Perceptions and Care Seeking Behavior of Obstetric Complication in Thailand

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ABSTRACT

Background

Importance of maternal health has been recognized over the last decade, however information about the perception of illness and healthcare behavior of obstetric complication is lacking.

Objective

This study assesses women's knowledge, perception, and experience of obstetric complication and care-seeking behavior and explores the factors associated with the morbidity and the constraints hindering them from seeking timely care.

Methods

Twenty one in-depth interviews on the perceptions, experience and care seeking behavior related to pregnancy and delivery of Women at Kanchanaburi Demographic Surveillance site of Thailand were conducted. A structured guideline was first prepared in English and translated into Thai language. An interpreter was hired to interview women at the Thai-Myanmar border to translate Thai into local language. A moderator note-taker, and interpreter were present throughout the interview period and tape recorded the conversation.

Results

In-depth interview revealed that even though quality maternal health care was accessible to most of the women, obstetric complication was prevalent and they were not seeking appropriate care specifically in highland. Too early and too late marriage, frequent child bearing, poverty, hard work, poor nutrition and traditional practices were the reasons for complications. Poor transportation, lack of health insurance, inadequate training of health personnel, poor health facilities and the perception that the complications are normal for pregnant women were the main reasons for not seeking appropriate care.

Conclusions

Perceived reasons for complications among women living in Kanchanaburi, Thailand were early marriage, frequent childbearing, hard work, poor nutrition and traditional practices. The constraints hindering them from seeking care for the complications were perceived to be the lack of access to health personnel, health facilities, and proper transportation. These issues seemed to be related to poverty.

KEY WORD

Care-Seeking, Complication, Obstetric, Perception, Thailand

INTRODUCTION

The importance of maternal health has been recognized over the last decade through the safe motherhood initiatives. There is, however, a lack of research on prevalence and determinants of maternal morbidity in developing countries.[1] There is also less information about the perception of illness and healthcare behavior with regard to obstetric complication in Thailand. Thailand has identified women's reproductive health as one priority area in its national health development policy. Interventions to increase access to health services and training of midwives have created an enabling environment to the extent that most deliveries occur in hospitals.[2]

One of such interventions is the "Universal Health Care Policy", which was started from the dual health insurance system for formal and informal sector aiming to come up

with the single-payer or national health insurance. Thailand has also launched the 30 Baht health policy since 2001. Purpose of the 30 Baht policy was to insure all Thai people who were not in any health insurance scheme. Under the 30 Baht scheme, the people would receive the universal health card or the gold card. To receive health care, recipient must show the 30 Baht card. The accessing health service has to follow the referral system from primary health center or nearby hospital, which are registered under the project. For emergencies and accidents, the insured can access any government health services. To access needy health services, the insured must contribute a co-pay of 30 Baht per episode. Quality of the service provided by 30 Baht Universal Coverage Policy is however being the same quality health services as offered by other health schemes.[2]

Despite these interventions including "Universal Health Care Policy" to improve the access to health care, deliveries are still carried out at home by Traditional Birth Attendants (TBAs) or family members without skilled attendants, particularly in the remote areas. There also appear high numbers of women reporting complications during pregnancy, delivery, and the postpartum period and not receiving appropriate care. Kanchanaburi Demographic Surveillance System data reveals that about forty percent of women who delivered babies in recent years reported severe obstetric complications and only half of them reported that they received care from trained health persons.[3] This has increased the interest in asking why women experience such complications and seem to avoid receiving care for these complications.

Socioeconomic and cultural factors are expected to affect maternal morbidity via health status, reproductive status, access to health services, and health behavior.[4] Recognizing the symptoms and receiving treatment is crucial for protecting women from death and disability. It is however a complex process because symptoms of maternal morbidity are perceived and interpreted differently by people in different social and cultural contexts.[5] Family members or social network, traditional healer, and the trained professional are three main sources whom women can contact when experiencing health problems.[6] Type of illness, perceived cause of illness, accessibility of services, and beliefs about the relative effectiveness of the source of treatment can all play an important role towards care-seeking behavior.[5]

There is less information about the perception of illness and healthcare behavior with regard to obstetric complication. Some researchers report that identification of symptoms and perceived severity of those symptoms have separate effects on treatment choice. Socioeconomic, behavioral and cultural factors also affect maternal healthcare use.[7] Different beliefs about disease causation such as attack by evil spirits or supernatural causes, food prohibitions, etc. were some mechanisms that were identified as socio-cultural factors that affect morbidity and care-seeking behavior.[8]

