. It is important to note the strength in tradition that elders' opinions hold. Childbirth practices worked in a specific way for so many years that it must be hard to see a transition in this sometimes ceremonial practice. And while statistics may show lower mortality rates and higher literacy, certain things are lost with the change from home-delivery, and the sense of community and partnership that women once had surrounding this issue has not necessarily disappeared, but has no doubt morphed into a different support system that inevitably involves a different type of connection and communication between Mustangi women.

METHODS

I prepared questions and had in mind a general idea of my goals for each interview before it took place, but the system of finding actual participants was a fluid process including some trial and error. My friend, guide and translator extraordinaire, Yangjin, was essential to this part of my work. Not only is she from Mustang herself, but also she has much experience doing field research in the area with professional American anthropologists. Through her previous work, family and friend connections, and her personal charm, she has or was able to make many connections on the spot in terms of finding interviewees. On a daily basis, we walked the streets of our village of interest, often knocking on doors or asking women on the street if they were willing to answer questions about their own experience with pregnancy and childbirth. Health practitioners and FHV's were a different and more calculated process. Interviews with health workers were found through showing up at the local health post and asking if and when someone might be free and willing to talk with us. FHV's were sought out by word of mouth, and they were never difficult to find, as they are often well known by the community. We simply had to ask for "the volunteer" in order to find out where they lived or their current whereabouts. Often, we stumbled upon them accidentally, walking by their front doors (marked with a sign noting FHV) by chance.

Each interview (conducted in either Nepali or the local dialect with the help of interpreter Yangjin) was started with a simple introduction of myself as an American Student, and my hopes of learning about maternal and child health in the area. I included the pretext that I am hoping to one day become a women's doctor, so that interviewees would better understand my questions and curiosity. Participants were told that they were not required to answer any questions, and women specifically were asked if they were willing to answer questions about their own experience with pregnancy and childbirth before the interview began. Only in one situation did I find a woman to be noticeably uncomfortable, in which case I continued with only more general and superficial questions. Yangjin was also an incredible help in gauging the level of appropriateness in different situations, and made it known if we needed to take the interview in a different direction or wrap up questions (which very rarely happened). Health workers were asked more surface level questions about their facilities, day-to-day work, common ailments that they treat, and to what extent they work with pregnant women. More personal questions came regarding their opinion of the health care system and if they would like to see anything change. Nobody seemed noticeably uncomfortable with these questions although some responded that they liked things the way they were and saw no change necessary. The names of interviewees have been changed in this paper for the sake of personal privacy. It is important to take into account the implications of myself as a researcher (being a young white female), and how this affected the response of interviewees and whether they felt required to speak with me. I used my laptop to record interviews and take notes (for which I asked the consent of the interviewee), but the presence of this technology could have been overwhelming or intimidating in the face of members in this population and could make them feel more or less inclined to share with me personal or controversial details.

INTERVIEW QUESTIONS

For Mothers

General

1. Name? Age? Occupation?
2. Where are you from?
3. How long have you been here?
4. How many people live in this village?
5. What is the highest level of education you completed?
6. Who lives in the house with you?
7. When you were younger, what did you do if someone in your family got sick?
8. What do you do if you get sick now?
9. How many times have you been pregnant?
10. How many children do you have?
11. How old are they now?

Birth Control and Family Planning

1. How did you know you were pregnant?
2. Do you use birth control? Did you know about it?
3. What kind?
4. How long have you been using it?
5. Did your family members teach you about pregnancy and childbirth? Did health workers?
6. Do you ever see a gynecologist or women's doctor?

Delivery

1. Where were your children born?
2. How did you choose for your children to be delivered in that location?
3. When did you know it was time to give birth?
4. Who was present at your children's birth? What did they do to help? Who caught the baby?
5. Did you receive any anesthetic or painkillers?
6. Were there any complications? What happened?
7. What was the scariest part about giving birth?
8. How did you take care of your baby after birth? Who showed you how?
9. Where do you bring your child when they get sick?

