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MATERNAL HEALTHCARE SEEKING BEHAVIOUR: A LIFE HISTORY APPROACH

Introduction

Cambodia in the early 1990s faced a healthcare system left in ruins after almost three decades of conflict, starting in the late 1960s with the Vietnam War extending into the country, succeeded by civil war and genocide under Khmer Rouge rule from 1970 to 1979. Much of the healthcare infrastructure—facilities, equipment and personnel—was destroyed: there were only an estimated 40 physicians left to meet the needs of the people by 1979 (Payne 2000). The health system's rebuilding began with health sector reform implemented in three phases from 1991-94, 1995-97 to 1998-2000, followed by the Health Sector Strategic Plan in two phases in 2003-07 and 2008-15.

Most maternity care is free for women who meet the eligibility criteria, Battambang province, October 2014

Maternal healthcare was one of the key priorities stated in Phase I and II of the Health Sector Strategic Plan, which set out the government's vision to develop the health sector for the better health and well-being of all Cambodians, especially the poor, women and children, thereby contributing to poverty alleviation and socio-economic development. This action plan was to respond to the high maternal mortality rates across the country, the main causes of which were haemorrhage, infection and hypertensive disorders (Yanakisawa 2004). The key underlying factors contributing to maternal deaths were (1) delay in seeking medical assistance, (2) delay in referring complicated cases, and (3) delay in receiving services (UNFP 2013).

An ethnographic study (Ovesen and Trankell 2010) tells of how prior to French colonisation, Cambodians relied heavily on traditional birth attendants (TBAs) or *chmob* for help during delivery, and this practice still continues today (Yanakisawa, Oum and Wakai 2006; Wang and Hong 2013). Compared with skilled birth attendants such as midwives, doctors and nurses, TBAs generally have no formal training, particularly in averting

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and managing complications during pregnancy and childbirth.

Cambodia has made positive progress in reducing maternal deaths in the last fifteen years. The Cambodia Demographic and Health Survey records a steady decline in maternal mortality ratios per 100,000 live births from 437 in 2000 to 206 in 2010 (NIS 2011). This was determined by several factors, one of which was a change in healthcare seeking behaviour due to improved availability of, and access to, a continuum of essential maternal healthcare services: antenatal care, skilled birth attendance and postnatal care (Wang and Hong 2013).

The shift in healthcare seeking behaviour from reliance on TBAs and home delivery to the use of skilled birth attendants with health facility admission is well documented (see, for example, Yanakisawa, Oum and Wakai 2006; Ir et al. 2008; Wang and Hong 2013). Yet few studies have focused on exploring behavioural pathways and the influence of political ideologies. This article argues that the country's recent history of military conflict and civil war contributed to behavioural change and a shift in choice of childbirth care.

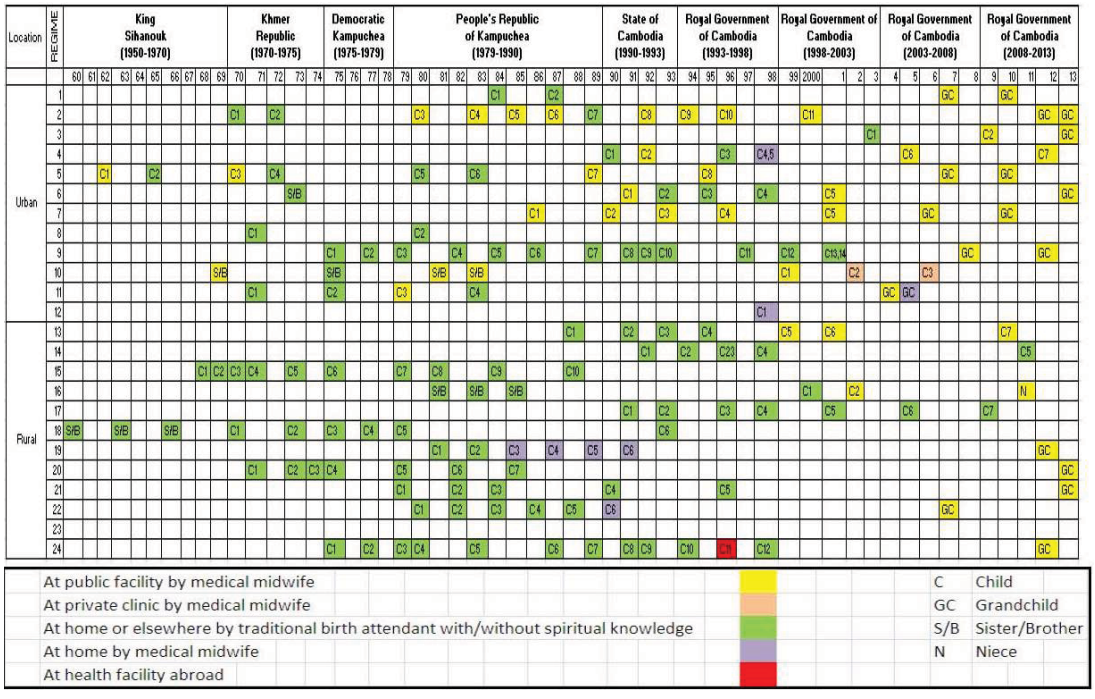
The study explores healthcare seeking behaviour during childbirth in Cambodia from the 1960s to the present, and analyses the factors that influenced decision-making on the use of childbirth services. The findings will inform policymakers about what causes behavioural change and how country factors influence both choices about childbirth services and the development of obstetric care in the country.