Existing literature indicates that Thai culture encourages women to become pregnant as soon as possible after marriage. Social support available to them and their position in the society influence the way women perceive motherhood, problems related with it, and the need (or not) for appropriate care.[9] It is also found that hill tribe women in Thailand get married and have children at a lower age and are even less likely to utilize maternal health services. Therefore, these women suffer more from high maternal morbidity and mortality.[10] A qualitative study carried out in Khon Kaen Province of Northeast Thailand indicates that about seventy percent of women experienced at least one gynecological problem in 1998.[11] Limited access to health services, traditional cultural and religious beliefs, and negative perception of health services were believed to be the possible reasons of maternal health problems.[11]

Different barriers, such as lack of quality service, attitude of health personnel, socioeconomic condition, cultural traditions and beliefs, and knowledge and perceptions concerning the health complications are perceived as factors that prevent women from seeking appropriate care. Urbanization, migration, and rapid transformation of society have increased the probability of marriage being unstable. These factors have raised the proportion of single-headed families, and diminished social ties causing psychological stress in society.[12] In-depth analysis of the relationship of these issues to perceptions and experiences of pregnancy labor and birth and care received at these times has been a neglected area of research in Thailand.

In order to plan for improved health service and community outreach, it is necessary to better understand the health culture of Thai women and the way existing health resources are being utilized for pregnancy-related problems.[13] The present study fills this gap by exploring the perceptions, knowledge, and experience of obstetric complication and care during pregnancy, labor, and birth of Thai women in the Kanchanaburi Demographic Surveillance System site. Specific objectives include,

- to assess women's knowledge, perception, and experience of obstetric complication and related care-seeking behavior
- to explore the factors associated with the complication and the constraints hindering them from seeking care

METHODS

This study is a descriptive cross-sectional qualitative study conducted in Kanchanaburi Demographic Surveillance System Site in Thailand. Respondent of the study were chosen from among the respondent of the Survey of Pregnancy Birth and Early Life (SPBEL). SPBEL was conducted in a sample of 86 villages and 14 urban tracks of Kanchanaburi Demographic Surveillance System (KDSS) site in Thailand. The survey identified 1067 women who were either pregnant or had given birth in the last three years preceding the survey. Out of 1067 eligible women 417

reported that they experienced obstetric complications. Out of the 417 women, ten percent (41) women were randomly selected for the in-depth interview, however only 21 women were traced.

We asked a number of issues concerning obstetric complication and care-seeking, including their perceptions, knowledge of danger signs, timing of healthcare, their perception about availability of health infrastructure, quality of health services, and transportation. Major obstetric complications during pregnancy, delivery or postpartum period included in this study were, high blood pressure, severe headache, severe vaginal bleeding, swelling of face, hand and leg, fits, seizure and convulsion, fever, foul smelling discharge, retained placenta, ruptured uterous, pitting edema, less or stop fetal movement. Other less severe complication included were back pain, abdominal pain, leg pain, vomiting, dizziness, and others if any. Institute for Population and Social Research (IPSR) ethical board granted the ethical clearance to revisit the women of SPBEL study. We also received informed consent from all participants before the in-depth interview.

We prepared a structured guideline in consultation with a maternal health expert, translated into Thai language and provided a one-day orientation to the three local interviewers who were familiar with the quantitative survey questionnaire. We also did a pilot test with the women who had recently given birth and revised the questionnaire before conducting the in-depth interview. We hired an interpreter to interview women at the Thai-Myanmar border to translate Thai into local language. A moderator, note-taker, and interpreter were present throughout the interview period and tape recorded the conversation. The in-depth interview lasted approximately up to 60 minutes.

We used the "*Domain Analysis*" approach suggested by Atkinson and Abu-El-Haj to derive patterns in the women's responses.[14] Core themes included community context, knowledge, perception and care seeking behaviour of obstetric complication. We transcribed the recordings of interviews for detailed analysis and examined the transcripts for the women's explanations that were related to the concept concerned. To compile the information we derived some important themes related codes and sub-codes for each theme and used Microsoft Word to copy and paste the important responses representing codes and sub-codes under each theme into separate file and prepared a summary finding from each new file. We also used simple descriptive statistics to examine the patterns of socio-demographic information of the respondents.

Main limitation of the study is that the obstetric complication is based on women's self-report. Self reports are found to have low correspondence with medical examination. The in-depth interview was carried out few years after the delivery; therefore women's response on their experience of obstetric complication may have recall bias.

