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PRENATAL HEALTHCARE AMONG *DALIT* WOMEN IN RURAL NEPAL: A CASE STUDY OF SIGANA VILLAGE, BAGLUNG

By

Dipa Sharma Gautam

A thesis

Submitted in partial Fulfillment

Of the requirements for the degree of

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To the Graduate Faculty:

The members of the committee appointed to examine the thesis of Dipa Sharma Gautam find it satisfactory and recommended that it be accepted.

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October 26, 2015

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RE: regarding study number IRB-FY2016-88 : Prenatal Healthcare among Lower Caste Women in Rural Nepal: A Case Study of Sigana Village, Baglung

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Sincerely,

Ralph Baergen, PhD, MPH, CIP
Human Subjects Chair

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ABSTRACT

Nepal had a maternal mortality rate of 190 per 100,000 live births in 2013, which in itself is a higher rate compared to the rate of developed countries. Moreover, within the nation, the gap between the non-*dalit* and *dalit* population is wide. Similarly, *dalit* populations, especially from rural areas are far behind the non-*dalit* population in terms of the utilization of prenatal care too. In this study, we attempted to understand the rural *dalit* women's prenatal experiences and explore the barriers in accessing prenatal care.

We interviewed 11 rural *dalit* women, residing in Sigana Village, Baglung District. From the qualitative interviews, we found that lack of cultural and economic capital, unequal domestic and economic burden, and gender and caste discrimination impact these women's use of prenatal care. Making the women aware of the free services and incentives, building birth center nearby the village or improving transportation to the hospital might encourage them to utilize the available services.

Chapter One

1. Background of the Study

The World Health Organization (WHO) reports that around the world, about 830 women die daily because of complications during pregnancy and childbirth, and those deaths are preventable (WHO 2015). Although the effectiveness of prenatal care has been a subject of debate (Alexander and Kotelchuck 2001), the WHO believes that good prenatal care can help in reducing maternal deaths and neonatal deaths (WHO 2015). Prenatal care might not directly save women from maternal deaths, but it definitely helps in preventing, detecting, and treating health problems (WHO n.d.). Identifying complications and problems and being treated by a skilled healthcare provider can save lives stemming from pregnancy related problems.

Most maternal deaths occur in developing countries, especially in the rural areas of developing countries. The maternal mortality ratio (MMR) in Nepal is far higher than that in developed countries. Nepal has an MMR of 190 per 100,000 live births in 2013 while Finland has 4 and the United States of America has 28 (WHO 2014). If we look at nationwide data, Nepal has made significant progress in reducing maternal deaths, with an MMR of 190 in 2013 compared to 310 in 2005 (WHO 2014). However, the gap between the non-*dalit* and the *dalit* women remains wide**.** The MMR among *dalit* women is 273 while it is 182 among non-*dalit* women (Suvedi et al. 2009). This gap might be attributable to the difference in prenatal care visits. It is reported that in Nepal, 80.5% of non-*dalit* women had at least four prenatal care visits whereas only 48.5% of *dalit* women had at least four prenatal care visits (Pandey et al. 2013).

Nepal is predominantly a Hindu country; its laws and practices are based on Hinduism. The caste system is one of those religious practices, which divides people in four hierarchical groups. Olcott (1944 : 684) defines the caste system as "a hierarchy of endogamous groups that individuals enter only by birth." It divides social classes into Brahmin, Chhetri, Vaishya, and Sudra. Brahmin is placed at the highest position; Sudra is at the lowest position of the hierarchy. Brahmin, Chhetri, and Vaishya are non-*dalit* groups and Sudra is a *dalit* group (based on personal knowledge). In this study, we compare Brahmin and Sudra groups and refer to them as non-*dalit* and *dalit*. The *dalits* are considered "untouchables" by every other caste. The *dalit* group includes *kami, damai, sarki, badi, gaine, chamar, musahar, dushad, tatma, khatwe, dhobi, baantar, chidimar, dom, and halkhor* groups (Pandey et al. 2013). *Dalits* are discriminated against and restricted from using public amenities; they are deprived of economic opportunities (Shrestha 2002). Birth into a *dalit* family is enough to make a person underprivileged. The caste system was established in Nepal in 1854 and became a major determinant of Nepalese people's identity, social status, and life chances (Bennett 2008 : 1). Despite being outlawed in 1962, the caste system is still prevalent and accepted as a way of life (Acharya 2002).

In order to maximize the utilization of prenatal care in Nepal, the Nepalese government has provided free maternal services in government clinics and cash incentives to those who complete the recommended four prenatal care visits and to those who give birth in a health institution (Subedi et al. 2014). Prenatal care in Nepal is available at sub-health posts, health posts, primary health care centers, and district hospitals (Karkee, Lee, and Binns 2013). Every village has a sub-health post (Bangdel

2002). Each Sub-Health Post is staffed by "a team of one Auxiliary Health Worker, one Village Health Worker and one Mother Child Health Worker" (Bangdel 2002). Some of the health posts are upgraded to a birthing center where a registered nurse is appointed to deliver babies. Such birthing center provides all the required prenatal care elements. Even health posts which are not upgraded as a birthing center provide prenatal care. However, they lack medical equipment and do not deliver babies. Although the prenatal care provided by a sub-health post does not provide all the required care, it provides general services like providing Iron tablets, checking blood pressure, or listening to babies' heartbeat. Prenatal care in every health care facility is free (based on a personal communication with a mother child health worker working in a sub-health post). Despite the free services, utilization of prenatal care is very low among Nepalese women, especially among *dalit* women from rural Nepal. To improve the utilization of prenatal care among *dalit* women, barriers to their access to health services, especially prenatal care, need to be exposed, so that policies can be redesigned to eliminate those barriers. The population remains invisible since "they are poor, rural and female, they are voiceless and marginalized" (Kristof 2016). In this study, we look for factors affecting the utilization of prenatal care among *dalit* women in rural Nepal.

Several studies have been conducted to determine the factors affecting the utilization of prenatal care in Nepal. Women with lower educational level, lower economic level, those from rural areas, those who do not have access to media, and those who lack decision making power are more likely to have a lower number of prenatal care visits, (Joshi et al. 2014; Shrestha 2013). Among rural women, economic status seems to affect the utilization of prenatal care (Shrestha 2013), even though prenatal care is

provided for free by the government of Nepal. Although free prenatal care and incentives are found to be effective in improving the utilization of healthcare services in many low- and middle-income countries (Morgan et al. 2013), such services do not seem to be effective in improving prenatal care in Nepal.

It is reported that 85% of pregnant Nepalese women had at least one prenatal care visit, but only 50% had four or more visits (Joshi et al. 2014). The reasons for the (dis)continuation of visits have not been studied, specifically for Nepalese women. However, research done in India demonstrates that perceived quality of prenatal care is one of the important factors in the continuation of prenatal care visits (Rani, Bonu, and Harvey 2008). Similarly, a relationship between perceived discrimination and healthcare seeking behavior was found among American Indian women. American Indian women who perceived discrimination were less likely to seek healthcare (Gonjales et al. 2013). This might also be true for *dalit* women in Nepal because of the prevalent caste-based discrimination.

Along with cost and quality, Thaddeus and Maine (1994) find the distance to the health facility as an important barrier in developing countries. A study from Uganda shows low utilization of maternity services among women who view pregnancy as a test of endurance (Kyomuhendo 2003). Similarly, women, who are attached to traditional healthcare, find modern healthcare unsatisfying, thus, they are less likely to utilize modern health services, even if they are easily accessible. (Niraula 1994; Subedi 1989). Nepalese women from rural areas believe in traditional healers, and as compared to men, they are more likely to visit traditional healers than modern health practitioners (Yamasaki-Nakagawa et al. 2001). Also, unintended pregnancy has been found to be a

factor for seeking prenatal care (Wado et al. 2013). In Nepal, unintended pregnancy is very common, as 41% of pregnant women reported their current pregnancy as unintended (Adhikari, Soonthorndhada, and Prasartkul 2009). It might be more common among *dalit* women because of their higher unmet need of family planning. In all Nepal, the unmet need for family planning is 27% (Ministry of Health and Population 2012), 35.2% of *dalit* women reported an unmet need for family planning (Pandey et al. 2013).

1.1. Social, Cultural, and Economic aspects of Nepal

Once a Hindu kingdom, Nepal has based its State policies on Hindu ideology. Although it has been declared a secular nation in May 2008, Hinduism is still an influential religion in Nepal, since 81.3% of Nepalese people practice Hinduism (Bureau of Democracy, Human Rights and Labor 2012**)**. Nepal's *Muluki Ain* of 1853 (the National Legal Code) legalized a caste system, which divided people into four different hierarchical groups on the basis of birth. The *Muluki Ain* assigned certain duties to certain caste. Even the punishment for the same crime varied based on the caste of the culprit (Cox 1994). Although the caste system was abolished and caste-based discrimination was outlawed in 1963, the caste system still persists, and *dalit* people are still discriminated. In 2011, The Caste-based Discrimination and Untouchability Act was passed declaring all acts of caste-based discrimination a crime (Bureau of Democracy, Human Rights and Labor 2012). Despite this, caste based discrimination is still practiced in Nepal, especially in rural areas (Imagechannels.com 2013). The caste system is the main barrier to social mobility for *dalit* people.

Since Nepal is an agricultural country, most of the people, especially in rural areas, own agricultural land and work on farms. Seventy one percent of rural households own farm land and 80% of the rural households possess farm animals. Rural households lag far behind urban household in terms of their economic status. While 62.3% of urban households fall under the highest wealth quintile, only 19.5% of rural households are from the highest wealth quintile (Ministry of Health and Population 2012).