Research methods

A life history approach was used to interview 24 participants from Phnom Penh and Takeo province on the delivery services sought for childbirth. Women and men aged 40 or older were selected to take part in the study based on their poverty status as identified by local authorities. Lifelines were drawn to chart birth episodes over participants' lifetimes. Life history with the use of lifelines helps to explain why individuals progress along different life trajectories and to identify pathways of influence on those life trajectories. This method is particularly suitable for health policy research, especially that exploring past learning for informing future practices (Gramling and Carr 2004). For the purpose of this study, these techniques helped to provide a deeper understanding of shifts in choice of childbirth care and what triggered those shifts.

The study used a coding framework to analyse the data collected. During this process, data was coded and grouped into clusters around commonly recurring themes that emerged through the analysis. Then, using colour grids, we constructed path matrices to explore patterns in maternal health seeking behaviour across Cambodia's political regimes from 1960 through to today.

Table 1: Behaviour pathways in childbirth



Findings

This study found that the participants had sought five methods of delivery care: at home with the help of a traditional birth attendant (TBA), at home attended by a medical midwife, at a public health facility, at a private clinic and at a health facility abroad. Life history analysis, depicted in Table 1, suggests that there has been a gradual

shift from TBA-attended homebirths to facility based care. TBAs were relied on consistently before, during and after the war. In the period of post-conflict transition, when the health system was being reconstructed and public health facilities were not yet easily available, demand for medically trained midwives to assist home deliveries became more evident. As road transport became increasingly available, people who lived near the border began to seek better services, particularly for complicated pregnancies, in a neighbouring country. Delivery in public healthcare facilities started to increase as health sector reconstruction picked up pace, while the emerging private clinics offered maternity services for those who could afford the cost.

The 1960s to the mid-1970s

From the 1960s to the mid-1970s, women and families seeking help with childbirth depended on the assistance of TBAs. Few opted to use public health facilities, though those residing in urban areas were more likely to do so. The most frequently cited reason for the common practice of using TBAs was inaccessibility of public health facilities due to a combination of a lack of hospitals, the distance to them and a lack of transport. Some recalled uncertainty about where hospitals were or whether they provided delivery services. Interestingly, even people who lived close to a hospital relied on TBAs; they felt it was safe to use their services if the delivery did not seem complicated, for example, no abnormal bleeding or prolonged labour.

Difficulty accessing public healthcare meant that people had to rely on services available in the community, that is, on TBAs. Traditional practice and the belief in the ability of TBAs to deliver safe childbirth services have been passed from one generation to the next. Participants said the practice of their parents and other villagers set an example for them to follow, thereby affecting their own childbirth choices. The Vietnam War and military tension also explains why people chose home deliveries with TBAs. After the coup d'état by General Lon Nol in 1970, the destabilisation and devastation wrought by American aerial bombing and the civil war with the communist Khmer Rouge forced massive population displacements in some parts of Cambodia. Accessing public healthcare at that time would have been virtually impossible.

Some participants spoke of similarities between maternal care in the 1960s and 1970s and that of today, claiming that a lack of information sharing about where to go for childbirth services is one of the reasons why some people still choose home deliveries with the help of a TBA. Unaware of the risks of homebirth and the importance of hospital birth, people still follow traditional practices.

From 1975 to 1979

TBAs were the only source of delivery assistance during Khmer Rouge rule. No hospital births were reported. The absence of healthcare facilities or childbirth services meant that women and their families had to rely on TBAs. Some participants explained that even access to TBAs became difficult because TBAs were often assigned to work in distant places. Others disclosed that, because they were often moved to work in new places or were worked right up until delivery, they could not find a TBA on time and gave birth unaided.

The 1980s and 1990s

Participants' life histories revealed four patterns of delivery care: at home with TBAs, at home with medical midwives, at a health facility abroad and at a local public health facility. Even so, it seems that people remained highly dependent on TBAs after the fall of Pol Pot to the late 1990s.

The use of TBAs at the time was related to several factors. Participants described the lack or destruction of local health infrastructure. Some mentioned the reopening of public medical centres or hospitals in some districts or provinces in the 1980s, but recounted either the absence of delivery services or the unresponsiveness of the health system due to poor facilities, their inadequate management, insufficient medical supplies and shortage of midwives. In some areas, the absence of delivery services in hospitals continued until the mid-1990s, which was why many of the participants did not consider a hospital birth. Another factor that might explain low healthcare utilisation was a lack of information sharing by local authorities and other stakeholders to improve understanding and raise awareness about the importance of hospital delivery.