RESULTS

Socio-demographic characteristics

A majority of the women selected randomly for in-depth interview were over 30 by age and only two were under twenty. Nine of them were between 20-30 years age. Most of them could speak Thai (17) in their daily communication and four were non-Thai. Half of the respondents completed high school (10) and six had no formal education. Seven women had only one living child and two had more than four living children. Half of them were not working and four were working in the agriculture sector. Eight women were living in upland areas; six were in rice fields, three in cash crops, and the rest in urban or mixed economy strata. Eight women were non-migrants, four were international migrants, and the rest were internal migrants. Almost all (except 2) were covered with health insurance (30 baht policy).

About a half of the respondents (10) reported that they did not have any health facilities in the village, however, accessing a health facility was not a big problem. …."for health care I can go to Thongpapun hospital first by taking a boat for one and a half hours and then by taking a pick-up for 15 minutes"…. (T19).

With regard to the health personnel, most of the respondents said that there were TBAs and community health volunteers in their village. But they could receive help from a Midwife and Doctor during illness within the village only when they were in the village. …."there are four TBAs in the village but no other health personnel. Every six months a mobile team of doctors from King Mother's Foundation comes to this village"….. (T13).

More than half of the respondents said that there was a bus route to the village. They reported that the bus passed by the village about two times a day on an average. Upon asking the common mode of transportation, most of the respondents reported that they can use motorcycles for transportation in case the bus was not available. Some women said they used car, taxi and pickups. A few respondents reported that they had to walk or had to use boat to reach the nearest health centre.

Many of the participants said that it took them half an hour to reach the nearest health center. Some replied that they could reach a health post in less than one hour but others said that it took more than an hour or two.

Most of the respondents said that they had the government's 30 baht card and that they had been benefited from the card. Some of them however noted that only one member of the family had the card while others said that no one had the card intheir family. Women who reported that they didn't have any access to health facility or had a problem accessing health services or a problem with lack of transportation or lack of health insurance were living in upland areas, and most of them had less than a primary education, were migrants, and were either unemployed or

working in the agriculture sector.

Respondents were asked about the main problem they were facing in the village. The response varied according to the place. Respondents from the upland area reported that their main problems were the lack of roads, electricity, bus routes, and health facilities. Women from the rice field strata reported that they were facing problems of getting tap water, building a concrete road, shortages of health personnel in health centers, and lacking good electricity supply. Women in the cash crop strata cited the lack of good quality roads. The respondents from Mixed Economy and Urban strata reported that they had good social and health infrastructure in their village.

Knowledge/perception of maternal health

Most of the respondents said that they gave birth at the hospital. They believed that giving birth in a hospital is safer than giving birth at home because good equipment and modern medicines are available at the hospital. They were also asked the reason why they thought home delivery was dangerous. They replied that giving birth at home is unsafe since it lacks essential materials for delivery. They also added that home born babies may be infected by tetanus, which may cause the baby to die. ….”Delivery at home is dangerous but hospital delivery is safe because it has good equipment and modern medicines are available there”….. (T9).

….”Giving birth at home is difficult because no one can help while giving birth but at the hospital it is convenient and safe”….. (T14).

Even if most of the respondents perceive that hospital delivery is safer for mother and child, some women still have their babies at home. They cite shortage of money as the main reason for home delivery. ….”It is safer to deliver the baby in the hospital but I delivered all my children at home because of lack of money”….. (T4).

….”It is easier to deliver at home compared to delivery at the hospital because I have to pay more for the hospital; I have no other concern except this”….. (T20).

….”Delivery at home is good but pregnant women nowadays prefer to deliver at the hospital”….. (T3).

Women with above views were particularly from upland and mixed economy strata. One was a migrant, all were Thai-speaking, and one of them was working in the business sector.

Discussion was also conducted to assess the level of knowledge and experience of women with regard to the danger signs during pregnancy, delivery, and the postpartum period. Almost all participants said that they felt back pain, abdominal pain, leg pain, vomiting, and dizziness. Some of them also felt rib pain, found water running out from the vagina and dark color of urine, dysentery, suffocation, swelling, and fainting. These symptoms were perceived as normal. The women were probed as to why they felt that these symptoms were normal. They replied that they occur when women get pregnant and that they all disappear after delivery. ….”I had morning sickness, bleeding, back pain, and leg swelling; I did not do anything as these are normal during pregnancy. I also suffered from pain and foul discharge from my vagina”….. (T3).