Nepal is one of the least developed countries in the world. According to a report by the United Nations Development Program (United Nations Development Program 2013), Nepal, with a Human Development Index (HDI) of 0.463, is ranked 157 among 187 countries. The Per capita Income of Nepal is only US$ 654 (Undata 2013). A wide socioeconomic gap exists between the non-*dalit* and *dalit* people. Since our study population is hill *dalit*, a comparison between hill Brahmin (non-*dalit)* and hill *dalit* is made here. According to a report by the National Planning Commission (2014), the HDI value for the non-*dalit* is 0.557 compared to 0.446 for the *dalit* people. The overall poverty rate in Nepal is 25.2%. The poverty rate for *dalit* people is 43.6%, far higher than the average national rate, while it is only 10.3% among non-*dalit* people. Similarly, the per capita income of non-*dalit* people is 1.7 times higher than that of *dalit* people.

According to the Nepal Demographic and Health Survey 2011 (Ministry of Health and Population 2012), only 76% of households in Nepal have electricity. Those who have access to electricity experience power outages, up to16 hours a day (Shrestha 2010). The Nepal Demographic and Health Survey 2011 mentions possession of durable goods as an indicator of household's socioeconomic status. Having access to radio or television keeps people updated on daily events and provides information regarding

health and safety. Only 50% of rural households have a radio, and only 42% of rural households have a television. More households have a mobile telephone than non-mobile telephone in rural areas. Almost 72% of rural households possess a mobile phone, and only 6.8% possess a non-mobile phone.

In Nepal, public transportation is a widely used form of transportation; very few people have private vehicles. Only six percent in urban households and 1.7% in rural households own a car, a truck or a tempo (three wheeled vehicle). Bicycle/bicycle-rickshaw is the mostly used means of transportation. Around 40% of rural households own either a bicycle or bicycle-rickshaw, and only eight percent of rural households own a motorcycle or scooter (Ministry of Health and Population 2012).

The report (Ministry of Health and Population 2012) shows that 41% of Nepalese women lack formal education. Disparity exists in education between urban and rural women, rural women and men, and rich and poor. About 27% of urban women and about 44% of rural women do not have education. Seventy nine percent of women from the highest wealth quintile have attended school, while only 45% of women from the lowest quintile have attended school. Eighty percent of males have attended school compared to 41% of women. Agriculture is the main job provider sector in Nepal. However, sex and residence of the respondents remain important in determining the type of occupation they hold. About 75% of women and 35% of men are employed in agriculture, but most of the women's work goes unpaid. It is reported that 76.4% of women do unpaid agricultural work (Ministry of Health and Population 2012).

Since media informs about health-related topics, programs, and policies, it is important to understand people's access to media. In Nepal, men have more access to media than women. Access to media also differs by the area of residence. While 20.4% of urban women have access to all three media—newspaper, television, and radio—at least once a week, only 5.2% of rural women have such access. Even among the rural people, the gap persists between men and women. The access to media among rural men is more than three times higher than that of rural women. While only 5.2% of rural women have access to all three media once a week, 17.3% of rural men have such access. In order to raise awareness on health related issues, some programs have been broadcasted on radio and television. The Nepal Demographic and Health Survey asked some questions about the exposure to such programs. More men reported access to such programs than women. Urban women have more access than rural women. Overall, respondent's level of education and their area of residence (urban or rural) influence the exposure to such programs (Ministry of Health and Population 2012).

Additionally, the internet can be used to improve health and education and reduce poverty in developing countries (Madon 2000). In Nepal, the number of internet users is increasing, although at a slow pace. It is reported that, currently, 38.09% of Nepali people use the internet (KTM2DAY 2015). KTM2DAY reports that most of the internet users, 9.5 million out of 10 million, use mobile internet, but the mobile internet in Nepal is not reliable (Nepalnews 2013). Moreover, internet use is concentrated in urban areas (Anderson 2014). Since (reliable) internet is not available in rural Nepal, raising awareness regarding health and education is hampered. The lack of access to media and

the internet leaves rural people, especially women, unaware of information on healthcare and policies.

In regards to the use of modern contraceptives, a gap between urban and rural women exists. About 60% of urban women, compared to 48% of rural women, use "modern" methods of contraceptives. This gap can be attributed to the relative ease of access to contraceptives in urban areas compared to rural areas. Yet, the unmet need for family planning is higher in rural areas. Posters and billboards are popular sources for disseminating family planning messages. More men than women see and can read the messages conveyed through posters and billboards. Fifty five percent of women and 70% of men report exposure to the messages. Although there are various methods of conveying the message like posters and billboards, radio, television, newspapers, and street drama, 26% of women and 15% of men do not have exposure to any of those forms of media. Lack of such exposure can be attributed to the limited access to media, which could be compensated if women would discuss family planning with their doctors. However, very few women were provided such information. Only nine percent of women who had postpartum visits were informed about family planning methods and services (Ministry of Health and Population 2012).

Believing that prenatal care is important for the survival and well-being of the mother and child, the Nepalese government implemented policies and programs in order to encourage women to get prenatal care. Despite the policies and programs, Nepalese women do not get the WHO recommended number of prenatal care visits. About six percent of urban women and 16.1% of rural women do not receive prenatal care. Lack of doctors in rural areas is one of the reasons for the lack of prenatal care. Only 23.3% of

rural women see a doctor for their prenatal care, while around 60% of urban women see a doctor for such care. Eighty-eight percent of urban women received care from a skilled health care provider as compared to 55% of rural women. The difference between urban and rural areas is pronounced in regard to the place of delivery. In Nepal, still 63% of children are born at home. Around 28% of urban mothers, compared to 66.7% of their rural counterparts, deliver their children at home. The women who give birth at home mentioned that they did not feel the necessity to go to a health facility for delivery (Ministry of Health and Population 2012).

Studies discussed previously show that women's empowerment plays a significant role in getting prenatal care. According to United Nations Population Information Network (n.d.) "women's empowerment has five components: women's sense of self worth; their right to have and to determine choices, their right to have access to opportunities and resources; their right to have the power to control their own lives, both within and outside the home; and their ability to influence the direction of social change to create a more just and economic order, nationally and internationally". Since Nepal is a patriarchal country, women lack empowerment. Findings from the Nepal Demographic and Health Survey show that in educational attainment, literacy, and exposure to mass media, women lag far behind men. Among married women and men, 76.8% of women and 98.2% of men are employed. Furthermore, men and women receive different type of earnings. While 81% of men receive cash only or cash and in-kind payment, only 30% of women get such payment. Sixty-one percent of employed women and only 12% of employed men are not paid. Among married women who are employed and receive cash for their work, only about half of them have control over their earnings.

Very few women own land or a house. About 93% of women age 15-49 do not own a house and 90% do not own any land. Divorced, separated, or widowed women are more likely to own a home and land compared to their unmarried counterparts. Rural women are less likely to own any assets. One third of women in Nepal do not have control over their own health; their husbands make the decisions. Only 28% of women are allowed to make decisions regarding their visits to their family or relatives, and 33% of married women decide about household purchases. Women who are employed and paid in cash are more likely to participate in decision-making (Ministry of Health and Population 2012).

1.2. Description of Sigana Village

In the previous section, we discussed women's status in Nepal, the difference between men and women and the difference between urban and rural women. Rural women lag far behind urban women in every aspect of their lives. Most of the studies regarding prenatal care in Nepal concentrate on urban women because of the ease of access. In order to understand rural women's problems, this study focuses on the issues typical to rural women. We discussed earlier that rural women are more disadvantaged than men and urban women. However, we did not find specific information regarding *dalit* rural women, which is the most disadvantaged group among all. A rural *dalit* woman is disadvantaged in multiple ways: as a woman, as a member of *dalit*, and as a rural resident and poor person. Rural *dalit* women have a very low literacy rate and a short life span. The literacy rate of the rural dalit women is 12% (United Nations Human

Rights 2013). Their life expectancy is reported the lowest in the world (Bishwakarma 2012). Bishwakarma reports that life expectancy for rural dalit women is 50 years. The life expectancy for one of the *dalit* groups—*musahar*—is only 42 years. In order to understand prenatal experiences of rural *dalit* women, we chose one of the rural villages of Nepal, Sigana Village in the Baglung district.

We base our description of Sigana Village on "National Population and Housing Census 2011 Baglung," published by the Central Bureau of Statistics (2014). Sigana Village Development Committee (VDC) includes 777 households. The population of Sigana VDC is 3,031—1,257 male and 1774 female. Nineteen percent of the population are *dalit* people. Among the various groups of *dalit* of Nepal, *Kami, damai,* and *sarki* reside in Sigana VDC. Most of the households (764) own their own house. Almost all houses (772) in Sigana VDC are made of mud bonded bricks/stone. The main source of water for 772 households is tap/piped water. A similar number of households uses firewood as the fuel for cooking. Most of them (751) use electricity for lighting. Ninety five households do not have any toilet facility.

As we discussed earlier, health education and programs are broadcasted on radio, television, and newspaper. To understand whether such information reaches the targeted audiences, the accessibility of such media needs to be understood. Among the 777 households of Sigana VDC, 594 (76%) households have radio, 379 (48%) households have television, 21 households have computers, and only seven households have internet access. Eighty five households do not have any of these media. Only three households own a motorcycle, one household owns a bicycle, and the others have no means of

transportation. Only three households have landline telephones; 642 (82%) households own mobile phones (Central Bureau of Statistics 2014).

Sigana is a small village in the Baglung district of the Dhaulagiri zone located in the western hilly part of Nepal. Elevations in this area range from 1000 to 2000 feet. Located approximately 275 km west of the capital Kathmandu, the village is rural. As it is a perched village, people have to hike uphill and downhill for their everyday life. A road is built to connect the village with the district headquarters. Jeeps are available for public use, but they are not running on a frequent schedule. The waiting time is long and the fare is expensive. Therefore, people prefer walking over taking a ride. The village experiences temperate climate throughout the year. The highest temperature is 37.5 ° Celsius (99.5° F) and the lowest temperature is -15° Celsius (5° F). The summers are warm and the winters are mild.