Changes Over Time

1. Where were you born? Where was your mother born?
2. What are the biggest differences you can tell between your mother and grandmothers birth experience vs. your own?
3. Are there religious or cultural rituals that you practiced through your pregnancy and birth? Did your parents practice any traditions or rituals? Grandparents? What has changed?
4. Will you educate your children more about birth control and pregnancy? Will you give them more information than you had growing up?
5. How do you feel about giving birth in a hospital or giving birth at home? Is one better than the other? Why?
6. What do you think about C-sections?

For Health Workers

General

1. Name? Age? From?
2. What is the name of your occupation?
3. Where did you get trained? How long did it take? What kinds of things did you learn?
4. How long have you been at this health post?
5. Did you choose to come here? Are you required to be here for a certain amount of time?
6. How many other staff members work at this post? What is their training?

Daily Life

1. How many patients do you see in a day?
2. What is the most common ailment you treat?
3. Do you see patients of different economic and or religious backgrounds? Do you notice differences in treating different types of patients? What are they?
4. What is your experience with pregnant women?
5. What kinds of medicine do you most commonly distribute?

Family Planning

1. Do you provide birth control here? What kinds?
2. Is it commonly used?
3. What is the most popular type of birth control used by the people in this village?
4. Can you give women the implant/IUD or do they have to travel to Jomsom for these contraceptives?

Pregnancy/Delivery

1. Are you trained in the delivery process?
2. Is this Health Post equipped for delivery?
3. Do women come here for check-ups while they are pregnant? How often?
4. Are they given any medicine while they are pregnant? What are they taught?
5. How often are there births here?
6. Do you give women anything for the pain during delivery?
7. What do you think about home vs. institutional delivery?

Government Involvement

1. Are there government programs at work in this institution?
2. Do women receive a government stipend for delivery here?
3. What information or assistance do they provide?

Change

1. Are you happy with the health system here? What would you change?
2. What are the biggest health care changes you have seen during your time in the field?
3. Are you happy with your job?

For Female Health Volunteers

General

1. Name? Age? Occupation?
2. Where are you from?

3. How long have you been here?
4. How many people live in this village?
5. What is the highest level of education you completed?
6. How long have you been the FHV for this ward?
7. How were you chosen for the position?

Training

1. Where did your initial volunteer training take place? How long did it last?
2. What types of things did you learn?
3. Do you still attend trainings now?
4. How often? Where? From who?
5. What new information do you receive?
6. Is everyone required to attend these trainings? Do you always attend?

Daily Life

1. Do you do volunteer work on a daily basis?
2. How often do community members come to you with questions or in need of health care?
3. What is the most common thing you do or provide?
4. Do you work with pregnant women often? What do you tell them?
5. How often do you interact with or report to the local health post?
6. Do you like working as the FHV?

**Including "For Mothers" questions as well, when appropriate.*

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26. Jomsom, 60, Mother (11.19.14)

**Names are with the author to ensure privacy and confidentiality for all interviewees, all demographic information shown is accurate.*

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IDEAS FOR FUTURE RESEARCH

I think there is much to be learned about both Mustang as a district and about pregnancy and childbirth as a general topic in Nepal. More in-depth research of Mustang health posts would be very interesting; how they are funded, what their daily work includes, what types of patients they can or cannot treat? It would also be interesting to look into the influence of western presence on the health care system, what has changed since Mustang became open to tourism in terms of health care, is there a health care volunteer presence in the area, has this influenced an increase in the use of western medicine? I would also be interested to learn more about the process of pregnancy today throughout Nepal and how it compares to the choices of Mustangi women. A study of the incidence of C-sections in Nepal would be very interesting; are they needed, are they planned in advance, what is the view of MDs on their necessity, are there differences in religious or economic background that influence how common they are in different areas? Or a more quantitative study of pregnancy and childbirth in Nepal, what are statistics like from different areas regarding home vs. institutional delivery, what nation-wide efforts is the government making to change or improve the process?



Fig. 15. Annika (travel partner, left) and I conduct an interview outside the Thini health post with a medical practitioner.

Cailin Marsden completed an undergraduate thesis using information she collected from field research about maternal and child health in rural Nepal during her time as an SIT student. Cailin is now a member of the SIT Program Coordinator staff.