….”I did not have any major complications but felt only morning sickness, swelling feet, and vomiting, I think those symptoms are normal”….. (T2).

….”I did not suffer from any major complications but I fainted and felt like I was suffocating before delivery. I did not do anything as it was a short”….. (T5).

Women could not recall the danger signs and symptoms immediately. Upon further questioning they said that anemia, hemorrhage, fainting, and vaginal tear with serious bleeding were danger signs because these may lead mother and baby to die. When they were asked further, they recalled other complications such as abnormal presentation, high blood pressure, and low blood volume.

…. “I had sat too long and had gas hitting the pit of my stomach. I suffered from pain under my belly and sometimes I felt faint and disoriented, had pain in the ribs, back pain, and felt like I was being suffocated. I experienced bleeding in the fifth and sixth month of pregnancy, as well as dysentery, loss of appetite, water running out from my vagina, and dark urine. My belly had not enlarged; it was quite small, I thought it was abnormal and went to see the doctor”….. (T21).

….”My vagina was torn open with bleeding but I did nothing. I just lay near the fire after giving birth for 7 days and I felt better. Light color water was running out from my vagina and it itched”….. (T11)

In assessing their health behavior, women were asked, about what they did upon experiencing problems during pregnancy, delivery, or the postpartum period. At first they replied, “Nothing,” but after probing majority of them said that they sought care from health facility.

….”I lost a large amount of blood, my three dresses were totally wet, but after treatment I recovered”….. (T14).

Some women also reported that they received traditional care.

….“I fainted and fell down during the 7th and 9th months of pregnancy, but after some time things returned to normal. I also had a urinary problem but it was cured after home treatment. I used traditional methods of care, such as lying by the fire”….. (T11).

Information was also gathered regarding any benefits pregnant women gained if they visited health centers. Most of them said that women could receive many benefits from doctors. They gave suggestions concerning many beneficial things that pregnant women should do to take care of themselves and their babies.

…."It is better to visit the doctor, as they teach how to do breast feeding, how to hold the baby, give the baby a bath, and many other necessary things"….. (T17).

Care-seeking behavior

Women perceive antenatal care as an important aspect of their pregnancy. Majority of them reported that common places for antenatal care were hospitals and health centers. Most of the respondents thought that transportation was convenient while seeking care during pregnancy, delivery and postpartum period. They also said that the cost for the transportation was manageable. Even in the village where frequent public transportation was not available, some women reported that they could manage by hiring private vehicles.

…."I had antenatal care in the first month of pregnancy and visited the hospital once a month until the eighth month. In the eighth month, I had to go to the hospital 3-4 times a month, and in the ninth month, once; altogether 12 times"…. (T6).

…."The mode of transportation to get to the health facility is bus or motorcycle; the cost for renting one is 300 to 700 baht"….. (T1)

…."Mostly I use my brother's truck; sometimes I pay for fuel for his truck. If I go to nearest hospital (Borpoly), I pay about 300 baht"….

Most of the participants replied that they made the decision to seek healthcare either by themselves or jointly with their family. Some women also replied that it took them a long time to make a decision to seek care, and others did not seek care at all for their complications

…."My family decided that I should get treatment; they thought treatment is important for my child and me because active bleeding is abnormal and not so good"….. (T14)

…."I had many problems. Sometimes I decided on my own to get treatment, and sometimes it took a lot of time to make a decision. Sometimes I spent more than 24 hours trying to decide whether to seek care; other times I did nothing and left it as it was"…. (T16)

Money, transportation, availability of a doctor, and quality of services were some reasons for delay in seeking care or inability to seek care. Most of the respondents said that they used vehicles such as a car, bus, taxi, or motorcycle to seek the care. They also added that they had spent the sum total of 500 baht on an average for seeking care. Some of them pointed out that transportation were a problem to seek the care. They also replied that they had to spend more time on the road to go to seek care due to bad road conditions and poor transportation. Some respondents also reported that it was difficult to seek care during rainy seasons since buses did not play during the season due to bad roads.

…."Waiting time to seek care depends on the time you arrive at the hospital. If you go to hospital early in the morning, no need to wait for long time. For me, sometimes I waited for medical service for 1-2 hours because of a long queue. I had to wait 3 hours to finish the whole process"…. (T1).

When women were asked to explore reasons for other delays in receiving health service, common replies were the lack of resources in the health center and the heavy patient load at the hospital. Some, respondents also said they did not seek care because they had neither health insurance nor money to seek care.