There are no industries in the Sigana village. Although some of the young people are employed in foreign countries, the main income source is agriculture. Agricultural work does not pay sufficient wages for survival, and it is seasonal too. Therefore, the main income source does not sustain the people living there. Those who depend on agriculture for work are trapped in economic hardship. No matter how hard they work, they never have enough money (based on personal knowledge). Since the people are not employed all year-round, they get some leisure time too. In their leisure time, male members of the village gather in a tea-shop and chat with each other, especially about politics whereas female members gather in an elderly person's house and talk about their family, kids, and farming. For the women, these gatherings are a platform to exchange and share information.

In Nepal, most healthcare facilities are concentrated in the district headquarters. However, a sub-health post is available in each village. In a sub-health post, no doctors or registered nurses are available; only health assistants or auxiliary health workers and auxiliary nursing midwives work. These health providers obtain only a few months of training (Gyawali et al 2013). Similar to other middle and low-income countries (Lehmann, Dieleman, and Martineau 2008), rural areas of Nepal face the lack of skilled health professionals and medical supplies (based on personal knowledge). Sigana village is not an exception in this regard; it too lacks skilled healthcare professionals. The district headquarter, which has a government hospital and some private hospitals, is 12km away. People have to walk three hours to reach the district headquarters where medical facilities are available.

A traditional household in Nepal includes an extended family; however this has been gradually changing. The typical household includes a couple, their son and daughter-in-law, their children, and unmarried daughters. The daughter-in-law is in charge of household and farming. Male household members are expected to help with agricultural work, but not with domestic work. If a husband helps his wife in domestic work, he is considered hen-pecked and made fun of. The daughter-in-law has less freedom and liberty but more duties (Luitel 2001). She is responsible for all of the household chores. A daughter-in-law is expected to wake up before other members of the family. She has to prepare breakfast, feed all of her family members, and then eat last. Then, she goes to farm and comes home for lunch. Most of the time, the mother-in-law cooks lunch for the family. The daughter-in-law eats the left over and does the dishes for the whole family. Then she goes back to farm, or washes clothes, or any outside jobs.

When she comes back home, it is already dinner time. She has to cook the meal, feed all family members, eat last, and again do the dishes and clean the house. She typically goes to bed late (based on personal knowledge and Luitel 2001). A mother-in-law has authority over her daughter-in-law (Bennett 1983) and thus, she plays an important role in the life of her daughter-in-law, especially in terms of maternal health and fertility. The fertility rate of Nepalese women is 2.6 children; however, the rate differs for rural and urban women. Urban women have 1.6 children on average and rural women have 2.8 children (Ministry of Health and Population 2012). Education, caste, socioeconomic status, birth cohort, and age at menarche determine the age of first marriage among females in Nepal (Aryal 2006). The average age at first marriage is 17.5 years for women age 25-49 Similarly, the average age at first birth is 20.2 (Ministry of Health and Population 2012).

Although outlawed, caste based discrimination is still prevalent in Nepal and affecting every aspect of life. In the caste system, only blue collar jobs are assigned to *dalit* people. The lack of well paid job adds to the discrimination and makes their life more miserable. They are not affluent enough to send their children to a (good) school. Since the children lack good education, they do not get well paid jobs later. Even though there is no restriction on jobs in the present, because of the lack of social networks and education, *dalit* people are forced to continue their caste based occupation, which is not well paid. Therefore, the poverty continues among *dalit* people.

Nepal, as a whole, is a poor country. The situation of rural people is even worse. Among them, rural dalit women are the one who face extreme hardship. Because of the lack of cultural capital—awareness of the importance of education—and economical

capital—sufficient money to go to school, children are deprived of education. Those who are lucky enough to attend school either have to drop out of the school or have to miss classes regularly to help their families. When they grow up, they are not academically competent enough to find a well-paid job. So, they end up working on the farm, which is not paid or underpaid. The rural *dalit* women's situation is exacerbated by their household and agricultural duties. The women are expected to take care of the family, work on the farm, and to provide for their family. These expectations put a lot of burden upon these women. They are exhausted and stressed, allowing them no time to think about their own life or health. Even when they are pregnant, they have to do all the hard manual work (Narang 2014).

Rural *dalit* women live their life in economic and physical hardship. Lack of support from their husbands and families make the women solely responsible for the survival of the family. Sometimes, the women have to endure domestic violence too. Since they lack education, economic stability, support in domestic and agricultural work, and access to media, they are stuck on the same economic level. Stressed and exhausted by the daily burden, the poor and disadvantaged rural *dalit* women get no time to take care of themselves. This situation affects their health and is worsened by the lack of access to healthcare facilities in rural areas. The lack of access to media leaves them ignorant of the need for and availability of healthcare. Therefore, in order to better understand the prenatal experiences of *dalit* women, their education level, economic status, their daily activities, the burden of domestic and agricultural work, the availability and awareness regarding the healthcare should be considered. Because we believe that the situation of Nepali women, especially that of rural dalit, has an impact on their health,

we utilize the framework of the Cairo Conference to explore and explain the prenatal health care of rural *dalit* Nepali women (Kawachi et al 1994).

Chapter Two

2. Theoretical Framework

Using the framework developed by the 1994 Cairo conference on Population and Development (Kawachi et al. 1999) , Bourdieu's concept of cultural and economic capital (Applerouth & Edles 2011), and Judith Lorber's concept of illness as social construction (Lorber 1997), data is analyzed to understand access and barriers to prenatal care of *dalit* women. The Cairo conference reached a consensus that "socioeconomic inequality, women's empowerment, unequal burdens of domestic labor, constraints on women to determine their own sexuality and reproduction, political participation, literacy, and the epidemic of male violence against women" are some determinants of women's health (Kawachi et al. 1999 : 487). Nepali women experience inequality in all spheres of their lives: even from their early childhood, daughters "have responsibility to help their mothers while men and boys are not expected to assist with domestic work" (CARE NEPAL 2015 : 2). CARE NEPAL (2015 : 2) reports that Nepali women have "much higher work load than the global average." These women have very limited access to the economic resources.

Education is considered a key of empowerment and a tool to improve both men and women's socioeconomic status and quality of life (Bhushal 2008). In Nepal, women are not getting equal educational opportunities, thus their literacy rate is far lower than that of Nepali men (Ministry of Health and Population 2012). Lack of education and skilled training among Nepali women compel them to do domestic household work and agricultural activities, which are unpaid or underpaid. Economical dependence on the

male member of the family discourages women to go against those men and compels them to accept decisions made by men. Thus, economically dependent women lack decision-making power (Acharya et al. 2010). Not only uneducated, unemployed, rural women lack decision-making power, even women political leaders are not allowed to make decisions. Although 33 % of seats in parliament are reserved for women, their voice in parliament is suppressed (Delaney 2011). Moreover, decisions regarding women's own bodies and lives are made without consulting the women themselves (Das 2014). Since Nepali women experience all the variables of the framework developed by the 1994 Cairo Conference (Kawachi et al 1999), we utilized the framework to explain and explore the access and barriers to prenatal care among *dalit* women.

As the Dalit Welfare Organization notes, *dalit* people are "backward in social, economic, educational, political, and religious fields" (2010a) Due to the lack of education and access to "productive resources such as land, capital, skills, training, and other natural resources," *dalits* are trapped into the circle of poverty. In addition, due to the untouchability and discrimination in society, they are economically exploited (Dalit Welfare Organization 2010b). The Dalit Welfare Organization (2010b) reports that *dalit* children experience "caste based discrimination and untouchability in the school." The lack of economic resources and their caste status are major causes of both poverty and the lack of education among *dalit* populations. Thus, it can be said that the *dalit* lack economic and cultural resources, which Bourdieu refers to as capital (Applerouth and Edles 2011). According to Bourdieu, the acquisition of economic and cultural capital impacts the opportunities an individual can have throughout the life.

By economic capital, Bourdieu refers to "the material resources—wealth, land, money—that one controls or possesses" (Applerouth & Edles 2011:449). Economic capital can be used to maintain better health (Pinxten and Lievens 2014). Cultural capital refers to "nonmaterial goods such as educational credentials, types of knowledge and expertise, verbal skills, and aesthetic preferences that can be converted into economic capital" (Applerouth & Edles 2011 : 449). Bourdieu's theory of capital provides insight to the effects of cultural elements on health (Pinxten and Lievens 2014). Since capital is transferred from generation to generation, it can reproduce inequality (Gilbert 2015). Cultural and economical capital is useful in acquiring good health and making choices related to health behavior and lifestyles (Pinxten and Lievens 2014).

Education, a form of cultural capital, is found to be a strong health determinant ((Pinxten and Lievens 2014). Educational attainment is very low among *dalit* people of rural Nepal (Ministry of Health and Population 2012). Because of their own lack of education parents are unaware of the importance of education. Moreover, they lack economic capital to send their children to school. Even though caste discrimination is outlawed, and there is no restriction in choosing occupations, *dalit* people lack education to compete in workforce, which is exacerbated by the lack of social networks among *dalit* people. Therefore, the cycle of poverty continues among *dalit* people.

Regarding healthcare, rural dalit people inherit the cultural knowledge of health care and practice. Since they lack education, lack access to media, and have low economic status to utilize the modern healthcare, they follow what their elders are doing. Thus, the inherited cultural knowledge makes them stick to the traditional practice of healthcare rather than trying new methods and practice. And, in a Nepali married

women's life, a mother-in-law plays a significant role (Nepal Safe Motherhood Project n.d.). A mother-in-law decides where and how to get healthcare. We hypothesize that since mothers-in-laws are used to traditional health practice, they do not recommend biomedical health care to their daughters-in-laws. Studies found that rural people are typically not willing to change their cultural practice (Baniya 2014).