Poor security and an inaccessible environment were also cited as affecting people's ability to reach services. Government troops continued to battle the Khmer Rouge until 1998 in some parts of the country. Participants talked about the deployment of Vietnamese forces at the border where the Khmer Rouge fighters stayed, explaining that people dared not travel outside their home villages to access public healthcare services. Landmines were deployed widely and indiscriminately during the war and remained a risk for decades afterwards. Besides causing death, injury and disability, they had many indirect public health consequences, hindering infrastructure improvement and severely limiting access to public hospitals.

Although the services of TBAs continued to be popular, the hiring of independent medical midwives to attend home deliveries began to emerge. Some participants mentioned calling on former midwives who had survived the Pol Pot era to assist them at home while others recalled hiring newly trained midwives in the late 1990s. The use of independent midwives started after people became more aware of delivery risks and wanted reliable services, as access to public healthcare facilities was not always assured.

From the mid-1990s onwards, as economic conditions improved and road transport became more widely available, people living near the border began to seek services in neighbouring countries. This was mainly because they could not rely on local health facilities that did not yet have the capabilities to deal with birth complications.

Increasing utilisation of public healthcare facilities for delivery services was also evident in this period, especially among urban dwellers. This reflected the restructuring of the healthcare system and healthcare delivery that led to the establishment of hospitals, mainly in urban areas. Urban participants reported knowing of more than one hospital in an urban area and the transport available to get to hospital. In addition, military families could have free access to childbirth services at a military hospital.

Individuals appeared more aware of health information in urban areas. Everyday interactions enabled people to share information with their neighbours and friends about delivery care, helping people to understand their needs and consider the options open to them.

Economic factors and household poverty also affected decision-making about childbirth care. While in some areas official user fees in public health facilities were waived for those identified as poor, this was not the case everywhere: some participants reported no hospital charges but others had to pay for treatment. Those who could afford it decided to use a public health facility and those who could not turned to the far cheaper option of a TBA. Participants often reported that TBAs did not request money or that they attended births to help people who lived in the same village or nearby: they were often paid in gifts or in kind based on what people had.

From 2000 to the present

While the behaviour pathway still showed continued use of three types of delivery care (at home with a TBA, at home with a medical midwife and at a public health facility), interviews indicated the emergence of private maternity clinics. Their use was mainly determined by socio-economic status and the demand for higher quality maternity services.

Reliance on TBAs began to decline gradually in this period. From the interviews, it appeared that participants, as well as their relatives and grown up children (see Table 1), who could afford the cost, had switched to using public health facilities while those who could not still called on TBAs. A key factor underlying the increased use of public health services was the quality of maternal health services combined with the availability of adequate equipment, drugs and supplies. Respondents mentioned they switched from TBAs to public hospital for critical conditions or complicated deliveries.

In some areas, the new pro-poor health policy encouraging people to access free healthcare services influenced the decision to use a public health facility. People talked about exemptions and waivers under the health equity fund and community-based health insurance scheme for fees usually charged for delivery services. In other areas, however, despite the ID Poor scheme and subsidised public healthcare for the poor, people were effectively denied access to public health facilities because they could not afford the indirect costs including unofficial fees charged by midwives. Another factor that discouraged people from using public health services was the poor attitude of some healthcare workers towards clients' low socio-economic status.

Heightened awareness about the importance of pregnancy care and concomitant perceptual change, particularly among the younger generation, contributed to the greater use of public health facilities. This perception shift was achieved through information sharing and outreach programmes initiated by the government, NGOs, mass media, community groups and local authorities.

Conclusion

Findings from this study suggest that Cambodians' health behaviours, especially since the late 1990s and early 2000s, have increasingly shifted from relying on traditional birth attendants to seeking modern healthcare services and facilities in both the public and private sector. Three sets of factors that influenced this change in healthcare seeking behaviour stand out: i) development of obstetric care services in both public and private facilities, ii) socio-political aspects such as improved security and accessibility of modern healthcare, and iii) individual attributes such as awareness and household economic conditions.

The life history accounts reveal a pattern of obstetric care development in the country that emerged and disappeared and then re-emerged, shaped by a succession of political regimes and conflict situations, thereby influencing the choice of childbirth services. Before, during and after the war, people appreciated the services of TBAs because they were inexpensive and convenient when modern obstetric care either was not yet available or absent. Traditional health practices and beliefs passed down through the generations started to fade once people learned—through intra- and inter-household health information transfers—about the importance of childbirth at public health facilities. At the same time, obstetric care provision at private and public health facilities or even across the border was developed and expanded geographically, roads were built and transport was increasingly available.

The findings also highlight the emergence of pro-poor health financing schemes to remove financial barriers to poor families in response to health financing reform in the early 2000s. These initiatives had an effect on promoting access to obstetric care at public health facilities, but the performance of those schemes needed to be monitored.

In sum, a detailed history of the adaptation of healthcare seeking behaviour based on actual experiences can be a useful tool to deliver effective interventions across a continuum of healthcare services. Such evidence-based information on childbirth choices can support policymakers in their efforts to deliver life-saving interventions, address the leading and underlying causes—the "three delays"—of maternal mortality, and improve the use and provision of obstetric care in Cambodia.

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