…."Even if a public health station has three doctors, only one stays permanently. The other two doctors may go away for study. When I went there with an emergency situation, I had to wait for a very long time"…. (T17)

…."I wanted to see a doctor but I did not have money or a health care because I was an illegal migrant "…. (T20).

Some women replied that they paid more money for health care even if they had a 30 baht card because they thought that the service provided in health centers where their card was valid was not good, so they had to go to a better hospital elsewhere.

…."Service in Sriswat hospital is not good due to the 30 baht card system and medical equipment is also not good there, but the service in Bangplee hospital is good. In Bangplee hospital doctors are good, but nurses are not"…. (T7).

…."I spent 1000 baht for health care because the 30 baht card did not work there. Each time I also paid more than 100 baht for medicine at Siriraj hospital"…. (T9).

…."I spent 800 baht in hospital because I did not know about the 30 baht card at that time. The price for delivery at hospital was 1500 baht, but I could afford only 800 baht, so I gave only 800 baht to the hospital"….. (T21).

Most of the participants replied that the quality of service in the health facility was good. They said that even though the medical equipments are in good condition, health person's behaviour, cleanliness and delivery and operation room space were some reasons why they do not prefer to go to hospital for maternal health care.

…."Quality of medical materials in the hospital is okay, but in case of serious illness, I will not go to this hospital anymore because I met nurses who talked very badly with me. I would rather go to Paholponpyanhasena hospital because doctors are more responsible there"….. (T1).

Most of the respondents said that they had to pay the 30 baht fee for the health service. They replied that they had the 30 baht scheme, which made it very easy for them to access healthcare. They also said that they had to pay extra money for living, food, and other activities. Some participants said that the 30 baht was a nominal fee for them.

DISCUSSION

This study may not represent the perceptions and experience of all Thai women in Kanchanaburi Province of Thailand; however, we seek to provide a deeper understanding of women's perception of illness during pregnancy and factors related to the timing of care-seeking behavior. Three important themes came out of the women's responses: community context, knowledge and perceptions concerning obstetric complication, timing of healthcare.

Community context

Easy access to quality medical services plays an important role in maternal health. Availability of health facilities and trained health personnel in the community would help protect pregnant women from maternal morbidity and mortality. Regular transportation and good roads would help to reduce delays in seeking care in emergencies. In one study, rural Tibetan women complained that it was impossible for them to use health facilities because they were too far and regular public transportation was not available, transportation by car or truck was quite expensive.[15] Respondents of this study reported that hospitals were located on an average more than 5-7 kilometers from their residence. To arrive at a hospital took about 30 minutes to one and half hours traveling time, either by bus or other vehicles. They also explained that it was hard to get a bus at night, in the event that they encountered a problem related to pregnancy and needed to see a doctor immediately. Traveling cost also varied, according to participants' reports. However, most respondents did not highlight these factors as a reason for delay in seeking care. Some of them, (especially from highland areas) reported that they didn't have any transportation facilities in their village except for a boat. As they didn't have any health facilities in the village itself, receiving timely treatment from the nearest hospital was a problem in emergency situations.

Most of the participants in this study reported that there were a number of health volunteers or TBAs, but receiving health service from a midwife during illness within the village is not always easy. They also reported a lack of special health related activities in the village. It is therefore worth noting that villagers were poorly informed about services and activities of midwives and health volunteers who were supposed to bring health services to the village.

Some women, particularly in upland areas and those who had migrated from Myanmar reported that they did not have any privilege card and thus were afraid to go out of their village because of their illegal status. Few also perceived that the quality of service provided in the hospital that their card could cover was not good; therefore, they had to go to another hospital and spend more money.

Marshall et al. reports that lack of employment and health insurance as well as low income are the most prevalent barriers to healthcare for both documented and undocumented immigrant women.[16] The barriers and their effects are exacerbated by language barriers and lack of familiarity with the healthcare system as well as fear of being arrested and deported. A similar problem was reported by migrant women in Kanchanaburi in this study. To address this issue, the importance of the role that immigrants play should be recognized and action should be initiated to provide needed health services to all immigrants, most importantly to pregnant women, regardless of their legal status.