Because of proximity, affordability, availability, family pressure, and favorable community opinion, alternative medicine is preferred in Nepal (Shankar, Paudel, and Giri 2006). Traditional healing is widely practiced in rural areas (Subba and Subba 2014), and biomedical services are limited and are concentrated on urban area (Tamang 2010). *Dalit* people's, especially in the rural areas, lack of education and limited access to financial resources result in the lack of biomedical health care. Most of the people in rural area give birth at home assisted by relatives and call for a traditional healer if complications arise. During the time of delivery, only survival of a mother and child, not comfort, is a priority (Gaestel and Shelley 2013).

Using Bourdieu's concept of cultural and economic capital, we hypothesize that lack of cultural and economic capital among *dalit* women explains their lack of modern prenatal care. *Dalit* women's perceived discrimination, their attachments to traditional healthcare practice and its easy accessibility, lack of advice from friends and relatives, and their lack of economic resources are some factors affecting their prenatal health care.

The preference for traditional healer is also a function of their caste and tribe. Traditional healers can be of any caste and tribe (Shamanic Drum 2013). Thus, we hypothesize that since most of the biomedical providers are from non-*dalit* groups, and

there is the possibility of finding a traditional healer from one's own caste, *dalit* people prefer to go to traditional healers. Since they share the same experiences in society, *dalit* people might feel more comfortable to talk with traditional healers than with biomedical doctors.

Lorber argues that illness is socially constructed (1997). What constitutes illness differs by cultural and moral values. Using this concept, we argue that since pregnancy does not affect men, patriarchal societies do not treat pregnancy as something that needs special care and attention. In a patriarchal society like Nepal, not only the pregnancy period, but everything that is related to women has less importance. Despite women's significant presence in parliament, "issues pertaining to women are far from being prioritized" (Center for International Private Enterprise n.d.). Similarly, Lorber (1997) maintains that most women do not get the best healthcare service because most healthcare providers are men, and men discriminate against women when providing health services. She also argues that patients are more interested in receiving healthcare from healthcare providers of their own race.

The caste of a doctor, in addition to his/her sex, may be a significant factor affecting healthcare-seeking behavior. Since most of the doctors are non-*dalit* and urban males, *dalit* rural women experience the impact of status difference in health services (Kitts and Roberts 1996). As Lorber points out, patients prefer a healthcare provider of their own race, we hypothesize that the same condition applies to the caste system. These arguments help in formulating another hypothesis: the availability of female healthcare provider from the *dalit* will encourage *dalit* women to seek prenatal care.

CHAPTER THREE

3. Methods

3.1 Qualitative Case Study

We take a qualitative approach to understand the prenatal care among the *dalit* women of rural Nepal. Qualitative research is mostly used by sociologists "to study culture and social settings" (Quick & Hall 2015). Through this qualitative research, we try to get a holistic description of the rural village of Nepal and the participants' perspectives and experiences regarding prenatal care (Sallaz 2011). Since these perspectives and experiences cannot be "meaningfully expressed by numbers," we need to collect textual data (Berg 2009 : 3). Moreover, quantitative research cannot incorporate the "social and cultural construction of the 'variables' studied" (Silverman 2011). And, in an attempt to predict the relationship between dependent and independent variables, quantitative research does neglect how those variables are defined by the participants (Blumer 1968), whereas qualitative research attempts to describe the social world from the participants' perspective (Berg 2009).

We look for the quality and the essence of the problem. In our study, we examine what prenatal care means to our participants and how exactly they get their prenatal care. We explore barriers in accessing prenatal care. We take a case study approach to understand the prenatal care of *dalit* women in rural Nepal. Berg defines a case study as an approach which is capable of systematically examining a phenomenon to uncover the manifest as well as latent factors of the phenomena (2009). Generally, a case study approach is used to get a "thick description" of a phenomenon.

Our focus is on a particular aspect—prenatal care of *dalit* women of rural Nepal. To obtain a "deep understanding" of the problem and get a holistic description of the participants' lifeworld, we conducted interviews and utilized documentary sources (Ryan, Coughlan, and Cronin 2007). Eleven *dalit* women who have been pregnant within last five years were interviewed for this study.

3.2 Sampling

In qualitative research, we focus on the depth of an issue, rather than in the breadth. Therefore, we take a small sample to conduct in-depth interviews. There are several methods of sample selection, and not all methods work for all types of study. Probability method is the best way to select a representative and unbiased sample. However, we were unable to use this method because of the lack of detailed records of our desired participants. We used a snowball method to recruit our research participants. In the sampling process, a few participants who have the desired characteristics are found at first, and they "refer researchers on to other respondents" (Atkinson and Flint, 2001; Sadler. 2010). The chain of referral continues until the desired number of participants is reached. Since the people with similar ethnic and economic background tend to live in the same area and know each other, a snowball method is the best way to reach our participants because we are interested in understanding the prenatal care of women with similar backgrounds.

3.3 Variables

After an extensive literature search, we were interested in finding the effects of certain circumstances on the prenatal care of *dalit* women in rural Nepal. We used open-

ended questions to explore participants' experiences. Basically, we are interested to know whether the *dalit* women perceive any discrimination in their daily lives and in the health-care facilities. We try to understand whether such experiences discourage the utilization of available medical services. Moreover, we examined in depth the need for health services, the perceived quality of health-services, and their beliefs about and practice of traditional health practices. We ask questions regarding the caste and gender of healthcare providers and whether it encourages or discourages health care seeking of the *dalit* women. We examine the roles of husbands, mothers-in-law, and other family members and friends in the care during pregnancy. We asked questions to understand whether distance to the health center is affecting the utilization of health services. Demographic variables like age at the time of pregnancy, economic status, and educational level of the respondents and of their husbands are obtained. *Dalit* women's view regarding pregnancy and care during pregnancy, their decision making status and its effect on prenatal care is examined. *Dalit* women's knowledge regarding the importance of prenatal care and the knowledge of free prenatal care and cash incentives is studied.

3.4 *Data Collection*

Since we attempted to understand the problem from the participant's perspective, we used open-ended question. Because of the geographical distance between the researcher and the participants, telephone interviews were the only viable method for the data collection for this study (Berg 2009). The reliability and quality of data collected through telephone interview has been documented. A comparative study of telephone and face-to-face qualitative interviewing finds no significant differences in the interviews and concludes that telephone interviews can be used productively in qualitative research

(Sturges and Hanrahan 2004). Since it allows flexibility and wider access, telephone interviews have become an increasingly popular data collection method among qualitative researchers (Block and Erskine 2012).

Although it is has been argued that telephone interviews lack face-to-face nonverbal cues which might affect the quality of the data, no evidence has been found to support the argument that telephone interviews produce lower quality data (Novick 2008). Telephone interviews benefit the data collection by avoiding interviewer bias (Berg 2009) and allow respondents to be relaxed and able to disclose sensitive information (Novick 2008). Telephone interviews might eliminate some potential respondents because of the lack of phones. However, this was not a problem in our data collection. We used the research assistant's mobile phone in the interview. A research assistant from the locality helped in recruiting the participants and setting up phone calls between the researcher and the participants.

Our interview questions focused on the demographics of the participants, their education level, their socio-economic status, and their prenatal care. We used a semi-structured interview schedule "to ensure that all of the interviews would be focused on the same general topics, while allowing the opportunity to raise additional topics that they felt might be relevant" (Jozaghi & Reid 2014 : 567). In order to understand the prenatal care of *dalit* women of rural Nepal, we examine the social setting too (Berg 2009). We try to get the holistic picture of the society through the analysis of published reports and research. We utilized findings of the "Nepal Demographic and Health Survey 2011" in order to get the holistic description of Nepal (Ministry of Health and Population 2012). To get more specific information of Sigana Village, we used the "National Population

and Housing Census 2011," which contains detailed information of the Baglung district (Central Bureau Statistics 2014).

Since the researcher is from the study area, the cultural, economic, social, and geographic settings are familiar to her. She is, thus, able to conduct the interviews in the native language. Although she is familiar with the lifestyle, she will not take anything for granted. She is stepping back and keeping her knowledge of the setting aside, doing the interviews and the data analysis. Being a non-*dalit* woman, she has not experienced the life of *dalit* women.

3.5 Data Analysis

We adopt grounded theory method to analyze our data. It is "among the most influential and widely used modes of carrying out qualitative research" (Strauss & Corbin 1997 : vii). We attempt to generate a theory rather than testing any hypothesis. Grounded theory is a method for "building inductive theories through data analysis" (Charmaz 2007 : 82). As Charmaz defines, in grounded theory, the approach to data analysis is inductive in nature. We start with "individual cases, incidents or experiences and progressively create more abstract categories that explain what these data indicate" (Charmaz 2007 : 83). We conduct several rounds of coding to identify the pattern in our data. First, the interview data is coded by paragraph; then, categorical coding across all interview section is conducted. Lastly, data are analyzed using theoretical categories. Throughout the data analysis, memos are written which serve as the foundation for the theoretical analysis. We record in-vivo codes to illustrate categories and theoretical codes (Charmaz 2006).

CHAPTER FOUR

4. RESULTS

4.1 Characteristics of the Respondents

Name	Age	Education	Own Home	Own Land	Electricity	Television	Radio	Mobile	No. of Children	Place of Delivery	Number of Prenatal care Visits
Eliza	19	0	Yes	No	Yes	No	No	No	3	Home	0
Dikshya	24	0	No	Yes	Yes	No	No	Yes	2	Home	3
Tara	18	0	No	No	Yes	No	No	No	1	Home	0
Charu	19	0	Yes	No	Yes	No	No	No	2	Home	1
Paru	35	0	Yes	No	No	No	No	No	3	Hospital	0
Chhaya	23	2	Yes	No	Yes	No	Yes	No	2	Home	4
Sita	20	5	Yes	Yes	Yes	No	No	Yes	1	Home	1
Aasha	25	6	Yes	Yes	Yes	No	No	Yes	2	Home	0
Nita	27	5	Yes	Yes	Yes	Yes	No	Yes	2	Home	4
Diya	29	0	Yes	No	Yes	Yes	No	Yes	2 and pregnant	Home	0
Ekta	29	6	Yes	No	Yes	No	No	No	1 and pregnant	Home	3

Table 1 (Characteristics of the Respondents)

4.2Economic and Demographic Characteristics of the Respondents

My respondents were women who were pregnant in the last five years. I interviewed 11 *dalit* women. In order to protect their confidentiality, I used pseudonyms. In this thesis, they will be referred as Eliza, Dikshya, Tara, Charu, Paru, Chhaya, Sita, Aasha, Nita, Diya, and Ekata. The respondents are between 18 and 35 years of age. Seven of them are in their 20s; three of them are below 20; and one respondent is 35 years old. Most of the respondents were hesitant to tell their age; some of them were not sure about their exact age. The ignorance of their exact age can be attributed to the lack of knowledge of numbers. It seems that Eliza confused the number 19 with 29. She said that she is *unnis* (19) years old. But the analysis of her interview shows that she is older than that. She said she has three children and the youngest is four years old. Moreover, she also mentioned that she is married for 11 years. And, she said she had never been to school. (Nineteen and 29 are slightly different in Nepali language—*unnis* (19) and *untis* (29). Thus, it can be assumed that she is *untis* (29) years old. Diya knew the year of her

birth but did not know her age. “I am not sure how old I am. I was born in 2043 (1986/87A.D.) umm may be 27 or 28.” Most of the respondents lack both formal and informal education. The highest level of education is 6th grade. None of them had attended non-formal adult classes. All of them work in farming; mostly on others’ farm land. Only four of them own land, and this land is not enough to provide food for the whole family. Therefore, all of them, even those who own land, live on daily wages. Besides working on farm land, some transport goods for others.

4.3 The Husbands

It seemed that the responsibility for providing for the family falls on these women since most of their husbands are either physically disabled, “drunkards”, or live abroad. The physically disabled husbands are not able to provide for the family. Since they are illiterate, they have no other option than working on the farm land, but they cannot perform heavy manual work. Dikshya mentions that her husband is suffering from jaundice and hepatitis. She borrowed a “loan and took him to hospital. Now, I don’t have a way to pay off the loan. He was prescribed bed rest for at least one and half year.” According to Charu, her “husband is “lame”. He cannot do heavy work. He does only light work. He cannot work for a long time too.” Tara does not want to talk about her husband. “He is a mad man. He drinks a lot.” When I asked whether he works or not, she said that “he works during the daytime and spends all of the earnings the same night drinking.” When I asked Paru about her husband’s typical day, she said that her husband spends all the day drinking. She even mentions that she “works all day long and goes home for food and rest. Rather than helping me, the husband comes and beats me. Sometimes I have to take my children outside the home and spend the night outside with

an empty stomach." Ekta says that her husband is a drunkard. According to her, "a drunkard thinks nothing else than drinking. He does not even work." Sita's husband lives in New Delhi (India) but he is not able to provide financial support to the family. "His income is hardly enough for him." Aasha's husband used to work in Madras (India). "His income was not enough to support the family. So he went to *bidesh* (abroad) to earn more. He is not making good money there either and wants to come back." Nita's husband went abroad too, but he is out of contact. "He went abroad when I was pregnant. The daughter is four years old now. Since then he has not contacted the family. He is lost."

4.4 Living Arrangements and Living Conditions

All of the respondents but Tara and Dikshya own their own home. Tara lives in her uncle's house. Dikshya lives in one room of her in-laws' house. Except for Paru, all of them have electricity in their home. Only two of them—Diya and Ekta—have television, but they do not watch it regularly. Both of them mentioned that they are too tired after their daily chores and do not have any interest in watching television. Even if they watch TV, they watch TV series and songs, but not news or health related programs. When I asked if they go to neighbors' houses to watch television, Dikshya and Aasha mention they go occasionally. They also watch TV series and songs. Paru does not have time to go to other houses and watch television. Only one of the respondents, Chhaya, has a radio. Her "husband listens to the radio. But, I do not get time to listen to it." Only Diya, Nita, Aasha, Sita, and Dikshya carry mobile phones, but they are not their personal phones. They share it with their family members, especially with their husbands. None of them have landline phones.

None of our respondents live with their in-laws. Except for Diya, all of them live close to their in-laws. Some of the respondents have good relations with their in-laws, some do not. Dikshya mentions that all of her in-laws are better off than her family. She does not "expect any help and advice from them. The brother in-laws are better off. My husband is sick. We are living in economic hardship. I have never got any advice or help from my in-laws." Those who have good relationships give advice and the daughter in-laws ask for advice. Some daughter-in-laws do not seek advice from their in-laws and relatives. Tara does "whatever I think is right." Charu discusses decisions more with her husband than with her in-laws and relatives. Chhaya neither asks her in-laws for advice nor do they give advice or suggestions.

4.5 Decision Making

All of the respondents but Sita take part in decision making. Sita's husband works in India, but he is the one who makes decisions. Other respondents either make decisions on their own, although their husbands are at home, or take part in the decision making.

4.6 Biomedical Health Care vs. Spiritual Healers

When it comes to health care, all of the women believe more or less in spiritual healers. Some find it less expensive than biomedical health care. However, some prefer biomedical healthcare to spiritual healers because free services and medicines are provided by the sub-health post. Despite this, the respondents still go to spiritual healers if they feel they are touched by an evil spirit. They feel that some illnesses are cured by biomedical health care and some by spiritual healers. Eliza mentions that she believes in these healers and prefers to see them, but they are not available when needed. So she

mostly goes to the sub-health post. Dikshya took her husband to a spiritual healer when he had jaundice and hepatitis. Later, she took him to biomedical doctors. Charu is a strong believer in spiritual healers. She is a new mom and is experiencing problems with breastfeeding. She has "lumps in my breasts, and my milk supply is clogged. "I feel irritated, my body becomes cold, and my head becomes heavy and cold. I saw a spiritual healer and he said that I have been trapped in the web of a witch. The spiritual healer will treat it. I have experienced such conditions in the past and they improved with the treatment of the spiritual healer." Paru states that when she feels sick, the first thing that comes to her mind is that she is touched by an evil spirit.

Only one of the respondents, Sita, uses herbal medicine, and she makes it herself. She mentioned that she learned it from her mother. She believes neither in spiritual healer nor in bio-medical doctors. For her, "everyone requires money. None of them provide treatment if you don't have money. Spiritual healer's treatment is momentary. You can't get anything in the hospital if you don't have money." She believes that the type of treatment depends on the nature of the illness. "If it is treatable by a spiritual healer, you have to go to them; and if it is treatable by medical doctors, you have to go to biomedical doctors." Aasha and Ekta believe in both types of treatment, and they too believe that it depends on the nature of the illness. However, they prefer to go to the sub-health post because they can get free medicine at the sub-health post. Nita also believes in spiritual healers, but they are not always available when needed. Therefore, she goes to the hospital. Diya also feels that there are not enough spiritual healers in the village. She believes in the practice of spiritual healing but she does not believe in the spiritual healer in her village. "I prefer spiritual healer. But, there is only one healer, and he is not good at

it. If there were four or five spiritual healers, we could choose the best one. We do not have options." She is not satisfied with the treatment of biomedical doctors. She went to the hospital when she had abdominal pain. The doctor prescribed an ultrasound and some "unnecessary" medicines but she is not feeling any better. Now she is regretting it: "I wish I had not gone to see doctor. I spent a large amount of money. That money could have been used to do lots of things. I had to buy lots of medicines; even the iron pills were not free." (Iron pills are typically provided for free at the sub-health post).

4.7 Discrimination

None of the respondents mention caste discrimination in the health care facilities. However, they do experience it in their daily life. Dikshya and Paru talked about the caste based discrimination they perceive from non-*dalit* villagers. Some of the respondents mention that they experience discrimination in the health care facilities. Diksha feels that "the health-care providers do not give equal attention to the manual workers. It is a problem here. I do not get all the health services." Paru thinks that "all the health-care providers are concerned with the health of rich people." Diya believes that "if you have money, healthcare providers do not care who you are. Money is everything."

4.8 Money as Barrier to Health Care

All of the respondents mention money as the main barrier to receiving healthcare. And, this is exacerbated by the long distance to the hospital. It seems that although a few jeeps are available for transportation, the women do not use them because the fare is too expensive. Because of their limited economic resources, they want to save money in every possible way. Nita goes to the district hospital if her children are sick. Rather than

taking the Jeep, she walks to the hospital and carries her children on her back. "I carry the baby on my back all the way to the hospital. What can I do? The fare is expensive. If I take a 1000 Rs, I have to pay some for the medicine; I have to buy snacks for the kids too. So I always walk." Eliza also mentions that she "walks to the *Bazaar* (districts headquarter) if I have to go."