Knowledge and perception of obstetric complication

Jirojwong et al, argued that whether or not women seek pregnancy-related care depends on their knowledge and perceptions of risks associated with it.[17] If women believe that their pregnancy is at risk, they may seek care.[18] Currie & Wiesenberg also argued that despite good medical knowledge, better health can come only through behavior change.[19] If women do not change their behavior, even if services are available, there is no guarantee that women will use them. Empowered women can create social and economic conditions that lead them to utilize health services as an exercise of their rights.[17] Women participated in this study highlighted their experienced symptoms as swelling, back pain, morning sickness, bleeding, and fainting, but they did not perceive them as threats to their health. Their neglecting the significance of these symptoms can lead to further complications, either during the pregnancy, at the point of delivery, or after delivery. However, most of the study respondents did not give much importance to such a scenario. This could be due to poor understanding of the meaning of the questions, lack of knowledge about the complications, or notions that complications during pregnancy are "normal".

Care seeking behaviour

In-depth interview participants highlighted their healthcare-seeking practice starting from the very early months of their pregnancy. Most of them visited a hospital for antenatal and delivery care, even though hospitals were not located in their own village. They also replied that they saw a doctor almost every month. This style of seeking care remained until delivery, according to their description. Potential complications might have been prevented due to regular consultations with a doctor. Therefore, the respondents might not have noticed minor complications that occurred during the time between doctor's visits and those that were treated by the doctor. It may also be possible that the respondents could not recall their complications during the pregnancy since some of the pregnancies had occurred more than three years before. Or, the interviewer may not have been able to probe properly to help them recall the real situation. There were, however, some particular cases in which women reported that they had terrible experiences with a lot of complications and an inability to seek modern care due to financial constraints.

Most of the participants reported that they received care within an hour once they reached to the hospital. Oftentimes, however, they were faced with long queues at the hospital. Overall, they were satisfied with the services and quality of care they received in the hospital. But they complained about the behavior of nurses on most of their visits. They mentioned that they were poorly informed by doctors and nurses about their pregnancy status and their symptoms. They often had few minutes to spend with doctors. They observed that doctors seemed to be rushed most of the time. All this indicates dissatisfaction towards the services and behavior of the health staff in the hospital. Such a negative perception could widen the patient-provider gap, and women may decline to receive pregnancy-related services in health facilities as a result. It is therefore equally important to maintain the respect and dignity of pregnant women as well as to welcome them when they come to receive care.

Rice and Naksook also found similar dissatisfaction among Thai women with the nursing staff's behavior and attitude during their stay in hospitals for delivery in Australia.[20] They argue that even if Thai women give birth in a hospital, many of them still believe in Thai traditional customs surrounding birth. Contradiction of traditional practice with modern maternity care may be the main reason of dissatisfaction with the maternity services they receive from nurses. Thus it might be suggested that a more flexible strategy be adopted and that communication be enhanced so that cultural needs can be met and that women have realistic expectations concerning the hospital environment. Therefore, health professionals should acknowledge women's cultural practices in the period following birth when the women are in hospital.

We also found that some women prefer to have maternity services from TBAs over professional services, even though they know the benefit of and have access to medical assistance. Financial barriers and the traditional belief may be the reason for such practice. Hunt et al. argue that women used TBAs more frequently because they placed greater value on TBAs than on medical services for normal delivery.[21] They view medical services appropriate only for very severe conditions. They believe that TBAs know more techniques and tricks to facilitate smooth delivery than do physicians. TBAs also help them in their home in front of their family. Women can also choose their preferred position rather than a specific one, as they have to be while in the hospital. Doing massage, bathing of women and baby and frequent visits are other reasons for preferring TBAs in maternity care. Programs to promote medical delivery will therefore be more effective if the women are allowed to choose the location and position for delivery, the freedom to have family members present during delivery, and increasing availability of female practitioners rather than focusing primarily on improving knowledge and access to medical services.

CONCLUSION

In summary, we found several positive aspects of the system of maternal health care in Kanchanaburi. Most of the women who participated in the study had appropriate knowledge about obstetric complication and sought appropriate care in time. Quality maternal health care is readily accessible to most of the women. However, there are some issues which need to be addressed in order to improve maternal health, particularly in disadvantaged areas especially in upland areas. Prevalence of early marriage, later marriage, and frequent childbearing seem to be the reason for complications among few women. Similarly, hard work, poor nutrition and traditional practice are other reasons for ill health. Lack of access to health personnel, health facilities, and proper transportation were mentioned as the main constraints for seeking care when complications arose. All these issues seemed to be related to poverty. Those who were unable to seek care for their morbidity were living in villages with poor social and health infrastructure, and such residents frequently cited financial constraints that prevented them from consuming nutritious food and accessing modern services.

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