4.9 Hardship

All of the respondents experience some sort of hardship. There is no doubt: they live in physical and economic hardship. And they endure additional problems. When I asked Eliza whether she would suggest to any pregnant woman to go to the hospital, she said "*kohi bole po bhannu (*Noone talks to me, how can I suggest anything to anybody)." It shows that she is isolated. Dikshya mentions that she gave birth to three children, and now she thinks she has a prolapsed uterus. But she did not have it checked yet. Since her husband is sick and needs bed rest for at least one and half years, the entire burden of taking care of the family is upon her. Moreover, her "better off" in-laws do not care about her "poor" family. On top of this, her newborn baby died, which, she thinks, is due to the lack of proper care during her pregnancy and after birth. Tara does not have a house, so she lives in her uncle's house. Her husband is a "drunkard," and does not help her. She labels him as a "*baulaha"* (mad man), and does not want to talk about him. Charu's husband is physically disabled and cannot work much. She is a new mom and does not feel good. She believes that she is "trapped in the web of a witch" and she is waiting for a spiritual treatment to get rid of it. She feels lumps in her breasts, and her milk supply is clogged. Paru is a victim of domestic violence. Her husband also is a "drunkard." He spends all his earnings on drinks and comes home to beat Paru. Sometimes she has to

take her kids outside the home to keep them save them from her husband. Due to poverty, she has not sent her children to school; rather, she takes them with her to work. When she is sick and cannot work, her family goes to sleep hungry. She also feels that her "uterus is weak. But, I have to work to feed my kids. I have no money to get checked up. There is no way to get checked up, so I ignore my illness." Chhaya mentions that when she is sick, she "does nothing and just rests." She is the only one among these women who can afford to rest when she is sick. For Sita, money is everything, and they lack that "powerful" money. Aasha's two nine days old daughters died; another daughter is physically disabled but she has no money to get her checked. She "sent" her husband abroad to earn money so that they can pay for her treatment, but her husband is not making good money. He is complaining about his situation and wants to come back.

Nita's husband also went abroad when she was pregnant. It has been over four years since he left and he has not contacted her since. Diya's husband is in India. She experiences frequent headaches. Her husband told her to go to the hospital, but she does not have enough money to go. If she gets "*dui/chaar paiso* (a small amount of money)," she has to buy food with it. Her son also complains about headache. She "goes to the sub-health post and gets some "*cetamol"* (Tylenol) for him. She said that she "is in constant tension." Ekta has one child and is pregnant again. She is due next month. Even in this condition, her husband does not help her. In her words, he is a "*jadiya* (drunkard). He does not care about anything else than drinking. I am in this condition (pregnant)." Since she is pregnant, her friends and relatives "advised me to take care of myself and avoid doing certain things, but they don't understand my situation. Even the health-care

providers suggest limiting heavy work, but the condition at home does not allow me to rest."

4.10 Regrets

We found that all of these women are living with some sort of regrets. The main regret is the lack of education. Since they feel "*laata na baatha jasta"* (we cannot speak up because we are illiterate), they want to send their children school and make them "great." But, they lack economic resources to provide them good education. Another regret is either seeing and or not seeing the biomedical doctors when needed. Those who visited doctors for certain illness feel that they are not feeling any better. It would be better if they could have saved that money and use it for something else than spending it on treatment. And, those who did not see doctors believe that they could have saved their child's life if they had seen a doctor.

4.11Birth

All of the women except for Paru delivered their babies at home. Even Paru did not go to the hospital right when her labor started. She tried home birth, but later knew that the baby was in a breeching position. So she went to the hospital. Diya and Ekta are pregnant again and they again want to give birth at home. All of the respondents mention that "it went well at home", so they feel they do not need to go to the hospital to deliver their baby. It is clear that they all believe that babies should only be delivered in the hospital in case of complications. If everything goes well, one does not have to go to the hospital.

4.12 Prenatal Care

Although some of the sub-health posts in Nepal are birthing center, the sub-health post in Sigana is not a birthing center. The women mentioned that they have to go to *bazaar* (district hospital) if they want to deliver their babies at a health facility. Some of the women received (biomedical) prenatal care, and they received the care at the sub-health post. Chhaya got her prenatal check-up four times at the sub-health post; Dikshya, Nita and Ekta went to the sub-health post three times for prenatal check-ups; Charu and Sita went just once. Diya went once for an ultrasound but she did not go for a regular prenatal checkup. Eliza did not go for a prenatal check-up because she did not know she should go: "no one told me. I did not go to the hospital. I did nothing." Although her mother in-law was there when she was pregnant, her mother-in-law did not tell her to go to the hospital because "the mother-in-law herself did not know." She did nothing special during her pregnancy. She "ate whatever I could find and did all the work no matter how physically demanding it was. I did not even know I had to take special care during pregnancy. Even if I knew, I did not have any option but to work." Eliza was not aware of free prenatal care and incentives for receiving prenatal care. She delivered all of her three children at home. She said that "they were born at home, and everything went well."

Dikshya got prenatal care three times from a sub-health post, but she did not go to the sub-health post for her two previous deliveries. Healthcare providers advised her to go to the hospital to deliver her baby, to eat nutritious food, and to not lift heavy items. "We are not fortunate to get nutritious food and take rest." Although she was told to deliver her baby at the hospital, she delivered him at home. The baby died within 24

hours, which she believes is due to the lack of care. She thinks that his life could have been saved if he was born in the hospital. She did not go to the hospital because she was in labor during the night and no public transportation was available. And, one top of that, she "did not have enough money. It costs NRS 3,000 to 3,500 to deliver a baby at the hospital. I thought that money can be used to get some nutritious food." She did not know about the free services and incentives. She thinks "I have to pay for the services. *Khasai thah bhayan (*I really did not know). I thought that even if incentives were given, I might have to pay for the services. I have to buy all the stuff, which costs double of what I get in incentives."

Tara did not know she needs prenatal care. She did not get prenatal check-ups and she delivered her baby at home. A few of her friends and relatives told her to go to the hospital, but she "had no money to go to the hospital." She did not know about the free services and incentives. She is not sure if she would go to the hospital to deliver her baby, if she is pregnant again. Charu had one prenatal check-up. She is not sure what they did. "They (health care providers) put something in my arm. They suggested taking iron pills and eating fruits and eggs." She was in India when her first child was born. She went to the hospital then. This time, she delivered her second child at home. "If the hospital was near, I would go to the hospital to deliver the baby. It went well so I did not go to the hospital." She knew about the incentives but it did not encourage her to go to the hospital to deliver her baby.

Paru never went for prenatal check-ups. She tried to deliver her baby at home. She went to the hospital only after she knew that the baby was breeched. People carried her on a stretcher. In the hospital, the staff asked her to pay the bill, but someone talked

to the staff about her "poverty" and arranged for free care. She did not get the incentive either. She was not aware of the required care during pregnancy. She mentions that it is not in her fate to get nutritious food. Even after delivery (In Nepal, the time after delivery to 2 months is considered a time for nutritious food and rest for a new mother), she did not get to eat "*jwano ko jhol ra nikhlo bhaat* (plain rice and the soup of ajwain seeds). Lack of (nutritious) food has made me physically weak."

Chhaya received prenatal care four times. She went to the sub-health post but not to the hospital because "most of the services at the sub-health post are free but I had heard that the hospital charges for all services." She was told to "take care of myself and not to lift heavy things, and my husband helped me." Health-care providers advised her to go to the hospital to deliver, but "the baby was born at home." I did not go to the hospital because my labor was short." She knew giving birth to a baby in a hospital is safe for both baby and mom, and she knew about the incentives too. She believes that "if there is a complication, one should go to hospital, but if the labor is short, babies are born at home."

Sita went to the sub-health post to check her pregnancy status but did not get any other prenatal check-ups. No one told her to get prenatal care. She was "busy working. I did not want to miss a day of my work. I had no time to think except working." Her baby was born at home. "I did not have money. My husband was not earning money. I was wishing for a home birth." She did not know about incentives and free services. Even if she knew about incentives, she would not have gone to the hospital because "you have to pay the double amount than the money you get for incentives. It is better not to greed for *dui chaar paisa* (a small amount of money)." She did not take special care during her

pregnancy. She ate “only two meals a day and I did all types of jobs (even physically demanding ones). Luckily, the baby is good for now. I don’t know what will happen in the future.”

Aasha gave birth to her daughter at home. “It was not easy to deliver a baby at home. I was too weak. I almost died.” She believes that two of her daughters died and another one is physically disabled because they were born at home. She wanted to go to hospital but “there is no sense to go to the hospital without a huge amount of money.” She did not know about incentives and free service. She blames her lack of education for this ignorance.

Nita went to the sub-health post three times for prenatal check-ups. She was advised to take care of herself and to go to the hospital when she was nine months pregnant. So she went. Doctors at the hospital told her that she was not close to her due date. They said the baby was breeched and prescribed medicines for which she had to pay NRS 750. She walked back home. The baby was born that same night. “If the doctors had told me that that baby was due today, I would have stayed in the hospital.” She knew about the incentives, and for her it was not a motivating factor to go to the hospital.

Diya already has two children and she is pregnant again. Both of her children were born at home. “There was no complication, so I did not go to the hospital to deliver them.” For this pregnancy, she went to the hospital for an ultrasound because she had abdominal pain. Her mother gave her NRS 16,000 to do the ultrasound. She had to pay NRS 3,000 for the medicine only. But she is not feeling better. Now, she is regretting that she went to the hospital. This time, too, she is wishing for a home birth. “I do not have

enough money to go to the hospital to deliver. There is no public transportation. The main thing is money. If I had money, I would overcome other obstacles. When you do not have the main important thing (money), you can do nothing." She is not aware of incentives and free services. "The staff at the sub-health post and hospital might know about it, but they don't share it with me." She was advised to eat nutritious food and get rest but nutritious food is expensive. "If I can save money, it can be used to buy books, notebooks, and pencils for my children." She is not feeling well, and she should rest, but "I have to work."

Ekta went to the sub-health post three times for prenatal check-ups. She was advised to go to the hospital, but she has not gone yet because "the hospital is far." She was told to take care of herself, but she "has to work to get something to eat. Everyone suggests things but no one understands my situation." She, like Diya, is wishing for a home birth. She "has not thought about going to the hospital to deliver the baby." For her, the distance to hospital is a major barrier. She has heard about incentives and free services, but she is not sure she will get them.

Although prenatal care is free and incentives are provided, most of the respondents mention that the government should make services free. Charu, Chhaya, Nita, and Ekta knew about the free services and incentives, but they are not quite sure how to get them. Paru delivered her one baby at the hospital, but she did not get any incentives. Instead, she was asked to pay the bill. Some of the respondents believe that even if a small amount of money is provided as incentives, they will be charged double the amount of that incentive. The respondents think that there might be some hidden fees, which will make the care and delivery expensive. They mention that they have been told

by the staff at the sub-health post to go to the hospital for delivery, but they did not tell them about free services and incentives.

All of the respondents are living in economic and physical hardship. They “have to work” under any circumstances to provide for their families. They do not get enough and nutritious food when they are pregnant. Only a few of them get help from their husbands. Some of their husbands either are unable to work, “drunkards”, or they are not at home. The main barrier to receiving health-care is poverty: the women have to work hard, cannot rest even when they are sick, and cannot afford spiritual healers or biomedical health care. Access to health care is exacerbated by the long distance to the hospital and lack of (affordable) means of transportation. Seeing spiritual healers does not affect the utilization of biomedical healthcare. The nature of sickness determines the type of health care that is sought. If the sickness is due to the “touch of an evil spirit,” they see spiritual healers; otherwise they seek modern health care.

CHAPTER FIVE

5. Discussion

In this study, we identified some barriers to prenatal care for rural *dalit* women. These women mention lack of money, lack of information regarding the required care during pregnancy, misinformation and lack of awareness regarding the free services and incentives, distance to the hospital (and lack of (affordable) transportation), economic and domestic burden, and lack of help and support from family members, especially the husbands as main barriers in getting prenatal care. We found gender discrimination and lack of cultural and economic capital at the root of all the barriers.

All of our respondents are on their own. They alone are responsible to carry all economic and domestic responsibilities of the family. They live in physical and economic hardship. As they said, they cannot rest from work or get sufficient nutritious food because they are female which means they are required to perform their (domestic and other) duties and to feed others first. Since they depend on daily wages and their work is not well-paid, it is hard for them to provide good and enough food. Even the limited food has to be offered to family members first. Since they eat last, the mothers do not get enough food, which is harmful for pregnant and lactating women (Eynon 2010).

We found that most of our respondents do not get help from their husbands. They say that they are “useless” in “helping” their wives, and this is mostly because of strict traditional gender roles in Nepalese society. A husband’s economic duty is generally accepted in Nepal but not his “help” in domestic chores. It is a woman’s duty to do all the domestic chores under any circumstances. If a husband wants to help his wife, he is

criticized as hen-pecked and discouraged from helping (Mullany 2005). Their only socially accepted duty is to provide financially. But the husbands of our respondents do not fulfill this duty either and put more burden on the women. As mentioned in the Cairo Conference (Kawachi et al. 1999), this unequal financial and domestic burden is impacting women's health, limiting the time to take care of their own health or to get enough rest and food. The situation of the women in my study shows that prenatal care is not only a health problem but also a gender problem (Gaestel and Shelly 2013).

These women do not get help and support to acquire the required rest and nutrition during pregnancy. Their lack of both cultural and economic capital prevents them from seeking prenatal care. In order to assess their cultural capital, we look at their education, skills and knowledge gained from older generations, and information obtained through media. Most of the women had never been to school, and those who went to school dropped out of the school when they were in 5 or 6 grade. Although some non-formal adult education classes are available in Nepal (Government of Nepal, 2008), these women are unable to attend such classes because of their duties towards their families. They "have to work for food" throughout the day, and they are too tired at the end of the day. They have no time or energy to attend classes. Lack of education can be considered as one of the barriers in accessing prenatal care which is consistent with the existing literatures (Joshi et al. 2014; Sayami, Bhandari, Tamrakar, and Banjara 2014; Shrestha 2013; Shrestha and Shrestha 2011).

These women who lack education are further deprived of the information regarding their health care due to the lack of access to media. They have no or little exposure to media—radio, newspaper, and television. Those who own a television do not

watch television regularly. Even if they watch it, they mostly watch music and some T.V. series but not news, or informational programs. For some of the women, their only sources of information are their relatives and neighbors. But the relatives and neighbors are not well informed either. Therefore, these women either are not aware of the free services and incentives or are misinformed. If they had access to media and more information about care during pregnancy, free services, and incentives, they might be encouraged to seek prenatal care and give birth in a hospital. Thus, as also mentioned in the existing literatures (Joshi et al 2014; Shrestha 2013), lack of media access was found as a barrier to accessing prenatal care.

Lack of education and lack of access to media leave them ignorant of existing healthcare services. Moreover, the cultural capital these women possess is not enough to seek health care, especially during their pregnancy. Most of the women mentioned that they were not advised to seek prenatal care. They do not receive information or advice from their husbands, parents, or in-laws. These possible sources of knowledge lack knowledge themselves or do not give advice to the women. The mothers and mothers-in-laws do not know enough about healthcare services to encourage their daughters and daughters-in-laws to get prenatal care. This lack of cultural capital in seeking prenatal care is consistent with existing literatures. Pinxten and Lievens (2014) also found the effect of cultural capital on health.

Most of these women know that institutional birth is better than home birth. Yet, they believe that if there are no complications, home birth is fine. As mentioned by Gaestel and Shelly (2013) in their study, for these women (rural and poor), survival matters, not comfort. Although they say that “everything went well at home,” we are not

assured that everything indeed was fine. They tell themselves and others that everything was fine because they cannot afford a hospital birth. It appears that they rationalize their behavior and choices, and thus justify the home birth. As mentioned by the respondents, two main barriers for a hospital birth are affordability and the distance to the hospital. The women believe that they cannot afford a hospital birth. Although some services are free and an incentive is given for institutional birth, these women either are unaware of the service and incentives or do not believe they will get that incentives. We found that even for the women, who are aware of the free service and incentive, these programs are not enough to motivate them to give birth at the hospital. They assume that they will have to pay more to the hospital than the amount they get as incentives. They do not know the details of the program. They do not have to pay hospital charges and doctor's fees. If they have a normal birth, everything will be free; no medications will be required. And, if they have a caesarean section, they will have to pay for medicine (mostly, only antibiotics are required). The cost of the medicine will be less than the incentive they get for a hospital birth (based on personal communication with a doctor working in a district hospital). As an incentive for hospital delivery, the mothers are paid between Rs 500 ($5) to Rs 1500 ($15) depending on the region (Gaestel and Shelley 2013). Mothers who deliver their babies at Baglung hospital receive Rs 1000 in incentives. However, the women do not know which services are free, which are billable, or the amount of the incentives. Similarly, they lack information regarding the free prenatal care services. Although prenatal care services are free of cost throughout Nepal (Mahara et al. 2015), the women assume that it is not free in the hospital, thus, they do not want to go there. We can conclude that without making the targeted women aware of the details of free services

and incentives, such programs cannot be effective in motivating women to get prenatal care or deliver their babies in the hospital.

Along with the affordability, distance to the hospital is another equally important barrier to prenatal care and hospital birth. This finding is similar to what Choulagai et al. (2013) and Thaddeus and Maine (1994) found. The women have to walk up hills and down hills to reach the birth center/hospital. The nearest birth center is a three hour walk from the village. Although a motorway was built to connect the village with the district headquarter (where the only hospital of the district is located), no (affordable) transportation is available to get there. The scarcely available transportation is also very expensive. The women prefer to walk and save the money for something else. Thus, going to the hospital demands both physical and financial effort which these women cannot afford.

Both of these barriers—lack of awareness and distance to the hospital—are rooted in the economic status of women. If these women were more affluent, they would not have to worry about the health care costs, amount of incentives, as well as the transportation. Therefore, although free services and incentives are available, their economic status still affects their health care. An effect of economic status on prenatal care in Nepal was also found by Joshi et al. (2014) and Shrestha (2013). A few of these women mentioned that they get financial help from their mother or brother. Those who get such help get prenatal care and see doctors regularly. Women who used to go to the doctor in their childhood see a doctor in their later life too. Therefore, we can say that these women's prenatal care is affected by both cultural capital and economic capital.

The lack of cultural capital is, more or less, a result of lack of economic capital. The knowledge they could acquire through education and media is compromised by their economic status. Because of poverty, they had to drop out of the school (Wagle 2012) and are unable to attend non-formal education classes. Also due to poverty, they do not have access to media, thus, they lack information. As demonstrated by Pinxten and Lievens (2014), we also found the impact of cultural and economic capital on healthcare seeking behavior.

Even if the women are able to make it to the hospital despite the barriers, they perceive some discrimination. Although they do not perceive caste-based discrimination in the healthcare settings, some of the women said they prefer healthcare professionals of their own caste and gender. Moreover, a few women believe that they are discriminated because of their low economic status. They feel that doctors look for nothing else than money, and money determines the quality of the treatment. We found that the healthcare professionals at the sub-health post in the village recommend hospital births; however, the women did not receive detailed information about free services and incentives. The women believe that the health care professional do not care about them (since they are poor and *dalit).* Based on the Lorber's (1997) concept of discrimination in the health care setting, we can argue that discrimination might play a role in the lack of information that these women receive from the health care professionals. The women in this study feel the discrimination on the basis of their economic status; and, they prefer healthcare professionals from their own caste and gender.

We found that cultural capital and economical capital play a significant role in the prenatal care of *dalit* women. In addition, the unequal burden of domestic and economic

responsibility creates barriers to seeking prenatal care. The very root cause of their hardship and lack of prenatal care is their caste status. Although caste discrimination is outlawed in Nepal, we can still see its effect on prenatal care. Even if they do not perceive caste-based discrimination in the health-care setting, they do experience hardship in their daily lives as a result of their economic and social status. The lack of education can be attributed to their lack of material resources. They did not go to school because they had to work from their early childhood on. If their parents were more affluent, these women would go to school and would work in a better paying job now. Since they lack education, they have very limited job opportunities, the jobs they get are underpaid. Thus, they, like their parents, are poor again. Their children lack proper education. All of the children, even those who go to school too, help their mothers in the farmland and learn this job early on. The children lack formal education but acquire training in farm work. Thus, they cannot compete in the job market and end up in the same jobs their parents are holding. Similarly, they inherit nothing from their parents to help them financially. Thus, the cycle of poverty continues.

Most of our findings are consistent with the existing literature. But, we found something different in regard to women's decision making power and their practice of traditional health care (Joshi et al. 2014; Niraula 1994; Shrestha 2013; Subedi 1989). In existing studies, women's decision making power was found to positively affect prenatal care. We did not find that in our study. Although decision making status is a sign of empowerment, in our study it is a result of their sole financial and domestic responsibilities. The women make decision not because they are "empowered" but because their husbands are not contributing to the family or are not present. Similarly, we

found that these women practice both spiritual and biomedical health practice. However, their practice of spiritual healing does not seem to affect their use of biomedical health care. They determine the nature of care by looking at the nature of sickness. If they are "touched by an evil spirit," they seek spiritual healing. Since, for them, pregnancy is not something caused by "evil spirit" they do not go to spiritual healers for prenatal care. Therefore their practice of spiritual healing does not seem to interfere with their use of biomedicine.

The existing gender roles in Nepalese society, poverty, distance to the hospital, and the lack of awareness of the free services and incentives are found to affect *dalit* women's prenatal care and hospital birth. If they were to receive financial and domestic help from their husbands, they would have time and money to get healthcare. If they were more affluent, they could afford transportation and the distance to the hospital would not be a problem. They could take a ride which would be less time-consuming and less physically demanding. It is less than half an hour drive to the hospital. The long distance to the hospital would not be an issue if they would not have to carefully allot their limited resources. Similarly, if they would have more time and money to access media and education, they would be aware of the recommended prenatal care, free services, and incentives. Therefore, the lack of economic resources is at the root of the situation. The lack of economic resources can be traced back to the past where caste discrimination was stronger than today. However, the effects of the caste discrimination still impact the present economic condition of these women. Therefore, one way or the other, the lack of prenatal care among these women is due to their caste status.

Limitations of the Study

As we used telephone interviews for the data collection, visual cues were absent; however, we do not think that we missed important data. Since our study is concentrated on the prenatal care experiences of rural *dalit* women, the results might not be applicable to the urban *dalit* and rural non-*dalit* populations. However, the results will be applicable to areas of similar socio-economic and geographical composition. Although some of our respondents mentioned perceived caste-based discrimination in their daily life, we did not study this discrimination in detail. We focused on discrimination in the health care setting. Effects of caste –based discrimination on their social and economic life should be studied in future.

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Interview Schedule

Basic Demographics

1) How old are you?
   Nepal study
   a) <20
   b) 20-24
   c) 25-29
   d) 30-34
   e) 35+

2) What is your highest level of education?
   a) S.L.C. or lower
   b) +2
   c) Bachelors degree
   d) Others

3) What is your occupation?

4) What is your husband's education level?
   a) S.L.C. or lower
   b) +2
   c) Bachelors degree
   d) Others

5) What is your husband's occupation?
   a) Where is he working?
      a. If he works out of town, how often do you meet?

6) What is your mother-in-law's education level?
   a. S.L.C. or less
   b. +2
   c. Bachelors degree
   d. Others

7) Do you live with her?
   a. Yes
   b. No
      i. Does she live nearby?
         1. Yes
         2. No

8) Does she give some suggestion regarding household, healthcare, etc?
    a. Yes
        i. What type of advice does she give?
        ii. What does she help with?
        iii. Do you ask her for advice?
    b. No
        i. Who do you ask for advice?

9) Could you please describe the relationship between you two?

10) Does your mother live nearby?
    a. Yes
    b. No

11) How often do you meet your mother?
    a. Every month
    b. Only during festivals
    c. Whenever I miss her
    d. Rarely

12) Does she give some suggestions regarding household, healthcare, etc?
    a. Yes
        i. What type of advice does she give?
        ii. What does she help with?
        iii. Do you ask her for advice?
    b. No

13) Who makes decisions regarding the household and family?
    a. Mother-in-law
    b. Father-in-law
    c. Husband
    d. You
    e. All family members together

14) What is a typical day in your life? What do you do?

15) What is your husband's typical day looks like? How does he help you? Does he support you decision regarding household and healthcare?

16) What is your mother-in-law's typical day look like? What does she do?

Accessibility to Information and Healthcare

1) Do you have electricity at home?
    a. Yes
        i. How many hours?
    b. No

2) Do you have telephone at home?
    a. Yes
        i. Is this a landline phone or a mobile phone?
            1. Landline
            2. Mobile Phone
                a. Does this phone belong to you?
    b. No
        i. Do you have access to someone else's (friend, relative, or someone else in village) telephone?

3) Do you have television at home?
    a. Yes
        i. How many hours in a week do you spend watching television?
        ii. Do you watch any program related to health and pregnancy care?
    b. No
        i. Do you watch television at someone else's home?
            1. Yes
                a. Where do you watch?
                b. How often do you watch?
                c. Do you watch any program related to health and pregnancy care?
            2. No

4) Do you have a radio at home?
    a. Yes
        i. How many hours a week do you listen to radio?
        ii. Do you listen to any program related to health and pregnancy care?
            1. Yes
            2. No
    b. No
        i. Do you have access to someone else's radio?

5) Do you have internet access at home?
    a. Yes
        i. How many hours a week do you spend in internet?
        ii. What do you do mostly with internet?

b. No
    i. Do you have access to it somewhere else, like in someone else's house or in cyber café?

Health-care facilities

1) What do you do when you feel sick? Where do you go?

2) Do you have a health-post in your village?
    a. Yes
        i. How far is it?
        ii. Do you go to the health-post?
    b. No

3) Who provides health care in the health-post?
    a. Doctor
    b. Nurse
    c. Auxiliary Nurse Midwives
    d. I don't know

4) What is the cast and gender of most of the health care providers?
    a. Male upper-caste
    b. Male lower-caste
    c. Female upper-caste
    d. Female lower-caste
    e. I don't know
    f. I don't care

5) Do you feel they treat you well?

6) Who do you prefer to see when you go there?

7) Do you go to the district hospital?

    a. Yes
        i. How do you get there?
            1. Walking
            2. Motorcycle
            3. Public transportation
                a. Do you think it is expensive?
                    i. Yes
                    ii. No
                    iii. I don't know

ii. Do you have to give your first and last name to be registered for check-ups?
    1. Yes
    2. No
iii. Do you think doctors/nurses treat you differently than upper-caste people?
    1. Yes
    2. No
iv. Do you care about the caste and gender of the healthcare providers? Do you feel someone else with different caste and gender will treat you better than the existing?
v. Is ambulance service available in case of emergency?
    1. Yes
    2. No
    3. I don't know

b. No
    i. Could you please explain me why you don't go to hospital? Do you feel you don't need to see a doctor?

8) Do you go to traditional healer?
    c. Yes
        i. Could you please explain me why you go there?

9) Do you prefer traditional healer to modern health care providers?

10) Who do you feel comfortable with and why?
    a. Modern health care professionals
    b. Traditional healer
    c. I don't care

11) What keeps you from seeing a health care provider or healer?

Do you worry about missing work when you go to see doctor?
Do you worry about taking care of children when you go to see doctor?
Finances?

Pregnancy

1) How many children do you have?
    a. 1
    b. 2
    c. 3

d. More than 3

2) How old is your youngest child?
    a. Less than 12 months
    b. 12 to 23 months
    c. 24 to 35 months
    d. 36 to 47 months
    e. More than 47 months

3) Was your last pregnancy planned?
    a. Yes
    b. No
    c. I don't want to answer

4) Are you aware of contraception?
    a. Yes
    b. No

5) Do you have any idea who, wives or husbands, usually makes decisions regarding contraception in your village?

6) Who did you tell about your pregnancy first?
    a. Mother-in-law
    b. Husband
    c. Mother
    d. Friends and relatives
    e. I did not tell anyone

7) Where did you give birth to your child?
    a. Hospital
        i. Why did you go there?
    b. At home
        i. Who was there to assist you?
        ii. Why didn't you go to hospital?

8) When you were pregnant, did you do anything different regarding diet, rest, lifting heavy load etc.?

9) How do you view the pregnancy period?
        i. Is this a natural phenomenon? Why do you feel in that way?
        ii. Do you think you have to take special care during pregnancy?

10) Did you get prenatal care? And how? Do you feel prenatal care is important?

11) Who do you ask for if you have any questions, concerns, or problems regarding your pregnancy?
    i. Did your mother, mother-in-law, husband, relatives, and friends recommend going to doctor while you were pregnant?

12) What do you know about the care during pregnancy, and how did you know that?
    a. Are you aware of the signs of dangers during pregnancy?
    b. Do you know there are seven components of prenatal care?

13) Do you recommend your friends and relatives to go to health clinics during pregnancy?

14) Are you aware of free prenatal care and incentives?
    a. Yes
        i. How do you know that?
    b. No

15) Did you pay for prenatal care?
    a. Yes
        i. I went to private clinics.
        ii. I did not know about free care.
        iii. Some services were free and some were not.
        iv. I don't remember
    b. No
        i. If you had to pay for health services, would you go there?
            1. Yes
            2. No
            3. I don't know

16) Did you get any incentives?
    a. Yes
        i. Was it a reason for the prenatal check-up?
    b. No
        i. Were you aware of the incentives?
            1. Yes
            2. No

17) In your opinion, what, if anything, should be done to get women prenatal care?